S. HRG. 117–497

Senate Hearings

Before the Committee on Appropriations

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations

Fiscal Year 2022

117*th* CONGRESS, FIRST SESSION

H.R. 4502

DEPARTMENT OF EDUCATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF LABOR
NONDEPARTMENTAL WITNESSES

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations, 2022 (H.R. 4502)

S. HRG. 117–497

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

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

ON

H.R. 4502

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2022, AND FOR OTHER PURPOSES

Department of Education
Department of Health and Human Services
Department of Labor
Nondepartmental Witnesses

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BACK MATTER

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

WEDNESDAY, MAY 19, 2021

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

The subcommittee met at 10 a.m. in room SD–138, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.

Present: Senators Murray, Durbin, Reed, Shaheen, Merkley, Schatz, Baldwin, Murphy, Manchin, Blunt, Shelby, Graham, Moran, Capito, Kennedy, Hyde-Smith, Braun, and Rubio.

REVIEW OF THE FISCAL YEAR 2022 BUDGET BLUEPRINT FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION

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 Centers for Disease Control and Prevention. It is our first subcommittee hearing this Congress, and our first hearing on the CDC's annual funding request since 2014.

Senator Blunt and I look forward to continuing to work with you and our colleagues on both sides of the aisle, to build on the progress we have made previously, and help families in Washington State, Missouri, and across the country.

And I intend to follow the example you set when it came to chairing hearings, Senator Blunt, and making sure that every member has an opportunity to ask a question.

Senator Blunt and I will each have an opening statement. And then I will introduce our witnesses, Director Walensky, and Principal Deputy Director Schuchat. And after the witness' testimony, Senators will each have 5 minutes for a round of questions.

Before we begin, I do want to walk through the COVID–19 safety protocols in place. We are all very grateful to our clerks, and everyone who has worked hard to get this set up and help everyone stay safe and healthy.

Given the new guidance from the Centers for Disease Control and Prevention and the Office of the Attending Physician, I will be working with Senator Blunt, committee members and staff, going forward, to follow the new guidance.

For today, we will be conducting this hearing following similar COVID protocols to what we have used in the past. Committee members are seated at least 6 feet apart. Some Senators are participating by video conference, and 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.

I always say a budget is a reflection of your values and your priorities. And I think Americans can breathe a sigh of relief knowing this budget shows they have a President who values science and public health. COVID–19 has offered a stark reminder of why we must make and maintain robust investments in public health.

Experts at CDC (Centers for Disease Control and Prevention) have been on the frontlines of this crisis from day one, and every day since. We have seen first-hand how critical it is CDC be equipped to effectively collect and analyze data in real time, communicate science-based public health guidance, help communities across the country get tests, and vaccines, and clear, reliable information to people, and address inequities that undermine the health of people of color, people with disabilities, rural communities, and others.

That is why I have pushed for more funding for public health throughout this crisis. The tens of billions of dollars we have provided through six COVID bills so far, are supporting invaluable public health work at every level so we can finally end this pandemic.

It has helped update and modernize data systems needed to track infections, variants, tests, vaccines, and inequities among demographic groups. It has helped fight misinformation and promote simple protective measures that have saved countless lives, like wearing masks and social distancing.

It has helped expand our testing efforts, get vaccines into arms, and build partnerships with trusted voices in hard-to-reach communities. And I was pleased to hear the Biden administration announced last week, it was investing over $7 billion from the American Rescue Plan, through CDC, to create tens of thousands of jobs in public health at the State and local level to fight COVID–19, and to help transition some of those workers to permanent careers as public health professionals.

With new cases and deaths both down over 80 percent from their winter peaks, nearly three in five Americans vaccinated with their first dose, and over a third of Americans fully vaccinated, we can see the light at the end of the tunnel. But even as we get closer to ending this crisis, we know we are not there yet, and we cannot afford to come up short. That is why after years of underinvestment in CDC and attempted cuts to CDC by President Trump, this budget request is such a breath of fresh air.

President Biden's request of $8.7 billion would increase CDC's budget authority by nearly a quarter. I have been pushing for more public health funding for years now. And I am excited to say this would be the largest budget authority increase for CDC in nearly two decades. These investments will help us finish strong when it comes to this pandemic, prepare for the next one, and make progress on other public health challenges.

Investments in CDC, as well as requested increases for the Substance Abuse and Mental Health Services Administration will help address the record number of drug overdose deaths, and the spike in mental health issues, we have seen as a result of this pandemic. COVID–19 has also put a painful spotlight on how racism, sexism, ableism and bigotry hurt so many people in this country.

CDC's recent announcement of a 2-year plan to invest more than $2 billion to work on COVID–19-related health disparities was an important step towards addressing this reality, and the administration's request to dramatically increase the social determinants of health program, Congress established at CDC last year from 3 million to 153 million will help make sure our response to health inequities is truly comprehensive, because there are so many challenges we need to tackle head-on.

For example, Black, American Indian, and Alaska Native women are two to three times more likely to die from pregnancy-related causes than White women. And our overall maternal mortality rate is the worst in a developed country, so I am glad the administration budget request includes $200 million to reduce maternal mortality nationwide, and address disparities, an increase of 140 million.

It also invests in other public health threats that have gone too long with too little attention. It doubles funding for gun violence prevention research, and establishes a new 100 million community-based violence intervention program between CDC and the Department of Justice. And it increases funding for CDC's climate and health program by $100 million dollars.

Of course, the challenges we face are bigger than any one budget. Before this pandemic hit, only half of Americans were served by a comprehensive public health system. Our public health workforce has lost 56,000 people, and State health officials estimated a quarter of their workforce was eligible to retire.

So we have a lot of work ahead, not just to end this pandemic, but to build and maintain a public health system capable of addressing other pressing public health challenges and, of course, preparing for future ones.

That is why earlier this year I reintroduced the Public Health Infrastructure Saves Lives Act, which would finally end the dangerous cycle of crisis and complacency in public health funding by providing dedicated annual investments in public health.

Director Walensky, Principal Deputy Director Schuchat, I look forward to hearing from both of you about how investments like this, and like those put forward in the administration's budget request, can help families and States across the country. And I look forward to working with my colleagues to make the investments we need a reality.

Finally, Dr. Schuchat, I understand you are leaving CDC this summer after 30 years with the agency. And I know I speak for absolutely everyone on this committee, when I say I am grateful, grateful that we have had your expertise and leadership, helping to see our Nation through so many public health challenges. Thank you for your service, from all of us.

And with that, I will turn it over to Senator Blunt for his remarks.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Well, thank you, Chair Murray. This is your first hearing as the Labor, Health and Human Services chair. I certainly look forward to working with you in this role. We have had a lot of success working together in the past 6 years on this subcommittee, and I am sure we can continue with that this year.

I also want to share your welcome to the CDC director and the principal deputy director.

Dr. Schuchat, thanks for your service to our country, and your incredible time at CDC. As I mentioned to you earlier as we were visiting, I am sure there is not a single person who knows as much about CDC as you do. And there may never be a person who knows as much as you do after a 33-year career there, and that long list of things that we have worked together on in the last several years, but a list that goes beyond that.

So Dr. Walensky, Dr. Schuchat, this is really an important opportunity for us to hear about the CDC's budget proposal, and understand more about CDC's priorities for this year. I don't think there has been a year that CDC got more attention than it got in the last year. And so the profile of CDC, the understanding of the importance of CDC I think, is at a high point.

I want to recognize the tireless efforts of the CDC staff, working across the country during the pandemic. It has been a challenging year for all Americans, but particularly for those in public health.

Dr. Walensky, I look forward to hearing your testimony today on the administration's fiscal year 2022 Budget. Unfortunately, your comments will be limited somewhat by the fact that we are really waiting for more information about that budget. But from what we do know from the limited details released last month, there are several areas of alignment where we can work together.

For example, addressing the needs of the hard-hit public health infrastructure, responding to the opioid crisis, which has been exacerbated during the pandemic, along with other mental health and behavioral health challenges, and continuing the Ending the HIV Epidemic Initiative are important to both of us.

These are critical areas that may need even more attention as we emerge from the pandemic and gain an understanding of the full impact, of the health impact, and the behavioral health impact that the pandemic has had.

It also appears that Global Health Security and Preparedness programs will continue as a priority for this administration, as it has been for this subcommittee over the past 6 years. During that time the subcommittee invested heavily in these programs, increasing funding across the department of HHS (Department of Health and Human Services) by 46 percent. Unfortunately, the so-called

"skinny budget" also includes what I believe are excessive areas of increases in areas that are extremely partisan. I hope we can set those issues aside and invest in areas of common ground that benefit all Americans.

As this subcommittee thinks about the priorities for fiscal year 2022, I hope we can spend time learning from the lessons of the pandemic.

In 2020, Congress passed five bipartisan COVID relief bills, total more than $16 billion for CDC. During the infectious disease pandemic, that funding was critical for State and local public health preparedness and response. I think we would all agree that our focus on local public health in this country is not what it was just a few decades ago, and we can do better. Certainly those agencies and State governments, generally, have been critical in the vaccine distribution and planning.

Now, the other point to make is that $16 billion is a lot of funding to absorb. To put it in perspective that is about double your annual budget, or more than $50 million per day for the CDC's response efforts last year.

Pretty hard to spend all of that as effectively as this committee would like, but I think we understood that when we were sending money to CDC to try to respond to a pandemic that was unlike anything we had dealt with before.

We also really need to incorporate the lessons learned from the pandemic, moving forward. It is important we highlight what went right, when communities stepped up, when neighbors helped neighbors, when innovators came forward to provide novel solutions to some of the problems that plagued the pandemic.

Senator Durbin, and I, and seven of our colleagues went out Monday to NIH (National Institutes of Health), and we saw what happened there with testing and other things that, clearly, I think as we look down the road, those are going to be great advantages for us. In Missouri we saw a lot of those unique things happen.

For example, the pandemic brought out innovation with Washington University in St. Louis—Dr. Walensky, where you got one of your degrees—developing their own COVID test, when there was a nationwide shortage of testing, there was a test that was developed at the Washington University campus to be used on that campus.

Other resilience came through, other resourcefulness came through. Throughout Missouri, independent and rural pharmacists would drive 200 miles, some of them, to be sure they had the vaccine that would be available at their location the very next day, literally, going the extra mile, and the University of Missouri developed a cutting-edge technology to track COVID variants through wastewater epidemiology.

So I am proud of Missourians. I am proud of Americans across the country, as we reached out to deal with this. We are clearly not out of the woods yet. We need to continue to understand and learn from the mistakes we made to figure out where we fell short or missed the mark.

Also to understand, frankly, that there were lots of things we know now that we did not know then. And looking back at decisions where you don't have the same information, or anything like

it that we did now is a challenge. We need to figure out what we learned from that, how we could have found out more, earlier. I expect the budget to do just that. I want to work with Senator Murray and others on this committee to do that.

But under your leadership Dr. Walensky, I hope the agency will make the difficult decisions necessary to make great strides toward the enormous opportunity that I think public health has at this moment, for the rest of this century. So thank you for being with us today.

Chair, again, let me say, I look forward to your leadership and the things that we can do together, and I really appreciate where we are now compared to where we were 6 years ago. And I think our partnership was an important part of that.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Thank you, Chair Murray. This is your first hearing as the Labor/HHS Chair and I look forward to working with you in this role. We have had a lot of success the past six years working together on this Subcommittee and I'm sure it will continue this year. I also want to share your welcome to the CDC Director and the Principal Deputy Director.

Dr. Walensky and Dr. Schuchat, this is an important opportunity for us to hear about the CDC's budget proposal and understand more about the CDC's priorities for this year. I also want to recognize the tireless efforts of the CDC staff working across the country during the pandemic. This has been a challenging year for all Americans, but especially those who work in public health.

Dr. Walensky, I look forward to hearing your testimony today on the Administration's fiscal year 2022 budget. Unfortunately, I think your comments will be limited because we are still waiting for the Administration to release their budget. What we do know, from the limited details released last month, is that there are several areas of alignment where we can work together. For example, addressing the needs of the hard hit public health infrastructure; responding to the opioid crisis, which has been exacerbated during the pandemic; and continuing the Ending the HIV Epidemic initiative, are important to both of us. These are critical areas that may need even greater attention as we emerge from the pandemic and gain a better understanding of its full impact on our nation's public health.

It also appears that global health security and preparedness programs will continue as a priority for this Administration, as it was for the Labor/HHS Subcommittee over the past six years. During that time, this Subcommittee invested heavily in these programs, increasing funding across the Department of Health and Human Services by 46 percent.

Unfortunately, the so-called "skinny" budget also includes excessive increases in areas that are extremely partisan. I hope we can set those issues aside and invest in areas of common ground that benefit all Americans.

As this Subcommittee thinks about priorities for fiscal year 2022, I hope we will spend time learning from the lessons of the pandemic. In 2020, Congress passed five bipartisan COVID relief bills, totaling more than $16 billion for the CDC. During a global infectious disease pandemic, that funding was critical for state and local public health preparedness and response; for public health data modernization; and for COVID–19 vaccine distribution.

However, $16 billion is a lot of funding for the CDC to absorb. To put it in perspective, that is about double your annual budget or more than $50 million per day for the CDC's response efforts last year. Our Subcommittee has a responsibility to provide oversight and ensure accountability of that funding for the taxpayers.

We also must incorporate the lessons learned during the pandemic moving forward. But as important, we should highlight what went right. When communities stepped up. When neighbors helped neighbors. And when innovators came forward to provide novel solutions to some of the problems that plagued the pandemic.

And in Missouri, we saw a lot of that.

For example, the pandemic brought out innovation, with Washington University in St. Louis developing their own COVID–19 diagnostic test when there was a nationwide testing shortage.

It brought out resilience and resourcefulness. Throughout Missouri, independent and rural pharmacists will drive 200 miles a day to provide vaccines to vulnerable

and underserved populations. They are literally going the extra mile to ensure communities and rural areas across our state have access to the vaccine.

And it brought out ingenuity. The University of Missouri is developing cutting-edge technology to track COVID variants through wastewater epidemiology.

I am proud of how Missourians, and Americans across the country, stepped up to respond during this crisis.

But, we are not out of the woods yet. We need to continue to understand and learn from the mistakes we made. Figure out where we fell short or missed the mark. And I would expect the CDC's fiscal year 2022 budget to do just that. This is the time to think about a long-term strategy and not continue to jump from one disease outbreak to the next.

The CDC is facing unprecedented challenges, but the agency is also presented with an enormous opportunity to bring public health into the 21st Century. Under your leadership, Dr. Walensky, I hope the agency will make the difficult decisions necessary to make great strides to that end. Thank you for being with us today and I look forward to your testimony.

Thank you.

Senator MURRAY. Thank you, Senator Blunt. And yes, I do look forward to working with you on this as we always have. So I appreciate it.

I want to welcome both of our witnesses again. Thank you for being here.

Dr. Rochelle Walensky is the director of the Centers for Disease Control and Prevention, and the administrator of the Agency for Toxic Substances and Disease Registry.

Dr. Anne Schuchat is the principal deputy director of CDC, and has twice served as acting director of the agency. Welcome to you both.

Dr. Walensky, we will begin with you for your opening remarks.

STATEMENT OF DR. ROCHELLE WALENSKY, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. WALENSKY. Chairman Murray, Ranking Member Blunt, and everyone on the committee, I am grateful for the committee's support of the CDC.

I am here today, as you noted, with Dr. Anne Schuchat, CDC's principal deputy director. I have enormous gratitude for Dr. Schuchat's leadership and contributions over three decades, as well as during this very challenging period during our—for our country, and for her rock-solid support of me in my transition into this role.

Anne embodies selfless public service, the pinnacle of scientific and intellectual standards, and has given her heart to our agency and the public health community. I will be forever grateful that our paths crossed even for such a short period of time.

The COVID–19 pandemic threw the United States and the world into a health, economic, and humanitarian crisis. As the crisis unfolded, it put a spotlight on the fragility of our public health infrastructure. It illuminated great disparities in health outcomes by race and ethnicity; reminding us that—thus far—we have failed to address the systemic racism that results in poorer health for people of color in the United States.

I am committed to working with you, the administration, and our public health partners to ensure that every lesson from this horrible crisis is used to build a better, stronger, healthier America.

I also commit to using our public health expertise and experience in partnership with the global community to move the world into a safer, healthier future. CDC's fiscal year 2022 Discretionary Budget Request of $8.7 billion is an increase of $1.6 billion over fis-

cal year 2021—the largest increase CDC has received in nearly 20 years.

The increase is focused on four critical areas: building public health infrastructure, reducing health disparities, using public health approaches to reduce violence, and defeating diseases and epidemics.

These increases build on the investments made in the COVID–19 supplementals, and are an important first step in addressing deficits in the public health infrastructure. COVID–19 not only exposed the vulnerabilities within the United States public health infrastructure, but also how underlying chronic conditions and lack of access to healthcare, put too many Americans at great risk.

Across the globe we see billions of people without access to vaccines and medical care, which means that SARS-CoV–2, its variants, and other infectious disease threats will continue to threaten us all. Experts had warned for years that a pandemic of this scale was coming, and we must expect additional diseases to emerge.

We need to ask ourselves, are we ready? We must have a strong infrastructure that can identify and detect outbreaks at their source and can take quick action before diseases take hold.

Over the last 12 years, the United States has faced four significant emerging infectious disease threats: the H1N1 influenza pandemic, Ebola, Zika, and COVID–19; we also confronted a drug overdose epidemic with nearly 500,000 people dying from an opioid-related overdose between 1999 and 2019. This increase continued into 2020 and appeared to accelerate during the COVID–19 pandemic.

These experiences show that public health emergencies are here to stay. Each of those threats demanded a rapid and unique response, but none resulted in a sustained public health improvement. Long-term investments in flexible infrastructure will save lives and avert economic losses caused by public health emergencies and chronic public health problems.

The fiscal year 2022 request makes initial investments to continue public health data modernization, build the public health workforce, enhance global health security, and strengthen our immunization infrastructure.

In addition, we are requesting funds to help states and communities be climate-ready and prepare to confront new health risks, such as those associated with vector-borne diseases. The fiscal year 2022 Budget Request also makes specific investments in programs that work to improve health equity, such as maternal mortality review committees. With these new outlined resources in this request, CDC will also significantly expand efforts to address the social determinants of health.

Proposed increases will address public health problems that have been exacerbated by this pandemic, such as opioids, violence, HIV, and sexually-transmitted diseases.

We, at CDC, are grateful for your support and look forward to working together to build a sustainable and resilient public health system that can respond effectively to emerging threats, and meet the public health needs of every American. We will work tirelessly to ensure the health of this Nation and the world.

Thank you. Dr. Schuchat and I look forward to your questions. [The statement follows:]

PREPARED STATEMENT OF ROCHELLE P. WALENSKY, M.D., M.P.H. AND ANNE SCHUCHAT, M.D.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Committee, it is an honor to appear before you today to discuss how investments in the Centers for Disease Control and Prevention (CDC) are protecting American's health, now and in the future. I am grateful for this opportunity to address this committee, as well as for your long-standing and consistent leadership on issues of critical importance to the health of Americans, and the world.

It is my privilege to represent CDC at this hearing. CDC is America's health protection agency. For 75 years, CDC has been trusted to carry out its mission to protect America's safety, health, and security. Even during the unprecedented circumstances of the past year, CDC's scientific expertise, determination, selflessness, and innovation has helped the agency continue to advance its mission. We work 24/7 to prevent illness, save lives, and protect America from threats to our health, safety, and security. Addressing infectious diseases and pandemics, like COVID–19, is central to our mission. CDC's expertise lies in our ability to study emerging pathogens like SARS–CoV–2, to understand how they are transmitted, and to translate that knowledge into timely action to protect the public's health. CDC identifies and mitigates other causes of morbidity and mortality beyond infectious diseases, such as environmental and workplace hazards and intentional and unintentiona l injuries (such as those from falls, violence, or overdose). CDC promotes healthy behaviors, such as exercise and nutrition, to prevent chronic diseases such as diabetes and heart disease, and to prevent outcomes such as stroke. We promote healthy communities by increasing access to nutritious food and safe walking and green space.

By deploying experts on the ground to support our state, Tribal, local, territorial and global partners, we translate science into implementing guidance that protects individua ls, communities, and populations. In our work with other Federal agencies we ensure the safe and appropriate use of medical countermeasures, including vaccines, and collaborate with the academic and private sector to further our understanding of new diseases and problems that affect health.

The COVID–19 pandemic threw the United States and the world into a health, economic, and humanitarian crisis. As the crisis unfolded, it put a spotlight on preexisting weaknesses and gaps that threaten the health of Americans. It brought into stark light the great disparities in health outcomes by race and ethnicity. We must acknowledge the long-standing and too often unstated impact that racism has on public health. The pandemic has also highlighted our frail public health infrastructure, and the way that frailty impacted our ability to respond at thenecessary scale and speed.

Experts had warned for years that a pandemic of this scale was coming. Today, we know to expect additional novel and currently rare diseases to emerge and gain footing as a result of our changing climate, closer interaction with animals, and globalization. Over the last 12 years, the United States has faced four significant emerging infectious disease threats—the H1N1 influenza pandemic, Ebola, Zika, and COVID–19. These experiences show that public health emergencies and, specifically, infectious disease threats, are here to stay. While urgency demanded rapid and unique responses to each of these threats, none resulted in the sustained improvements needed in our nation's public health infrastructure. This lack of robust public health infrastructure continues to present significant challenges in our ongoing fight against COVID–19. In fact, emergencies have resulted in the rapid buildup of infrastructure needed to address the emergency, then dissolution of that infrastructure, often leaving no sustainable infrastructure in place to address the next threat. This lack of robust public health infrastructure continues to present significant challenges in our ongoing fight to tackle COVID–19.

World-wide, billions of people do not and will not have immediate access to COVID–19 vaccines. Cases will continue to increase, and variant COVID–19 strains are likely to emerge, persist, and cause outbreaks. As this becomes more common, our public health system at home and abroad must be ready with highly sophisticated detection and sequencing, combined with a rapid response at the source. The unprecedented investments provided to CDC through COVID–19 supplemental appropriations have helped our efforts to control COVID–19, and will also go a long way toward addressing deficits in the core components of the public health infrastructure that has long been ignored. Our ability to respond to the next public health crisis will depend on whether we invest in a public health system that is highly functional on a day-to-day basis and pivots to meet new threats, rather than

continue our partial defense, which ramps up in response to an urgent and often short-term event.

A resilient public health system can be realized with careful planning that builds on the gains made with COVID–19 emergency supplementals and incorporates lessons learned as a result of this crisis, including reliable, flexible funding. The FY 2022 Discretionary Budget Request for CDC and ATSDR includes a total funding request of $8.7 billion, an increase of $1.6 billion over FY 2021 Enacted. This is the largest increase in budget authority for CDC in nearly two decades and defends Americans' health in four ways: 1) building public health infrastructure, 2) reducing health disparities, 3) using public health approaches to reduce violence, and 4) defeating other diseases and epidemics.

First, building the public health infrastructure. CDC's FY 2022 request prioritizes foundational funding to rebuild the public health infrastructure needed to safeguard the Nation's health and economic security. Drawing on lessons learned, as well as the latest information and technologies, CDC will begin to address long-standing vulnerabilities in the U.S. public health network by training a larger cadre of experts who can deploy and support public health efforts, and building capacity to detect and respond to emerging global biologica l threats.

Public health action is driven by data. Earlier improvements in our systems for collecting information after other public health emergencies, including Ebola and EVALI, facilitated exchange of health information, linking local, state, and federal public health systems with healthcare systems and the public. With investments in public health data modernization in the FYs 2020 and 2021 appropriations and the COVID–19 supplementals, CDC increased the scale and speed of these systems during the COVID–19 response to protect people who are at risk for severe illness (such as older Americans), those with chronic medical conditions, and those from racial and ethnic minorities. These advancements must be applied across the public health system and at all levels of government. The funds requested in FY 2022 will be used to continue building a modern disease surveillance system at CDC, which will catalyze a multi-sectoral, comprehensive, and cohesive approach to documenting evidence, using state-of-the-art technology and analytical tools. CDC will continue working diligently to ensure its research and data are of the highest quality and are disseminated nationally to inform decision-making throughout the public health system, while supporting advances in data systems at all levels.

The COVID–19 pandemic made clear the role that CDC labs and public health labs across the nation play in conducting critical surveillance and responding to outbreaks and emerging threats. CDC and state laboratories were required to flex and surge during peak periods of illness, far beyond routine clinical testing. In FY 2019, CDC was only able to meet 50% of state and local health departments' stated needs for epidemiology and laboratory capacity funding, with personnel support being the biggest unfunded need, followed by equipment and supplies.

The FY 2022 request will foster innovation, collaboration with the clinical system, and a commitment to quality. Improving technologies at the state and local levels would enable public health labs to quickly utilize and scale up essential laboratory analyses. In a post-COVID–19 world, investments to maintain and improve laboratories will help prevent the failures we experienced while trying to address COVID–19.

The U.S. needs a workforce of qualified public health professionals who will prepare for, respond to, and prevent public health crises. Physicians working for states often earn less than$150,000 per year. This is after having taken on medical school debt of $200,000 on average. The FY 2022 request includes an increase to build a diverse and culturally competent workforce who can rapidly develop innovative approaches in surveillance and detection, risk communications, laboratory science, data systems, and disease containment. With this funding, CDC will support critical training programs for public health professionals that develop strategic and systems thinking, data science, communication, and policy evaluation. Existing cooperative agreement mechanisms will be leveraged to support public health jobs that meet current needs and attract new personnel to work in underserved and rural areas.

Addressing gaps in capacity across levels of government to detect and respond to outbreaks while maintaining and surging in other problem areas requires investments to be disease-agnostic and flexible. With FY 2022 funding, CDC will provide support to health departments to meet national quality standards, conduct performance improvement activities, increase communication and collaboration across the public health system, and reshape health departments to meet changing conditions and needs. Funding will help health departments strengthen their abilities to effectively respond to a range of public health threats, such as COVID–19, and build capacities that do not currently exist.

COVID–19 is a sobering reminder that a disease threat anywhere is a disease threat everywhere. Or as stated by WHO: no one is safe unless everyone is safe. We cannot adequately protect American lives and the U.S. economy without addressing global disease threats wherever they may arise. CDC's strategic investments in global health security are critical to U.S. health security by building sustainable global capacity to prevent, detect, and respond to emerging infectious disease threats. CDC works in more than 60 countries on more than 150 projects and is a key implementing agency for the U.S. Government's leadership role in the Global Health Security Agenda. With additional resources requested in FY 2022, CDC will build on existing partnerships with Ministries of Health, public health agencies, infectious disease research institutions, and international organizations to strengthen global laboratory capacity for early disease detection, enhance disease surveillance for accurate data to drive decision making, and foster effective regional and global coordination.

Next, I'd like to talk about reducing health disparities. The disparities seen over the past year among communities of color were not a result of COVID–19. In fact, the pandemic illuminated inequities that have existed for generations and revealed a known, unaddressed, and serious public health threat: racism. The well-being of our entire nation will be compromised as long as we fail to address this.

Racism is not just discrimination against one group based on the color of their skin or their race or ethnicity, but the structural barriers that impact racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they worship and gather in community. The social determinants of health (SDOH)—such as high-quality education, stable and fulfilling employment opportunities, safe and affordable housing, access to healthful foods, commercial tobacco-free policies, and safe green spaces for physical activity—are critical drivers of health inequities in this country. CDC is building the evidence-base for collaborative approaches to SDOH through community accelerator planning and expanding a network of community health workers to develop a sustainable infrastructure to improve health equity. CDC's FY 2022 budget request includes an increase of $150 million to use a social determinants of health approach to improve health equity and health disparities in racial and ethnic minority communities and other disproportionately affected communities around the country.

This budget directly responds to health disparities recorded in our public health data. For example, about 700 women die each year in the U.S. as a result of pregnancy or delivery complications, and American Indian, Alaska Native, and Black women are two to three times more likely to die than White women. Data show that about 2/3 of these deaths may be preventable. Children from lower-income and racial and ethnic minority households experience a disparate, increased risk for lead exposure.

Achieving health equity is central to addressing the HIV epidemic. The U.S. government spends $20 billion per year in direct health expenditures for HIV care and treatment. An estimated 1.2 million persons have HIV and approximately 15% are unaware they have it. With recent advancements in antiretroviral therapy and biomedical advancements in HIV prevention, such as pre-exposure prophylaxis (PrEP), along with effective care and treatment, we have the tools to end the HIV epidemic. An increased investment requested in FY 2022 for the Ending the HIV Epidemic (EHE) initiative will enable CDC to advance the four key strategies needed to end the epidemic in the 57 EHE focus jurisdictions. In addition, CDC will address health equity in the entire HIV prevention portfolio, test innovation in service delivery models to increase access to prevention services, use syndemic approaches to broaden reach to key populations and create efficiencies, and strengthen engagement of grassroots community-based organizations in implementing EHE initiative.

Third, the budget request also addresses the public health epidemic of violence. We know too well how this epidemic permanently alters the lives of its victims and their families and puts enormous strain on our communities and local economies. Increases in CDC's FY 2022 budget request will help address violence through public health approaches, which include improving reporting systems that provide the data needed to understand and address violent deaths and injuries in the United States.

And fourth, we must defeat other diseases and epidemics. Just as racism underlies a number of public health issues, climate issues underlie a number of infectious diseases and have significant health impacts. Climate changes are associated with changes in the geographical range of mosquitos, ticks, and other disease vectors. Climate-related events impact a wide range of health outcomes. Some of the most significant climate-related events—such as heat waves, floods, droughts, and extreme storms—affect everyone. These climate events compromise our access to clean air, clean water, and a reliable food supply. In addition, climate events can

impact the presence of allergens and vectors, like ticks and mosquitoes, and the subsequent health outcomes that can result from these changes in exposures. We know that a changing climate can intensify existing public health threats, and that new health threats will emerge: unequally distributed risks (age, economic resources, location), increased respiratory and cardiovascular disease, injuries and premature deaths related to extreme weather events, changing prevalence and geography of foodborne and waterborne illnesses and other infectious diseases, and threats to mental health as people feel less safe.

CDC works with states, cities, and tribes to apply the best climate science available, predicting health impacts, and preparing public health programs to protect their communities. To do this, CDC developed the Building Resilience Against Climate Effects (BRACE) framework to help communities prepare for the health effects of climate change by anticipating climate impacts, assessing vulnerabilities, projecting disease burden, assessing public health interventions, developing adaptation plans, and evaluating the impact and quality of activities. With the requested increase in FY 2022, we can further expand the Climate and Health Program by providing a larger number of health departments with technical assistance and funding and finding innovative ways to protect health via climate adaptations. As with every other public health threat, we will inform our effort by building and examining systems that collect data on conditions related to climate, including asthma and vector-borne diseases, and coordinate programs and communication that improve health outcomes.

The opioid epidemic has shattered families, claimed lives, and ravaged communities across the Nation—and the COVID–19 pandemic has only deepened this crisis. Addressing the current overdose epidemic remains a priority for CDC. The Administration's strategy brings together surveillance, prevention, treatment, recovery, law enforcement, interdiction, and source-country efforts to address the continuum of challenges facing this country due to drug use. CDC's role is to prevent drug-related harms and overdose deaths.

The additional funding requested in FY 2022 to address the opioid epidemic will enable CDC to provide more funding to all States, Territories, and select cities/counties. CDC will prioritize support to collect and report real-time, robust overdose mortality data and to move from data to action, building upon the work of the Overdose Data to Action (OD2A) program. To do so, CDC will partner with funded jurisdictions to implement surveillance strategies that include contextual information alongside data, as well as increase surveillance capabilities for polysubstance use and emerging substance threats such as stimulants. The additional resources requested will enable CDC to support investments in prevention efforts for people put at highest risk, for example, supporting risk reduction and access to medications for opioid use disorder for people transitioning from alternate residence (jail/prison, treatment facility, homeless shelter). CDC will also address infectious disease consequences, such as viral hepatitis, of the opioid epidemic.

I look forward to working together to address both the immediate challenges ahead in our fight against COVID–19, as well as the weaknesses in the public health infrastructure that left our country vulnerable to this pandemic. We at CDC are grateful for your support. We will continue to work tirelessly to ensure the health of this nation and the world. Together, we can build a sustainable and resilient public health system that can respond effectively to emerging threats and also to ongoing public health needs of every American.

Senator MURRAY. Thank you very much. And we will now begin a round of 5-minute questions of our witnesses. And I do ask my colleagues to keep track of the clock, and if you can stay within those 5 minutes.

Dr. Walensky, COVID has really exposed the importance of having a robust and well-funded public system before a crisis strikes; which is why I said it is so important that we make sustained investments in public health infrastructure and workforce a priority, including in CDC.

Over the last year Congress provided more than $8 billion to support public health data modernization and expand the public health workforce through six COVID supplemental bills. What more needs to be done to sustain our public health infrastructure and our workforce, so we don't lose gains when the funding runs out?

Dr. WALENSKY. Thank you so much, Senator, for that question.

INFRASTRUCTURE AFTER EMERGENCY

You have highlighted that we have had challenges with our public health workforce, indeed. We have 56,000—we are down 56,000 jobs just in the last decade. We need to train and upskill that workforce, in addition to bolster that workforce over the years ahead. We need to keep them trained because the science continues to evolve, we need training in bioinformatics, in genomic epidemiology, and all of that needs to live in our State and localities so that they are well informed and trained over time, not just in creating a workforce, but in keeping them skilled.

We need to do data modernization, as you noted, an initial investment in data modernization. When I spoke early on in my tenure to State and local health officials, I was hearing about faxes of test results for COVID, and then manual data entry of those results, and that those results were not received with racial and ethnic data in them. So we had no way of tracking how we were doing with racial and ethnic diversity across this pandemic.

And then we need to build our public health labs. We don't have—did not have the capacity to do genomic sequencing in all of these labs, we have had to scale that up. And there is many more, and in the infrastructure in the machinery, in the technology that we need to put and deploy, not just at CDC, so we are ready at CDC for this, but also in our public health and localities.

Senator MURRAY. So I am curious; if we had had all that in place before this pandemic, how would have things been different?

Dr. WALENSKY. I think they would have been extraordinarily different. We would have had contact tracers on the ground ready to go. We would have been able to identify cases quickly. We would have been able to see single, single outbreaks than in clusters that we might have been able to pin down to contact trace and not have outbreaks expand. I think we would not have seen the diverse—the racial discrepancy and what happened with this pandemic that——

Senator MURRAY. Because we would have known prior and made more of a focus?

Dr. WALENSKY. Exactly. We would have been able to find it. I think the testing, the inability of our public health systems to be able to conduct these tests in massive scale up, did not allow us to find the disease where it was, certainly, we had not done genomic sequencing until January, we did not know anything about the variants that were circulating here. There are numerable ways that this could have gone better if we had had a more robust public health infrastructure across all of those domains.

Senator MURRAY. Thank you. That is a lot to think about. We should all remember. We have now seen a lot of encouraging progress against COVID over the last several months, and as more people get vaccinated, and case counts, and hospitalization, deaths are falling.

PANDEMIC TRAJECTORY

Dr. Walensky, speak to us about where we are in this fight. How the funds Congress has provided have helped? And what we need to focus on next to bring this crisis to an end?

Dr. WALENSKY. Today, I am cautiously optimistic. We have, in the last several weeks, seen a stark downward trend in cases. The last 2 days we have had case rates that have been less than 20,000 per day. Our case rates now are around 30,000 per day, on average, for the last seven days; death rates, we have been seeing at around 500 a day, still too high, but the lowest we have seen since this pandemic began.

We have over 86 percent of Americans over the age of 65 who have received their first dose of vaccine. And just yesterday—today we have now 60 percent of Americans over the age of 18 having received their first dose of vaccine. I think that we have had extraordinary progress, and we have needed the resources to get here.

Senator MURRAY. So what do we need to focus on next?

Dr. WALENSKY. Certainly, a sustainable public health infrastructure that is not necessarily just tied to one disease, to one outbreak, to one disaster. We need longitudinal money so that we are able to have sustainable infrastructure that is up to date with the times. We need to focus on our racial and ethnic minority groups.

They were previously under-vaccinated. We have made a huge amount of strides just in the last 2 weeks in getting those groups vaccinated. But we need to—and we need to get into the communities. We need to have a public health infrastructure that looks like the communities that they serve, and that serves those communities a lot.

Senator MURRAY. Should we be worried about the variants?

Dr. WALENSKY. I think we would be remiss to say that we are out of the woods. This pandemic, this virus has sent us too many curve balls to say that we—too early to declare victory. Certainly, with the virus circulating in other parts of the world that is in high degree that it gives the opportunity for more variants to emerge, so I still am—it is among the things that keeps me up at night. But right now the variants that we see here and we are doing a lot of sequencing now, demonstrate that our current vaccines are working.

Senator MURRAY. Okay. Thank you very much.

Senator Blunt.

Senator BLUNT. Thank you, Chair.

CHANGES TO MASK GUIDANCE AND REOPENING

Let's talk about the guidance that came out last week on masks for people who have been fully vaccinated. There seems to be some concern about how that would be applied. I listened this morning to the CEO (Chief Executive Officer) at Target, who was on CNBC, and he said that—they had followed all the CDC guidance up till now, which meant until last week people in their stores had a mask on, this week people in their stores don't have a mask on unless they want to have a mask on.

In the Capitol, the attending physician, who has been the person we look to, put out guidance last week that said: on the Capitol grounds you would not need to wear a mask if you were vaccinated, but the Speaker decided that she was going to keep the mask mandate in place for the House until everyone was vaccinated.

What are you seeing there? And what kind of further direction have you been able to give? I know just yesterday the President had his mask on part of the time, largely based, it seemed to me, on what other people around him were comfortable with. But give us some more thoughts on that.

Dr. WALENSKY. Thank you, Senator, for that question. I think the first thing that we should do is celebrate where we are in this pandemic, that we can even be having this conversation, that cases are now down to 19,000 a day, reported this morning. As those cases are coming down, people are longing to understand what this means next.

How do we open up again? How do we take our masks off? With those cases coming down, and now the fact that every American who wants a vaccine has access to one, if you have not texted, text your zipcode to GETVAX (438829), you can find vaccine wherever you are in the country. Five pharmacies will show up so you can get the vaccine.

So we now have cases coming down and access to vaccines for everyone who wants one. Just in the last 2 weeks, we had scientific data emerge in three important areas, (1) that the vaccines are working in the public the way they worked in the clinical trials. That doesn't always happen, but it happened here. And we had one of the largest studies published on Friday in the MMWR (Morbidity and Mortality Weekly Report).

(2) That the vaccines are working against the variants we have here circulating in the United States. There have been data, neutralizing data that demonstrates against B.1.1.7, against B.1.351. These vaccines are working.

And (3), something that was not studied in the clinical trials is, can you—if you were to get infection with SARS–CoV–2 and were vaccinated, could you give it to somebody else? Were you silently able to spread it? Those data were not covered in the clinical trials, but now data have emerged again, that have demonstrated, even if you were to get infected during post-vaccination, that you cannot give it to anyone else.

Senator BLUNT. Yes.

Dr. WALENSKY. So that scientific data was enough for us to move forward. People had said we moved too slowly, people have said we have moved too fast, we moved at the speed that the science gave us.

Senator BLUNT. Well, I think that is right. I do think on the last topic if we—not evaluating, whether we could have made that decision quicker. But I do think that decision that you don't have to wear a mask once you have been fully vaccinated, will encourage people to get vaccinated. I think the fact that that is out there is good. I hope we got it out there as quick as you were comfortable having it out there.

RACIAL DISPARITIES

On your comments about racial health disparities which, of course, I am not for racial health disparities, and more than happy to look at that; what about the other obvious health disparities, like how low income, health disparities regardless of race, or rural health disparities? Are we just going to focus on racial health dis-

parities, and leave those others behind? Or why were those the disparities you specifically mentioned in your comments?

Dr. WALENSKY. We have seen a lot of data on racial health disparities in this pandemic. But, Senator, you are absolutely right. Twenty percent of Americans live in rural areas. As we talk about social determinants of health, this is not just racial—on racial lines, this is urban and rural.

We just, yesterday, had an MMWR come out that demonstrated that rural Americans were getting vaccinated around 39 percent, while non-rural counties were at 46 percent. So we are intent, and our values are going to be, to have public health reach all areas, all Americans.

Senator BLUNT. I am glad to hear that. My last question here before I run out of time would be on drug overdose deaths. You know, we saw this committee work really hard on this topic for about four straight years, and we felt we were making some real progress. And I think we were, the numbers were going down every year, but in 2020 we had the highest number to date of drug overdose deaths. Just comment briefly on that before my time is up here.

Dr. WALENSKY. It is tragic. Before being here, I was an infectious disease doc on the wards at Mass General, and while we were talking about deaths, the people on the wards were also talking about chronic infections, endocarditis, epidural abscesses, leaving young people paralyzed.

So we were making some progress, and this pandemic hindered that progress. And we, again, need to address this issue.

Senator BLUNT. Thank you.

Senator MURRAY. Thank you.

Senator Durbin.

Senator DURBIN. Thank you, Madam Chairman.

And Dr. Schuchat, let me join the chorus. Thank you for 33 years of remarkable service. I have a question for you in a minute, but I wanted to start with a little different approach.

LESSONS LEARNED

And let me say that I think this pandemic has not broken us, but it has taught us where our system is broken, and there are many areas we need to look at seriously. If you take a look at the public health scorecard and try to find an objective measure, the one that I return to frequently is the fact that the United States has less than 5 percent—has less than 5 percent of the world's population, yet 20 percent of the COVID–19 infections and deaths. And that tells us we can improve dramatically.

Where did we shine in this effort? Certainly vaccines, the quick response as we learned again this week, and the visit to the NIH, was because we were prepared, and we had the science ready, and we had good fortune in identifying the culprit, and in devising an effective strategy to go after it with vaccines.

I would also add that the Warp Speed program appears to have dedicated and invested funds in a dramatic way at a time when it was very important. And I think that accelerated the availability of the mass vaccines, and I give the Biden administration credit for administering them, and distributing. So those are the positive sides.

But one of the messages learned, that I learned out at NIH, was now let's get honest about this. We not only have to bring this pandemic to an end, we have to prepare for the next pandemic, which may be 5 years away or 15 years away. We don't know. But history tells us there will be another one. And the question is: will we be ready for it?

The CDC is going to play a critical role in this. And the first question I have to ask is to Dr. Schuchat. After 33 years of observing this agency and its role in the American scene when it comes to public health, there is a fear that it has been politicized in the last 4 years, or maybe even before. That now public health issues are so political, with the division on whether to get a vaccine, or a vaccination or not, seems to break out on party lines and political lines. We have reached a new stage.

What is your thinking? And having observed and worked with the CDC all these years, about this politicization—if that is the word—of public health?

Dr. SCHUCHAT. Thank you so much for your comments and your question. The viruses don't vote, and the pandemic has really told us that everyone is vulnerable, everyone in America, and everyone around the world. And CDC is a science-based agency, and we lead from science. We are data-driven, and we work together with State and local partners who reflect the values of their communities. So I think that focusing on the science and the service mission of the agency is what we need to do.

Senator DURBIN. Have you noticed any change, recent change in terms of the political image of CDC, which tries to be apolitical?

Dr. SCHUCHAT. You know, this pandemic has been so difficult for—you know, for the Nation, I think for all of us in public health, and certainly for our colleagues around the world. The messaging has really been difficult, you know, very conflicting messages that left Americans confused.

And so I think we are committed to clear, honest communication of what we know, and what we don't know, and what we recommend people do. So I do think the messaging environment during this pandemic has been really tough.

Senator DURBIN. I would agree with that.

GUN VIOLENCE

Dr. Walensky, I am worried about gun violence. I believe it is a public health issue because I represent the State of Illinois and the City of Chicago. And we have the equivalent of a mass shooting every weekend in Chicago. It is a disaster in terms of its impact on the lives of many people, and the life of the city.

You have a proposal to make a-hundred-million-dollar investment through the CDC, in community-based violence intervention, working with neighborhood organizations and hospitals to deliver services. I recommend to you a program, which we started in Chicago called the HEAL Initiative. I will send you some information on it. But I would like for you to say a few words about what you anticipate that $100 million is going to be used for.

Dr. WALENSKY. Thank you, Senator. Our intent here is to look for areas in high-violence cities, where we can accumulate data, we can get accurate information, where we have actionable interven-

tions to prevent all areas of violence, community violence, domestic violence, suicide, to increase public health using those resources in areas that have been highly impacted. We want actionable interventions for prevention.

Senator DURBIN. Thank you.

CHILD MENTAL HEALTH

Madam Chair, I would just say in closing, you are in a unique position being on the Authorizing and Appropriating Committee, but one element I hope we don't overlook, and I know you feel sensitive to this as I do, is the need in schools to have access to counselors, mental health counselors, and maybe traditional school nurses, so that any public health effort, which should focus first on our children, has the wherewithal to do that effectively. I find that we have allowed that to lapse in many areas of my State.

Senator MURRAY. Thank you, Senator Durbin.

Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Chairwoman Murray, and Ranking Member Blunt for having this hearing. And I certainly appreciate the speakers that are here today.

And Dr. Walensky, I appreciate being able to visit with you last week to discuss your work as director at the CDC. I thought we had a very good conversation, I certainly admire the work that you have done.

And Dr. Schuchat, I certainly admire the work that you have done over the past many years.

RURAL HEALTH DISPARITIES

I will be brief with my questions, but one thing that I am really concerned about is rural healthcare. I had the opportunity this past Saturday morning to visit with David Ready. He is a pharmacist in a town in Mississippi, Monticello, Mississippi; that has less than 1,500 people, and the concerns that he has about them being able to get their medicines. The reimbursements they get, because they are so small, they don't buy in bulk.

So those are things that I am sure that we will be having other conversations about. But the COVID–19 pandemic has highlighted numerous aspects, obviously, of our healthcare system that need improvements. One of them that we all recognize is the disparities of Americans living in rural health areas.

Addressing health infrastructure in rural areas is a serious concern, and as I said, one of my top priorities, and while the CDC has undertaken efforts to address that, there is no entity within the CDC tasked specifically with this work. And that is concerning to me.

I believe establishing a new Office of Rural Health within the Center of Disease Control would be an important way to support rural communities through the end of this pandemic, and to prepare for any other future public health crises that we could be faced with.

And, you know, I just envision this office to be empowered to look across CDC programs, to ensure the work of the agency is properly addressing the health needs of the 57 million Americans who live in rural communities.

Director Walensky, how strongly do you support establishing an official Office of Rural Health within the CDC? And how can we work together to get this done, if you see that the way that I see this?

Dr. WALENSKY. Thank you, Senator. As you noted, we have 20 percent of Americans, 57 million Americans living in rural areas. Part of the deep need for investment in a public health infrastructure is to develop a workforce that looks like the community, that is from these communities, that knows how to access and reach these communities, which is exactly one of the challenges that has that has occurred during this pandemic. And one of the reasons we had a differential distribution of vaccines between rural and non-rural communities.

We also know that there are other issues, outside of COVID, where we have learned from COVID, such as telehealth. We had a previous MMWR that demonstrated, ironically, that telehealth was not reaching rural communities. And that is, in fact, one of the areas that we should be using telehealth. So why was it not reaching their rural communities? CDC is investigating this just by virtue of the fact that they have had several MMWRs in the last 2 weeks examining these issues.

So as part of the public health infrastructure and the disease agnostic infrastructure that works on labs, that works on workforce that works on data; we are invested in urban communities as well as rural communities.

FUNDING FLEXIBILITY

Senator HYDE-SMITH. And I think a lot of that is broadband issues as well, that we have to get addressed. But I understand the CDC has a highly categorical manner for providing funding to State health departments, with most funding tightly tied to specific diseases, or specific purposes. And I am concerned that restricting CDC money to specified activities prevents States from being able to address issues that vary from State to State, because all of them are different, and it makes it difficult to respond efficiently to emerging challenges like COVID–19.

And I have always been big on flexibility because the States really know where their needs are, and I believe greater flexibility on funding might allow States to better target resources. So I just wanted to mention that to you, of the need for flexibility there, that we sure saw that our hands were tied in some cases during COVID. So I just wanted to address that with you.

Dr. WALENSKY. I would just echo your thoughts and say, yes. That one of the things that has been challenging for us at CDC is the line items that have to go to X or Y, when in fact what we need is the infrastructure, the disease agnostic infrastructure, so that when we see community—this community needs this, but they may both need to establish a lab, but one needs broadband and the other needs a genomic sequencer that we—it is flexible enough to be able to make sure that each of the communities can scale up for what they need. Absolutely.

Senator HYDE-SMITH. Thank you. That is very encouraging. Thank you.

Dr. WALENSKY. Thank you.

Senator MURRAY. Senator Reed.

Senator REED. Well, thank you, Madam Chairwoman; and thank you Director for your extraordinary work.

317 IMMUNIZATION PROGRAM

I have been now working and trying to bolster the Section 317 Immunization Program for many years. And as we recognize this year, because of the pandemic, there has been significant increases in vaccination funding going out, and building an infrastructure. But I don't want to take our eyes off the long-term need for Section 317 programs to sustain improvements that have been made in terms of routine immunization, which must be given.

And so will the CDC be requesting an increase in funding for the 317 Program this year, Madam Director?

Dr. WALENSKY. I am going to let Dr. Anne Schuchat take that question.

Dr. SCHUCHAT. I want to thank you for your long-time support for the immunization needs of the Nation, and the incredible progress we have been able to make, particularly among children. COVID, the pandemic, has really highlighted that we are not where we needed to be with adults. And that was part of the slow start that we had in terms of getting—you know, having the scale up of vaccination.

So there is a lot more work to do to catch up for the vaccines that were not given during the pandemic, in children, and to strengthen our infrastructure for adults going forward. And so that work is part of the priorities for the agency.

Senator REED. Thank you very much.

SUICIDE PREVENTION

Dr. Walensky, this is not the first time I think this thought has been bridged, but the suicide epidemic has been startling across the country related to the pandemic, and perhaps related to other factors, and CDC has released some startling statistics recently about suicide. And I know that the CDC has launched some new suicide prevention efforts over the last couple of years, and let me you to continue to do that. But I understand only a handful of grant applications were able to be funded. And one of those that were not funded was from my State, but we were not alone. And what are you intending to do with respect to the overall suicide epidemic and also the more robust funding for prevention?

Dr. WALENSKY. Thank you, Senator. This is such a challenging area it was—we had scale-up of mental health challenges before the pandemic, right? So these were issues that we really needed to tackle before the pandemic. And we saw during the pandemic that these have only gotten worse, among our youth, among our middle aged, we have seen challenges even since the pandemic began.

So part of our resources that we are requesting are to scale up these efforts. Again, we need surveillance data. We need to understand how much this is a challenge. How many people are presenting to the emergency room. We need toolkits to deliver to States, to physicians, organizations, so that they can—they are empowered as to how to prevent it. And then we need actionable im-

plementation that we can do for prevention in areas of mental health.

LEAD POISONING PREVENTION

Senator REED. Thank you. One final topic is lead exposure, which I have been working on through my responsibilities on the Banking Committee, and also the Appropriations Subcommittee on Housing and Urban Development, over the last year rates of screening for lead poisoning have decreased, obviously, as you know, movement and these types of activities have been curtailed. And then I think the statistics, although it would probably be very dubious coming out of the last year because of all these other factors, but it is a continuing problem.

And right now the CDC's Lead Poisoning Prevention Program is at a high mark of $39 million. But we know more funding is needed, and we also know that this initiative disproportionately impacts lower-income communities because of the housing circumstances, generally.

And I would hope that the President's CDC budget will prioritize this work, keep increasing funding and focus. I would note, he is going after the lead pipes, which I applaud. But in many respects, particularly in older communities like mine, the issue is not lead pipes, it is housing and lead paint, and it is a whole series of issues.

Dr. WALENSKY. Thank you. I think this raises a very similar point, as was previously raised by Senator Hyde-Smith, that each community needs individual things to improve the health of their community, which is why the public infrastructure flexibility, the funding to be able to get the resources that you need in individual communities.

One will be—you know, we need resources for broadband, but one will be, we need resources for lead. And as you note we, again, had an MMWR that demonstrated exactly what you said. Screening for lead this past year has gone down. We know we have missed lead toxicity that we really need to make up for.

Senator REED. Thank you very much.

Thank you, Madam Chairwoman.

Senator MURRAY. Thank you.

Senator Moran.

Senator Kennedy.

Senator KENNEDY. Thank you. Madam Chair.

Madam Director, thank you for being here today; I know how busy you are. I have been in my office listening to some of the testimony of both of you. And I am a little uncertain about some of the answers, which is probably a shortcoming on my part.

MASK GUIDANCE

Madam Director, could you, in one minute, summarize for me what the recommendations are today from your agency about wearing masks?

Dr. WALENSKY. Absolutely. First of all, can I just say, thank you for your YouTube video, for promoting vaccines, which I just adored.

Senator KENNEDY. Did you like my singing?

Dr. WALENSKY. Yes, I did. Thank you very much for doing that.
Senator KENNEDY. You are under oath, now, madam.
[Laughter.]
Dr. WALENSKY. Yes, I did—even so, I did.
Senator KENNEDY. Thank you for that.
Dr. WALENSKY. Last Thursday, we released guidance that demonstrated for an individual who is able—who is fully vaccinated and not immunocompromised, that they are able to safely unmask with the exceptions—certain exceptions, of course, in travel corridors, healthcare settings, that if you are an individual you can safely unmask if you are fully vaccinated.
Senator KENNEDY. Inside and outside?
Dr. WALENSKY. Inside and outside.
Senator KENNEDY. Okay. What role do the State regulations play with respect to that?
Dr. WALENSKY. We are working now to update all areas of guidance, but here is what is really, I think, important to understand. We are not a homogeneous United States. We have counties that have less than 20 percent vaccinated.
Senator KENNEDY. Yes, ma'am. But I don't want to get too off, off the question here. If I walk over to the House of Representatives, do I have to wear a mask?
Dr. WALENSKY. Those are locally-driven policies, but we felt that it was important for the science to—for us to convey the science of what is safe for individuals.
Senator KENNEDY. Well, I am trying to understand the CDC recommendations, and I appreciate it. Based on the CDC recommendations, if I walk over to the House, are you recommending I wear a mask?
Dr. WALENSKY. If you are—if you are by yourself walking over to the House and you are fully vaccinated?
Senator KENNEDY. No, ma'am. Once I am over there. I am vaccinated. Once I am over there and I am talking to some of my colleagues?
Dr. WALENSKY. We have really encouraged that the policies of mask-wearing be locally driven. And the reason for that is because every community, every county, has different rates of disease and different rates of vaccination. And that is really what——
Senator KENNEDY. What is different about the House? Do you know?
Dr. WALENSKY. I don't actively—I don't know the rate of vaccination around the Capitol, nor the rate of disease around the Capitol off the top of my head.
Senator KENNEDY. Okay. What about airplanes?
Dr. WALENSKY. What is the policy on airplanes? Currently, the policy on airplanes is to wear a mask.
Senator KENNEDY. Okay. And why is it different on an airplane as opposed to a restaurant?
Dr. WALENSKY. So the CDC provides guidance for what is safe to do. The Federal policy is obviously an interagency policy that we need to look at across different agencies. What I will say though, is that there is very little choice when you board an airplane as to——
Senator KENNEDY. Right.

Dr. WALENSKY [continuing]. Who is going to be sitting next to you, who is around you. And also, airplanes may be a place where we have more variants, because of the travel from international places.

VIRUS ORIGINS

Senator KENNEDY. Okay; last question. What, in your opinion, was the origin of the virus?

Dr. WALENSKY. This has been studied by the WHO——

Senator KENNEDY. Ma'am, I am asking your opinion.

Dr. WALENSKY. I don't believe I have seen enough data, individual data, for me to be able to comment on that.

Senator KENNEDY. What are the possibilities?

Dr. WALENSKY. Certainly, the possibility is that most coronaviruses that we know of are of origin from—that have infected the population, SARS-CoV–1, MERS, generally come from an animal origin, and——

Senator KENNEDY. Are there any other possibilities?

Dr. WALENSKY. Certainly, a lab-based origin is one possibility.

Senator KENNEDY. Okay. Is the United States funding gain-of-function research?

Dr. WALENSKY. Not to my knowledge.

Senator KENNEDY. Okay. Can you give an answer to that for me, and let us know, let the committee know?

Dr. WALENSKY. Dr. Fauci would be the one who knows best, and he testified last week——

Senator KENNEDY. Dr. Fauci seems confused. I am asking—with all due respect—I am asking you to get us that information. Where throughout the world, including, but not limited to the United States of America, are we doing research on these viruses to make them contagious in order to study them? That is what I mean by gain-of-function.

Dr. WALENSKY. I understand. I understand. We certainly can have our staff look into this. I don't know that we have access to labs across the world, just the ones that are funded here in the U.S.

Senator KENNEDY. Yes. But you are the Head of the CDC. I bet if you—I bet that you get your phone calls returned.

Dr. WALENSKY. Okay.

Senator KENNEDY. Would you get us that information?

Dr. WALENSKY. I would be happy to give you the information to the best of my ability.

Senator KENNEDY. Okay. And I am going to do long—a complete album of my singing. I will send you—I will send you a courtesy——

Dr. WALENSKY. Would you sign that, please?

Senator KENNEDY. Sure. Thank you. Thank you, both, for being here.

Thank you, Madam Chair.

Senator MURRAY. Senator Baldwin.

Senator BALDWIN. Thank you. Madam Chair.

MASKS IN WORKPLACES

I want to pursue a similar line of questioning that we just heard from Senator Kennedy, with regard to masking guidance. And when I reflect from the period of time when the pandemic was first identified, the Department of Labor and the agency charged with occupational safety and health, did not issue any sort of emergency temporary standard with regard to workplaces relating to this pandemic.

And, frankly, while there has been much work done on that in this new administration, we don't have one yet, and so I am just delighted by the progress we are seeing. Generally, I see that light at the end of the tunnel, getting brighter, and brighter, and brighter, and certainly the CDC's updated mask guidance for those who are vaccinated is a reflection of that progress.

But I am concerned about the impact of this guidance on workers, and particularly those who work in crowded conditions, such as meat-packing facilities, where we have seen horrendous outbreaks in the past year.

So, Dr. Walensky, I am wondering when we can expect perhaps more detailed guidance for workplaces, such as meat-packing plants, and other crowded facilities where there is going to be a mix of vaccinated and unvaccinated workers? And how that is going to interact with the very recent CDC guidance on mask use for those who are vaccinated? What should workplaces be doing right now?

Dr. WALENSKY. Thank you so much, Senator Baldwin. The meat-packing situation was really, really difficult, so many, people affected and lives lost. And a real challenge for the Nation to react to that.

Updating guidance for workplaces, including the higher-risk ones is a high priority for us that we are actively working on. As you know, the initial individual guidance came out last week, but updating guidance for particular settings is critical. Our National Institute of Occupational Safety and Health is working closely with OSHA around getting the best science to the Department of Labor who has regulatory authority, but we are at CDC, updating our guidance for the particular settings in light of the newer science.

Senator BALDWIN. I appreciate that.

PUBLIC HEALTH COMMUNICATION

I want to ask a question of you, Dr. Schuchat, about the importance of communication in public health. Early in the pandemic, again, we had to get out a lot of information on what COVID–19 is, how it is spread, what precautions people can take. And, likewise, now we are in the vaccination phase, and we have to communicate about its safety, efficacy, availability, et cetera.

Last year, I wrote the CDC requesting that they provide information on the spread of COVID–19 in Hmong language. The CDC later updated their material, which was extremely helpful for Wisconsin's vibrant Hmong community. But we also need to make sure that we are doing exactly the same to make information on the COVID–19 vaccine accessible and available for all communities.

So, Dr. Schuchat, how is the CDC using what it learned from sharing information about the spread of COVID–19 to communicate the importance of getting vaccinated, to those who have limited English proficiency? And will the CDC be making information on the COVID–19 vaccine, and how to get vaccinated available in more languages?

Dr. SCHUCHAT. Yes. Thank you so much for that set of questions. I think that communication has never been more important, nor more difficult than the past year, and reaching people with limited English proficiency has been really important.

We have a toolkit available in 34 languages, and our vaccine information, including our V-safe, the little app that helps people follow side effects after getting vaccinated, is available in multiple languages. But it is not just what we say, it is how we say it, and who says it; and so one of our strategies is working through trusted messengers and partners of the community, from the community, who work with groups day in and day out, and so part of our strategy is funding of jurisdictions for them to have community-based groups really get that message out in ways that are accessible.

These are really important issues, as we know. You know, back to the meat-packing outbreaks, we had people speaking multiple languages in very close quarters at risk for spread, but also not necessarily knowing who they could trust in what they should do. So we clearly want to get the vaccine information to them.

Another thing I would mention is the partnership that CDC and the administration has had with HRSA (Health Resources and Services Administration), around the federally-qualified health programs, because they have—the federally-qualified health centers have a real concentration of patients served with limited English proficiency, in both mobile clinics for vaccination, and through community clinicians—community vaccination sites. They have been able to reach those groups.

Senator BALDWIN. And Senator, if I am might add, just real briefly. One of the things that would be really helpful for us, is working with those industries to encourage employers to get their employees vaccinated, that time off, paid time off, to ensure that they—when they returned to work they are vaccinated.

Senator MURRAY. Thank you, Senator.

Senator Braun.

Senator BRAUN. Thank you, Madam Chair.

MASK GUIDANCE FOR VACCINATED INDIVIDUALS

Dr. Walensky, I am glad that the recent ruling was made that if you are vaccinated, you don't need to wear a mask. I think it was getting very confusing for not only getting more people vaccinated because they were saying, well, why should I get vaccinated if I still have to wear a mask? So thank you for that.

But I do have a question. I know that on March 29, the President was criticizing some governors about removing mask mandates. And of course that now has changed. And I think the reason is what I have just said. But what about, since the science now, and the guidance is clear, what about local mayors and governors that are not following the science, when that has kind of been ballyhooed as the thing to do. I believed in that from the get-go as

well, especially when the tools were very uncertain, distancing and all that stuff, made sense. And I thought you were silly not to abide by it.

What about now? For the places that are—I think there is a liberation feeling out there, and thank goodness for the Warp Speed, and getting the vaccines in the arms. Is this unnecessary for governors and mayors across the country to still keep a mask mandate in place?

Dr. WALENSKY. Thank you for that question, Senator. We released guidance on Thursday that said for individuals, if you are vaccinated, fully vaccinated, you can take off your mask with several exceptions. One of the things I think that is really key in this is to recognize that we are not a homogeneous country.

That there are some areas that—some counties that still have less than 20 percent of people vaccinated. There are some counties that still have greater than a hundred cases per hundred thousand in a seven-day period of time. And so I actually think, as I look at the map, a very heterogeneous map of how we are doing with cases, how we are doing with vaccinations, the decisions about whether to take off a mask mandate will have to be made at the local level, have to be made at the community level.

There are still some communities who are suffering. We know African-Americans lost 2.9 years of life compared to White Americans losing 0.8 years of life. And they are probably the communities that got access to vaccines last. We are working on that. We have had extraordinary improvements in our access to—in our racial and ethnic minorities having access to vaccines. But I do think that these need to be made at the local and community level for exactly that reason.

Senator BRAUN. Do you think it will be confusing though, even for those places that have lagged in getting their citizens vaccinated to see that there is not that incentive in place, even in the places that have been slower to do it, that would be an encouragement. If they see people without a mask and they say, well, they are vaccinated. I want to get one.

Dr. WALENSKY. I think it would be really amazing if our new guidance got more people vaccinated, and was an incentive for more people to get vaccinated. But I don't make CDC guidance, my whole agency does not make CDC guidance based on what it will help people do. We have to do it based on the disease that is out there, the access to vaccines, and based on the science that has emerged.

I really am hopeful that that will help to incentivize people to get vaccinated, but that was not the reason for our guidance.

COVID IN INDIA

Senator BRAUN. Okay. Another subject, since we are kind of at least ebbing into a situation, it looks like here in the U.S., other countries, some places it is still running rampant like India. When do we turn the focus? And I think we have been lucky that vaccinations have come this quickly, but therapeutics would seem to be that final defense for anyone that did not have a vaccination available. And now for the few cases that could still slip through the cracks to where it is impacted with so much data, such a small por-

tion of the population, disproportionately, and horrifically, elderly predisposed with other conditions.

COVID THERAPEUTICS

When do we start turning our attention to helping them once they get it? Because we are going to still have cases, depending on variants, how strong they are, to where the emphasis goes to therapeutics, and not vaccinations, especially for places where the vaccine is generally working, but you still want to have tools to help those who get it?

Dr. WALENSKY. Absolutely. And I know—first of all, I think we are—you know, we are working now, we have said, if anyone is not safe, then no one is safe. We really do need to make sure that we have resources to other places, if variants emerge they will come to our shores. So we have to be able to do that.

I also know that NIH has invested in making sure that we have therapeutics. One of the first things that we had when I was rounding on the wards last May, was Remdesivir. And that was the first sign of an antiviral.

We don't have anything really that we can give quickly over the—you know, by prescription to outpatients. Right now we are relying on monoclonal antibodies. They are hard, they are clumsy, they take a lot of resources, and they are expensive. And so I do believe that we need, in this next phase, after we get the majority of Americans vaccinated, we do need to turn to antivirals that are able to be easily administered in an outpatient setting.

Senator BRAUN. And a final comment. I think that is going to be important because we don't know how much variants will become an issue. And at some point when we have generally tamped it down, I think it is incumbent on us to put focus on how to help those that end up getting it, especially that are so predisposed with bad outcomes. Thank you.

Dr. WALENSKY. Thank you.

Senator MURRAY. Thank you.

Senator Manchin.

Senator MANCHIN. Okay. Thank you, Madam Chairwoman. Appreciate it very much. And I want to thank all of you for being here.

Dr. Schuchat, first of all, thank you for your service, many, many years of service. And I appreciate very much, what you have done. And my first question would go to you because you probably have the historical knowledge of how we got to where we are.

VULNERABLE PUBLIC HEALTH SYSTEM

Over the last decade, the United States has lost over 50,000 public health jobs. And during that time we have faced the H1N1 flu outbreak, Ebola, Zika, and now COVID, within the last 5 years alone, West Virginia has lost nearly 30 percent of our public health workforce. One thing we know from this pandemic is that we were not prepared. While we have been able to hire temporary public health workers in the last year, as these positions they were not permanent, and are at risk of disappearing after the public emergency, health emergency is over.

So can you speak to how we became so vulnerable and fell behind the curve in our ability to respond to this pandemic, and how can we keep it from not happening again? I know you have all touched on it, but I just cannot believe we were this—we were this unprepared.

Dr. SCHUCHAT. Yes. I think the state of our preparedness was a real tragedy. And part of that relates to the public health infrastructure over and over, we invest in response to a crisis, but in ways that haven't provided sustainable capacity at that frontline where the problems happen, so——

Senator MANCHIN. But these decisions made higher up within, whoever the administration may have been, whether they were Republican or Democrat. Was it made at that level? Or was it made at the Head of the CDC?

Dr. SCHUCHAT. The biggest funding increases we have gotten have been emergency funds from Congress that, you know, happily supported response for H1N1, and Ebola, and Zika, and COVID. But the dollars that were there day in and day out to provide reliable jobs for the local public health workforce were not there. And whether it was State budgets or Federal budgets that, you know, you cited the statistics of the job loss.

Beyond that, the jobs were not the same anymore. You know, we talked about the data. Our data systems have really not kept up with the times. We have very fragmented data systems that have not been modernized.

Senator MANCHIN. And my time—my time is limited, and I want to ask Dr. Walensky this question.

But on this Dr. Schuchat, what type of time basis would you say that we should be looking at for funding? I mean, to have confidence in the funding, permanent funding, over what, a 5-year, a 10-year period? So it is consistent you know what you can do and be prepared?

Dr. SCHUCHAT. You know, I think the approach that was taken for NIH to strengthen their capacity for vital biomedical research is what needs to happen for the vital public health infrastructure in the country, where it is not a feast and famine.

Senator MANCHIN. Sure.

Dr. SCHUCHAT. But that local, State, and Federals can plan.

Senator MANCHIN. And now will be the time to do it. If we are ever going to do it, we should do it now, since it is all very fresh in what we have been able to endure.

OPIOIDS IN WEST VIRGINIA

Dr. Walensky, as you are aware, we are facing an epidemic within the pandemic, West Virginia is ground zero for the drug epidemic, with the highest rate of drug overdose deaths in the country. To make matters worse, 2020 was the worst year yet with over 90,000 deaths, and we saw at least 47 percent increase in the State of West Virginia with overdose deaths. So what resources is CDC providing to States to combat the epidemic?

Dr. WALENSKY. Thank you, Senator, for that question.

Senator MANCHIN. And also, I would have made—and the second part of that would be: in working on helping—what CDC is—are

working on helping increasing the testing for viral hepatitis and HIV? We have had a tremendous—horrendous situation with that.

Dr. WALENSKY. I can tell you, just before coming here, I spoke to one of my infectious disease colleagues in West Virginia, and she was telling me that they have opened neonatal detox units, I understand, that it is unbelievable.

Senator MANCHIN. Unbelievable, unbelievable.

Dr. WALENSKY. It is unbelievable. And so we know that we need to tackle this. We need to counter this. We need accurate data. We need interventions that can—and we need resources to be able to invest in Opioid Naloxone Programs that are reaching the community. Community health workers that can do the outreach to talk to people and intervene at the local level where these are happening, we need toolkits, we need information, and mental health support services to intervene.

AMERICAN MEDICAL MANUFACTURING

Senator MANCHIN. Right. My time is running out. I want to ask you that one other thing that—we produce very little of the things that we basically needed for medicine, penicillin, do you think penicillin should be produced in America? Do you think doxycycline should be produced, an antibiotic in America? And if so, what should we do in order to do that? Or stockpile strategically for our own protection?

Dr. WALENSKY. I think we need to have a public health infrastructure and a pipeline that allows us to respond to pandemics, and to epidemics, and to infectious threats.

Senator MANCHIN. Do we have any manufacturers that are producing these in America?

Dr. WALENSKY. There are limited manufacturers producing penicillin, that I can talk to. Because, in fact, we have had penicillin shortages, penicillin has gotten extraordinarily expensive. And in fact, some colleagues of mine have once said, it should be cheaper than the pipe—than the tubing it runs through. And in fact, it is not.

Senator MANCHIN. Should the CDC basically—I mean, your recommendation would be for production. We should be producing these in America. You know, we need to have something from a professional, like yourself, to get back to producing things in American, and not depending on supply chains.

Dr. WALENSKY. So one of the things I can just mention for penicillin specifically, is it is particularly hard given the allergies related to penicillin. It is actually, particularly hard to do. There are limited plants that make penicillin. But your point is well taken.

Senator MANCHIN. Thank you.

Thank you, Madam Chair.

Senator MURRAY. Thank you.

Senator Moran.

Senator MORAN. Chairwoman, thank you. Thank you and Senator Blunt for this hearing. And welcome to our two Doctors, thank you for service.

COLLABORATION ON BIODEFENSE FACILITIES

I have four questions I am going to try to accomplish in 5 minutes. Let me first highlight something that is occurring in my home State. Kansas will soon be the home to the National Bio and Agro-Defense Facility. It is a $1.25 billion research facility, nearing completion. Its mission is to—or the facility is to protect U.S. livestock from foreign animal diseases, including zoonotic diseases that can pose significant threats to human health. NBAF (National Bio and Agro-Defense Facility) will be the first bio containment facility in the U.S. where there is a BSL4 laboratory, which zoonotic pathogens for which there no treatments, currently, exist.

NBAF is operated by the U.S. Department of Agriculture with cooperation from the Department of Homeland Security, right, so truly going to be as a state-of-the-art facility, COVID–19, which possibly is a zoonotic disease, has only highlighted the importance for the U.S. to invest in this type of research.

Are you engaged with USDA (U.S. Department of Agriculture) or Homeland Security on future research that could be conducted at NBAF in regard to the zoonotic diseases? What kind of research NBAF would be able to provide you with benefits in your mission of protecting human life?

Dr. SCHUCHAT. Let me just say that what we call One Health, the idea of human and animal health, and the environment has been a global issue for preparedness and response. We have seen so many terrible diseases emerge from the animals, and we have not been sufficiently ready for them.

Whether we are dealing with the genetic sequencing of strains, and whether the animals' strains have adapted better to humans, or research into containment interventions, it is really important. And so our principle of collaboration between Health and Human Services, and the Department of Agriculture, and Department of Homeland Security is very important.

I can say that the CDC and USDA both have oversight over select agents that, you know, are evaluated in those BSL4 facilities. And we work very closely with them to make sure that animal health is protected, and that human health is protected, and laboratories that are sending these pathogens do so safely without risk to the surrounding community.

As to exactly where we are with collaboration, I think we will have to get back to you, but it's a—congratulations on the facility. And I think we will look forward to working together.

Senator MORAN. This is a post1/11 development, and designed to replace the Plum Island and the research done there on a new advanced laboratory. I would welcome the opportunity to connect you and the folks at either Agriculture or—and those in Kansas as well.

INTERNATIONAL COLLABORATION

What, if anything, is steps that CDC, or perhaps broader, the Federal Government should do to bring China into this world of helping us combat diseases, the spread of viruses? Is there any opportunity for us to get better information, in any way that we can insist, encourage or demand that China behave differently than

what they did, after the arrival of this—the evidence of this disease in China?

Dr. WALENSKY. I think that we are all a global community at this point, and that when there is a threat anywhere, there is a threat everywhere. And so when it comes to our health, when it comes to science, it is helpful to have these connections we have in office, our regional office in China, where we exchange scientific information. So I think around the global community, it is important that we—that we convey scientific inference.

Senator MORAN. What is your evaluation of what cooperation occurred between China and the United States in regard to COVID–19? And has anything changed to increase or decrease that cooperation now?

Dr. WALENSKY. The WHO (World Health Organisation) has done a study—has numerous interactions to evaluate this. My understanding is that there is another phase of that study underway. And I think that that is really critically important, because quite honestly, and in my review of that study, and many have spent many hours reviewing this study—these studies, there was not a lot of transparency in line-level data that is able—that we are able to use to interpret.

Senator MORAN. Dr. Walensky, there is probably a longer answer than that. And maybe we can have that when you and I have a chance to have a conversation.

A couple of things in the 30 seconds I have left. I would highlight that you and I have had this conversation, Dr. Frieden encouraged me in regard to the Global Health Security Program, and I have tried to be an advocate for that program in this appropriations subcommittee, with some success.

And I just would—I am interested now, you don't have to answer this question in the lack of time that I have for you to do so, but I would love an answer that tells me how I should prioritize. You have said it, what happens elsewhere matters to us, and absolutely the truth and we have known that for a long time, but how do we prioritize now with the consequences of this pandemic in the United States?

How do we prioritize the appropriations that will go to programs that are outside the United States, that are protecting us as well as citizens of the world, as compared to things that need to be done domestically, which are significant? So I would love to have a broader discussion about where those priorities should lie.

LEARNING LESSONS FROM COVID

And finally, I would indicate, I am reading a book, which I do regularly, The Premonition, and I don't know whether you have read it, but I am two-thirds the way through. It is not terribly derogatory, but not terribly complimentary of the CDC. And I would welcome any suggestions you have of what the takeaway should be for the CDC, or if it is a book that is worthy of learning something from.

Dr. WALENSKY. Thank you, Senator. I would be happy to engage in those conversations. I have not read The Premonition, although I know of it, and I know many people who are in it. And what I will say is, there are many lessons that we can learn, some things

that we have to do better at the CDC, and some things that we have to do better as a country, and investing in multiyear public health infrastructure.

I think among the comments in the book that I am familiar with was one of the issues that I heard firsthand, you know, labs receiving results by fax and, you know, people working in data entry to do that. That is not a public health infrastructure of the future. It is not a way to respond to a pandemic.

And so I think the lessons to be learned from the book, are yes, we have to understand where things could have gone better at CDC, and we need multi-year infrastructure resources to make sure that we have, you know, work force, and data, and labs up to snuff to tackle whatever they need to tackle in the future.

Senator MORAN. It seems well written to me, and by a credible author. And I would encourage you to learn from it, as I am trying to.

Madam Chairwoman, the last comment I would make is. One of the things, my takeaway is the failure for CDC to authorize testing early on in circumstances in which it appears to me, testing should have been occurring.

Senator MURRAY. Thank you.

Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chairman. And thank you, Dr. Walensky, and Dr. Schuchat, for your service to the country, and for being here this morning.

OPIOIDS IN NEW HAMPSHIRE

Dr. Walensky, I very much appreciated our conversation earlier this week. And one of the things we talked about is the continuing challenge of the opioid epidemic that we are facing in this country. New Hampshire, like West Virginia, has been very hard hit. We are one of the 10 States in the country that has been hardest hit by the epidemic.

And I was pleased that Congress provided some new flexibility to deal with the epidemic last year, by including meth and cocaine as part of the drugs that could be included in programs to address opioid—the opioid epidemic. But can you talk—one of the things we discussed was the challenge that I have heard from providers in New Hampshire that we don't have a response for those overdosing on meth in the same way that we have Narcan for those who have overdosed on opioids.

Can you talk about what the CDC is doing to approach this issue and what kind of help you might have available for States like New Hampshire?

COMMUNITY HEALTH WORKERS

Dr. WALENSKY. Thank you, Senator. You know, I am thinking back to, sort of, 6 months ago and what we needed to do when we knew that one of our patients had relapsed, and how we get them into care. And it was our community health workers that knew where to find them. They knew where they were getting their drugs, and they knew where to find them, and to say, somebody cares for you, and brought them back.

And that, I think, is what we need in our public health infrastructure. We need the community workers who live in the community, who are from the community to make those interventions, to find the people. And that is really among the things that I think this public health infrastructure is going to be able to do. Certainly, we don't have something like Naloxone for meth overdose and that, you know, is unfortunate right now, and we need to address that.

And then quite honestly, we have statistics of the overdoses and the lethal overdoses. They are terrible. And yet we also have statistics of, you know, all these hospitalizations that are happening among young people that I was taking care of just 6 months ago, 30-year-olds getting their second valve replacement.

So this is something that we have to tackle, and it is not just that we have to tackle it with Narcan in a given community. We have to tackle it community by community, because there are all different kinds of communities, and we need the workers to be able to do so.

Senator SHAHEEN. Well, thank you. I hope that—and I know this is not a CDC issue—but I hope that you will weigh in, if you have the opportunity, with the administration on the importance of the set-aside funding for States like New Hampshire that have been hardest hit, because that has allowed us to up a real statewide response to the epidemic.

PFAS CONTAMINATION

I want to go on to PFAS, which is an emerging contaminant until we get the EPA (Environmental Protection Agency) to designate it as something else. But it is one that we have seen very directly in New Hampshire, and especially appreciate the response from the Agency for Toxic Substances and Disease Registry, which has been so helpful in undertaking a comprehensive health study in New Hampshire, Portsmouth, and Pease former Air Force base, have been one of the sites designated.

But one of the things we have learned is that too many of our members of the medical community don't have any idea about PFAS. They don't know what it is. They don't know how to respond to it. They don't know whether testing is appropriate or not.

And I worked with Chairman Murray and Ranking Member Blunt last year to fund a grant program to help educate our physicians. And I am very interested in how that unfolds, and the work that the CDC might be doing to help an ATSDR (Agency for Toxic Substances and Disease Registry) to educate our medical community.

So I don't know if either of you can speak to that on the update on where that effort stands.

Dr. SCHUCHAT. This has been such a complex and challenging area, and I really appreciate the leadership that you have shown, and the——

Senator SHAHEEN. Thank you.

Dr. SCHUCHAT [continuing]. Support you have given, and also the advocacy for us to learn what we need to learn so that people who have been exposed, and the clinicians that they see know what to do to get a result, and then not know what it means and what you

are supposed to do about it is challenging. So we really are incredibly grateful for the resources that are letting us begin to pave the way to get those answers.

I don't have specifics on the results of studies yet, but I know it is a very high priority for ATSDR and the leadership here.

Senator SHAHEEN. And do you know that, at one point in the last year, there was a suggestion that there was a connection between exposure to PFAS and severity of COVID–19. Do we have any more information about that?

Dr. SCHUCHAT. You know, I know that question came up and that we were looking into it. I don't believe we have a final. But we can get back to you if we do.

Senator SHAHEEN. That would be great. Thank you. If you could just let me know, either way, what we know about that, I would appreciate it. Thank you.

Thank you, Madam Chair.

Senator MURRAY. Senator Capito.

Senator CAPITO. Thank you, Madam Chair. And thank you for our witnesses today. Both of, Dr. Walensky and Dr. Schuchat, and I wish you the best in your—we won't call it retirement—in your repurposing. How about that? Wherever you may land?

Let me ask specifically. Senator Shaheen and Senator Manchin mentioned, obviously, the overdose rates in the State of West Virginia, so I won't go back through that. But I am concerned.

HIV IN WEST VIRGINIA

Dr. Walensky, I know you have a focus on ending the HIV epidemic. I know this is in your academic career as well. You mentioned it in the President's budget. West Virginia received a grant in the Integrated Viral Health—or Hepatitis, excuse me, Surveillance targeted funds to help us address certain areas, hotspots, I guess you would call them. But we are not—we are not in ending HIV epidemic focused jurisdiction, nor any of our counties. And in your testimony, you state that increased funding in the budget is for four key strategies in the focus areas, but not to increase the amount of focus areas.

So my question is, I think we need to be a focus area because we have some of the highest incidence. And how do you expand that footprint? Or, how can you help me with that?

Dr. WALENSKY. Thank you, Senator. As I think you noted, my 20-year career prior to January 20 was in doing exactly that. And I was really encouraged by ending the—the mission to end the HIV epidemic, really through a diagnosis, prevention, treatment and response. And, you know, when the initial tranche of HIV and the HIV epidemic money went out, it was to areas with the highest numbers, with truly a multi-year plan to expand to other areas that we needed to really curb things in the areas with the highest numbers.

Take some of the lessons that we learned and expand to some of the other areas. And so I have a vision, and hope that we will be able to do that in the—in the years ahead, and to continue that expansion.

Senator CAPITO. Thank you. Thank you. So expansion into areas such as ours, I think that would be welcome. I would make note

that in the initial disbursement of the vaccine, our State of West Virginia did an incredible job working with our public health infrastructure. But I think one of the lessons that we learned, and that I hope this becomes part of a manual to address future issues, is public health infrastructure cannot do this by themselves, not to what we saw at the—the breadth of what we saw.

So what happened? We had volunteers, we had county city governments, and we had our National Guard. And so I would encourage you while, I think, increasing our public health infrastructure is absolutely essential. I think growing those partnerships could be even more essential because there is a roadmap there to success. And so I just put that on your radar screen, as you are—as you are looking to expand.

MASK POLICY JURISDICTION

One thing I would like to ask, and Senator Blunt and I were in the Oval Office when the announcement was made with the President that we were going to lift the mask mandate. And I cannot tell you how joyful we all were as we ripped our masks off and had a great meeting after that.

But there is confusion still. And, you know, if we are going to get more people vaccinated, which is the ultimate goal all the way down through the age levels, we cannot have this confusion, because it is just: should I get my child vaccinated? You know, should I—how old can my child be to get vaccinated?

Does my child need to wear a mask at school? Who is the ultimate decider here? Is that the CDC? Is it the President? Is the governor? Is it the NIH? I mean, there is just too much coming at young families in particular, I think, to be able to feel, number one; that their child is safe, and they are doing the right thing for them to go to school. But also to get rid of that, I would say not antivaxxer, but vaccine hesitation. I think that is a large part of the people that are left as yet to be vaccinated. So how would you respond to that question?

Dr. WALENSKY. Thank you. The guidance that we put out on Thursday was individual guidance for people who are fully vaccinated can take off their masks.

Senator CAPITO. Right. Right.

COVID–19 VACCINES FOR CHILDREN AND ADOLESCENTS

Dr. WALENSKY. I have—or I was pleased actually the day before that the FDA (Food and Drug Administration) had authorized and the CDC had recommended vaccination with Pfizer vaccine for individuals as young as 12 years old, that is now recommended. And my 16-year-old has been vaccinated, and we have a lot of community workers out there encouraging vaccination of youth.

And, in fact, over 600,000 people between the ages of 12 and 15 have been vaccinated just in this last week. In terms of guidance, the CDC provides science-based, evidence-based guidance to anybody who is the consumer of said guidance, whether it be industries, jurisdictions, importantly the country is not uniform. And so I think you really do need to interpret our guidance in the context of what is happening in your community. And that is really important in the context of a transmissible agent.

Why is that important? Because the virus is going to be an opportunist, if you have a county that has low vaccination rates and high rates of disease, that county may interpret our guidance differently than a county that has high vaccination rates, and low incidence of disease.

So we really do have to do this at the local level because, in fact, the virus will—where there is less vaccination, the virus will emerge.

Senator CAPITO. So what do you say to the under-12 population, elementary school? The parents of those children who have low vaccination rates, which is probably close to nothing, they have low incident of infection and, you know, all the studies that show the younger generation is not as affected as older and even more senior. What do you—what do you tell them? Listen to your governor? Listen to your school Board?

Dr. WALENSKY. So what we would say is, vaccines are coming for youth. We are hopeful to have, they are doing dose de-escalation studies now down to 9 years old, soon thereafter down to six, soon thereafter down to three, and then down to 6 months. So we are working towards getting a vaccine that will be available for all people.

Senator CAPITO. So when would that be?

Dr. WALENSKY. Well, some of it depends on how much disease is out there in the community. So we cannot exactly predict, but we are hoping to have more available in late fall, and by the end of the year but through dose de-escalation studies.

And then of course, I think that the guidance that we have had for schools has actually demonstrated that even in the absence of vaccinations schools can be a very safe place, given the guidance that we have. We have recommended that schools not change anything for this school year, because it will be hard for our youth to get fully vaccinated before the end of this school year. We will be updating that soon. And then given that guidance it will be—there will be policies at the local and jurisdictional levels.

Senator CAPITO. Well, I still think it—I mean, I know you probably would agree that it is a bit confusing to folks all around the country who have children in school. I would just—just be as clear, and concise, and definitive, when this science comes forward and more vaccinations come forward, because I think it really is—it is really difficult, I think, for parents to decide how to do the right thing. Thank you.

Senator MURRAY. Thank you. That ends our first round of questions. And I will start a second round for any Senators who wish to ask additional questions.

RACIAL AND ETHNIC DISPARITIES

And Dr. Walensky, I will begin with you. You know, the pandemics deadly impact on communities of color show we do have a long way to go to address systemic racism and health inequities. Black and Latino populations are receiving vaccinations at disproportionally low rates, even as some of our recent polls suggest both groups are more likely than White people to say they want to get vaccinated.

And according to the CDC website data on race and ethnicity is available for just over half of vaccinated people. How is CDC working to improve vaccination access and collect more data on these demographic issues that we need to see in front of us?

Dr. WALENSKY. Thank you very much for that question, because we are working hard. We have placed our community vaccination centers, or mass vaccination centers in areas that have high Social Vulnerability Index, they are doing an extraordinarily good job in getting our minority communities.

Our Federal Retail Pharmacy Program sites were selected initially, in collaboration with the State, to see how we could get vaccine to the most vulnerable communities, to Black and Brown communities. And just this last 2 weeks, Federal Retail Pharmacy Programs, 47 percent of vaccines that they delivered were to minority communities.

And then our federally-qualified healthcare centers, in collaboration with HRSA, we have been delivering to people who are migrant workers, to people in rural communities, and people who have less access. One of the things we have been able to do to improve our race and ethnicity data, and this has been challenging because some people are electing not to report it, is to use HIPAA (Health Insurance Portability and Accountability Act)-compliant electronic case reporting, so that we can use cases—or this is on the case level, not the vaccine level, but looking at cases and then match it medical records via Cerner, via Epic, to be able to get case-level data.

We are working really hard with the counties to get both racial and ethnic minority data at the case and disease level, but then also the vaccination level. And this is, again, one of the areas where data has—you know, our data infrastructure has not been robust enough to deliver this to us in real time.

Senator MURRAY. Are you seeing any political ideology plan to this decision to get vaccinated?

VACCINE HESITANCY

Dr. WALENSKY. This is a personal choice. I think once we start saying: this group wants vaccine, this group doesn't, then we start telling the wrong message. When I was taking care of patients with HIV, and I was told—the new patient I had to deliver a new diagnosis. They always said to me, you deliver the diagnosis and then you pause, and you see what means to them, right?

Could it mean that they are worried about their baby, they are going to lose their job, they think they are going to die, they can't afford their meds? I think vaccines hesitancy is exactly this.

What is it about the vaccine that is making you hesitant? Is it that you are scared? Do you have to take the day off of work to get it? Is it that you saw a friend get it and they had a reaction? Is it that, wow, how did the science come so fast?

And so this is not about politics, this is about understanding where individuals are, meeting them where they are, and understanding what it is that is making them—making them hesitant.

Senator MURRAY. Okay. Thank you.

VACCINES IN PREGNANCY

Dr. Schuchat, recent research on the impact COVID–19 infection has on pregnant women is really alarming. One study last month showed pregnant women with COVID–19 are 22 times more likely to die compared to women who are not pregnant who contract the virus. What is the latest vaccine guidance for pregnant women?

Dr. SCHUCHAT. Yes. Thanks so much for that issue. COVID complicates pregnancy, so women who are pregnant and get COVID have worse experiences with the infection, than do non-pregnant women. More time in the intensive care unit, more risk of severe outcomes, including those rare deaths. COVID also complicates pregnancy by increasing the risk of prematurity, and leading to other types of complications.

While, as you know, clinical trials rarely enroll pregnant women, we are fortunate that there has been intense effort to get data about women who do get vaccinated while pregnant, to understand what happens, so that other women can learn from that.

Based on what we know right now, we recommend that women be offered vaccines during pregnancy, that they are eligible to get them, and that they make a choice about it; that choice might be based on how they value that risk or that unknown. But we do have reassuring data right now about vaccines given, particularly in the third trimester that have been followed and reported. We are continuing to follow and working closely with FDA on that. And so we will be expecting this summer to have even more data, particularly about vaccines given earlier in pregnancy.

Senator MURRAY. Is there any research about pregnant or lactating women who are vaccinated—who are vaccinated, transferring antibodies to their infants?

Dr. SCHUCHAT. We have emerging data that the antibody is transferred. And so we hope it will be like the influenza, where, getting vaccinated during pregnancy against influenza is really important because newborns and young children are very high risk for influenza complications. So, good news so far, and continuing to follow that.

Senator MURRAY. Thank you.

Senator Blunt.

Senator BLUNT. Thank you, Chair.

VACCINE BOOSTERS

The issue of a booster vaccine obviously is out there, so far most of the people that have said they think we are going to need it are from the companies that are making the vaccine. Dr. Fauci, former CDC Director Tom Frieden, others have said there is growing evidence that there will be enduring protection with the vaccine we have.

Now, I have been a big supporter of the Warp Speed effort to invest early in vaccines that were not approved yet, which I think made a big difference in availability. I do question the BARDA (Biomedical Advanced Research and Development Authority) decision to purchase 400 million doses of Moderna and Pfizer as a booster dose.

Were you asked about whether that was the right decision to make or not? And if you weren't, should CDC be involved in a $7.9 billion decision about a booster before we know whether we need one or not?

Dr. WALENSKY. Thank you, Senator. I think the first thing to recognize, and this has been miscommunicated, so I think it is very important, in the media, is that if you have received two doses of your Pfizer and Moderna vaccine, you are right now protected.

Senator BLUNT. Right.

Dr. WALENSKY. What we are looking at is whether we will need boosters over time. And I think that this is really—given how hard we were hit by this pandemic, I think it is really important to understand where we will be with that. Data suggest from SARS, not SARS-CoV–2, but from SARS, that is similar to coronavirus, that people have waning immunity over time.

And if you looked at what happened in the SARS outbreak several years ago, you saw that people were eligible for reinfection. So there is biologic plausibility that there would be waning immunity after you were infected. And we just don't know when that will be.

One of the concerns has been that if we first vaccinated our very most vulnerable, our people in nursing homes, that they may not have had as robust a response, and that they might be the first to—they would be a first who would need a booster anyway, because they were vaccinated first. But in fact that they may not have had a robust response is in——

Senator BLUNT. If we spend $7.9 billion, which I guess we did decide to do on May the 2nd, do we think those vaccines last for some time?

Dr. WALENSKY. I am not under the impression those are being made right now. I think part of the issue is what do they need to look like? Are we going to boost with the exact same mRNA structure as we do now? Or might we want to boost with a variant structure? And I think those are all conversations that are happening.

Senator BLUNT. Yes. Well, I think that is a pretty big spending decision to make based on the information we have. But we can talk about that more, later. If we do go forward with booster vaccines, are you all working to see if in an adult immunization program, we would try to combine more things with that booster? A flu shot, or whatever other shot that an adult might need at this point?

Dr. WALENSKY. I think it is pretty clear that we have had an immunization program for adults that was not prepared for what we needed in this, in this structure.

Senator BLUNT. Right.

Dr. WALENSKY. And yes, I think it would be advantageous. Currently, we don't have data as to whether you can co-administer vaccines, those data we are looking for. And in fact, the ACIP (Advisory Committee on Immunization Practices) just opined on this last week, because we are so behind on childhood immunizations, 11 million behind on childhood immunizations. So those are all the data that we are looking for, because I think it would be really great to be able to leverage what we are doing for COVID for influenza as well, and vice versa.

DATA MODERNIZATION

Senator BLUNT. Exactly. And I hope you will keep us posted on that as that happens. On data, that was actually where I was going next. You know, the data, we obviously had a data shortage, a shortage and some confusion about what data to input, which was not as helpful as it might have been.

Now, the committee, in what was then a fairly controversial decision, even among our colleagues, we decided, before COVID, to invest $50 million in base funding over the last 2 years for data. When COVID occurred, you know, and the numbers we were suddenly looking at and dealing with, we did another $500 million.

Dr. Schuchat, tell me where you think we are on better data preparation in the future? Or being better ready in the future to have data, and the tracking that comes with data? Where are we, and where would you think—that had CDC in the next fiscal year, for instance?

Dr. SCHUCHAT. This is essential. The $50 million base appropriations were vital, but you saw how behind we were. This is critical. We are so far behind, even with the increased resources. This is a long-term need; we are better, but we are not where we need to be. We have made huge progress this past year with electronic lab reporting of enormous numbers in terms of how many people were being tested, and getting us daily data. But the data were not necessarily complete, and as you heard the race/ethnicity data often missing.

We have a need to move to the cloud for many of our systems. We have a need to become—have a workforce that can handle the data at the local level, at the State level, that can use these sophisticated tools and not just react, but predict. So we still have a long way to go, but COVID, we have made a lot of progress on. We need to make that progress across the spectrum of public health issues.

Senator BLUNT. Well data, and tracking, and other things I think are an important part of the future of health. And we want to be helpful. And I would hope that the $550 million, collectively, in the last couple of years has made a substantial difference in where we are headed.

Thank you, Chair.

Senator MURRAY. Senator Blunt. Thank you.

I have one additional question for you. The CDC faced unexpected difficulties, as we all remember during those opening phases of the pandemic, especially around testing, and delays in establishing a large-scale testing, likely allowed the virus to spread undetected, as we know, one of the several factors that really hampered our efforts to contain that outbreak.

EARLIEST COVID LESSONS

Dr. Walensky, I just wanted to ask you today, what lessons has CDC learned from the experience in those first few weeks?

Dr. WALENSKY. There has been a lot of research going into what we could have done better during that period of time. My responsibility is to own that and to make sure that we are better. Among the challenges were quality—assurance quality control programs that were not in place the way they should have been. And in fact,

among the things that we are doing is to ensure that all labs, research and diagnostic labs are fully accredited.

So we are learning those lessons. Those were hard lessons to learn. I do also think that we need to recognize that among CDC's responsibilities is that when we have a new infectious pathogen, we are responsible for creating the diagnostics for that pathogen. Once we have done so, we need interagency collaboration with ASPER, with FDA to make—with the private sector to ensure that we can bring it to scale.

We are now at 1.1—we did one million tests yesterday, we are testing one to two million a day. That scale up has to be interagency. And so, yes, we have a lot of lessons that we can learn from what occurred, and we are learning them and taking resources that have been provided to us so that we can, not just take a line—a line item and improve X-lab, but we can improve all of the labs and through this accreditation process, for example, but then also to be able to scale at the national level.

Senator MURRAY. Okay. Thank you. Thank you very much. That will end our hearing today.

But I do want to thank both Director Walensky, and Principal Deputy Director Schuchat for joining us.

Thank you to all of our colleagues on the committee who participated as well.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due one week after the President's budget is delivered at 5:00 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 DR. ROCHELLE WALENSKY

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. Researchers in the United States continue to discover new variants of the coronavirus that are spreading throughout the country. Congress provided $1.75 billion in the American Rescue Plan for CDC to increase genomic sequencing of SARS–CoV2 to identify emerging variants. President Biden's fiscal year 2022 budget proposal includes $8.7 billion for the CDC, a $1.6 billion increase from fiscal year 2021's budget.

How will the CDC's budget be used to help state and local public health offices expand their surveillance capabilities to keep pace with new and emerging variants?

Answer. In May 2021, CDC awarded $240 million in American Rescue Plan (ARP) funds to state and local health jurisdictions to build sequencing and analytic capacity for all pathogens of interest, including SARS–CoV–2. CDC plans to fund these state and local labs for additional years, with ARP funds, to continue and to build on these activities, including funding support for equipment, supplies, and staffing. These activities build on expertise gained through the Advanced Molecular Detection (AMD) program. In addition, CDC is currently soliciting proposals for construction and renovation costs necessary to modernize the sequencing units of the nation's public health labs, which will also be funded through ARP funds. All of these labs are currently sequencing bacterial foodborne pathogens, and at last count, more than 60 labs were sequencing SARS–CoV–2. A subset of these labs are sequencing other pathogens, such as antimicrobial-resistant bacteria and fungi, influenza virus, and the agents of tuberculosis and Legionnaire's disease. The number of labs sequencing these pathogens, as well as the number of pathogens they are sequencing,

is expected to increase with the availability of these funds. CDC is also providing technical assistance, as well as support in planning and administration.

Question. How long will it take to revitalize all state and local jurisdictions so they are equally equipped to help stop the spread of COVID–19 and other future disease outbreaks?

Answer. All state public health laboratories, and an increasing number of county/local public health laboratories, have the potential to perform next-generation sequencing. At the beginning of the pandemic, the main limiting factors were (1) limited staffing; (2) the large number of competing priorities in responding to the pandemic; (3) a lack of bioinformatics capacity; and (4) limited experience and knowledge among epidemiologic staff in how to use genomic data as part of the response. With the long-term investments to strengthen public health infrastructure as proposed in the fiscal year 2022 Budget, including public health laboratories, we will be in a better position to respond and control future outbreaks. With experience from COVID–19, these organizations are already in a better position to apply genomic epidemiology during the next public health emergency. But over the next three to 5 years, with both the investments above as well as investments in the sequencing Centers of Excellence (also supported by the ARP funds) and large increases in training, state and local jurisdictions will be in a much better position to apply genomics to intervene at the start of a public health emergency.

Question. Thus far, the available COVID–19 vaccines protect against most of the variants currently circulating. A group of biostatisticians at Fred Hutchinson Cancer Research Center, based in Seattle, WA, are studying breakthrough infections of COVID–19 following full vaccination to determine which variants are able to evade the body's immune response. By understanding the correlation between needed level of protection and infection prevention, they hope to simplify the process of booster shots or vaccines against new variants.

What other research or studies would the CDC conduct to make sure the United States can quickly and proactively protect people from new, and potentially more dangerous, variants?

Answer. CDC has monitored for variant viruses since the beginning of the pandemic and continues to monitor for variants nationwide, in support of ongoing efforts by the SARS–CoV–2 Interagency Group. We use genomic information in combination with hospitalization and other case and outcomes data to identify the spread of, and potential consequences of, variants of concern.

CDC leads the National SARS–CoV–2 Strain Surveillance (NS3) program, which identifies new and emerging SARS–CoV–2 variants to determine implications for COVID–19 diagnostics, treatments, and vaccines authorized for use in the United States. Genomic sequencing allows scientists to identify SARS–CoV–2 and monitor how it changes over time into new variants, understand how these changes affect the characteristics of the virus, and use this information to better understand how it might impact health. A notable strength of NS3 is the regular collection of specimens from across the United States to support variant characterization efforts, which provides important data to inform public health decision-making.

Since January 2021, CDC has significantly increased domestic genomic surveillance platforms to monitor circulating viruses. NS3 was scaled up to process 750 specimens per week from public health laboratories across the U.S. CDC also is contracting with large commercial diagnostic laboratories to sequence samples. CDC has commitments from these laboratories to sequence more than 20,000 samples per week, pending the availability of SARS–CoV–2 positive specimens, with the capacity to scale up in response to the nation's needs.

Since 2014, CDC's Advanced Molecular Detection Program has been integrating next-generation sequencing and bioinformatics capabilities into the U.S. public health system. Many state and local health departments have been applying these resources as part of their response to COVID–19. Public health departments support local investigations, conduct studies, and make genomic data available to public databases. To further support these efforts, on December 18, 2020, CDC released $15 million from COVID supplemental funds through the Epidemiology and Laboratory Capacity Program.

In May 2021, CDC made available $240 million in American Rescue Plan funds to state and local health jurisdictions through the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement. These funds are to be used over 3 years to build sequencing and analytic capacity for all pathogens of interest, including SARS–CoV–2. In addition, CDC plans to fund these state and local labs for at least an additional 3 years, with ARP funds, to continue and to build on these activities, including funding support for equipment, supplies, and staffing. These activities build on expertise gained by the

Advanced Molecular Detection (AMD) program since 2014 in the application of pathogen genomics to public health.

Furthermore, we have issued 29 awards, totaling approximately $37 million, as part of the SARS–CoV–2 Sequencing for Public Health Emergency Response, Epidemiology, and Surveillance (SPHERES) Initiative. These awards are intended to fill knowledge gaps and promote innovation in the U.S. response to the COVID–19 pandemic and will help integrate next-generation genomic sequencing technologies with bioinformatics and epidemiology expertise across the US public health system.

As CDC and our public health partners sequence more SARS–CoV–2 genomes, we will continually improve our understanding of which variants are circulating in the US, how quickly variants emerge, and which variants are of most concern to public health, and thus the most important to characterize and track.

Question. Is the CDC continuing to monitor other public health concerns such as influenza?

Answer. Yes, CDC has continued to maintain and strengthen its surveillance systems during the COVID–19 pandemic. For example, in preparation for the 2021–2022 influenza season, CDC made several enhancements to influenza surveillance systems, which improve detection of influenza circulation and illness, to differentiate influenza from COVID–19, and support COVID–19 surveillance. Data enhancements include adding more than 1,000 emergency departments to the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet), adding new data sources from the National Long Term Care Facility Surveillance system that reports data from approximately 15,400 facilities weekly, and integrating HHS Protect hospital data from approximately 6,000 hospitals. Differentiation between influenza and COVID–19 is supported by the CDC-developed multiplex assay for use by CDC-supported public health laboratories, which simultaneously tests for type A and B seasonal influenza viruses and SARS–CoV–2. These and other updates have further strengthened the U.S. influenza surveillance system.

Question. I am alarmed by increasing antimicrobial resistance, and the fact that high levels of antibiotic use during the COVID–19 pandemic have likely driven the development of new resistance threats that have not yet been identified. The 2020–2025 National Action Plan for Combating Antibiotic Resistant Bacteria calls for expanded efforts that will only be possible with significant new Federal resources. Addressing AMR is central to preparedness, as resistant secondary infections complicate public health emergencies.

How does the President's Budget Proposal support the CDC Antibiotic Resistance Solutions Initiative in fiscal year 2022 to expand efforts to preserve the effectiveness of antibiotics, reduce inappropriate antibiotic use, increase surveillance and ensure that we are prepared to address this public health threat, as outlined in the 2020–2025 National Action Plan for Combating Antibiotic Resistant Bacteria?

Answer. The fiscal year 2022 President's Budget has $172 million for the Antibiotic Resistance Solution Initiative, consistent with the fiscal year 2021 appropriation. CDC is working to effectively leverage resources and invest in key prevention strategies, such as early detection and containment, infection prevention, and ensuring the appropriate use of antibiotics. The availability of safe, effective, and quality-assured antibiotics underlies much of modern medicine, and the emergence and spread of AR threatens to undo this progress at enormous human and economic cost.

COVID–19 has potentially created a perfect storm for antibiotic resistance (AR) infections in healthcare settings, with longer lengths of stay, crowding, severely ill patients, antibiotics frequently prescribed upon admission, and infection control challenges like PPE shortages. CDC supports a robust domestic infrastructure through its AR Solutions Initiative to respond to emerging threats wherever they occur across healthcare, the community, and the environment while building key capacity to address AR internationally. CDC continues to use a One Health approach to tackle AR and to gain a better understanding of AR transmission, interactions, and impact between humans, animals, and the environment.

CDC has also proposed ambitious plans to strengthen international public health infrastructure as outlined in the 2020–2025 National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB). Over the next 5 years of the plan, it proposes that CDC would establish two networks—the Global Action in Healthcare Network and Global Antimicrobial Resistance Laboratory & Response Network, which would expand CDC's surveillance efforts globally.

Working together, these new global networks would enhance detection and response to infectious disease threats internationally, and implement prevention and containment strategies at local, national, and regional levels. CDC also has proposed plans to expand surveillance of AR threats in the environment, domestically and globally. These activities would help to better understand resistance in the environ-

ment, the connections between resistance in healthcare, agriculture, and environmental settings, and its impact on human health. CDC is piloting investments in these activities in fiscal year 2021.

Question. The COVID–19 pandemic laid bare the gaps resulting from decades-long erosion of support for the public health workforce, which did not have the people or resources needed to surge to meet the demands of the emergency response. Strategic investments in a diverse, robust, well-trained public health workforce at the community level are critical to ensure that we are able to tackle local public health challenges and be prepared for the next infectious disease outbreak. President Biden's fiscal year 2022 budget proposal includes a request for $106 million, a $50 million increase above fiscal year 2021, to develop the next generation of essential public health workers.

How does CDC envision this proposed investment in fellowship and training programs will translate in rebuilding the public health workforce of epidemiologists, contact tracers, lab scientists, community health workers, data analysts, behavioral scientists, and communicators?

Answer. The COVID–19 response shone a stark light on deficiencies in the nation's investment in its public health workforce, which did not have the people or resources to surge to meet the demands of a pandemic emergency response. Strategic investments in a diverse, well-trained public health workforce are needed. CDC's fellowships and training programs continue to supply a competent and sustainable workforce capable of surging in response to imminent public health threats.

CDC hosts approximately 300 fellows across seven fellowship programs each year in 45 U.S. states and five territories. In fiscal year 2021, all 137 EIS officers and Laboratory Leadership Services (LLS) fellows contributed to the COVID–19 response, leading COVID–19 responses in their assigned states and publishing key findings in the MMWR leading to actionable recommendations around mitigating the spread of disease. CDC designs its fellowships and curricula to meet the evolving needs of the public health workforce. A survey of human resources directors identified the highest priority workforce needs as epidemiologists, laboratory scientists, and public health informatics specialists. CDC's fellowships are a pathway for training the next generation of public health leaders.

Actions taken now to invest in developing the next generation of essential public health workers will better position our communities and the nation to respond to the current pandemic and to build back a better workforce to safeguard Americans' health. With the fiscal year 2022 request of $106,000,000 for Public Health Workforce, CDC will rebuild the workforce of epidemiologists, contact tracers, lab scientists, community health workers, data analysts, behavioral scientists, and communicators who can help protect America's health.

While health departments are the frontlines of emergency response, Federal investment in workforce development is essential to a coordinated national health workforce strategy. In fiscal year 2022 CDC will:

—Expand the pathway of critical public health workers through fellowship programs; assisting state, tribal, and local health departments to conduct barrier assessments and implement best practices for recruitment, hiring, and retention, and publishing training materials for state, tribal, and local use and STEM resources highlighting pathways to careers in public health.

—Modernize workforce development information technology systems.

—Increase participants in CDC fellowship programs and place them in areas of critical need.

CDC will invest in understanding barriers and facilitating solutions around matching graduates in critical discipline areas with positions serving local, tribal, and state communities. Developing robust pathways to attract graduates to public health is essential to future health security of the United States.

CDC will expand fellowship opportunities, from the Public Health Associate Program to Epidemic Intelligence Officers. CDC will enhance recruitment efforts and pave pathways for careers in public health at the Federal, state, tribal, and local levels. Increasing the cohort of EIS officers will provide critical applied learning and pathways for the next generation of public health leaders. CDC will increase the number of fellows in the field that provide essential assistance and expertise to CDC and state, local, territorial, and tribal health departments.

CDC will also strengthen the laboratory workforce to support clinical and public health laboratory practice. Of the 800,000 laboratory professionals who work across 295,000 CLIA-certified laboratories, less than 10 percent of the nation's clinical laboratory professionals currently access CDC training and workforce development resources. CDC will:

—Expand the reach of CDC's training and workforce development resources beyond the public health laboratory community into the broad clinical laboratory

community, including those who perform point-of-care testing, building critical bridges between healthcare and public health.
—Continue data-driven development, promotion, and dissemination of laboratory capacity- building initiatives and resources that enhance the laboratory community's ability to combat emerging threats, learn evolving practices, and stay current with the newest standards and technologies
—Formalize partnerships to expand its reach and accessibility of its training products and resources to the laboratory community through its learning course syndication system.
—Expand development of its virtual reality training portfolio to meet the evolving needs of laboratory professionals.

Question. How will state and local health departments benefit from an expansion of these training programs?

Answer. With investment in CDC's fellowship and training programs, CDC will rebuild the workforce of epidemiologists, contact tracers, lab scientists, community health workers, data analysts, behavioral scientists, and communicators who can help protect America's health. These investments are essential to build a competent and empowered public health workforce prepared to respond to future public health emergencies. CDC will work with state, tribal, local, and territorial health departments to rebuild the workforce and support these partners to assist in hiring and recruitment; identify and address barriers to hiring at the state and local levels; address workforce gaps; and build capacity to respond to current and future public health threats. These funds will support recruitment and training of public health leaders through Epidemic Intelligence Services (EIS), Laboratory Leadership Service fellowship programs, and Public Health Associate Program (PHAP). They will complement other initiatives including:
—Public Health AmeriCorps, a new public health workforce program in partnership with AmeriCorp, supported by investment from the American Rescue Plan, will deploy a nationwide cohort of workers, who will receive applied learning training and a stipend in non-Federal term positions.
—Modernization of the public health workforce in which CDC will work with public health leaders across Federal, state, local, and territorial jurisdictions to create a new grant program to provide under-resourced health departments with the support they need to hire staff and build a public health workforce for the future.

QUESTIONS SUBMITTED BY SENATOR JEANNE SHAHEEN

Question. Given that diabetes is one of the co-morbid conditions that puts patients with COVID–19 at highest risk, I was pleased to see CDC guidance that recommended prioritization of both Type 1 and Type 2 diabetes patients for vaccination. With 34 million Americans currently living with diabetes, the economic cost of the condition now exceeds $300 billion per year. Now more than ever, we need to do more to help prevent Type 2 diabetes where possible and help people with diabetes improve their management of the condition, so that we can see improved outcomes.

How is CDC approaching the rapid growth in diabetes prevalence in this country and what can we do in Congress to help?

Answer. CDC established the National Diabetes Prevention Program (National DPP) to address the growing epidemic of type 2 diabetes. The National DPP lifestyle change program is led by trained coaches who facilitate participants' strategies for eating a healthy diet, increasing physical activity, and developing coping skills. The Diabetes Prevention Program clinical trial showed that participants who engage in these lifestyle changes through a structured program can lose five to 7 percent of their body weight and reduce development of type 2 diabetes by as much as 58 percent (71 percent for those 60 years of age and older).

CDC supports state health departments and other stakeholder organizations in expanding access to the National DPP for populations at greatest risk for type 2 diabetes. Achieving insurance coverage is a critical step for increasing access to this highly effective program. Based on recipient reported data from September 30, 2018 to June 30, 2019, state health departments and other partners have secured health insurance coverage for the National DPP for more than 1 million public employees and their dependents in 24 states. In addition, the National DPP lifestyle change program is currently a covered benefit for more than 2.2 million private sector employees and their dependents across 21 states, a 61 percent increase from 2018. More than 1.4 million Medicaid beneficiaries have the National DPP lifestyle change program as a covered benefit, which includes participation from 30 states.

In March 2016, the Centers for Medicare & Medicaid Services (CMS) certified the expansion of the National DPP into the Medicare program. This was the first preventive service model from the CMS Innovation Center to become eligible for expansion into the Medicare program—a landmark for public health. The future of the MDPP as a covered service will be determined by the outcome of the CMS Innovation Center's expanded model evaluation. However, based on findings from the original DPP research trial, subsequent translation studies demonstrating the program's effectiveness in non-clinical settings, and the 15-year results of the DPP Outcomes Study, this intervention has been studied extensively and already has substantial evidence supporting its effectiveness across settings and populations.

Question. Can you provide an update on CDC's investments in the Division of Diabetes Translation (DDT) and the National Diabetes Prevention Program (NDPP)? How is CDC measuring success for those programs?

Answer. More than 550,000 people at high risk for developing type 2 diabetes have participated in the National DPP lifestyle change program across the U.S. Evaluated participants have lost an average of 5.5 percent of their body weight. To date, there are almost 1,900 CDC-recognized organizations offering the program in-person, virtual and through distance learning. CDC aims to enroll 1 million participants into the National DPP lifestyle change program by 2025.

Since the onset of the COVID–19 pandemic, a majority of the CDC-recognized organizations are offering virtual (telehealth) options for the National DPP lifestyle change program, an especially critical feature to ensure participant safety. A 2017 study (Vadheim, L.M, et al., 2017) found that participants who received the National DPP lifestyle change program through telehealth videoconferencing (distance learning) had similar rates of participation and achieved similar weight loss as participants who attended the program in-person.

Through implementation of the National DPP, CDC aims to reduce the number of adults newly diagnosed with type 2 diabetes. The national rate of diabetes incidence (6.4 new cases per 1,000 adults in 2018) has successfully moved below the Healthy People 2020 target (7.2 new cases per 1,000 adults). The continued growth of the diabetes burden in terms of absolute prevalence, lifetime risk, years spent with diabetes, and the incidence rate remaining considerably higher than it was in the 1990s, are all contributing factors indicating a need for continued prevention efforts like the National DPP.

Question. The COVID–19 pandemic has exacerbated challenges in our response to the substance use disorder epidemic. As you know, the 2020 state-level CDC data on opioid overdose deaths will also dictate the distribution of Federal opioid response dollars through the State Opioid Response (SOR) grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).

When does CDC expect to publish state-level data for 2020 on drug poisoning deaths per capita? When CDC does publish the data, please keep my office informed.

Answer. The National Center for Health Statistics provides provisional drug overdose death data by state: Products—Vital Statistics Rapid Release—Provisional Drug Overdose Data (cdc.gov). Provisional data currently provides information on drug overdose deaths occurring through October 2020. Final drug overdose death data for 2020 will be available in late 2021.

Question. Often there are discrepancies in state rankings on opioid overdose deaths per capita compared to overall drug poisoning deaths per capita. For instance, in examining CDC's WONDER data on 2018 opioid overdose deaths per capita, as reported by the National Institute on Drug Abuse (NIDA), compared to CDC's publication of 2018 overall drug poisoning deaths per capita, New Hampshire ranks third in opioid overdose deaths per capita and sixth in overall drug poisoning deaths per capita. Will CDC publish data on opioid specific overdose deaths per capita by state for 2020, as a supplement to its publication of overall state-by-state drug poisoning deaths per capita in 2020?

Answer. Yes. In addition to drug overdose death data (including deaths attributed to opioids) CDC provides analyses on final drug overdose death data, including deaths related to prescription opioids, heroin, synthetics opioids, and psychostimulants. CDC will update the data once final 2020 overdose data are available.

CDC currently funds 47 states and the District of Columbia to improve the timeliness and comprehensiveness of unintentional/undetermined drug overdose mortality data. The State Unintentional Drug Overdose Reporting System (SUDORS) captures detailed information on toxicology, death scene investigations, route of administration, and other risk factors that may be associated with a fatal overdose from funded recipients. CDC continues to release analyses of data received through this

program. For example, CDC published a report describing decedent demographic characteristics and circumstances surrounding overdose deaths during January—June 2019 among 25 jurisdictions participating in SUDORS, and it highlights the involvement of opioids and stimulants, separately and in combination.

Question. I was pleased to see that the administration's budget proposal calls for a continued commitment to efforts to defeat HIV in this country. At the same time, we are also seeing significant increases in the spread of sexually-transmitted diseases, including a heartbreaking 40 percent increase in congenital syphilis passed from mother to child during pregnancy in recent years. I have been concerned that we have underfunded state and local STD prevention efforts for a long time, which may impede our abilities to stop the spread of STDs.

Can you discuss how CDC is addressing growing rates of STD infections, and congenital syphilis infections in particular?

Answer. CDC provides national leadership, research, policy assessment, and scientific information about STDs to the medical community and the public. CDC coordinates and publishes national STI Treatment Guidelines and Recommendations, which translates research into practice and serves as the gold standard for STI care in the United States. Further, CDC supports health departments in all 50 states, Washington, D.C., and select cities and territories to conduct core and essential STD prevention work through our flagship STD prevention program, totaling $95.5million in 2020. CDC also has seventy field staff embedded in state and local STD programs around the country, who provide technical assistance and capacity building in disease investigation to support communities and public health partners, including investigating STDs in the community through field testing, public health detailing, outbreak response, and contact tracing.

COVID–19 mitigation necessitated innovative approaches to delivering STD care that may prove to be valuable investments into the infrastructure for STD care in the U.S. for years to come, including (but not limited to):

—STD express clinics, which provide walk-in testing & treatment without a full clinical exam

—Partnerships with pharmacies & retail health clinics, which can provide new access points for STD services (e.g., on-site testing and treatment)

—Telehealth/telemedicine, which can close gaps in testing and treatment, ensure access to healthcare providers, support self-testing or patient-collected specimens, and is especially critical in rural areas

These strategies and more are outlined in HHS's first ever STI Federal Action Plan, which provides a roadmap to develop, enhance, and expand prevention and care programs at the national, state, tribal and local levels over the next 5 years to reverse the course of the STD epidemic.

Further, through its flagship STD prevention program, CDC supports state and local public health departments to prioritize and strengthen their efforts to eliminate congenital syphilis by matching syphilis surveillance data with birth and mortality data and strengthening congenital syphilis morbidity and mortality case review boards. On July 13, CDC funded four state STD programs, working in cooperation with the state epidemiologist, to ensure that the implementation of congenital syphilis projects prioritize sustainable system level or policy level interventions in alignment with local epidemiology.

Finally, CDC is working diligently to support the Disease Intervention Specialists (DIS) Workforce with funding from the American Rescue Plan. For many years, DIS have provided invaluable support to prevent and control STDs, tuberculosis, HIV, and other infectious diseases. More recently, DIS were called to support the COVID–19 response, conducting case investigation and contact tracing in a variety of community settings. CDC is making a $1.13 billion investment over a five-year period to continue supporting the COVID–19 response and other infectious disease prevention and response, by:

1. Expanding and enhancing frontline public health staff
2. Conducting DIS workforce training and skills building
3. Building organizational capacity for outbreak response
4. Evaluating and improving recruitment, training, and outbreak response efforts

In addition to helping to contain and prevent COVID–19, we expect that this cadre of culturally competent and experienced DIS will be able to address STDs, such as congenital syphilis, as well as other infectious diseases.

Question. In 2016, the New Hampshire Department of Health & Human Services requested that the CDC's Agency for Toxic Substances and Disease Registry (ATSDR) conduct health consultations for the public water systems and private wells in the Merrimack-area of southern New Hampshire after the discovery of per- and polyfluoroalkyl substances (PFAS) contamination in drinking water. It is my

understanding that these health consultations remain ongoing, and I am concerned that residents are still waiting and wondering about their exposure risks.

Can you provide an update on the status of these health consultations and when you expect they will be concluded and released?

Answer. ATSDR continues to work on the private well and public water health consultations. ATSDR received comments on the private well health consultation from the state environmental department through our data validation review process and is working to address those comments. After the comments are addressed the document is reviewed through CDC's clearance process, it will be released for public comment.

In addition, ATSDR is currently completing a draft of the public water health consultation and preparing for internal review and clearance.

Question. The last thing firefighters should have to worry about is the safety of the equipment they wear while in the line of duty. Yet many active and retired firefighters are deeply concerned about exposure to harmful PFAS chemicals from their protective gear. I was proud to include my bipartisan Guaranteeing Equipment Safety for Firefighters Act provisions in the fiscal year 2021 National Defense Authorization Act (NDAA), which as you know, includes collaborative efforts at the National Institute of Standards and Technology (NIST) and National Institute for Occupational Safety & Health (NIOSH) to study of the personal protective equipment worn by firefighters. I have also worked through the Appropriations process to kick start this research at NIST.

Can you discuss the CDC's current collaboration with NIST as they work to identify a firefighter's relative risk of exposure to PFAS released from their protective gear? How will NIST's study inform the CDC's work—within both ATSDR and NIOSH—to better understand the health effects of PFAS exposure?

Answer. CDC's collaborates with NIST, sharing information, presentations, and collaborating on research activities such as characterizing PFAS in turnout gear textiles. In 2021, NIST and NIOSH provide overviews of PFAS activities and identified three topics for further discussion, analytical and collection methodologies, selection of and access to turnout gear textiles, and PFAS toxicity testing. Meetings on these topics were conducted with smaller groups to help facilitate targeted discussions.

NIST's research into PFAS in firefighter turnout gear is anticipated to provide valuable information on potential exposures for firefighters by identifying PFAS present in textiles and the conditions contributing to the release of PFAS from said material. The analytical methods included in NIST's study comprise a larger panel of PFAS than is currently used in many studies of human exposure. Results from this expanded panel will help guide future PFAS analyses of serum collected from this occupationally exposed population as well as inform future in vivo and in vitro studies of toxicity. When paired with studies of dermal absorption and exposure assessments of firehouse air or dust, NIST's research will also provide insight into the contribution of PFAS from gear to a firefighter's total exposure, providing a more complete understanding of the relevant pathways and routes of exposure in this population.

NIOSH's National Personal Protective Technology Laboratory (NPPTL) has been collaborating with NIST to determine which PFAS compounds are on firefighter turnout gear and if they are released through laundering. NPPTL collaborated with NIST, providing 20 different textile swatches laundered using current fire service protocols. These samples will undergo additional aging and stressing techniques to measure PFAS release from textiles by NIST researchers.

NPPTL's comprehensive laundry study to identify and quantify the individual PFAS compounds on firefighter textiles and to measure their release through a series of washings, supplements the ongoing NIST work . Additional NPPTL research studies the ability of PFAS compounds to migrate through the 3-layered garment to be in direct contact with a wearer's skin.

The NIST–NIOSH research collaboration will provide valuable information regarding possible PFAS exposures related to firefighter PPE and will yield time and monetary cost savings to both institutes.

Question. The Firefighter Cancer Registry Act, which was passed by Congress and signed by the President in 2018, directed the CDC to establish and maintain a voluntary National Firefighter Registry to better understand the link between on-the-job exposure to toxic substances and cancer in firefighters. The National Firefighter Registry will be used to track and analyze cancer trends and risk factors among firefighters. I have heard from firefighters in my state interested in volunteering to participate. It is my understanding that at this time, however, enrollment for the National Firefighter Registry is not yet open.

Can you provide an update on the work being done to establish the registry and a timeline of when it will be open for enrollment? When the registry is opened for

enrollment, will you work with my office to provide information to active and retired firefighters about how to participate if they so choose?

Answer. The National Firefighter Registry (NFR) has made substantial progress in developing a rigorous scientific protocol, enrollment questionnaire, and consent form. These documents have been posted publicly at www.cdc.gov/niosh/bsc/nfrs. The enrollment questionnaire has been submitted to OMB for review under the Paperwork Reduction Act. The NFR program has also drafted an Assurance of Confidentiality (AoC), which provides additional protection for identifying information.

The NFR program has also made progress on the online NFR Registration System. However, any public-facing data collection portal must meet numerous Federal data security regulations and requirements—some of which are relatively new and costly. NIOSH is working closely with our IT and security specialists to ensure that the NFR Registration System is compliant with these requirements. This has extended the original timeline for the launching of the NFR. NIOSH also recognizes that the registration system not only needs to be highly secure, but also needs to be relatively easy for firefighters to complete in order to maximize voluntary participation across the United States.

The NFR team has been working closely with key scientific and fire service stakeholders to determine the optimal design of the NFR Registration System and what data must be collected. Launching of the NFR Registration System is one step in many that will be needed over the next several years to ensure the success of the program and meet the requirements under the Firefighter Cancer Registry Act of 2018.

Once the NFR opens for registration, NIOSH will work with numerous fire service organizations and other stakeholder groups to encourage firefighters throughout the country, including career and volunteer, active and retired, and firefighters with and without cancer, to enroll in the NFR. The NFR team has developed a robust communications plan and strong connections to fire service organizations such as the International Association of Fire Fighters (IAFF) and National Volunteer Fire Council (NVFC), which are the two largest organizations representing career and volunteer firefighters, respectively. We welcome opportunities to work with congressional offices to reach firefighters within your state or district.

Question. Can you discuss how you expect this epidemiological information and analysis will help public safety officials, researchers, scientists and medical professionals find better ways to protect those in the fire service?

Answer. The enrollment questionnaire will serve as the primary data collection instrument when firefighters initially register collecting information about work history (including large or unusual responses), implementation of control measures, family history of cancer, and healthy behaviors. The questionnaire will also ask for identifying information, such as name and date of birth, which can be used to make linkages to state cancer registries. Collecting identifying information will allow NIOSH to periodically link to existing cancer diagnosis databases to detect new cases of cancer long-term that may not have been reported.

Additional follow up questionnaires will allow for analysis of specific workplace factors as well as topics of special interest to the public safety community. The NFR program also plans to work with fire departments to capture fire and incident information to build an exposure profile for the NFR participants. Over time and with broad participation, all this data can be used to better understand the amount and types of cancer among firefighters; the prevalence of cancer risk factors and healthy behaviors among firefighters; and the relationship between firefighter cancer and workplace characteristics, exposures, and practices. We will explore cancer risk among understudied firefighter groups including women, minorities, volunteers, and firefighters in sub-specialty assignments like wildland firefighters or fire-cause investigators. We will also evaluate how the adoption of certain control measures, like routine laundering of turnout gear, affects cancer risk. These analyses will help scientists at CDC/NIOSH identify the most important factors associated with firefighters' risk of specific types of cancer, including rare forms of cancer. Results can then be used by public safety officials to implement new evidence-based policies or procedures to reduce firefighters' cancer risk. Medical professionals will also have more knowledge about the types of cancer that are most elevated among the different groups of firefighters, which could assist them in providing advanced screening and healthcare for firefighters.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. The Food and Drug Administration reports that nearly 40 percent of finished drugs and roughly 80 percent of active pharmaceutical ingredients are manu-

factured abroad. During the COVID–19 pandemic we saw factories shut down in order to prevent spread of the virus, drug supply chains disrupted, and drug shortages increase. As a result American's access to essential medicines was put into jeopardy. To avoid future shortages of essential medicines, domestic manufacturing is key to shoring up our supply chain.

How important is a strong domestic supply chain for essential medicines?

Answer. Ensuring a safe and consistent public health supply chain for medical materials, ingredients, and supplies is critical for any national response to public health emergencies.

Question. How can we ensure we don't experience future drug shortages when global supply chains are disrupted?

Answer:

—Investments in securing the industrial base and domestic supply chain require dedicated and persistent management and engagement.

—Throughout the COVID–19 response, ASPR has leveraged the authorities delegated to the Secretary under the Defense Production Act (DPA) to issue 62 priority ratings for United States Government (USG) contracts for health resources, eight priority ratings for USG contracts for industrial expansion, three priority ratings for non-USG contracts to support the production of resins for both diagnostics and infusion pumps, and the manufacture of closed suction catheters for treatment of patients with COVID–19—all to ensure private sector partners making life-saving products are able to acquire the raw materials, components, and products requisite to deliver for the response.

—Also under the DPA, ASPR is strengthening the industrial base to secure and develop domestic capacity, retool and expand industry machinery, scale production facilities, train workforces, and ultimately infuse the supply chain and marketplace with products the US needs to contain further pandemic waves. ASPR continues to invest in critical funding in expanding domestic manufacturing including investments of: $250 million in manufacturing PPE; $268 million in manufacturing of testing consumables; $14.8M in vaccine raw material manufacturing; $160 million in fill finish capacity; $65 million in vaccine vial manufacturing; $168 million in manufacturing capacity for at home and point of care tests; and, $53.8M in testing raw materials. Each of these domestic manufacturing initiatives meets current, as well as future COVID–19 needs, and seeks to create or sustain high-value domestic jobs.

Question. Last week, the CDC announced $7.4 billion from the American Rescue Plan to support the public health workforce and the response to the COVID pandemic. This funding included $2 billion for state health departments. This will go a long way to shoring up our public health workforce as you outlined, in particular the requirement for at least 40 percent of the funding to support local hiring through local health departments or community-based organizations. West Virginia led the country in vaccination rates in large part due to our local health departments and health centers across the state establishing Local Leadership Planning teams to roll out vaccination plans in all 55 counties. These teams are multisector, multidisciplinary local health leaders. They know their communities, and have stepped up to respond to this virus.

In addition to this funding, what is CDC doing to support local initiatives like West Virginia's Local Leadership Planning teams?

Answer. Partnerships and trusted community members have been critical to reaching communities disproportionately affected by the pandemic. Community health workers (CHW) are frontline public health workers who have a trusted relationship with the community and are able to facilitate access to a variety of services and resources for community members. Scaling up and sustaining a nationwide program of CHWs who support populations hit hardest by COVID–19 is critical. In addition to the $7.4 billion to support the public health workforce awarded from the American Rescue Plan, CDC also plans to provide $300 million to jurisdictions for CHW services to support COVID–19 prevention and control. CDC plans to provide an additional $32 million for training, technical assistance, and evaluation. CDC expects to award funds to approximately 75 organizations through the "Community Health Workers for COVID Response and Resilient Communities." Notices of awards will be issued in the summer, with the amount each jurisdiction receives determined by population size, poverty rates, and COVID–19 statistics.

CDC also provided funding with specific guidance to focus on reaching disproportionately affected communities, including:

—$3 billion to strengthen vaccine confidence (awarded early April 2021): Funding focuses on reaching 64 communities hit hardest by the pandemic, including those in rural areas, to ensure greater equity and access to vaccine and expand COVID–19 vaccine programs. To ensure health equity and expanded access to

vaccines, 75 percent of funding must focus on specific programs and initiatives intended to increase vaccine access, acceptance, and uptake among racial and ethnic minority communities, and 60 percent must go to support local health departments, community-based organizations, and community health centers.

—$3 billion in cooperative agreements to support broad-based distribution, access, and vaccine coverage (awarded Jan. 2021): A minimum of 10 percent to jurisdictions must be allocated for high-risk and underserved populations, including rural communities.

—75 percent of the total funding must focus on specific programs and initiatives intended to increase vaccine access, acceptance, and uptake among racial and ethnic minority communities; and,

—60 percent must go to support local health departments, community-based organizations, and community health centers.

—$2.25 billion in grant funding to states and localities (anticipated to be awarded June 2021) to address COVID–19 in high-risk and underserved communities, including rural communities and communities with large populations of racial and ethnic minorities. Recipients are strongly encouraged to collaborate with and provide funding and resources to reach organizations such as community-based and civic organizations, faith-based organizations, non-governmental organizations, and state offices of rural health or their equivalent such as state rural health associations.

Question. How can we maintain local efforts like these to ensure they continue to operate after the public health emergency?

Answer. CDC must build on initial investments and lessons learned from COVID–19 with sustained, flexible investments in the nation's public health infrastructure as proposed in the fiscal year 2022 Budget. This work must include public health workforce development, as well as public health data modernization and epidemiology and laboratory capacities, so that we can address the broader public health consequences of the pandemic such as opioids, injuries, violence, immunization, and chronic disease control. It will also help us prepare for the future, because there are and will be more public health threats.

Question. Just last week the CDC updated its guidelines in regards to people who have been fully vaccinated. One guideline has caused confusion in my state, specifically in regards to reporting and the quarantining of people who have been vaccinated with a known exposure to COVID. Currently, the guidelines require a fully vaccinated person to quarantine for 10 days only if they develop symptoms. However, there does not appear to be a clear reporting requirement for persons who have been exposed and develop minor symptoms. Nor is there flexibility for a fully vaccinated person to quarantine for a shorter period of time if their symptoms disappear. Tracking these breakthrough cases is important to ensure we know if and when a booster may be needed to ensure protection for our population, and tracking potentially problematic COVID variants.

How does the CDC plan to effectively monitor breakthrough cases?

Answer. The goal of national surveillance for COVID–19 vaccine breakthrough infections is to identify unusual patterns, such as trends in age or sex, the vaccines involved, underlying health conditions, or which of the SARS-CoV–2 variants made people sick. To date, CDC's monitoring of breakthrough cases shows there are no unusual patterns in cases that have been detected in the data CDC has received. Despite the high level of vaccine efficacy, it is expected that a small percentage of fully vaccinated persons will develop symptomatic or asymptomatic infections (i.e. breakthrough infections) with SARS-CoV–2, the virus that causes COVID–19.

Vaccine breakthrough surveillance focuses on those cases resulting in hospitalization or death. CDC coordinates with state and local health departments to investigate vaccine breakthrough cases and identify patterns or trends. Health departments report breakthrough cases to CDC on a voluntary basis. However, it is important to note that tracking and publicly reporting vaccine breakthrough via national surveillance is just one way CDC measures vaccine effectiveness. CDC is leading multiple vaccine effectiveness studies, some of which include information on vaccine breakthrough infections, to ensure COVID–19 vaccines are working as expected. Through these studies in various populations, locations, and settings, CDC can obtain more representative, scientifically valid, and complete information about these types of infections.

CDC is also using the Coronavirus Disease 2019 (COVID–19)-Associated Hospitalization Surveillance Network (COVID–NET) to track and analyze breakthrough infections. This population-based surveillance system includes data on laboratory-confirmed COVID–19- associated hospitalizations in 99 counties in 14 states, representing approximately 10 percent of the U.S. population. COVID–NET cases are hospitalizations occurring in residents of a designated COVID–NET catchment area

who are admitted within 14 days of a positive SARS–CoV–2 test. COVID–NET personnel collect COVID–19 vaccination status (doses, dates administered and product) from state Immunization information systems (IIS) for all sampled COVID–NET cases in 13 sites, which also include information on clinical outcome. Some sites have expanded collection of vaccination status to non-sampled cases, which were included for analysis if all cases in a single month had vaccination status available.

Question. Is the CDC considering reducing the required isolation period for fully vaccinated persons after their symptoms disappear?

Answer. CDC data indicates that vaccinated people are less likely to contract COVID–19 and are much safer from having serious outcomes if they do contract it. If they become infected, they can spread the virus to others. Moreover, if the infection is caused by the Delta variant, based on what we know at this time, they can likely spread it as easily as unvaccinated people who are infected, at least initially. As infection progresses, vaccinated persons with COVID–19, including COVID–19 caused by the Delta variant, appear to be infectious for a shorter period of time than infected unvaccinated people.

CDC is reviewing all the emerging evidence and will continue to monitor the data on duration of infectiousness for breakthrough cases. Throughout the pandemic, CDC has updated guidance to reflect the latest available information about COVID–19 and would consider changing recommendations for isolation periods for vaccinated people who have breakthrough infections if the accumulating science indicates such a change were both safe and reasonable.

Question. As you are aware we are facing an epidemic within a pandemic. West Virginia is ground zero for the drug epidemic, with the highest rate of drug overdose deaths in the country. To make matters worse, 2020 was the worst year for drug overdoses, with over 90,000 deaths. West Virginia saw at least a 47 percent increase in overdose deaths last year. The drug epidemic has led to a sharp increase in opioid-related infectious diseases, including HIV and viral hepatitis. This has stretched the resources of our public health departments and health providers even further.

What resources is the CDC providing to states to combat this epidemic?

Answer. CDC is providing resources to states through Overdose Data to Action (OD2A), a cooperative agreement that began in September 2019. It combines strategies from previous surveillance and prevention funding agreements to address the complex and changing nature of the drug overdose epidemic. Through OD2A, 47 states, Washington D.C., 16 localities, and two territories are receiving almost $300 million in funding.

CDC is also addressing the infectious disease consequences of the opioid epidemic. Nearly $13 million of combined fiscal year 2019 and fiscal year 2020 funding was awarded through the Infectious Disease and the Opioid Epidemic initiative to state and local health departments and national organizations to address the infectious disease consequences of drug use.

In light of the COVID–19 pandemic, CDC has worked to provide flexibilities to the 66 grantees by extending the funding for an additional year and providing additional guidance and assistance as needed. We have also engaged grantees to identify innovative ways to respond during the pandemic. We are also using COVID–19 funding to:

—Understand how substance use patterns and attitudes among youth have changed due to COVID–19 and disseminate tailored public health messaging and interventions to help address increased substance use during this period of time and prevent detrimental long-term consequences.

—Identify innovative harm reduction practices to assess the extent to which these strategies can be sustained and scaled. CDC plans to summarize these strategies and disseminate them to state, local, and Federal partners.

In addition, CDC is Combating Opioid Overdose Through Community-level Intervention Initiatives (COOCLI). CDC, through its Opioid Response Strategy partnership, provided funding to the Office of National Drug Control Policy to create public health/public safety interventions at the local level. COOCLI sub-awards funded pilot programs to implement innovative, evidence- based, community-level interventions.

Question. Is the CDC working on helping increase testing for viral hepatitis and HIV as well as linking patients to care?

How can CDC help improve testing and surveillance of opioid-related infectious diseases with our current substance use treatment programs and recovery facilities?

Answer. Our nation has seen steady increases in infectious diseases—including viral hepatitis and HIV—among people who use drugs since the start of the opioid crisis over a decade ago. Making testing for viral hepatitis and HIV accessible, convenient, and routine is critical, especially in populations disproportionately affected

by these diseases, including people who inject drugs (PWID). CDC developed programs to increase infectious disease testing among PWID and continues to invest in these programs through state and local health departments and through community-based organizations. Specifically, CDC is focusing investments on scaling up HIV self-testing—like the Take Me Home self-testing program that provides free HIV self-tests—making HIV screening a regular part of healthcare, and delivering viral hepatitis and HIV testing in non- traditional settings, such as correctional facilities and syringe services programs (SSPs).

As viral hepatitis, HIV, and substance use disorders continue to impact communities throughout the United States, CDC is not only increasing support for testing, but also diagnosis, linkage to care, and treatment. CDC is also improving implementation of and access to high-quality SSPs across the country, where legal, through dissemination of best practices and providing technical assistance. CDC's core Integrated HIV Surveillance and Prevention for Health Departments program (PS18–1802) supports the implementation of comprehensive SSPs as part of a key community-level HIV prevention strategy. In addition, CDC's National HIV Behavioral Surveillance system collects important data among persons at high risk for HIV infection, including persons who inject drugs. These programs work to ensure the provision of high-quality, comprehensive harm reduction services, which include testing for infectious diseases, linking patients to opioid use disorder treatment, and providing infectious disease care for clients of syringe services programs.

In addition to testing and treatment for infectious diseases, CDC works to increase linkage to substance use disorder treatment within SSPs and during healthcare encounters for PWID.

Question. The COVID–19 pandemic has revealed public health data infrastructure shortcomings within both our Federal and state institutions. West Virginia's response to the COVID–19 pandemic, however, shows our ability to adapt in times of crisis. In addition to the strong leadership of our National Guard, our local health information exchange stepped up to track important health data, such as hospitalization and vaccination rates, demographic data, and much more. Most importantly, our health information exchange helped us build out systems so that West Virginia health providers were able to fully utilize the CDC's Vaccine Administration Management System (VAMS). As outlined in President Biden's national strategy, we need improved systems for public health data exchange and surveillance. This will allow us to better track outbreaks, testing, vaccination rates and much more.

How will you ensure Federal investments into public health data will support data sharing between public health and healthcare delivery, such as the West Virginia's health information exchange?

Answer. The success of CDC's Data Modernization Initiative (DMI) is critical for our nation's response to COVID–19 and beyond. Improving data sharing between public health and healthcare delivery is key to realizing the full potential of public health data modernization. Monitoring and evaluation are how we make sure we are delivering on the promise of data to protect America's health. The need for modernization never stops. Within DMI, we are monitoring progress on a growing suite of modernization projects. These investments touch nearly every part of the public health data ecosystem.

All of CDC's data modernization investments are guided by a Roadmap of Activities and Expected Outcomes that guides all current and future investments in data modernization. This strategic roadmap lays out our priorities and keeps our end goals in front of us. It ensures work going on through any given stream ties into and benefits the others—and that we are moving toward the same definition of success. The roadmap is the basis for our DMI monitoring and evaluation framework. Robust monitoring and evaluation will maximize our impact on public health. This is where we track our progress consistently and scientifically to see what our investments have produced. We can also see which solutions are working well and which may need additional support to reach their goals.

Electronic case reporting (eCR) has demonstrated success in improving data sharing between public health and healthcare. eCR is the automated, real-time exchange of case report information between electronic health records (EHRs) and public health agencies for review and action. It moves data quickly, securely, and seamlessly from EHRs in healthcare facilities to state or local health departments. All 50 states, D.C., and 11 large local jurisdictions are now capable of receiving COVID–19 electronic case reports, up from only a handful of jurisdictions in late 2019. As of May 15, more than 8.1 million COVID–19 reports have been sent to 61 public health agencies and more than 7,900 healthcare facilities in all 50 states can send COVID–19 electronic case reports. There are currently 236 facilities in West Virginia actively using eCR, including West Virginia University.

CDC is actively working to expand the number of healthcare organizations implementing eCR and support public health agencies to fully use the case reports within their data ecosystem. This includes collaboration with healthcare systems, EHR vendors, and with the Office of the National Coordinator for Health Information Technology (ONC) to improve exchange of health information.

Question. Will you work with state partners like WVU Health Sciences to continue to improve data analytics?

Answer. Support and engagement with partners to improve data and analytics is an important component of the CDC Data Modernization Initiative (DMI). Data modernization requires an ongoing commitment and partnership across the public health sector—and especially with our state, tribal, local, and territorial partners. CDC will continue to support and engage with partners to improve data collection, interoperability and data analytics. CDC is working closely with public health partners to provide technical assistance focused on:

—Developing interoperable data systems to reduce the burden on healthcare systems, facilities and laboratories that report critical data to jurisdictions

—Increasing the overall efficiency of public health data systems at the state level

CDC also supports public health partners like the Association of Public Health Laboratories (APHL) and the Council of State and Territorial Epidemiologists (CSTE). These partners are providing technical assistance to jurisdictions focused on improving data sharing, accelerating use of shared decision support services, data science upskilling of the public health workforce, and developing and increasing use of standards to improve quality and timeliness of reported data.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Walensky, several of the COVID–19 vaccine developers have indicated we may need a vaccine booster. To that end, BARDA notified an intent to purchase 400 million doses of COVID–19 vaccine from Moderna and Pfizer for $7.9 billion on May 2nd as booster shots.

Was that the right decision? Because many public health experts indicate, including former CDC Director Tom Frieden, that there is growing evidence that a first round of global vaccinations may offer enduring protection. What is your opinion here? What I think could be very dangerous is if vaccine companies, rather than public health experts, are setting the public's expectations around COVID–19 boosters.

Answer. CDC will update its recommendations on re-vaccination or additional doses of COVID–19 vaccines when additional information is available. CDC is closely collaborating with Federal partners and the global science and public health community to determine next steps on COVID–19 vaccine boosters. Currently, there is not enough data to support recommending boosters.

Question. Adult immunization programs are not typically done well in the U.S. Should we face the prospect of COVID–19 boosters next year, what is CDC doing now to plan for that possibility?

Answer. CDC will update its recommendations on re-vaccination or additional doses of COVID–19 vaccines when additional information is available. CDC is closely collaborating with Federal partners and the global science and public health community to determine next steps on COVID–19 vaccine boosters. CDC works continuously with our state and local immunization programs to strengthen their capacity to deliver vaccines, monitor their safety and effectiveness and address identified gaps.

The fiscal year 2022 budget request includes nearly a $100 million increase to expand existing efforts to enhance the adult immunization infrastructure to increase routine vaccination rates, detect and respond to outbreaks of VPDs, and address vaccine hesitancy. Adult immunization program funding will build on recent investments in the COVID–19 vaccine program to support essential activities aimed at strengthening the safety net for uninsured adults, addressing disparities in adult vaccine coverage, and supporting vaccine efforts across the lifespan.

Question. Will you try to team other adult vaccinations with the COVID vaccination?

Answer. COVID–19 vaccines were previously recommended to be administered alone, with a minimum interval of 14 days before or after administration of any other vaccines. This was out of an abundance of caution and not due to any known safety or immunogenicity concerns. However, substantial data have now been collected regarding the safety of COVID–19 vaccine currently authorized by FDA for use under Emergency Use Authorization. Although data are not available for COVID–19 vaccines administered simultaneously with other vaccines, extensive ex-

perience with non-COVID–19 vaccines has demonstrated that immunogenicity and adverse event profiles are generally similar when vaccines are administered simultaneously as when they are administered alone.

COVID–19 vaccines and other vaccines may now be administered without regard to timing. This includes simultaneous administration of COVID–19 vaccine and other vaccines on the same day, as well as coadministration within 14 days. When deciding whether to co-administer vaccine(s) with COVID–19 vaccine, vaccination providers should consider whether the patient is behind or at risk of becoming behind on recommended vaccines, their risk of vaccine-preventable disease (e.g., during an outbreak or occupational exposures), and the reactogenicity profile of the vaccines.

Question. There are reports, many of which the CDC has published, highlighting the toll this pandemic has had on our nation's public health. And there's an increasing number of reports that the overall health of Americans has suffered as a result of the pandemic. It is increasingly evident that in the coming months, as we emerge from under the shadow of this pandemic, existing and emerging public health challenges will have to be addressed.

How are you planning to address these challenges and how does the fiscal year 2022 budget reflect those needs?

Answer. CDC is committed to upgrading the public health system so the nation is ready for whatever may come next by building on investments and lessons learned during the pandemic. Key priorities include modernizing our public health data systems, supporting a diverse and skilled public health workforce, enhancing laboratory capacity, and promoting global health security. We now know that long-term and flexible funding—as proposed in the fiscal year 2022 budget—will be required to sustain improvements and address broader consequences of the pandemic and historical underinvestment in areas like health equity, opioid use and misuse, injuries and violence, immunization planning, and hypertension control.

Question. What are the areas where this budget request may fall short—perhaps because we're only just beginning to understand the vast impact of the pandemic in areas such as chronic conditions, delayed care and immunizations, or reemerging infectious diseases, such as STDs and hepatitis?

Answer. The nation's public health system has not recovered from the economic downturn in 2008, which resulted in significant reductions in public health staffing at the state and local level. Similarly, CDC has become increasingly reliant on infusions of supplemental funds to address specific health crises. Building back a robust public health infrastructure will take sustained investments over time to address both foundational needs like data, lab capacity and workforce as well as strategic investments to address health equity and social determinants of health. The fiscal year 2022 President's budget includes request for increased funding needed to address some of the consequences of the pandemic including mental health, opioids, and prevention of chronic and infectious diseases.

Question. Conversely, our nation has made great strides these last several months against the COVID pandemic and we've gained a greater understanding as to what is needed for a robust public health system—from the public health laboratories to health statisticians and academic researchers to private enterprise—advancements have been made across the board.

How does the fiscal year 2022 budget request account for the lessons learned over the last year to improve our public health infrastructure?

Answer. The ability to respond to a public health emergency requires a strong day-to-day public health system, supported by infrastructure that is not highly segmented by disease, condition, or activity. In addition to the COVID–19 pandemic, over the past 24 months, CDC has also responded to diverse public health threats from E-cigarette or Vaping Product Use-Associated Lung Injuries (EVALI), Ebola, complex multi-state food-borne disease outbreaks, wildfires, and hurricanes. Responding to the unique characteristics of each of these public health emergencies has required deep scientific expertise to deploy a specialized approach and called for a robust public health system with world-class infrastructure nationwide to stop disease at its source. Unfortunately, this recent history has revealed the effects of inadequate public health infrastructure. Ongoing health disparities made us as a nation more vulnerable to pandemics and large-scale public health emergencies, as well as burdening large segments of our population with chronic public health concerns. Additional investment in both domestic and global public health infrastructure is needed as requested in the fiscal year 2022 Budget.

With investments requested in fiscal year 2022, CDC will begin to address mission-critical gaps in public health infrastructure and capacity nationwide. Transitioning from sporadic influxes of supplemental funding tied to a specific emergency to flexible funding that can prevent another crisis will strengthen the current

public health system. Flexible, sustainable investments in infrastructure and capacity are critical for saving lives and averting economic losses caused by public health emergencies and chronic public health problems. In fiscal year 2022, CDC will prioritize funding to rebuild the most critical public health infrastructure needed to safeguard the nation's health and economic security.

Question. The budget includes $400 million for Public Health Infrastructure Capacity.

How does this request account for the flexibility needed to scale certain functions or respond in the future to a wholly different public health threat?

Answer. CDC will expand its ability to leverage public health infrastructure to address emerging and longstanding issues by providing direct funding for capacity-building resources, guidance, and collaboration to states, localities, and territories. These resources will be disease-agnostic investments in core public health infrastructure and capacity to expand programs and systems that address long-standing public health issues and support public health response.

Question. How, specifically, will this $400 million be divided between the different activities outlined in the budget?

Answer. This investment must be flexible, stable, and keep pace with inflation and technological advancements in order for states, localities, and territories to address their most urgent needs, such as: a diverse, data-savvy workforce with secure funding that attracts the best talent to public health; robust technological infrastructure that is nimble and scalable; innovations and collaborations with multiple sectors; and programs that address disparities during and after the COVID–19 pandemic.

Question. Unfortunately, there is no question that the pandemic has been challenging for many people—our nation has faced an unprecedented mental health crisis and a rise in overdoses. CDC's provisional data shows a 28 percent increase in overdose deaths in the 12-month period ending in October 2020. More than 88,000 lives were lost to an overdose during that period, the highest number of fatal overdoses ever recorded in the U.S. in a single year, three-quarters of which were opioid-related. Throughout my time on this Subcommittee, I made it a priority to combat the opioid crisis and I'm concerned we have suffered a significant setback. We need to better understand the impact that the pandemic has had on overdoses and substance abuse.

What can you say about these trends in fatal overdoses and what are some of the immediate needs to combat them?

Answer. Provisional 2020 data reveal that over 93,000 people died of an overdose in 2020, a nearly 30 percent increase over 2019. The recent increase in drug overdose mortality began in 2019 and continued into 2020, prior to the declaration of the COVID–19 National Emergency in the United States in March.

There are many factors that can be driving the increase in overdose deaths including:

—The changing illicit drug marketplace and the wider availability of illicitly manufactured fentanyl and fentanyl analogs,

—Co-use of illicitly manufactured fentanyl with other drugs such as cocaine and methamphetamine, and

—Mixing of illicitly manufactured fentanyl into the drug supplies of methamphetamine and cocaine

CDC's Overdose Data to Action (OD2A) funds health departments in 47 states, the District of Columbia, two territories, and 16 cities and counties to obtain high-quality, comprehensive, and timely data on fatal and nonfatal drug overdoses to inform prevention and response efforts. To help curb this epidemic, Overdose Data to Action strategies focus on enhancing linkage to and retention in substance use disorder treatment, improving prescription drug monitoring programs, implementing post-overdose protocols in emergency departments, including naloxone provision to patients who use opioids or other illicit drugs, and strengthening public health and public safety partnerships, enabling data sharing to help inform comprehensive interventions.

The President's Budget for fiscal year 2022 includes a requested increase of $237.8 million for opioid overdose prevention and surveillance. Immediate needs to combat the acceleration in overdoses include:

—Expanding the provision and use of naloxone and overdose prevention education;

—Expanding access to and provision of treatment for substance use disorders;

—Intervening early with individuals at the highest risk for overdose; improving detection of overdose outbreaks due to fentanyl, novel psychoactive substances (e.g., fentanyl analogs), or other drugs to facilitate an effective response;

—Continued partnerships with public safety to monitor trends in the illicit drug supply, including educating the public that drug products might be adulterated with fentanyl or fentanyl analogs unbeknownst to users.

A comprehensive and coordinated approach from clinicians, public health, public safety, community organizations, and the public must incorporate innovative and established prevention and response strategies, including those focused on polysubstance use.

Question. The Labor/HHS bill provides funding for opioid-related programs at the CDC, and a particular area of focus addresses infectious diseases associated with the opioid epidemic. Those resources help strengthen our understanding of the full scope of the burden of infectious diseases associated with substance use disorders. As a result of the pandemic, many public health departments' staff that would normally work on surveillance and prevention of infectious diseases, such as hepatitis, have been detailed to work on the COVID response.

What do we know about the impact of the pandemic on surveillance and prevention of infectious diseases associated with the opioid crisis?

Answer. The COVID–19 pandemic has deepened the opioid crisis and is having a profound impact on the fight against infectious diseases associated with this epidemic. We don't yet know the full impact but we are concerned that the major disruptions in access to prevention services and deferral of healthcare services during the pandemic may result in more infections and lead to severe health consequences in the long run. Deferral of healthcare services ultimately delays diagnosis and treatment, leaving people living with Hepatitis C and/or HIV unaware of their status and vulnerable to disease progression while also increasing the risk of spreading the viruses. Available data from CDC's funded programs also indicates that 50 percent of syringe services programs (SSPs) have reduced operations and 25 percent have closed further impacting opportunities for hepatitis testing and linkage to care. The closures of these SSPs severely limited access to vital hepatitis C virus and HIV prevention services, including referrals to treatment services as well.

In October 2020, CDC released a health advisory about the possibility of new injection-related HIV infections and outbreaks and noted how prevention efforts could be hindered because of the COVID–19 pandemic. Many HIV and viral hepatitis program staff were reassigned to support the COVID–19 response which further hindered prevention efforts. In the context of the pandemic, ongoing delivery of core public health services to address the injection drug use crisis and the infectious diseases associated with this epidemic, like hepatitis C and HIV are essential. CDC is committed to helping states build capacity to combat both epidemics and will continue to provide guidance as we address new and evolving challenges.

Question. In response to the COVID 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. Congress passed five bipartisan emergency supplemental funding bills last year, four of which included funding specifically for CDC activities totaling $16.25 billion for the agency. The vast majority of the funding, roughly 75 percent, is to support state and local public health preparedness and response, laboratory capacity, and surveillance. 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 as part of the American Rescue Plan reconciliation bill for the same purpose. While it is important to know how fast CDC is getting this funding into the hands of the frontline responders on the state level, it is just as important to know if they're spending the money.

What are the spend rates that CDC is seeing at the state level?

Answer. States have multiple funding sources, including disbursements from the treasury, that are used for public health purposes. The amounts and purposes vary greatly by state and it is not possible to generalize about spend rates. Recipient cash drawdowns are a lagging indicator of recipient performance because the recipient draws down cash to reimburse at the time of, or after, they pay their bills. In addition, as recipients have their own project plans and cash management processes, cash drawn totals provide a high-level picture for that recipient and are generally not comparable across a cohort of recipients in the same program.

Question. What accountability do the States have to tell you how they have used the funds?

Answer. Recipients regularly report on their use of funds and the outcomes they achieved per the terms of the funding agreement by which they are awarded the funds.

Question. Given the unprecedented volume of funding going out from the CDC as a result of the partisan reconciliation bill—can you explain CDC's decisionmaking infrastructure, process, and planning mechanisms for deploying unprecedented sums of money in such a short period of time? How does CDC plan for states and the

public health infrastructure to sustain these advancements when the supplemental and mandatory funding runs out?

Answer. CDC is allocating funding to states based on the provisions included in the statute. CDC uses funding mechanisms available to fit the purpose outlined in the statute, and where needed, has developed new ones.

The ability to respond to a public health emergency requires a strong day-to-day public health system, supported by infrastructure that is not highly segmented by disease, condition, or activity. In addition to the COVID–19 pandemic, over the past 24 months, CDC has also responded to diverse public health threats from E-cigarette or Vaping Product Use-Associated Lung Injuries (EVALI), Ebola, complex multi-state food-borne disease outbreaks, wildfires, and hurricanes. Responding to the unique characteristics of each of these public health emergencies has required deep scientific expertise to deploy a specialized approach and called for a robust public health system with world-class infrastructure nationwide to stop disease at its source. Unfortunately, this recent history has revealed the effects of inadequate public health infrastructure. Ongoing health disparities made us as a nation more vulnerable to pandemics and large-scale public health emergencies, as well as burdening large segments of our population with chronic public health concerns. Additional investment in both domestic and global public health infrastructure is needed as proposed in the fiscal year 2022 Budget.

With investments requested in fiscal year 2022, CDC will begin to address mission-critical gaps in public health infrastructure and capacity nationwide. Transitioning from sporadic influxes of supplemental funding tied to a specific emergency to flexible funding that can prevent another crisis will strengthen the current public health system. Flexible, sustainable investments in infrastructure and capacity are critical for saving lives and averting economic losses caused by public health emergencies and chronic public health problems. In fiscal year 2022, CDC will prioritize funding to rebuild the most critical public health infrastructure needed to safeguard the nation's health and economic security.

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?

Answer. Data continue to show the disproportionate impact of COVID–19 on population groups, including people living in rural or frontier areas. CDC's publication examining disparities in COVID–19 vaccination coverage found COVID–19 vaccination was lower in rural counties (38.9 percent) than in urban counties (45.7 percent). These data are available on the county tracker, which provides an integrated, county-level view of key data for monitoring the COVID–19 pandemic in the United States. It allows for the exploration of standardized data across the country. The footnotes describe each data source and the methods used for calculating the metrics. For the most complete and up-to-date data for any particular county or state, visit the relevant health department website.

Question. How does the CDC's health equity work account for the needs of rural communities?

Answer. Rural areas face unique challenges both during the COVID–19 pandemic and when confronting ongoing public health challenges. The CDC COVID–19 Response Health Equity Strategy, developed under the leadership of the Chief Health Equity Officer Unit, affords a robust platform from which CDC and its partners are pursuing deeper engagements of diverse communities, stronger infrastructures to better support data-driven action, and culturally responsive approaches optimized for serving diverse, differentially impacted populations in different areas, including rural and frontier populations. CDC has provided historic funding to address health disparities, including support for rural areas, as follows:

—$3.0 billion to strengthen vaccine confidence (awarded early April 2021): Funding will focus on reaching communities hit hardest by the pandemic, including those in rural areas.

—$3.0 billion to ensure broad-based distribution, access and vaccine coverage (awarded Jan. 2021): A minimum of 10 percent to jurisdictions must be allocated for high- risk and underserved populations, including rural communities.

—$2.25 billion to states and localities to address COVID–19 in medically underserved communities including rural communities and communities with large populations of racial and ethnic minorities

Additionally, the Federal Retail Pharmacy Program continues to be an important component in our commitment to address the disproportionate and severe impact of COVID–19 on communities of color and other underserved populations, including rural populations. From February 10 to May 19, 2021, 46,811,020 vaccine doses had been administered and reported by retail pharmacies across programs in the U.S.

A total of 21 retail pharmacy partners are participating in the program, with more than 41,000 locations online and administering doses nationwide.

CDC has numerous initiatives working to reduce disparities in rural populations. A few examples include:

—Community Health Workers for Covid Response and Resilient Communities (CCR) supports the training and deployment of community health workers (CHWs) to response efforts and by building and strengthening community resilience to fight COVID–19 through addressing existing health disparities. Priority populations are those with increased prevalence of COVID–19 and are disproportionately impacted by long-standing health disparities. Recipients to be announced at the end of August 2021.

—Racial and Ethnic Approaches to Community Health (REACH) program works to reduce racial and ethnic health disparities, including those found in rural communities. Interventions focus on proper nutrition, physical activity, tobacco use and exposure, and chronic disease prevention, risk reduction, and management.

—The Healthy Tribes Program funds tribal communities across the country to strengthen connections to culture to promote healthy lifestyles and reduce risk factors for chronic diseases. These programs together support community-developed strategies that work in rural settings to address the unique challenges that contribute to health disparities for these communities.

—Scaling the National Diabetes Prevention Program in Underserved Areas funds 10 national organizations to expand the reach of the National Diabetes Prevention Program lifestyle change program to underserved areas and populations, including hard-to-reach rural regions of the US with fewer resources to address health disparities. Priority populations include Hispanic/Latino, African American, American Indian/Alaska Native, and Asian American persons; Pacific Islanders; and noninstitutionalized people with visual impairments or physical disabilities.

Question. Dr. Walensky, as more Americans are vaccinated, there are certainly going to be more "breakthrough" cases—individuals who test positive for COVID–19 even after being fully vaccinated. This is to be expected since no vaccine is 100 percent effective. What concerns me is that while we're seeing breakthrough cases, for example the New York Yankees reported a staggering number of breakthrough cases in the spring, the CDC announced it will no longer track all breakthrough cases.

Are we letting down our guard—should all COVID–19 cases continue to be counted?

Answer. Despite the high level of vaccine efficacy, a small percentage of fully vaccinated persons will develop symptomatic or asymptomatic infections (i.e. breakthrough infections) with SARS–CoV–2, the virus that causes COVID–19. The goal of national surveillance for COVID–19 vaccine breakthrough infections is to identify unusual patterns, such as trends in age or sex, the vaccines involved, underlying health conditions, or which of the SARS–CoV–2 variants made these people sick. To date, no unusual patterns in cases have been detected in the data CDC has received.

Question. Can you explain why the change was made and exactly what CDC is now tracking with regard to breakthrough cases?

Answer. State and local health departments report COVID–19 vaccine breakthrough cases to CDC voluntarily. The number of COVID–19 vaccine breakthrough infections reported to CDC likely are an undercount of all SARS–CoV–2 infections among fully vaccinated persons. Reports may not be complete and because not all infected persons get tested, not all breakthrough cases will be identified. This is particularly true in instances of asymptomatic or mild illness. The shift to focus on hospitalized or fatal cases will help maximize the quality of the data collected on cases of greatest clinical and public health importance, while representative, scientifically valid data on vaccine effectiveness comes from studies CDC is leading across the country.

Reporting vaccine breakthrough cases through national surveillance is only one of the ways CDC measures COVID–19 vaccine effectiveness. CDC continues to lead studies in multiple U.S. sites to evaluate vaccine effectiveness and to collect information on COVID–19 vaccine breakthrough infections from these sites regardless of clinical status. For example, CDC is working with Emerging Infection Program (EIP) sites in nine states to compare SARS–CoV–2 sequence data from vaccinated and unvaccinated cases, regardless of clinical severity. CDC also is working on more than 30 ongoing studies to assess vaccine effectiveness, some of which include information on vaccine breakthrough infections in patients with asymptomatic and milder illness. Through these studies in various populations, locations, and settings,

CDC can obtain more representative, scientifically valid, and complete information about these types of infections.

CDC is also using the Coronavirus Disease 2019 (COVID–19)-Associated Hospitalization Surveillance Network (COVID–NET) to track and analyze breakthrough infections. This population-based surveillance system includes data on laboratory-confirmed COVID–19-associated hospitalizations in 99 counties in 14 states, representing approximately 10 percent of the U.S. population. COVID–NET cases are hospitalizations occurring in residents of a designated COVID–NET catchment area who are admitted within 14 days of a positive SARS–CoV–2 test. COVID–NET personnel collect COVID–19 vaccination status (doses, dates administered and product) from state Immunization information systems (IIS) for all sampled COVID-NET cases in 13 sites, which also include information on clinical outcome. Some sites have expanded collection of vaccination status to non-sampled cases, which were included for analysis if all cases in a single month had vaccination status available.

This strategic, deliberative approach will yield better information on vaccine effectiveness and provide critical insight on cases of greatest concern.

Question. Related, there is increasing concern about the public health impact of long-term symptoms weeks or months after an individual has had COVID–19.

What monitoring or tracking is the CDC undertaking with regard to COVID "long-haulers"?

Answer. CDC is spearheading rapid and multi-year studies to further investigate post-COVID conditions (PCC), also known as "long COVID" or "long-haul COVID." These studies will help us better understand post-COVID conditions and how to treat patients with these longer-term effects. For example, ongoing studies will follow patients for up to 3 years and provide information on the percent of persons who develop post-COVID conditions, assess risk factors for development of post-COVID conditions, and evaluate different virus strains and antibody responses.

Question. How many long-haulers would you estimate are living with post-COVID related symptoms?

Answer. At this time, we do not have a precise way to measure and capture the prevalence of persons living with post-COVID–19 related symptoms, but we know there are many people who are suffering from this.

Currently, CDC and its Federal partners have proposed a new PCC ICD–10 code and are looking at all considerations on how this may impact the final version of this new code. The new ICD-code could potentially be used for a range of conditions, including subsequent chronic respiratory failure to help track and monitor people living with PCC. CDC's National Center for Health Statistics (NCHS) presented a proposal for public input to implement the code U09.9, post-COVID–19 condition, based on a proposed international classification of diseases, tenth revision (ICD–10) code from the World Health Organization (WHO) last year. This proposal is expected to move forward after public input and may be implemented in October 2021 (as part of the regular ICD–10 code process/timelines) to allow clinical data systems and health insurers to adapt and fully implement it. We hope this will provide us with a better estimate of those who may be living with PCC.

Question. How does CDC plan to continue to monitor and track the long-term impacts of COVID?

Answer. CDC is using multiple de-identified electronic health record (EHR) databases to examine persistence of symptoms and incidence of post-COVID conditions. CDC has also partnered with health systems to perform in-depth medical record reviews, which can provide insight into the patterns of health effects that patients are experiencing.

Question. Dr. Walensky, CDC has received a lot of criticism throughout the pandemic. A lot of it is justified. And most of it transcends political leadership at the agency. There are a lot of lessons to be learned from what we did right and what we did wrong. As I said in my opening statement, we did a lot right—so much so, in fact, that we have three FDA authorized vaccines that are getting into Americans' arms as we speak. But we also must recognize the missteps when they happen as well. That is how we learn and how we become better for the next public health emergency. Unfortunately, much of the criticism about our pandemic response, that continues to this day, revolves around the CDC. As Chair Murray and Senator Burr work on a pandemic reform bill in the health authorizing Committee, I think it would be a benefit to this Subcommittee to hear from you on these issues as well. Can you please respond to the comments below:

Answer. First, CDC is risk adverse. I think that we have seen that in several cases, from mask mandates for campers to discouraging travel for the fully vaccinated.

Question. Second, CDC guidelines are impractical. The agency simply doesn't issue guidelines that are clear and straightforward enough to be useful. What I con-

tinually heard is that Federal guidance needs to be practical for implementers on the ground or the American people to follow it.

Answer. Since the early days of the pandemic, scientists at CDC have been using evidence from systematic reviews and expert judgement to develop guidance that informs various populations on how to slow the spread of COVID–19 and protect their health and their communities. The process and information communicated can be complex and evolves as our understanding of the virus increases. CDC's group of multidisciplinary stakeholders assesses the benefits and risks informed by data from the field and issues evidence-based guidelines. State and local health departments then decide how the research and guidance is implemented.

Question. Third, CDC has an entrenched bureaucracy that is unwilling or unable to think big or implement on a large scale. The perfect, and befuddling, example is why CDC didn't engage with private sector partners like Abbott or Roche to commercialize their assay. Testing was one of the early failures. Was this the reason why?

Further, at the outset, lab testing followed the flu model. Asymptomatic spread requires significant testing, but this was low-balled and kept in-house which could only produce about 100,000 tests when what needed to happen was to engage the private sector labs to get 1–2 million higher volume throughput.

Answer. CDC aids and equips state and public health laboratories in diagnostic testing for novel pathogens. When a new virus emerges or a public health need for a new diagnostic tool arises, CDC may develop a new diagnostic tool and, in partnership with state and local public health partners and non-governmental organizations, strategize distribution. This process is intended to fulfill needs within the public health scope of outbreaks or new technologies. It is not currently intended to replace or fulfill testing that may need to be developed or distributed by commercial vendors to meet broader health sector needs.

Furthermore, the EUA process for diagnostic (IVD) test development and analysis/validation follows a predetermined framework at CDC, as does deployment of the test after FDA authorization.

Question. Lastly, the Center structure at CDC is stove piped and hampered the response. As a result, response efforts were locked into the flu center, which treated COVID–19 like the flu—which spreads symptomatically. Is this the reason we missed asymptotic spread? Because we didn't have the right experts in charge or a CDC-wide body responsible?

Answer. On January 7, 2020, the Director of the National Center for Immunization and Respiratory Diseases (NCIRD) issued the directive authorizing a Center Level Response, Novel Coronavirus (nCoV) 2019 Response, for the pneumonia outbreak in Wuhan, China in consultation with the CDC Director. This Directive was effective January 6, 2020. As the situation evolved, CDC escalated its response from the Center and activated its Emergency Operations Center facilitating a CDC-wide response on January 20, 2020.

When reports of asymptomatic spread first emerged, CDC's guidance addressed the current circumstances. CDC proactively and aggressively investigated evidence from the field, and updated its guidance accordingly based on the best available data.

Question. Dr. Walensky, the Influenza Hospitalization Surveillance Network (FluSurv-Net) is a population-based surveillance system that collects laboratory confirmed influenza associated hospitalizations from 14 states. The coverage area for FluSurv-Net is roughly 29 million people, or 9 percent of the U.S. population. There is no site in Missouri and the Midwest is not represented at all, except for Iowa.

How can the CDC accurately track an influenza outbreak without real-time data from 36 states?

Answer. CDC's influenza surveillance systems are a collaborative effort between CDC and its many partners in state, local, and territorial health departments, public health and clinical laboratories, vital statistics offices, healthcare providers, clinics, and emergency departments. The system consists of complementary components that capture virologic surveillance, outpatient illness surveillance, hospitalization surveillance, and mortality surveillance. This comprehensive surveillance infrastructure is used to identify when and where influenza activity is occurring, determine which influenza viruses are circulating, detect changes in influenza viruses, and measure the impact influenza is having on outpatient illness, hospitalizations, and deaths. Surveillance is performed continuously throughout the year and data are presented in FluView, a weekly influenza surveillance report, and FluView Interactive, an online application which allows for more in-depth exploration of influenza surveillance data, which are updated weekly.

Additionally, the HHS Protect Hospital Data reporting system provides daily information on the number of patients hospitalized with influenza-related and

COVID-related illnesses from over 6,000 hospitals in all 50 states and U.S. territories. This system provides situational awareness of severe respiratory illness and local hospitalization trends for influenza and COVID–19 on a daily basis that is beneficial for monitoring severe illness during an outbreak.

Question. And how did the lack of real-time data stymy the response to COVID–19?

Answer. COVID–19 highlighted the importance of real-time data needed to get ahead and stay ahead of the disease. CDC must build on initial investments and lessons learned from COVID–19 by investing in the nation's public health infrastructure. The ability to respond to a public health emergency requires a strong day-to-day public health system, including efficient data sharing, and supported by infrastructure that is not highly segmented by disease, condition, or activity. With investment in fiscal year 2022, CDC will begin to address mission-critical gaps in public health infrastructure and capacity nationwide. Transitioning from sporadic influxes of supplemental funding tied to a specific emergency to flexible funding that can prevent another crisis will strengthen the current public health system. Flexible, sustainable investments in infrastructure and capacity are critical for saving lives and averting economic losses caused by public health emergencies and chronic public health problems.

Question. Reports are already speculating that the next flu season may be bad after a year of hardly any flu cases.

How concerned should we be that many Americans are left without an immunity to flu—especially children—who may be more susceptible than any other recent year?

Answer. A flu vaccine is the best way to protect children from flu. CDC recommends that everyone 6 months and older should get a flu vaccine every season. Annual vaccination is important to protect both yourself and to provide protection for those who are more vulnerable to serious flu illness, including children, older adults, and people with certain chronic health conditions.

The flu can be dangerous for children. During the 2019—2020 season, nearly 200 flu deaths in children were reported to CDC in the United States, which was the highest reported number of pediatric influenza deaths on record. About 80 percent of those children were not vaccinated. Last year, childhood influenza vaccination coverage is estimated to have dropped 4.1 percentage points from 62 percent during 2019–2020 to 58 percent.

CDC is working diligently to support the vaccination of as many Americans as possible during the upcoming influenza season. Vaccine manufacturers have projected that they will supply 188 to 200 million doses of influenza vaccine for the 2021–2022 season. CDC will continue to emphasize the importance of influenza vaccination through targeted communication outreach. CDC will build off its 2020–2021 communication campaign, which was estimated to have been seen more than 5 billion times. This year's media campaign will include population-wide outreach and will have a special emphasis on targeting disproportionately affected audiences, including people ages 40–64 with chronic medical conditions, African American and Hispanic persons, essential workers, pregnant women, and parents.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

Question. The Alabama Department of Public Health saw a delay in the reporting of vaccine distributions upon the initial allocation of vaccine allotments to states. Ultimately, there was not a delay in the distribution of the vaccine, but in the reporting of administered vaccines. In the last 15 months, Congress has appropriated $1.1 billion to the CDC for the purpose of public health data modernization and addressing public health data reporting issues that were experienced in Alabama. In 2019, CDC stakeholders requested $1 billion over a ten-year period to tackle public health data modernization, which CDC has indicated is needed and Congress has far surpassed to this point. $500 million was appropriated through both the CARES Act and the American Rescue Plan Act of 2021, and $50 million was appropriated for both fiscal years 2020 and 2021 annual appropriations for the funding of public health data modernization through the CDC.

Could you give a detailed description of how that $1.1 billion has been used to date, who that funding has gone to (e.g., through contracts, cooperative agreements, and grants), and for how much? Please also provide a detailed plan for the remaining funds.

Answer:

ANNUAL APPROPRIATIONS

Table 1. Budget Plan for Annual Appropriations [1,2]

Major Activity	Fiscal Year	
	2020	2021
Partnering with State and Local Public Health, Partners, and Health Care Systems	$32.5M	$32.5M
Accelerating Public Health Data for Action	$15.5M	$15.5M
Sustaining Innovation	$2 million	$2 million
Total	$50 million	$50 million

[1] Working Capital Fund and program support costs are spread across all activities.
[2] Amounts per activity are based on current information and may require adjustment.

Data Modernization Base Funding

Congress recognized the need to modernize CDC's data systems and provided funding in fiscal year 2020 dedicated specifically to data modernization. DMI base funding is focused on strengthening and sustaining the core foundational surveillance systems that state, local and territorial jurisdictions use every day. These systems benefit all of public health and serve as "early warning signals" for our biggest threats—systems that handle emergency room visits, case reporting, notifiable diseases, lab results, and death data. Investments to date have laid the groundwork and spurred real progress, but much work remains to be done.

In fiscal year 2020, CDC focused on solutions for the timely, secure, and accurate flow of health data from electronic health records, laboratories, and other primary data sources to state and local jurisdictions and the multi-directional data flows between these jurisdictions and CDC. The focus of these efforts has been on the following:

—Expanded use of eCR and connectivity to Electronic Health Records (EHR)
—Increasing the number of emergency departments and use of syndromic and disease surveillance data through the NSSP
—Enhancing automated electronic laboratory reporting (ELR) and implementation of Electronic Test Orders and Results (ETOR) at clinical and public health laboratories
—Implementing improvements to birth and death reporting in NVSS
—Modernization of disease reporting through NNDSS and of states' National Electronic Disease Surveillance System (NEDSS) Base System (NBS)

CDC has continued to reimagine what its core surveillance systems could deliver in fiscal year 2021. CDC works closely with public health partners to reduce their reporting burden and make sure everyone has the capacity to connect with each other. The pandemic drove huge leaps in electronic case reporting (eCR), with thousands of healthcare facilities now exchanging automated, real-time health information. All 50 states, D.C., and 11 large local jurisdictions are now capable of receiving COVID–19 electronic case reports, up from only a handful of jurisdictions in late 2019. The National Vital Statistics System (NVSS) expanded its modernization community and began delivering provisional COVID–19 death data and new data on excess deaths. Currently, 67 percent of deaths are reported electronically in less than 10 days, up from 7 percent in 2010. CDC has dramatically improved the quality of laboratory report data received by public health through nationwide use of standardized messaging with Electronic Laboratory Reporting (ELR), with 56 jurisdictions reporting lab data directly to CDC, up from zero in 2019. Data from 70 percent of all U.S. emergency departments is reported to CDC through the National Syndromic Surveillance Program (NSSP), with 75 percent of emergency department data received in less than 24 hours of a visit. As a result, more early warning signals from systems that track emergency department visits and notifiable diseases were and are being captured.

In fiscal year 2020, approximately $22.5 million was distributed through a cooperative agreement to 58 awardees, including states, cities, and territories, with an average award of $391,417. These funds supported specific strategies, activities, and outcomes to improve health information systems infrastructure, workforce development, and public health laboratories. States have used these funds to conduct needs assessments, strengthen technical and informatics skills, streamline changes to surveillance systems, and identify a lead person in each jurisdiction to support data modernization.

CDC is continuing to improve core public health data systems, enhance data science and informatics workforce capabilities across the public health systems, improve interoperability and innovation through adoption of new standards and ap-

proaches for public health reporting such as Fast Healthcare Interoperability Resources (FHIR) standards, and support ongoing data modernization at CDC and with its partners.

Our focus in fiscal year 2021 has been on providing technical assistance to state and local jurisdictions to leverage progress made at the Federal, state, and local levels on electronic case reporting (eCR) and Electronic Test Orders and Results (ETOR), as well as other core systems and processes for data exchange. Technical assistance is being provided by CDC and through a cooperative agreement with public health partners like the Association of Public Health Laboratories (APHL) and the Council of State and Territorial Epidemiologists (CSTE). These partners are providing technical assistance to jurisdictions focused on improving data sharing, accelerating use of shared decision support services, data science upskilling of the public health workforce, and developing and increasing use of standards to improve quality and timeliness of reported data. Focus on continuing to improve core public health data systems, enhance data science and informatics workforce capabilities across the public health systems, improve interoperability and innovation through adoption of new standards and approaches for public health reporting (such as FHIR standards) and support of ongoing data modernization at CDC and with its partners

CDC also provided funding through a cooperative agreement to three tribal health entities to focus on three activity areas: augmenting workforce development and capacity, identifying and deploying specific enhancements in public health data and health information systems, and employing shared services to improve data quality, exchange, and management. CDC has provided funding to tribal entities in fiscal year 2021 to focus on the improving access to data, modernizing infrastructure for data collection and analysis, and expanding workforce data skills.

To keep CDC at the forefront of innovative, data-driven public health solutions, we are strengthening skills for a state-of-the-art data science workforce by supporting workforce development to assure capable data scientists and informatics-skilled staff are available to state, territorial, local, tribal, and Federal public health agencies. In fiscal year 2020, CDC completed a pilot cohort of team training through the Data Science Upskilling (DSU), which included 79 unique learners on 18 teams. DSU is a new model of team training using experiential learning tailored to agency priorities. Teams include both CDC staff and fellows from the Public Health Informatics Fellowship Program utilizing curated online courses and in-depth, bootcamp-style training on topics like machine learning. Team projects align with agency DMI priorities, CDC's winnable battles, or COVID–19 response. CDC also funded the Council of State and Territorial Epidemiologists (CSTE) to implement a similar program, Data Science Team Training (DSTT).

DSTT was designed as a replica to CDC's Data Science Upskilling program, with modifications to better meet state, tribal, local, and territorial, needs. Training activities began in January 2021 with 20 teams and 86 learners. There is representation from a mix of state, local, tribal, and territorial health departments.

CARES ACT FUNDS

Together with base funding, the Coronavirus Aid, Relief, and Economic Security (CARES) Act extended and accelerated CDC's data modernization goals for the nation. CARES funding focuses on infrastructure, innovations, and connecting systems and data sources. Rather than discrete, one-off projects or a narrow focus on individual capacities, we have looked at the entire surveillance and data ecosystem and identified the areas most in need of investment and modernization. While COVID–19 is the priority, the end goal of DMI is to create lasting, adaptable solutions that will make public health more responsive and resilient in the future.

CARES funding is being invested across three major areas:

—Data Sharing across the Public Health Ecosystem
—Modernizing critical tracking capabilities and core surveillance systems
—Extending data lakes and services that support electronic laboratory reporting and immunization information
—Expanding the type, variety, and quality of data available to CDC programs and STLT
—Automating the flow of data from electronic health records and other sources
—CDC Systems and Service Enhancements for Ongoing Data Modernization
—Expanding enterprise cloud services to bring in and use large datasets from partners in new ways
—Expanding CDC's enterprise data hub, orchestration, warehouse, lake, analytics, and visualization capacity
—Building a state-of-the-art data science workforce
—Ensuring open and accessible data while protecting privacy and security

—New Standards and Approaches for Public Health Reporting
—Implementing new standards and approaches, such as FHIR across the public health ecosystem
—Assessing policy/legal barriers to sharing data, including STLT data

Our work focused on data sharing across the public health ecosystem includes modernizing critical tracking capabilities and surveillance systems, such as the National Healthcare Safety Network (NHSN), Public Health Environmental Tracking Network, the National Electronic Injury Surveillance System-All Injuries Program (NEISS–AIP), and the National Vital Statistics System (NVSS). We are also rapidly expanding electronic case reporting (eCR) from healthcare to public health. We have rapidly extended data lakes and services that support electronic laboratory reporting and immunization information, including the creation of a new immunization data lake that is now actively receiving and making available 3.1M administration records per day. Funding has also supported the creation of the Pan Respiratory Surveillance Initiative, informing our knowledge of molecular surveillance, viral evolution, and helping track trends in emerging variants.

Enhancements to CDC systems and service enhancements for ongoing data modernization include deploying cloud-based technology to bring in and use large data sets from partners in new ways, while also providing highly scalable data analytic and visualization capabilities. This is already strengthening our data sharing capabilities. For example, we modernized data sharing with Homeland Security to ingest daily international passenger arrival contact tracing information, parse it, and provide it overnight to states through a secure, cloud-based file transport system for STLTs to ingest into their individual tracking systems. In the past year, the percentage of usable data has improved to over 95 percent and time to transmit to STLTs has decreased from days to overnight. Ongoing work to expand CDC's enterprise data hub, orchestration, warehouse, lake, analytics, and visualization capacity makes us better able to support modernization project needs across the agency. We have streamlined identity proofing and access management, use of enterprise code repositories, and enterprise security and code complexity scanning. The CDC Data Hub actively continues to ensure that analytics, including machine learning and artificial intelligence, are enabled in cloud-based data pipelines. At the same time, we have Initiated training opportunities to build a state-of-the-art data science workforce, including CDC's Data Academy, which has delivered more than 1000 hours of free training.

Our modernization efforts include developing new standards and approaches for public health reporting. We are preparing CDC and our STLT and healthcare partners to implement technologies and standards that make systems interoperable and help these systems "speak the same language." Federal policies and advancements in technologies are opening doors to make new connections for exchanging public health data, and a major focus is on implementing Fast Healthcare Interoperability Resources, or "FHIR," across the public health ecosystem. FHIR application programming interfaces (APIs) can help public health to access detailed and timely data from EHRs while lowering burden on and delivering greater value to data providers. We are also working closely with jurisdictions and research partners to innovate toward FHIR-based interoperability at every level. This will give us more complete data and surveillance capabilities nationwide. Our goal is to take what works and scale nationwide, through pragmatism and collaboration to realize significant benefits to the way we use and share data across all of public health.

Table 2. Budget Plan for CARES Act Appropriations [1,2]

Thematic Area	Funding Levels for Fiscal Year 2020–2021
Data Sharing Across the Public Health Ecosystem	$140.55M
CDC Systems and Service Enhancements and Ongoing Data Modernization	$120.62M
New Standards and Approaches for Public Health Reporting	$13.83M
Additional fiscal year 2020 funding for Emergency Operations Center public health surveillance activities	$41.44M
Future fiscal year 2022–2023 funding	$183.56M
TOTAL	$500 million

[1] Working Capital Fund and program support costs are spread across all activities.
[2] Amounts per activity are based on current information and may require adjustment.

AMERICAN RESCUE PLAN FUNDS

CDC appreciates further appropriations in data modernization awarded through The American Rescue Plan Act. Where possible CDC is evaluating recent invest-

ments made in national data infrastructure and working with states to understand the gaps that still exist and barriers to modernizing to further drive the best practices for efficient and effective data modernization across the public health ecosystem. Planning is currently underway to apply ARP data modernization resources to drive a flexible, responsive, and modern, response- ready data infrastructure.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Question. In February, the CDC issued an order requiring face masks on conveyances and at transportation hubs. Last week, you updated your guidance for fully vaccinated individuals, saying they can stop wearing masks indoors and outdoors. However, the CDC has not taken any steps to update the February transportation order.

When can we expect such an update?

Answer. While those who are fully vaccinated may resume many activities without wearing a mask, the travel environment presents a unique set of circumstances based on the number and close interaction of travelers (both vaccinated and unvaccinated). Traveling on public transportation increases a person's risk of getting and spreading COVID–19 by bringing people in close contact with others, often for prolonged periods. Staying 6 feet away from others is often difficult on public transportation conveyances. People may not be able to distance themselves by the recommended minimum of 6 feet from other people seated nearby or from those standing in or passing through the aisles on airplanes or buses, for example.

Correct and consistent use of masks on public transportation conveyances and at transportation hubs protects travelers and workers, enables safe and responsible travel during the pandemic, and helps to reduce the spread of coronavirus disease 2019 (COVID–19).

CDC will update the Order and other recommendations as more people get vaccinated, as rates of COVID–19 change, and as additional scientific evidence becomes available.

Question. Given the different risk levels of COVID transportation across the transportation network, for instance traveling on public transportation verses operating a freight locomotive, can we expect different guidance?

Answer. CDC will continue to evaluate the requirements of its Order and determine whether other changes are warranted by examining characteristics like the transportation environment as well as indoor and outdoor locations. CDC will update the Order and other recommendations as more people get vaccinated, as rates of COVID–19 change, and as additional scientific evidence becomes available.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. There are two FDA-approved buprenorphine products for the treatment of moderate to severe chronic pain. Both buprenorphine-based products have been classified by the U.S. Drug Enforcement Administration (DEA) as Schedule III meaning they have less abuse and addiction potential compared to Schedule II drugs like oxycodone, fentanyl, and oxymorphone. Furthermore, buprenorphine provides an important safety advantage as it is the only opioid with a demonstrated ceiling effect on respiratory depression, which is what typically leads to death in an opioid overdose. In addition, there are several buprenorphine-based products approved to treat opioid addiction. This means that one of the same drug compounds that help millions of Americans curb their addiction to illicit and prescription opioids can also be used effectively to treat chronic pain with a lower chance of addiction, abuse and overdose. However, it's my understanding that the CDC's Guideline for Prescribing Opioids for Chronic Pain, which was published in 2016, doesn't include any language about the benefits of Schedule III buprenorphine products, even though they have less potential for addiction and abuse, for the treatment of chronic pain. Instead, the Guideline recommends starting opioid therapy with immediate release Schedule II opioids, which have been shown to have higher rates of addiction, abuse and overdose.

Do you know why the Guideline doesn't differentiate between Schedule II and Schedule III opioids and recommend the use of Schedule III opioids given their enhanced safety profile and lower risk of abuse, addiction and overdose?

Answer. The evidence reviews informing the 2016 Guideline found evidence of increased risks from extended-release/long acting (ER/LA) full agonist opioids but did not identify other differences in safety or effectiveness by type of opioid, including by schedule. Therefore, there was no evidence on which to base recommendations

to use different types of opioids (except recommendations on ER/LA vs. short-acting opioids).

Question. Can you provide an update on the process and timing of the CDC's efforts to update the Guideline? Do you expect the updated Guideline to consider DEA scheduling and recommend prescribers begin opioid therapy with Schedule III drugs, when clinically appropriate, before advancing to a Schedule II Drug?

Answer. CDC funded the Agency for Healthcare Research & Quality (AHRQ) to conduct systematic reviews of the scientific evidence that has been published since the Guideline's release in March 2016. These reviews are the following:

—Noninvasive Nonpharmacological Treatment for Chronic Pain (An Update)

—Nonopioid Pharmacologic Treatments for Chronic Pain

—Opioid Treatments for Chronic Pain

—Treatments for Acute Pain: A Systematic Review

—Acute Treatments for Episodic Migraine

Based on AHRQ's completed reviews, CDC has determined that an update to the Guideline and an expansion of the Guideline to certain acute conditions is warranted.

On December 4, 2019, the Board of Scientific Counselors of the National Center for Injury Prevention and Control (BSC/NCIPC) established the Opioid Workgroup (OWG). The OWG will report to the BSC/NCIPC, a Federal advisory committee. The primary purpose of the OWG is to review the updated draft Guideline for opioid prescribing (as prepared by CDC) and to develop a report that will provide the workgroup's findings and observations about the draft GL to the BSC/NCIPC.

The OWG began reviewing a draft Guideline for opioid prescribing (as prepared by CDC) in March 2021. The OWG met for a total of 11 times since October 2020 and developed a report of findings and observations about the draft Guideline update (prepared by CDC). The OWG presented its findings at the July 2021 BSC/NCIPC meeting. The BSC/NCIPC will then review the OWG's report and provide recommendations for CDC to consider as part of the Guideline update process.

It is anticipated that a revised Guideline will be posted in the Federal Register for a 60-day public comment in late 2021, which will provide a critical opportunity for diverse input from the public.

Release of a final updated Guideline is anticipated to occur in late 2022.

On opioid therapy—there are very limited clinical trial data comparing safety and efficacy of partial agonist buprenorphine with full agonist/schedule II opioids for chronic pain. In order to ensure that the updated guideline would be informed by available clinical evidence on types of opioids, CDC asked AHRQ to specifically address, in its evidence review on opioids for chronic pain to inform CDC's guideline update, the following questions on effectiveness and safety of opioids by type of opioid:

> "Key Question 1. Effectiveness and Comparative Effectiveness . . . . b. How does effectiveness vary depending on . . . (4) the type of opioids used (e.g., pure opioid agonists, partial opioid agonists such as buprenorphine or drugs with mixed opioid and nonopioid mechanisms of action such as tramadol or tapentadol)?"
>
> "Key Question 2. Harms and Adverse Events . . . . b. How do harms vary depending on . . . (5) the mechanism of action of opioids used (e.g., are there differences between pure opioid agonists and partial opioid agonists such as buprenorphine or drugs with opioid and nonopioid mechanisms of action such as tramadol and tapentadol) . . . ?"

The AHRQ evidence review published in 2020 found very limited evidence on comparative safety or effectiveness of opioids for chronic pain by type of opioid. Please see the report for additional detail, which can be found at https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioids-chronic-pain.pdf.

CDC is considering all findings from the AHRQ evidence reviews in developing updated recommendations.

SUBCOMMITTEE RECESS

Senator MURRAY. The committee we will next meet in Dirksen 562, Wednesday, May 26 at 10 a.m., for a hearing on the Biden Administration's Budget Request for the National Institutes of Health.

Thank you very much.

[Whereupon, at 11:50 a.m., Wednesday, May 19, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, May 26.]

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

WEDNESDAY, MAY 26, 2021

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

The subcommittee met at 10:01 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.

Present: Senators Murray, Reed, Shaheen, Schatz, Baldwin, Murphy, Manchin, Blunt, Shelby, Graham, Moran, Kennedy, Hyde-Smith, Braun, and Rubio.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

STATEMENT OF FRANCIS S. COLLINS, M.D., PH.D., DIRECTOR

ACCOMPANIED BY:

DIANA BIANCHI, M.D., DIRECTOR, EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

ANTHONY FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

GARY GIBBONS, M.D., DIRECTOR, NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

ELISEO PÉREZ-STABLE, M.D., DIRECTOR, NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES

NED SHARPLESS, M.D., DIRECTOR, NATIONAL CANCER INSTITUTE

BRUCE TROMBERG, PH.D., DIRECTOR, NATIONAL INSTITUTE OF BIOMEDICAL IMAGING AND BIOENGINEERING

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 please come to order.

Today, we are having a hearing on the Biden Administration's fiscal year 2022 Budget Request for the National Institutes of Health. Senator Blunt and I will each have an opening statement, and then I will introduce our witnesses. And after the witness testimony, Senators will each have 5 minutes for a round of questions.

Before we begin, I do want to walk through the COVID–19 safety protocols that are in place today. And again, I really want to thank

all of our clerks and everyone who has really worked hard to get this set up and help us all stay safe and healthy. So, thank you to them.

For today, we are going to be conducting this hearing following similar COVID protocols to what we have used in the past. Committee members are seated at least 6 feet apart. Some Senators are participating by videoconference. However, I do expect that this will be our final hybrid hearing, and we will be able to return to regular, in-person hearings at our next hearing.

Consistent with CDC guidance, those who are fully vaccinated do not need to wear a mask, though they may still choose to do so. And 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.

As of today, almost half of U.S. adults are fully vaccinated. And while we have a lot of work left yet to do to reach communities who still cannot get vaccines and reassure people who still have many questions about them, we can see the light at the end of the tunnel. And, I really want to thank all of our witnesses, especially Dr. Collins and Dr. Fauci, for putting in long hours and putting science first.

Where we are at today is a testament to the tireless work scientists at NIH have been doing to study this disease and how we can best fight it, and oversee clinical trials for vaccines and therapeutics and more, to ensure they are safe and effective. And, of course, as our witnesses know, our historically fast progress in fighting COVID–19 and developing safe and effective vaccines was actually years in the making.

The pace of discovery we have seen this past year was made possible by research into mRNA vaccines we funded in response to Ebola and other viruses, and biomedical research enterprise that has been built over decades to become one of the most cutting edge in the world.

This should be an important reminder when it comes to biomedical research. You can never fully predict how the discoveries of today will prepare you for the challenges of tomorrow. That is why you have to build the robust research enterprise and recruit diverse, world class talent, and make sure scientists can do their work free from political interference.

And President Biden's budget, which proposes over $40 billion for NIH (National Institutes of Health), the largest increase in the agency's history, will go a long ways towards making sure we can continue to prioritize this. This budget will reinforce our work to fight COVID–19, along with many other diseases and disorders that threaten families in my home State of Washington, or Missouri, or across the Country.

It includes funding to improve treatments for addiction and substance use disorders, and funding to aid the fight against cancer, Alzheimer's disease, and rare diseases families across the Country are grappling with.

President Biden's budget request will also fund research to help us study the health effects of climate change, which may be in-

creasing the number of infectious disease outbreaks; identify solutions to gun violence, which continues to claim tens of thousands of lives each year in this Country; and root out the health inequities in our Country, which are undermining the health of people of color, people with disabilities, rural communities, those paid low incomes, and more.

The President has also proposed $6.5 billion for a new initiative—the Advanced Research Projects Agency for Health. Like the defense initiative it is inspired by, ARPA–H is envisioned as breaking the mold for how cutting-edge research is conducted, speeding up the development of medical treatments by funding innovative projects. I am interested to hear more about how it can add to NIH's work and operate as something truly distinct from its other traditional, biomedical research programs.

Of course, at the end of the day, innovation is not just driven by new programs and new investments. It is driven by people, which is why with as much as we invest in NIH each year, and as important as its work to its families, our families, we cannot afford to have this agency's potential limited or its success threatened by bias, discrimination, harassment, or assault in the workplace.

Unfortunately, we know that in the biomedical research community, the prevalence of researchers of color is too low, and the prevalence of sexual harassment is too high. These are real problems with real consequences for biomedical research and the people who do the lifesaving work we are all benefitting from today.

I commend NIH for the efforts it has taken on both of these fronts so far. NIH has done work to examine barriers to diversity among its researcher ranks and how its own practices have reinforced structural biases that allow discrimination to persist. But, more work remains to tear down barriers and create lasting change.

And when it comes to sexual assault, Director Collins, I am glad you have taken some forceful action to address the problem among the NIH workforce, but NIH must do more to use its enormous influence with the research community to enforce change in the Nation's universities and research institutions. I expect NIH to continue building on its efforts so far to remove racism, discrimination, and harassment from research, and I will continue to follow up on that progress.

Finally, as proud as we all are of our Nation's biomedical research institutions, we do not invest billions of dollars in biomedical research out of pride, nor do we invest in them to help pharmaceutical companies make astronomical profits. We do it to bring new treatments, cures, and hope to people across the Country and across the world. It is important that we never lose sight of this because even the most brilliant miracle cure can only save people if they can actually get it.

Just as I hope to work with my colleagues on both sides of the aisle to make lifesaving investments in biomedical research like those proposed in the President's budget, I also hope we can work together to bring down the cost of healthcare, especially for prescription drugs; keep working towards universal health coverage; and bring the cures we are investing in to the families who need them.

With that, I will turn it over to Senator Blunt for his remarks.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Well, thank you, Chair Murray. I appreciate having this hearing today and appreciate being able, again, to start this process with you as we did last week on our first hearing.

I am certainly glad that Dr. Collins and the Institute directors are here with us today. I think two of the directors are testifying before the committee for the first time, and, so, welcome to the two of you. And this is a helpful relationship for us, and hopefully for you.

Certainly, the challenges we have faced over the past year have been unanticipated and significant. I think the global pandemic reinforced the importance of the National Institutes of Health. In less than a year, NIH was able to take this novel coronavirus and help develop two FDA (Food and Drug Administration)-authorized vaccines, two FDA-authorized therapeutics, and 16 rapid diagnostic tests, including the first FDA-authorized point-of-care diagnostic test for COVID–19 to combat its spread and its effects.

A year ago, when we would have had a similar discussion, one of the big topics would be, why can't we get enough tests? NIH stepped up and really played a big role in seeing that we had enough tests. We have not heard that discussion for a long time. And that does not mean that millions of tests are not being taken every day. It just means we figured out at this committee and NIH to be part of meeting that need.

It was revolutionary to watch NIH work, but it did not just happen. In a time of crisis, during shutdowns, during social distancing, dealing with a disease that has never been seen before, the system and its nationwide grantees were able to use their expertise and infrastructure to, again, develop tests, treatments, and vaccines. Our research infrastructure was tested like never before and, in my opinion, it succeeded in remarkable ways.

I believe there are really three reasons for that. First, in the past 6 years, this committee and the Congress, in a bicameral, bipartisan way have prioritized and invested in NIH. Within that 6-year timeframe, funding for medical research increased by almost $13 billion, or nearly 43 percent over that 6 years after a decade at virtually level funding. This investment encouraged young scientists, young researchers, and mid-career researchers that were leaving the field before that to stay in the field. And, with your insistence, Dr. Collins, some of that money every time was set aside to be sure that it was going to first-time grantees.

We were able to shore up the research infrastructure across the Country and provide research into mRNA, an idea that had never produced a vaccine before and, of course, became the foundation for the two principal vaccines that were developed very much with the involvement of NIH.

Our ability to pivot so quickly and so successfully to fighting COVID–19 could not have been accomplished had we stayed at the funding levels we were at 7 years ago. The buying power was not where it needed to be. Young researchers were leaving the field. Tough budgetary decisions meant that people were not only getting their applications rejected at significant levels; they just, frankly,

stopped making a lot of applications. That is not your problem, by the way, today.

Second, at the height of the pandemic, Congress gave the Department of Health and Human Services significant funding and flexibility to create Operation Warp Speed. It was successful in developing two FDA-authorized COVID–19 vaccines and commercializing another with the help of NIH because we united in our effort to make that happen.

One of the things we did was to really invest in vaccines that we did not think were certain to work, but thought were likely to work, and that meant that vaccines were available when they got FDA authorization rather than months after they got FDA approval. Because of that, fully half of all adults have been vaccinated now in the United States as we work toward a bigger number than that.

We pushed private industry and worked with private industry in ways we had not before. I have said at the time, one way to win the horse race is to bet on all the horses. And I think to a great extent we did in the vaccine effort, bet on all the horses we thought had a chance to finish the race, and it made a difference.

Finally, one of the most important lessons learned from the pandemic is the value of having the Federal Government, on occasion, as a more active partner in research and development instead of just a sponsor. The ambitious speed and goals that pushed private companies to research, develop, and manufacture a COVID–19 vaccine, along with what we did in testing, really created the kind of breakthroughs we needed.

RADx and Warp Speed, I think put us in a different place than we would have been 2 years ago in thinking about how we can look at some of our research efforts in another way. That is why I want to work with the Administration to support the ARPA–H initiative. This will be a new institute, or is proposed to be a new institute, and I think that is what should be the case. They will have the flexibility and tools necessary to both nimbly and innovatively respond to both the next pandemic and also some of the big health issues we face today.

This is a critical moment in a rapidly changing healthcare world. Finding those things that the kind of Warp Speed, Shark Tank, RADx relationship could enhance in cancer, in Alzheimer's, in every disease where there is an opportunity; where we see that moment and know that this is something that does not necessarily call for a 5-year research grant, but some sort of partnership different than that that moves toward a real conclusion sooner than we might otherwise be able to do that.

ARPA–H should not do what the other institutes do, but it should do what the other institutes cannot do in a crosscutting way that goes throughout the institutes, looking for opportunities, frankly, in the other institutes where there is a breakthrough moment that we could look at differently. I think we can help fill gaps here that otherwise would not be filled and look forward to that discussion.

Now, also, as someone working with Senator Murray for the last 6 years to increase the funding and the focus in what NIH has been doing, we clearly want to be sure that this somehow does not

take away from the solid research that proves so effective in getting us ready for what we just saw.

So, Dr. Collins, I look forward to working with you and Chair Murray and the Administration in making ARPA–H a reality. I think the moment is ready for that. I think because of what has happened in the last 2 years, NIH is ready for that, and look forward to the discussion today.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Thank you, Chair Murray. I appreciate Dr. Collins and the other Institute Directors for being here today.

The challenges we have faced over the past year in a global pandemic reinforced the importance of the National Institutes of Health.

In less than a year, NIH was able to take this novel coronavirus and develop two FDA-authorized vaccines, two FDA-authorized therapeutics, and 16 rapid diagnostic tests, including the first FDA-authorized point-of-care diagnostic test for COVID–19, to combat its spread and effects.

This was revolutionary, and it didn't happen without decades of preparation.

In a time of crisis, during shutdowns and social distancing, for a disease never seen before, the NIH and their nationwide system of grantees were able to use their expertise and infrastructure to develop tests, treatments, and vaccines for COVID–19. Our research infrastructure was tested like never before, and it succeeded. And I believe there were three key reasons behind this success.

First, for the past six years, this Committee and Congress have prioritized and invested in NIH. Within this timeframe, funding for medical research increased by $12.85 billion, or nearly 43 percent, after having spent the previous decade at virtually level funding.

This investment encouraged young and mid-career scientists in the field, who often have the most novel and innovative research ideas, shored-up the research infrastructure across the country, and provided research into mRNA, which is the foundation for two of the COVID–19 vaccines.

Our ability to pivot so quickly and so successfully to fighting COVID–19 could not have been accomplished had this Committee let NIH funding stagnate for another decade, dragging down its buying power, and letting young researchers leave the field. Making the tough budgetary decisions necessary to prioritize the NIH paid off.

Second, at the height of the pandemic, Congress gave the Department of Health and Human Services significant funding and flexibility to create Operation Warp Speed. It was successful in developing two FDA-authorized COVID–19 vaccines and commercializing another, with the help of NIH, because it united the federal government, private companies, and researchers around a common goal.

The reason that we have been able to fully vaccinate half of all US adults is because there was a deliberate strategy in the last Administration to focus and provide funding for any COVID–19 vaccine or therapeutic that had the likelihood to work. We took financial risks to manufacture vaccines as the development process was still underway.

We pushed private industry to innovate their own approaches. And we forever changed the drug approval process. As I have said before, the way to win a horse race is to bet on all the horses. That is what this Committee and the previous Administration did.

Finally, one of the most important lessons learned from the pandemic is the value of having the Federal Government become a more active partner in research and development, instead of just a sponsor.

The ambitious speed and goals that pushed private companies to research, develop, and manufacture a COVID–19 vaccine through Operation Warp Speed demonstrated that active collaboration in public-private partnerships, in conjunction with significant funding, are game changers in creating scientific breakthroughs.

Now we must learn from these lessons. There is an opportunity to build upon Operation Warp Speed and NIH's RADx diagnostic testing program to leverage public-private partnerships to dramatically accelerate the development and approval of new treatments and technologies. What two years ago would have been termed risky and financially unpalatable now is possible.

And that is why I want to work with this Administration to support the ARPA–H initiative. This will be a new Institute that will have flexibility and tools necessary to nimbly and innovatively respond to both the next pandemic and also to

some of the biggest health issues Americans face today, like cancer and Alzheimer's disease.

ARPA–H should do what other NIH Institutes cannot. It needs to be cross-cutting throughout all the NIH Institutes and collaborative both internally with NIH and HHS and externally with partners. It needs to be innovative. And it should help fill the gaps we clearly saw during the pandemic between basic science and commercialization of COVID–19 vaccines and therapeutics.

Simply put, there are aspects of NIH research that could move much faster outside the traditional NIH grant cycle. The NIH peer review process is the gold standard, but we also need to recognize that it doesn't work for all research at all times.

I look forward to working with you, Dr. Collins, and you, Chair Murray, on making ARPA–H a reality.

It will take collaboration between the Administration, NIH, and Congress. But as we work toward a new Institute to accelerate the application and implementation of health discoveries, we must make sure that basic science is not abandoned. ARPA–H should not be the shiny new toy we all focus on, especially not to the detriment of the NIH research community as a whole.

If there is one lesson we must take from this pandemic, it is that our nation's success depends on the medical research infrastructure across this country supported by the NIH. Now is not the time to abandon it. Now is the time to make it even stronger.

Thank you.

Senator MURRAY. Thank you very much, Senator Blunt.

I will now introduce our witnesses.

Dr. Francis Collins is the director for the National Institutes of Health.

Dr. Diana Bianchi is the director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

Dr. Anthony Fauci is the director of the National Institute of Allergy and Infectious Diseases.

Joining us virtually is Dr. Gary Gibbons. He is the director of the National Heart, Lung and Blood Institute.

Dr. Eliseo Pérez-Stable is the director of the National Institute on Minority Health and Health Disparities.

Dr. Ned Sharpless is the director of the National Cancer Institute.

And, finally, Dr. Bruce Tromberg is the director of the National Institute of Biomedical Imaging and Bioengineering.

So, Dr. Collins, we will turn to you for your opening remarks.

SUMMARY STATEMENT OF DR. FRANCIS S. COLLINS

Dr. COLLINS. Thank you, Chair Murray and Ranking Member Blunt and distinguished members of the subcommittee. I am honored to be here today with my colleagues representing the National Institutes of Health, the NIH.

I could spend hours describing the exciting work the President's budget is proposing for NIH, including major investments to address impacts of the COVID–19 pandemic, reduce health disparities in maternal mortality, improve mental health, broaden approaches to pain and opioid addiction, and establish a bold, new agency within NIH called ARPA–H.

But, in our brief time together, it is also important to emphasize how steady funding increases that you have provided to NIH, starting well before the pandemic, made it possible for NIH to meet the challenges of the pandemic and to prepare for what comes next.

Often at these hearings, I share a story of a patient whose life has been saved by NIH research, but in this uniquely challenging year, it is hard to single out any one person. In fact, all of the more

than 160 million Americans who have received COVID–19 vaccines as of today are success stories made possible by the sustained investment that this committee made years ago to basic biomedical research.

The road to these mRNA vaccines actually started back in the 1960s when the function of messenger RNA was first understood. These messengers carry instructions from the cell's DNA manual to produce the proteins that do the work. Now, for vaccines, we knew that certain proteins, like the spike proteins on the coronavirus, could spur an immune response. But, might it be safer and just as effective to use the RNA, the codes for those spike proteins, to instruct the patient's body to produce them? And it took a lot of obstacles to surmount to get there over more than 20 years, but we are blown away by how well it works.

In parallel, other NIH-supported scientists, including some at our own Vaccine Research Center, learned that locking those spike proteins into the right configuration could make an even better vaccine. So, when COVID hit, we knew exactly what to do, but we needed the help of the American people enrolling in clinical trials to finish the job. To facilitate that, NIH opened a dialogue with communities disproportionately affected by COVID to ensure that they had access to the vaccine trials.

The Community Engagement Alliance, or CEAL, c-e-a-l, Initiative built on some existing, long-term partnerships with trusted leaders in underserved communities to engage directly on trial enrollment, and later with hesitant individuals on issues related to vaccine safety and efficacy.

We were able to use the enrollment techniques we learned in the large, longitudinal studies, such as All of Us, that you have championed. The result is that all Americans can look at the major vaccine trials and see that people like them were included.

While the vaccines were in early trials, the world was clambering for rapid diagnostics to understand and manage our risks. Members of this committee, most notably Senator Blunt, asked what NIH could do to ramp up innovation. And thanks to your support, and using a novel Shark Tank approach, NIH took on a new role as a venture capitalist through the Rapid Acceleration of Diagnostics, or RADx program.

Today, there are 33 novel testing platforms helping perform just today, millions of tests daily, due to RADx. This program demonstrated the remarkable innovations that are possible when NIH brings together experts in engineering, business, and manufacturing to fund big ideas.

Now, the President's budget proposes a major investment to build on this momentum the Advanced Research Projects Agency for Health, or ARPA–H. This new agency within NIH will catalyze novel strategies to speed transformational and innovative ideas, ideas such as simple blood tests to detect free-floating DNA or protein markers that signal a cancer is growing somewhere in the body; a micro needle patch that delivers a vaccine to hard-to-reach communities in the mail; using an innovation funnel to recruit, test, and scale up new technologies for ambulatory blood pressure measurement with the potential to transform the management of hypertension.

These are just a few of the bold ideas that ARPA–H could tackle, but they are not science fiction. With standard approaches, well, they might happen in a decade or two. With ARPA–H, we believe it could take half that time.

The President believes that with your help, we can learn from the lessons of pandemic and transfer this scientific momentum into big improvements in the health of all Americans. I do, too.

My colleagues and I would be pleased to answer your questions.

[The statement follows:]

PREPARED STATEMENT OF FRANCIS S. COLLINS, M.D., PH.D., DIANA W. BIANCHI, M.D., ANTHONY S. FAUCI, M.D., GARY H. GIBBONS, M.D., ELISEO J. PÉREZ-STABLE, M.D., NORMAN E. SHARPLESS, M.D., AND BRUCE J. TROMBERG, PH.D.

Good morning, Chairwoman Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee. I am Francis S. Collins, M.D., Ph.D., and I have served as the Director of the National Institutes of Health (NIH) since 2009. It is an honor to appear before you today.

First, I want to thank this Subcommittee for your commitment to NIH, which allowed the biomedical research enterprise to respond quickly to the greatest public health crisis in our generation over the past year. We mounted vigorous research efforts to understand the viral biology and pathogenesis of the coronavirus disease 2019 (COVID–19), develop vaccines in record time, support and commercialize diagnostics at the point of care, and test therapeutics for both outpatient and inpatient settings. This work is far from finished.

The President's Discretionary Request proposes budget authority of $51 billion for NIH in fiscal year (FY) 2022. The Biden Administration places great emphasis on research and development in general. At NIH in particular, the Request proposes to build on the successes of pandemic era research and to put the research enterprise to work on some of our Nation's most persistent and perplexing health challenges, including cancer, Alzheimer's disease, opioid use disorder, health disparities, maternal mortality, HIV/AIDS, gun violence, climate change, and other areas with major implications for our Nation's health.

First and foremost, the President's Request proposes $6.5 billion to establish the Advanced Research Projects Agency for Health—ARPA–H to drive transformational innovation in health research and speed application and implementation of health breakthroughs. ARPA–H will tackle bold challenges requiring large scale, cross-sector coordination, employing a non-traditional and nimble approach to high risk research, modeled after DARPA in the Department of Defense. To achieve this, ARPA–H will invest in emergent opportunities by conducting advanced systematic horizon scans of academic and industry efforts, leveraging novel public-private partnerships, recruiting visionary program managers, and using directive approaches that provide quick funding decisions to support projects that are results-driven and time-limited. Potential areas of transformative research driven by ARPA–H include: the use of the mRNA vaccines to teach the immune system to recognize any of the 50 common genetic mutations that drive cancer; development of a universal vaccine that protects against the 10 most common infectious diseases in a single shot; development of wearable sensors to measure blood pressure accurately 24/7; and leveraging of artificial intelligence technology to advance care for individual patients and improve detection of early predictors of disease.

ARPA–H represents the kind of transformative idea for biomedical research that only comes along once in a long while. Our confidence that NIH is ready has been greatly advanced by our experience in addressing the COVID–19 pandemic—developing vaccines in record time, establishing an unprecedented public-private partnership on therapeutics that has made it possible to test more than a dozen possible therapeutics in rigorous trials, and building a venture capital model for assessing SARS–CoV–2 diagnostic technologies that has yielded millions of daily tests in just months.

But while we begin to imagine a life after COVID–19, we must acknowledge that there are COVID-related impacts that we have yet to understand and address, including the full impact of the pandemic on children. Children were largely spared from COVID–19 but for some children, exposure to the COVID–19 virus led to Multisystem Inflammatory Syndrome in Children (MIS–C), a severe and sometimes fatal inflammation of organs and tissues. The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) is leading a multi-institute initiative known as the Collaboration to Assess Risk and Identify loNG-term

outcomes for Children with COVID (CARING for Children with COVID), which will assess both short-term and long-term effects of MIS–C and other severe illness related to COVID–19 in children, including cardiovascular and neurodevelopmental complications.

For many Americans, this pandemic and its related socioeconomic effects have had an overwhelming impact on their mental health. Prior research on disasters and epidemics has shown that in the immediate wake of a traumatic experience, large numbers of affected people report distress, including new or worsening symptoms of depression, anxiety, and insomnia. To aid in mental health recovery from the COVID–19 pandemic, NIH will continue to focus on research in this area. This will be done, in part, by utilizing participants in existing cohort studies, who will be surveyed on the effect of the pandemic and various mitigation measures on their physical and mental health.

The COVID–19 pandemic has brought into sharp focus the dramatic health disparities that exist across the American population. In addition, the Nation has been shaken by the killing of George Floyd and other attacks on people of color, forcing a recognition that our country is still suffering the consequences of centuries of racism. NIH will continue to address these disparities, specifically through research managed by the National Institute on Minority Health and Health Disparities (NIMHD), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute of Nursing Research (NINR) and the Fogarty International Center (Fogarty).

NIMHD looks to better understand the human biological and behavioral mechanisms and pathways that affect disparity populations, better understand the long-term effects of disasters on health care systems caring for populations with health disparities and research focusing on the societal-level mechanisms and pathways that influence disease risk, resilience, morbidity and mortality. NINR and Fogarty both look to better understand and reduce rural health disparities in low-income counties in the southern United States, support nursing science focused on racial, ethnic, and socioeconomic health disparities, with the goal of closing the gap in health inequities and increase health disparity research in low and middle income countries.

In addition to the core health disparities research, the President's Request puts an additional specific focus on maternal morbidity and mortality (MMM), which disproportionately affect specific racial and ethnic minority populations. Black and American Indian/Alaska Native individuals are two to four times more likely to die from pregnancy-related or pregnancy-associated causes compared to white individuals. Furthermore, Black, Hispanic and Latina Americans, Asian, Pacific Islander, and American Indian/Alaska Native individuals all have higher incidence of severe maternal morbidity (SMM) compared to white individuals. The Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) initiative supports research on how to mitigate preventable MMM, decrease SMM, and promote health equity in maternal health in the United States.

As the climate continues to change, the risks to human health will grow, exacerbating existing health threats and creating new public health challenges. Major scientific assessments document a wide range of human health outcomes associated with climate change. While all Americans will be affected by climate change, underserved populations are disproportionately vulnerable. These populations of concern include children, the elderly, outdoor workers, and those living in disadvantaged communities. NIH is poised to lead new research efforts to investigate the impact of climate on human health, with the goal to understand all aspects of health-related climate vulnerability. Therefore, the President's Request includes a $100 million increase for research on the human health impacts of climate change.

The FY 2022 President's Discretionary Request makes a major additional investment to address the opioid crisis. The crisis of opioid misuse, addiction, and overdose in the United States is a rapidly evolving and urgent public health emergency that has been exacerbated by the coronavirus pandemic. Since the declaration of a public health emergency for COVID, illicit fentanyl use and heroin use have increased, and overdoses in May 2020 were 42 percent higher than in May 2019.

The use of opioids together with stimulants, such as methamphetamine, is increasing; and deaths attributed to using these combinations are likewise increasing. Taking note of these trends, FY 2021 appropriation language expanded allowable use of Helping to End Addiction Long-term (HEAL) funds to include research related to stimulant misuse and addiction. Identifying how opioids and stimulants interact in combination to produce increased toxicity will enhance our ability to develop medications to prevent and treat comorbid opioid and stimulant use disorders and overdoses associated with this combination of drugs.

Finally, I'd like to take a moment to thank this Subcommittee for its recognition over the last two years that America's continuing leadership in biomedical research

requires infrastructure and facilities that are conducive to cutting-edge research. With your support, we will break ground in the near future on a new Surgical, Radiological, and Laboratory Medicine division of our Clinical Center, which will replace severely outdated and deteriorating operating suites and lab space with state-of-the-art facilities. NIH continuously works to ensure that the buildings and infrastructure on its campuses are safe and reliable and that these real property assets evolve in support of science—but NIH's backlog of maintenance and repair is now nearly $2.5 billion. The President's FY 2022 Discretionary Request includes $250 million to make progress on reducing this backlog and requests flexibility for Institutes and Centers to fund construction, repair, and improvement projects.

COVID–19 compelled us to perform a stress test on biomedical research enterprise. The enterprise performed nobly. We found what worked, and also identified barriers we hadn't fully appreciated before, and invented new ways around them. The President's FY 2022 Discretionary Request is a roadmap for how to build on the successes of research, address our gaps, and apply our insights to the most important problems we face as a nation. With your support, the future is filled with opportunity. My colleagues and I look forward to answering your questions.

Senator MURRAY. Thank you very much, Director Collins. I have to say, I have always loved your success stories. They are usually really beautiful. But, I will say, I think many of us in this room are grateful to be your success story this time. So, thank you.

We will now begin our 5-minute rounds of questions, and Dr. Collins, I will start with you.

As you just talked about, the President's budget includes $6.5 billion to create the ARPA–H within NIH that is modeled after DARPA. DARPA is a small, $3.5 billion agency that is composed mostly of program managers and empowered to push the limits of their disciplines and shape some milestone-driven breakthrough technologies in short 3- to 5-year stints.

Given that the nature of NIH's work is different, relying on a peer review system or multi-year grants that is traditionally risk-adverse, where progress is often measured in decades, how do you envision ARPA–H fitting into the NIH ecosystem?

ARPA–H STRUCTURE

Dr. COLLINS. Senator, it is a great question. I think you are right that much of what NIH does requires this kind of careful, deliberative, investigator-initiated, hypothesis-driven research, and that is going to be the mainstay of what we do going forward. That has been the success story of NIH for many decades.

But, there are opportunities, as we have seen happen during COVID, such as the need to develop diagnostics in a hurry, to develop vaccines in a hurry, that are not really amenable to that approach, where you need to have program managers that are empowered to move things swiftly and have the flexibility and the resources to do so. And that is the DARPA model. We have studied that closely, and we do think that there are projects in biomedicine now that would be greatly advantaged by that. That is not the typical peer review process that may take a year from the idea to the first award. With RADx, we made those first awards 5 days after the Congress gave us the budget for it, and that played out really well.

So, we want to incorporate that mindset, and we want to bring on perhaps a hundred of these program managers, give them the opportunity to build the kind of collaborative ventures that include such organizations as small businesses that might otherwise not be likely to write an NIH grant.

Ride herd over these things carefully so that if they are not doing well, they get basically stopped immediately. We expect there will be failures—this is high risk—but identify the areas of greatest opportunity. And every Institute at NIH is now coming forward saying, I have at least five ideas of what I would like to do with ARPA–H that I cannot do right now.

So, this should not be seen as competing with the Institutes. It is going to be a synergistic relationship that will allow us to do things otherwise that would take a very long time.

Senator MURRAY. Okay. Well, you have said that it should be within the office of the director. In that structure, how would decisions be made about what projects to fund?

Dr. COLLINS. So, we will need to hire a director for ARPA–H, who will need to be a visionary person, and the idea is to bring on somebody who is not probably going to be doing this as their long-term career, but maybe for one term, 5 years, with one possible renewal.

That person will be very much engaged then in bringing onboard these very creative program managers who have to make a pitch about what kind of projects they think are worth investing in and convince the director that that is the case. And, then, they are given the flexibilities to go out and find the right partners and see what can happen. But, that is all going to be done in a way that is quite nimble. It is not going to involve our traditional peer review process.

Senator MURRAY. Okay.

STRUCTURAL RACISM AND HEALTH EQUITY

Dr. Pérez-Stable, your career has really focused on improving the health of communities of color and underserved populations. And NIH recently released a $30 million funding opportunity to study the impact of structural racism and discrimination in order to promote health equity and eliminate health disparities. Can you talk to us a little bit about what more can NIH, and particularly NIMHD (National Institute on Minority Health and Health Disparities), be doing to address those issues, and what would be the benefit of making additional investments?

Dr. PÉREZ-STABLE. Thank you, Senator Murray, for that question. So, first of all, we had to recognize that structural racism could be operationalized as a research construct and not just an organizational construct, and we went through a workshop and scientific reflection on this. I think the moment earlier this year for all of the NIH Institutes and Centers agreed that this was an area that we needed to move on and advance more quickly in the research side. And, so, we had a commitment from all the institutes that do this, although NIMHD was leading it from the beginning.

We believe that two areas are susceptible for improvement. One would be the healthcare setting, where I think through interventions at the structural, as well as the clinician and the patient level will help. And, also, in promoting healthy communities so that we can have easier access to green space, to healthy food, accessible healthcare in community health centers.

These are two areas that we believe are susceptible for improvement, although we will depend on our scientific community to pro-

mote and submit ideas that will be reviewed and hopefully funded within fiscal year 2022.

Senator MURRAY. Okay. Thank you very much. I look forward to working with you and hearing more about that.

Senator Blunt.

Senator BLUNT. Thank you, Chairman.

ARPA–H FUNDING LEVEL

Dr. Collins, on the ARPA–H budget request, $6.5 billion, one part of the question will be, how do you think that number was arrived at, and is that a realistic number to commit in year one?

And two, our concern would also be that we do not get in a position that—we have already given NIH $6.5 billion and level fund everything else. I do like the President's $2.5 billion. I am sure you could figure out how to spend more than that in the other institutes. That is pretty close to the average of the last 6 years from our committee. I would certainly like to stay at least at that level.

But, how do you think those two numbers compete with each other? And how do you feel about actually being able to commit $6.5 billion in that first fiscal year of ARPA–H?

Dr. COLLINS. That is a great question, Senator, and we have thought a lot about it. I am pleased the President's budget proposes that this would be 3-year money because, obviously, you are going to start from a standing start whenever the budget actually gets approved for fiscal year 2022. We hope that will be September 30th, right? Well, it might not be. So, at any rate, we would then really be benefitted by being able in that first year to stretch those dollars over a little bit.

I do think we could, with a hundred program managers, readily come up with a number of projects that would fit within that envelope on an annual basis. But, I hear what you are saying about a concern because I have heard it also that this might in some way compromise the interest of the Institutes. I guess I would look at it a different way, though.

As I said earlier, every one of the Institutes is coming forward with great ideas about how they would like to use ARPA–H. They think of this as an augmentation of their capabilities, not a subtraction. And, so, they will be feeding ideas into this and have a lot to do about how those are chosen. So, even though the base number that is being proposed, $2.5 billion for the ICs (NIH Institutes and Centers), may sound like a sort of average one, in terms of the science they can do, ARPA–H is going to add to that.

Senator BLUNT. All right. Thank you.

ARPA–H AND CANCER RESEARCH

Well, Dr. Sharpless, one of the things the President, of course, talks about in this issue, in this topic, is more rapidly moving toward ending cancer. Obviously, we want to do that. We also want to make the point that that is not the only thing that ARPA–H would be focused on, nor would it just be cancer or Alzheimer's. But, on that topic, how do you envision the ARPA–H role in cancer research and what might you be able to do with ARPA–H that you are not able to do in the traditional restraints of the National Cancer Institute?

Dr. SHARPLESS. Thank you for the question, Senator Blunt. It is great to be testifying in front of this committee again. Good to see you virtually, at least, today.

Yes, as the President has said, ending cancer as we know it is a top domestic priority for this Administration. We are obviously, the cancer research community, is galvanized by this notion and very excited.

I think, as you know, the National Cancer Institute does some things really well. You know, we fund basic foundational science very well. We can do clinical trials quite well. But, there are some areas where we are challenged, where we have struggles, and I think the scale and nimbleness and ability to interact with industry is very appealing about ARPA–H for certain kinds of cancer projects.

I think a good example of that is this blood-based cancer detector technology that Dr. Collins mentioned in his opening statement where you can, you know, find cancers at a very early stage in otherwise asymptomatic, healthy people, and that could have a profound effect on cancer mortality.

So, you know, getting up a huge trial of that technology as quickly as possible is the kind of thing that I think would be a good fit for ARPA–H.

Senator BLUNT. Okay. Thank you, Dr. Sharpless.

RADX PARTNERSHIPS

Dr. Tromberg, let me see if I can get one more question in. I think what you were part of at RADx is one of the reasons that gives me real optimism about new kinds of relationships that we might develop at ARPA–H. But, would you talk just a little bit about RADx and how that partnership continued right through the entire process of these companies that you were choosing to invest money with, going ahead and making the first home-based test, and I think producing well over two million tests every day now, in addition to the tests that would have come through the regular process?

Dr. TROMBERG. Yes. Thank you so much, Senator Blunt, and thank you for your question and for your generous support of the RADx program.

The bioengineering-technology community has formed partnerships all across the government. That has included working with BARDA, FDA, DOD (Department of Defense), CDC (Centers for Disease Control and Prevention), HHS (Department of Health and Human Services), and the White House Testing Board. More than 900 scientists are working across government, academia, and the private sector in a very unique way to make this work.

And, as you have mentioned, if we fast-forward to now, about 1 year later, we now have 33 RADx-supported companies that have increased the Nation's testing capacity by more than 300 million new tests, and there have been 23 new FDA authorizations. And we have really changed the dialogue from laboratory testing of symptomatic folks to over-the-counter, widely available tests, point-of-care tests that are accessible to all. Greater choice and greater capabilities. And this has really happened because of all of these partnerships that we formed, the accelerated innovation.

We have brought out new technologies. About 20 percent of our portfolio actually—not many people know about—has been based in nanoscience and nanotechnology.

Senator BLUNT. Good.

Dr. TROMBERG. So it has been a tremendous surge for innovation.

Senator BLUNT. Thank you, Doctor.

Thank you, Chairman.

Senator MURRAY. Yes. Senator Reed.

Senator REED. Thank you very much.

I want to welcome all the panelists and thank them for their distinguished service to the Nation, particularly during this difficult and challenging COVID pandemic.

Dr. Collins, one of the things that is becoming unfortunately and painfully obvious is the increase in suicides, and this is very disturbing. And we are concerned, also, about the impact of COVID–19 on accelerating, perhaps, that phenomenon.

SUICIDE PREVENTION

So, the question I would have is, what research is NIH doing on suicide prevention so that we can recognize the warning signs, better communicate with friends and family, and also give healthcare providers more insight? I am told that many suicide victims visit emergency rooms frequently before their suicide and those signs are not picked up. So, your comments would be appreciated.

Dr. COLLINS. Well, I appreciate the question, Senator, and it is a source of great concern and obviously great heartache for the way in which this is taking a toll amongst people across our Nation, and certainly at a time where mental health issues have been even further heightened by all the stresses of COVID–19. One can see this also becoming even more of a threat to people who have lost hope.

NIH is deeply engaged in trying to understand ways to prevent this terrible outcome, and the National Institute of Mental Health has in fact invested in a number of new initiatives as a result of that concern.

One that I would point to that has turned out to be a pretty encouraging development is the recognition that the drug Ketamine, which is used in anesthesia and sometimes used as a party drug, unfortunately. It also turns out to have benefits for people with serious depression, including people with suicidal ideation. Now approved by FDA, and the drug Esketamine, this is now available and it is being used in those acute situations of acute suicidal threat.

You also mentioned that many people who are on the brink do end up visiting healthcare facilities. We have worked hard to try to make sure that this idea of having a screening tool that was used in emergency rooms for individuals who are there, even if they do not appear to be there for psychiatric reasons, gets used to identify, particularly with adolescents, whether they might be in a situation of contemplating self-harm.

On top of that, certainly NIMH is investigating other means of treating depression, and also thinking hard about other interventions that might be beneficial here in terms of cognitive behavioral therapy combined with pharmacotherapy to try to assist those indi-

viduals who are in this difficult place. But, it is a terribly difficult problem.

I will say, it is interesting, but it is not necessarily that encouraging, the actual suicide rate, as best we know, in the course of the last year has not gone up. It has actually gone down slightly, and that has tended to be the case in national crises before. But, what I worry about is what happens when we seem to be getting past the crisis, is there a pent up backup there that might in fact result in an even greater risk in the coming months.

I would be glad to give you more information. I am sure Dr. Gordon would, as well, in terms of all the things that we are doing.

Senator REED. Thank you very much.

LONG COVID

Very quick question to both—to Dr. Fauci. The long haul COVID–19 is beginning to trouble a lot of people. They never seem to be able to recover from it and recurrences. What attention are we paying to that issue?

Dr. FAUCI. Thank you for that question, Senator. We are paying a considerable amount of attention to it. In fact, we have a program to the tune of $1.15 billion, looking at developing cohorts of individuals so that we can study them for the incidence, the prevalence, underlying pathogenesis, and, if possible, if we can find this out, anything that we can do from an intervention. So, the NIH is taking this very seriously. Thank you.

Senator REED. Thank you very much.

I have to commend Dr. Sharpless for his efforts on childhood cancer. I was teamed up with Senator Capito. We passed the Childhood Cancer STAR Act. We have been funding it, thanks to the Chairwoman, at $30 million a year, and I want to commend NIH on its renewed emphasis on childhood cancer, not only treatments, but also gathering data about these victims as they age so that we can see if there is any interventions that we can use later on. So, thank you, Dr. Sharpless, and thank you, panelists. Thank you very much.

Senator MURRAY. Thank you. Senator Graham.

Senator GRAHAM. Thank you, Madam Chairman.

VACCINE DEVELOPMENT

The vaccine, developing the vaccine as fast as we did, what is your biggest takeaway, Dr. Collins? How did we do that? And how can we do it again if we have to?

Dr. COLLINS. It is really important to look and see that this was built upon decades of research in basic science that many people might have said would not probably end up being as relevant as it turned out to be.

Senator GRAHAM. So, all of our money in the past paid off here, right?

Dr. COLLINS. Absolutely. This committee, and then the Congress, especially over the course of the last 6 years where you have increased the NIH support by 40 percent, has made it possible for us to do a lot of things that otherwise we would still not have been able to start. So, yes, it is all built upon that foundation.

Senator GRAHAM. Do you feel like the budget request being made is enough to continue to build on what we have done?

Dr. COLLINS. I am very supportive of the President's budget request, as you might expect I would be. And I am particularly excited about this new proposal of ARPA–H, a new component of NIH that would give us kind of a DARPA attitude that we could bring to projects that are waiting for that kind of opportunity.

Senator GRAHAM. Well, I just hope we can memorialize what we did to get the vaccine out so quickly.

GLOBAL VACCINE DISTRIBUTION

The developing world—Dr. Fauci, one thing I worry about is getting the vaccine out into the developing world, particularly Africa. What can we do better in that regard? And why should we?

Dr. FAUCI. Well, first of all, the answer to your second question, which is very relevant, Senator, is why should we? And the reason we should is that a global pandemic requires a global response. And even though, as you well know from the numbers, we are doing extremely well in this Country—we now have over 60 percent of adults having at least one dose, and about almost 50 percent of the adult population in this Country fully vaccinated.

However, even if we get this pandemic under control, which I believe we will within a period of a few months, there is always the danger, when you have viral dynamics in other parts of the world, for the generation of variants that might actually undermine the protectiveness of the vaccines that we have.

Senator GRAHAM. So, it is in America's interest to get the vaccine out to as many people as possible?

Dr. FAUCI. It is absolutely to our interest. I believe—not only do I think it is a humanitarian, moral responsibility, but it is in what I call enlightened self-interest for us to do that.

ORIGIN OF COVID–19

Senator GRAHAM. So, let's talk about our enlightened self-interest for a moment. Has there ever been a pandemic that we know of that started in a laboratory somewhere?

Dr. FAUCI. To our knowledge, no.

Senator GRAHAM. Okay. If this were in fact a breach of protocols in China, if it did come out of a lab, that would be a first for the world; is that right?

Dr. FAUCI. I believe so. There was a situation with an influenza where there was a suspicion that it might have escaped from a laboratory in Russia.

Senator GRAHAM. But this——

Dr. FAUCI. But that has never been validated or confirmed.

Senator GRAHAM. So, have we found any animals that carry COVID–19 that could have been the source of the transmission to humans thus far?

Dr. FAUCI. Thus far, not. I mean, if what you are referring to, Senator, is an intermediate host——

Senator GRAHAM. Right.

Dr. FAUCI [continuing]. We know clearly, for example, with SARS-CoV–1 that a bat virus went into a civet cat, which then

transmitted it into the human population. With MERS, it was a bat to a camel to human.

The intermediate host, if there is one, has not yet been found.

Senator GRAHAM. And we have been looking for that intermediate host; is that fair to say?

Dr. FAUCI. That is fair to say, sir.

Senator GRAHAM. At what point in time would it become more likely it came from the lab if we do not find an intermediate animal host? How much longer?

Dr. FAUCI. I do not think we can give a time element on that, Senator, for the simple reason we still have not yet confirmed what the host is from Ebola. We know that Ebola jumps from an animal reservoir to human, and it has been many years now since the original Ebola outbreaks, and we have not yet nailed that down.

Senator GRAHAM. But we believe that Ebola did not come from a lab?

Dr. FAUCI. Yes.

Senator GRAHAM. Okay.

Dr. FAUCI. Yes.

Senator GRAHAM. So, I guess my point is, who should look, what should we be doing to make sure we find out how it started?

Dr. FAUCI. Right.

Senator GRAHAM. And finally, what should be the consequences to any country, China included that allowed this to happen? What should the world expect of a country if they in fact allowed this virus to come from one of their labs through negligence?

Dr. FAUCI. Well, first of all, when you said, who should, you know, the WHO (World Health Organization) did what they are referring to now as phase one of an investigation, which they felt was not completely adequate, as you know. You have heard me and Dr. Collins and others in the Administration calling for a continuation of the investigation.

I do not think I can comment on your second question. It would have to be the circumstances under which something like that happened, if indeed it happened.

Senator GRAHAM. Well, just very briefly—I know my time is out—I think we should send a clear signal to China—seems to be a source of a lot of pandemics—that if this did occur in the lab, expect something to happen because if we do not, we are just going to reinforce this in the future. And what that something is, I am open-minded to, but I am closed-minded to the idea of doing nothing.

Senator MURRAY. Thank you. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chairman, and thank you to you, Dr. Collins, and everyone at NIH for all of your hard work over the last very difficult year and for everything else you are doing.

ARPA–H AND DIABETES

As you are aware, diabetes is one of the most expensive and pervasive of our chronic diseases, and I was pleased that in the authorization at the end—re-authorization at the end of the year, we funded the Special Diabetes Program for 3 years and the work that is being done to advance treatment for Type 1.

But, can you talk about this new ARPA–H agency and to what extent it might be looking at ways to help address diabetes?

Dr. COLLINS. I would love to, and thank you for the question, Senator. This is the hundredth anniversary year of the discovery of insulin, so we have come a long way in those hundred years, but we are not where we really need to be to say we have conquered this one.

ARPA–H, because of its ability to tackle problems in a team-oriented, nimble way, offers us some new opportunities here. Certainly, one of the ones that the Diabetes Institute has been promoting to me of late, sending me ideas, is to transform the way that we actually develop and test therapeutics, shouldn't we at this point be able to come up with therapeutics for diabetes that do not require injections. A totally new approach to how we would treat this disease.

Another one that I am excited about, and I know you have done a lot of encouragement about this, is the artificial pancreas.

Senator SHAHEEN. Right.

Dr. COLLINS. And we have made real progress there, Senator. But, I think we could go a lot faster if we had this coordinated, ARPA X kind of attitude brought to this, both for artificial pancreases that are built on engineering and sort of a feedback loop that gives insulin when it needs to, but maybe even more so the ones that built upon the patient's own stem cells that can be converted into that.

Senator SHAHEEN. And how do we make sure that diabetes is one of those diseases that ARPA–H addresses?

Dr. COLLINS. Well, fortunately, because I think we do have a pretty good budget being proposed here, and diabetes is already mentioned by the President as one of the three areas of interest, I think diabetes is extremely likely to be on the list.

Senator SHAHEEN. Good. Thank you. I am glad to hear that.

COVID–19 VACCINE BOOSTER SHOTS

Dr. Fauci, the question that everybody is asking is, are we going to need a booster shot to complement our COVID vaccination? Do you have any sense of that and what the timing might be for that?

Dr. FAUCI. Two parts to that question, and they are separate but important. I do not anticipate that the durability of the vaccine protection is going to be infinite. It is just not.

Senator SHAHEEN. Right.

Dr. FAUCI. So, I would imagine we will need at some time a booster. What we are figuring out right now is what that interval is going to be. We know from studies following people from the original clinical trials that the protection goes out at least 6 months, and likely a year. But, we do not know right now how long that will be.

So, what we are doing is we are following those cohorts because there is a level of protection that is called a correlate of immunity, and we know that if you are above that level, you are in quite good shape to be protected.

The vaccine itself gives you a level up here. So, how long it takes to start coming back down, we are following it, and two ways of understanding that. One, does, from a lab standpoint, it get below a

certain level; or, do we start seeing a lot more breakthrough infections. Either of those would be a trigger. But, we are following that very carefully.

So, in answer to your first part of your question, I believe we will need a booster. I am not exactly sure when.

Senator SHAHEEN. Thank you.

SUBSTANCE USE DISORDER AND METHAMPHETAMINE RESEARCH

And, Dr. Collins, you may remember that New Hampshire is one of the hardest hit States by the substance use disorder epidemic. And we have seen a decline over the last year because of the pandemic, but we have also seen a replacement of many of those opioids by meth. I think there is a belief among some people who use substances that meth cannot kill you in the same way that an opioid can. And, yet, as I talk to providers, they tell me there are very few treatments that they have available to them to deal with meth.

So, can you tell me what the National Institute on Drug Abuse is doing to try and address the meth piece of substance misuse?

Dr. COLLINS. Absolutely. This is an area of intense interest and concern because what was primarily an opioid crisis is now very much becoming a mixed crisis of opioids and stimulants, and particularly methamphetamine.

I was pleased to see that NIDA (National Institute on Drug Abuse) ran a trial, a phase three trial, on treatment for methamphetamine addiction, which is a combination of injectable Naltrexone and oral Bupropion, and showed benefit. We have not previously had anything to offer to help people who are addicted to meth. That is one step forward.

We also now are running this effort to vaccinate people against methamphetamine. I know that sounds odd, but you could immunize against that compound in a way that it would no longer provide anybody much of a benefit if they decided to use it anyway. We are doing that for heroin and Fentanyl, and we are doing it for meth. But it is very helpful.

Senator SHAHEEN. Excuse me for interrupting. Does that work if people have already been users?

Dr. COLLINS. It will. So, basically, getting your immune system to make an antibody so that in the future, if you encounter that drug, it cannot get to your brain because the antibodies grab onto it.

Senator SHAHEEN. I will have to learn more about that. Thank you. My time is up.

Thank you, Madam Chair.

Senator MURRAY. That is very interesting. Thank you.

Senator Kennedy.

Senator KENNEDY. Thank you, Madam Chairman, Chairwoman.

GAIN-OF-FUNCTION RESEARCH IN CHINA

Dr. Fauci, I believe you have testified that you did not give any money to the Wuhan lab to conduct gain-of-function research. Is that right?

Dr. FAUCI. That is correct.

Senator KENNEDY. How do you know they did not lie to you?

Dr. FAUCI. Excuse me, sir?

Senator KENNEDY. How do you know they did not lie to you and use the money for gain-of-function research anyway?

Dr. FAUCI. Well, we have seen the results of the experiments that were done and that were published and that the viruses that they studied are on public databases now. So, none of that was gain-of-function, so——

Senator KENNEDY. How do you know they did not do the research and not put it on their website?

Dr. FAUCI. There is no way of guaranteeing that, but in our experience with grantees, including Chinese grantees, which we have had interactions with for a very long period of time, they are very competent, trustworthy scientists. I am not talking about anything else in China. I am talking about the scientists. That you would expect that they would abide by the conditions of the grant, which they have done for the years that we have had interactions.

Senator KENNEDY. So you do not think the Chinese would lie to you?

Dr. FAUCI. Well, when you say the Chinese, the Chinese are a rather broad group. I know the scientists that we have dealt with have been trustworthy.

Senator KENNEDY. You think all the scientists have told the truth in terms of the origin of the Wuhan virus and not been influenced by the communist party of China, do you?

Dr. FAUCI. I do not have enough insight into the communist party in China to know the interactions——

Senator KENNEDY. Right.

Dr. FAUCI [continuing]. Between them and the scientists, sir.

Senator KENNEDY. Right. Why are we giving them money in the first place?

Dr. FAUCI. Well, that is a very good question, and thank you for giving me the opportunity to——

Senator KENNEDY. You are welcome.

Dr. FAUCI [continuing]. Answer it. Well, SARS-CoV–1 started in China in Guangdong Province, and it went from a bat to a civet cat to a human.

Senator KENNEDY. Yes, and excuse me, Doc, for interrupting you, but our time is so limited.

Dr. FAUCI. No, no. I am going to be real quick.

Senator KENNEDY. Our time is so limited. Why are we giving money to the labs in China to study virology?

Dr. FAUCI. Well, I am going to give you a rather succinct answer to that, sir.

Senator KENNEDY. I would appreciate that.

Dr. FAUCI. And that is why I was saying the SARS–CoV–1, clearly the bats that have the viruses that are the coronaviruses are in China. As I said a couple of times, it is not in Fairfax County, Virginia or is it in New York. It is in China. So, if you want to show and study importantly the animal-human interface, the viral——

Senator KENNEDY. Because that is where the bats are?

Dr. FAUCI. Yes, the bats.

Senator KENNEDY. Okay. I got it.

Dr. FAUCI. That is where the bats are.

Senator KENNEDY. I want to be sure I understand your testimony. You did not give money to the Wuhan lab to do gain-of-function research?

Dr. FAUCI. That is correct.

Senator KENNEDY. And you believe they did not do gain-of-function research because they told you they did not?

Dr. FAUCI. We have seen the results of the studies that they conducted and they were not gain-of-function.

Senator KENNEDY. Including any private studies?

Dr. FAUCI. Excuse me? Including?

Senator KENNEDY. Any private studies.

Dr. FAUCI. I am not sure what you are getting at, sir.

Senator KENNEDY. Here is what I am getting at. You gave them money and you said, don't do gain-of-function research.

Dr. FAUCI. Correct.

Senator KENNEDY. And they said, we won't?

Dr. FAUCI. Correct.

Senator KENNEDY. And you have no way of knowing whether they did or not except you trust them; is that right?

Dr. FAUCI. Well, we generally always trust the grantee to do what they say, and you look at the results——

Senator KENNEDY. Have you ever had a grantee lie to you?

Dr. FAUCI. I cannot guarantee that a grantee has not lied to us because you never know.

Senator KENNEDY. Yes. Can we agree that if you took President Xi Jinping and turned him upside down and shook him, the World Health Organization would fall out of his pocket?

Dr. FAUCI. I do not think I can answer that question, sir. I am sorry.

Senator KENNEDY. Well, do you think President Xi Jinping has undue influence over the World Health Organization, do you?

Dr. FAUCI. I have no way of knowing the influence of the president of China over the WHO.

Senator KENNEDY. Okay. So you think the WHO is a completely independent body and level playing field, call-it-like-you-see-it, and they really want to get to the bottom of the origin of the virus? Do you believe that?

Dr. FAUCI. My interaction with the WHO and for Dr. Tedros, the Director General, has been one——

Senator KENNEDY. Okay.

Dr. FAUCI [continuing]. That I do believe he is a person of high degree of integrity.

INVESTIGATION INTO ORIGIN OF COVID–19

Senator KENNEDY. I got it. I want to ask one last question. Why did you guys spike—not guys, and ladies. Why did you all spike the prior administration's investigation into the origins of the coronavirus and whether it could have come out of the Wuhan lab?

Dr. FAUCI. Sir, I—we did not spike anything in the prior administration. I am not sure what you mean by spike. But, we have no influence——

Senator KENNEDY. The State Department spiked the prior administration's study.

Dr. FAUCI. But that has nothing to do with the National Institutes of Health.

Senator KENNEDY. So they did not consult with you all?

Dr. FAUCI. They did not.

Senator KENNEDY. Did they consult with you, Dr. Collins?

Dr. COLLINS. I read about it in the press this morning.

Senator KENNEDY. Doc.

Dr. BIANCHI. No.

Senator KENNEDY. They just spiked it without talking to their experts?

You do not want to answer that one, do you?

Dr. COLLINS. I just read about it.

Senator KENNEDY. Thank you, Madam Chair.

Senator MURRAY. Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair.

Listen, the World Health Organization is the most influential global public health institution in the world, whether my friends like it or not. They have more people and more influence on the ground across the world than anybody else, including the United States.

And, so, if the complaint is that any country, including China, has too much influence, the answer is not for the United States to walk away. The answer is for the United States to double down and make sure that any grievances we have are addressed. Otherwise, the problem for which you are identifying is exacerbated by the United States not being at the table with the WHO.

And while the major donors to that organization certainly have lots of influence, as is the case with every international organization, it is an oversimplification to suggest that they are in the pocket of the Chinese government. China has influence. The United States has influence, as well, so long as we are at the table.

FIREARMS RESEARCH

I have two areas to cover, and the first I wanted to raise with you, Dr. Collins, and that is around the budget request to double the firearm injury and mortality prevention research account. Let me place myself solidly behind that request. Thank you for making it, and I was hoping you might—I apologize if you have gotten a question on this already. I have been listening but in and out a bit.

I am hoping that you might be able to talk a little bit about how you might prioritize that additional funding, especially as it might relate to research on community-based interventions and what works and what does not. And, then, you know, how to make sure that all that information gets out to community partners, folks who are boots on the ground, maybe not the exact set of players that NIH is used to disseminating information to.

Dr. COLLINS. Well, I appreciate the question, and we are enthusiastic about expanding our approach and the amount of funds we can put into research on firearm violence. After all, some 40,000 deaths happen each year from firearms. About 60 percent of those are suicides, which is another topic that came up earlier and is also part of our suicide prevention, is to think about availability of guns.

I think you are right, though, that community approaches are very much ripe for this kind of approach, where you might not just try to change one thing in the community, but see if by coordinating the efforts across multiple different ways in terms of making sure that firearms are not accessible to those people who might misuse them; in terms of particularly adolescent and youth risks of violence and how to intervene.

Maybe we could take an approach that would be more holistic as opposed to trying to fix one thing at a time. With a larger amount of funding here and a community focus, I think we might be able to do that.

Senator MURPHY. The President has proposed, I think, $5 billion to support these community-based interventions. Maybe some of that will be used for assessment and study. But, given the fact that I think we probably can get bipartisan agreement about supporting these investments in prevention, it really would be helpful to use some of this increased funding to assess which ones work and which ones do not.

SOCIAL DETERMINANTS OF HEALTH

Second broad topic, and maybe I will address this both to Dr. Collins and I think, via video, Dr. Pérez-Stable, is on the topic of social determinants of health. And I am just interested to hear a little bit about how we have adjusted research based upon our growing understanding that people's health is dictated by where they live and how much money they make and how close they are to pollution sources.

My sense is that, you know, this is not an easy sort of thing to incorporate into a research community that is sort of used to working in labs and not always used to thinking about how factors outside the body impact health. What have we learned? How has that changed the way that we fund research and encourage applications to come to NIH that might support social determinant research?

Dr. COLLINS. I am going to ask Dr. Pérez-Stable to respond.

Dr. Pérez-Stable: Thank you, Dr. Collins, and thank you, Senator Murphy, for that important question.

At the National Institute on Minority Health and Health Disparities, and throughout NIH, the topics of social determinants of health have always been present. We consider self-identified race and ethnicity and socioeconomic status standard measures to be fundamental factors that influence health in ways that we do not really understand, and that is why we believe that all research with human beings should measure these routinely and follow them.

In addition to these two, though, there are other demographic and individual social determinants of health, of which many are issues related to age and gender, sexual orientation, but then structural social determinants of health that you refer to. Where one lives, plays, and prays, relate to both transportation, housing, and issues around green space and, of course, Internet access, which has become incredibly important, as we know, in the last year. So, we have these fundamentally incorporated into our standard research, and community engagement is really part of everything that we do at NIMHD, and increasingly across the Agency.

Senator MURPHY. Well, thank you for that. I appreciate the new focus you are putting on this. Again, this is an area of potential bipartisan agreement. Senator Sullivan and I have legislation in this space and look forward to working with you on it.

Thank you, Madam Chair.

Senator MURRAY. Thank you. Senator Shelby, are you ready? You want me to——

Senator SHELBY. Yes, I am ready.

Senator MURRAY. Okay.

Senator SHELBY. I just got here. Thank you. I have been at another hearing, and this question may have been asked.

Dr. Collins, always good to see you.

Dr. COLLINS. Likewise.

Senator SHELBY. I agree with a lot of people on this committee that the money we put in to biomedical research benefits mankind, period. Not just our people, but the world, what it has taught.

AUTOIMMUNE RESEARCH BREAKTHROUGHS

Two or three promising areas, biomedical research in the area of autoimmune—that is a big, big topic. You know it better than anybody. What are we—what are the breakthroughs there, the hopes, in two or three of those top areas?

Dr. COLLINS. Well, thank you, Senator. It is good to see you, and I know you are running from one place to another. I am glad you are here.

I just had a wonderful experience yesterday afternoon listening to presentations from a consortium of researchers that we have funded jointly with industry. So, this is called the Accelerating Medicines Partnership, and it is focused on rheumatoid arthritis and lupus.

What they have done is to take this field, which was looking at immunology in a way that was pretty cutting edge 5 years ago, and now completely transformed it by looking at individual immune cells in the synovium of people with rheumatoid arthritis—the lining of the joint—and say, what are you doing there, immune cells, and how does that teach us what the real pathogenesis about——

And for lupus, they are looking at kidney biopsies, because, of course, lupus affects the kidney and that is one of its serious consequences. Same thing, looking at individual cells.

It has completely revamped our understanding of these diseases. We have learned, for instance, that the pericyte, which was just sort of a cell that we thought was hanging out watching in the kidney of somebody with lupus, might be the driver of what is really happening there as far as the immune response. This is not p-a-r-a. This is p-e-r-i, cyte, in case that is not clear. For rheumatoid arthritis, it is the fibroblasts.

And we are so excited about this. We are now planning to expand that same approach to other autoimmune diseases, to psoriasis, to psoriatic arthritis, to Sjogren's Syndrome, and maybe others, as well.

So, you hit me at a great moment. I was so jazzed yesterday to see what has been possible.

Senator SHELBY. All based on bacteria, is it?

Dr. COLLINS. It is all based on this ability to look at single cells, one at a time. We have not really been able to do that until about 5 years ago. We would have to look at thousands of cells and try to infer what was there, and now you can ask each one. And the cell is, after all, the basic unit of all life, and it has been outside of our reach, but not anymore.

Senator SHELBY. What could that do for the autoimmune area?

Dr. COLLINS. I think it can have a huge impact because we now have new targets coming out of this recognition that I think in the next 4 or 5 years, we are going to see a whole new generation of drugs for autoimmune diseases based upon that insight that is just now emerging.

CYSTIC FIBROSIS RESEARCH

Senator SHELBY. I brought this up many a time, but in the area of cystic fibrosis, there have been so many breakthroughs in that area, extending children's lives, adults' lives, and everything. Where are we going there? We have come a long way, but we are not there yet.

Dr. COLLINS. We are not completely there, but, oh, boy, have we come a long way, especially in the last 2 years now with this 30-year effort, and I have been deeply engaged in this having had a role in——

Senator SHELBY. I know.

Dr. COLLINS [continuing]. Discovering the gene back in 1989. And, now, we have this triple drug therapy, which for 90 percent of patients with cystic fibrosis is dramatically beneficial. I get messages almost every week from somebody who was really in tough shape, and now they are back at work; or somebody who was on a transplant list, and now they were taken off of it because their lungs are doing so much better.

But, there is still that 10 percent. This is where I think the gene-editing approach, where you actually figure out how to fix that misspelling of the cystic fibrosis gene in the lungs of somebody who is affected, might be the way to get to 100 percent, and there is a lot of work going on that.

LUPUS RESEARCH

Senator SHELBY. What promises are out there that you have talked about before dealing in lupus, which is an autoimmune disease?

Dr. COLLINS. Well, as I mentioned, we have this ability now to be able to see individual immune cells, what are they up to in lupus, both in the kidney and in other areas, as well. I think that is teaching us some new things about what the real fundamental cause is. And it will tell us that some of the treatments we have been giving, like steroids, are kind of a little bit too much of a sledgehammer, and what we need now is something much more subtle to go after the fundamental problem. We have a better chance at that now.

PANCREATIC CANCER RESEARCH

Senator SHELBY. What about the area of pancreatic cancer? That is a fast-moving thing, I know.

Dr. COLLINS. It is, indeed. And if Dr. Sharpless is listening, maybe he would like to quickly give a response since that is his area at the Cancer Institute. Ned, are you there?

Dr. SHARPLESS. Sure. Yes. Thank you, Francis.

Pancreatic cancer is an area where we have not seen the success that we have seen in other cancers, but it is not for lack of good ideas. So, there are a number of——

One of the realizations is that pancreatic cancer comes in lots of flavors, and each one needs its own treatment. So, now we are working on the subset approach to pancreatic cancer. I think there is also a real opportunity to detect pancreatic cancer earlier at a more curable stage.

So, I think those are the exciting areas of pancreatic cancer research.

Senator SHELBY. Thank you. I would like to get in—I know my time is moving on. The chairperson has been very kind.

CTSA PROGRAM

Dr. Collins, in the area of the CTSA Program, the Clinical and Translational Science Award Program. The CTSA hubs and their partners, I think, have done a lot of good work in that area, and valuable work, especially during the COVID–19 thing. It is my understanding that the NIH, National Institutes of Health that you head, is considering significant changes to that program that would discourage hubs, like UAB, for example, in Birmingham, from forming partnerships with certain non-clinical universities in research questions.

Is this true, and why is that?

Dr. COLLINS. That is not a correct assumption. I know there are some rumors flying around about that, and there will be a public announcement about this.

Basically, just, without trying to get too far ahead of what has not been revealed publicly, I think we are trying to simplify the application process to make it easier for those hubs, and we intend to keep them going in vigorous ways; to apply when they are up for renewal in a way that does not require an application of 2,000 pages, which is what it has been. But, we would not want to do anything to discourage these collaborations that you are mentioning. Take that from me.

Senator SHELBY. Thank you. Madam Chair, thank you.

Senator MURRAY. Thank you. Senator Manchin.

Senator MANCHIN. Thank you, Madam Chairman, and thank all of our presenters. I appreciate very much them being here.

DOMESTIC DRUG SUPPLY CHAIN

My first question will go to Dr. Fauci. The Food and Drug Administration reports that nearly 40 percent of finished drugs and roughly 80 percent of active pharmaceutical ingredients are manufactured abroad. During the COVID–19 pandemic, we saw factories shut down in order to prevent the spread of virus, drug supply

chains disrupted, and drug shortages increase. As a result, America's access to essential medicines was really put into jeopardy.

As a preeminent infectious disease doctor, you know better than anyone how important it is to have access to essential medicines. So, my question will be, Doctor, can you comment on the importance of a strong domestic supply chain for essential medicines? And how can we ensure we do not experience future drug shortages when the global supply chains are disrupted?

Dr. FAUCI. Thank you very much for the question, Senator Manchin. I think it is absolutely critical that we have the capability, independent of supplies from foreign countries, to be able to supply the necessary medicines that we need in the United States. I have been of that opinion for a very long period of time.

The solution to the problem is to be doing much less of the outsourcing to foreign countries for the important ingredients of many of our medications. So, right now, we are not in that good position, and I believe, particularly since the disruptions of the supply chain that have occurred with the COVID–19 pandemic, that this might be a good lesson for us for the future to make sure we have much more dependency on what we can do domestically as opposed to in foreign nations.

Senator MANCHIN. Doctor, have you all looked at why? Why has most of the manufacturing left the United States and why are we not able to manufacture? Are we at a disadvantage in the United States for other reasons, cost wise, or basically different types of things, that we make people jump through hoops and everything else as far as permitting and all that? What would be the cause?

Dr. FAUCI. You know, Senator, to be honest with you, I do not know why that has happened. I think it was because it was felt it would be much less expensive to get this done outside, but I do not really know the answer to your question of why we have so much of a dependency of important materials outside of the Country. But, certainly, whatever the reason, I believe it needs to be corrected.

Senator MANCHIN. Well, I need to work with you on that, Doctor, if I can, basically, in making sure this Administration—I think they understand the urgency we need to start basically manufacturing again, not only just our drugs, but so many things in our Country. So, I look forward to your support on that.

RURAL HEALTH OUTCOMES

Dr. Collins, West Virginia is constantly ranked last in the Nation for health outcomes. In 2020, the America's Health Rankings reported my State of West Virginia 50th for premature deaths, frequent mental distress, and multiple chronic conditions. We also ranked last in life expectancy.

What is the NIH doing to bridge this gap in health outcomes? And how do you ensure that the medical research that you do benefits people in poor, rural communities?

Dr. COLLINS. Well, it is very troubling to see the fact that you have just cited that health outcomes are not what we would all want them to be. And, of course, there are many factors that play into that, Senator, and we are deeply engaged in research in trying to identify the ones that are addressable.

Certainly, one of the things I might point to is the increasing focus we have on disease prevention. If we simply are limiting ourselves to trying to help people who have already developed a serious disease, we have kind of missed the opportunity. Unfortunately, our healthcare system does not do a great job in that situation of providing support for disease prevention, and it seems happier to pay for things once people are already quite ill, so there is additional work that needs to be done there.

One of the things that I think I would point to is a series of large-scale efforts to really understand what are the factors that play out in people staying healthy or getting a chronic disease or how you manage that.

The All of Us Program, which this Congress has supported, on the way to enrolling a million participants, including in West Virginia, is a way in which we can collect that kind of evidence, including their electronic health records and lots of information about their environmental exposures, and try to figure out in a holistic way, how can we take that information and bring forward a better chance for people to live not just a good lifespan, but a good health span. So, we are——

Senator MANCHIN. Thank you, Doctor.

Dr. COLLINS [continuing]. Deeply engaged.

Senator MANCHIN. Thank you, sir.

Dr. Fauci, finally, you know, my home State of West Virginia is battling an epidemic during the middle of a pandemic. We have been devastated by the drug epidemic, COVID–19, and now—we now lead the Nation in new HIV infection rates. You spent much of your career focused on prevention, diagnosis, and treatment of HIV/AIDS, and your research has been instrumental in saving countless lives in the United States and around the world.

INFECTIOUS DISEASE SURVEILLANCE EFFORTS

So, Doctor, what is being done to replicate testing and surveillance efforts we saw put into place for COVID–19 for other infectious disease, like HIV/AIDS? And what public health infrastructure would be required to bring better infectious disease testing and surveillance to fruition?

Dr. FAUCI. Thank you for that question, Senator. The HIV testing situation, unfortunately, has been somewhat interrupted by the COVID–19 pandemic because of the interruption of multiple services.

But, as you know, we have a 10-year plan to end HIV as an epidemic in the United States, and that is going to require access to testing for those who are not infected to put them on, if they are at risk, to pre-exposure prophylaxis; and those who are infected to immediately put them on antiretroviral therapy. Because, as we know, when you bring the level of virus to below detectable, not only do you save the life of the individual, but you make it essentially impossible for that individual to infect someone else.

So, testing is really at the fundamental basis of how you address the epidemic and, for that reason, it is going to be extremely important to get our testing capabilities back up to snuff once we get the Country back on a degree of normality following control of the COVID–19 pandemic.

Senator MANCHIN. Thank you. Thank you, Madam Chairman.

Senator MURRAY. Thank you. Senator Braun.

Senator BRAUN. Thank you, Madam Chair.

Dr. Fauci, I was listening with interest in Senator Kennedy's line of questioning, which probably was asking you to maybe answer some things based upon what the WHO should do or not.

INVESTIGATION INTO ORIGIN OF COVID–19

I would like to discuss something that is probably a little simpler to answer in terms of transparency in general. From the time I have known you and Dr. Collins, it has generally been in this seat, and we have been talking about something related to COVID. Would you agree that in the whole process of—now that there are second thoughts on how this thing derived, that it may have come from a lab, that we should emphasize as much transparency as possible in pursuit of getting the answer?

Dr. FAUCI. Without a doubt, Senator. No doubt.

Senator BRAUN. And the next logical question would be that we do not know what we are going to get from the communist regime or the WHO, but we do know that through our Director of National Intelligence and probably DHS (Department of Homeland Security), from Haines and Mayorkas, that they have probably got information there. And, so, since you believe in transparency, wouldn't you think that we should declassify all the information that we own so that you, Americans, independent researchers, can see what we have got to sort through how this thing started?

Dr. FAUCI. Well, Senator, I have said publicly and most recently that I believe that there should be transparency, and open, fair, and independent, continue to look. As I have said, I still believe that the most likely scenario is that this was a natural occurrence, but no one knows that 100 percent for sure. And since there is a lot of concern, a lot of speculation, and since no one absolutely knows that, I believe we do need the kind of investigation where there is open transparency and all the information that is available to be made available to scrutinize.

Senator BRAUN. So, since you have been the point person on just a variety of topics through the COVID saga, does that mean then that you will ask President Biden to declassify that information?

Dr. FAUCI. I do not think I can promise you——

Senator BRAUN. But, I mean, would you ask him since you believe in transparency? Wouldn't it make sense that we get the information that we have? And I think if it does not come from you, Dr. Collins, someone that has been in the mix from the get-go, that we will not see it. And we owe it to the American people with what we have been through to at least look at the information that we have.

Dr. FAUCI. Yes. I am not sure the information we have, but—I am not sure if it is my place to tell the President of the United States to declassify——

Senator BRAUN. But you have been very engaging on a wide range——

Dr. FAUCI. Right.

Senator BRAUN [continuing]. Of topics, and I think he would respect your opinion as much as anyone.

Dr. Collins, where are you at on that subject of giving the American people the information that we house?

Dr. COLLINS. Well, I am very much where Dr. Fauci is with the desire to be as transparent as possible in this situation and really try to find out what happened. I agree with him that it is most likely that this is a virus that arose naturally, but we cannot exclude the possibility of some kind of a lab accident. That is why we have advocated very strongly that WHO needs to go back and try again after the first phase of their investigation really satisfied nobody, and this time we need a really expert-driven, no-holds-barred collection of information, which is how we are mostly really going to find out what happened.

I am just not in a position to know what might be in the classified documents and what else might be there that would not be relevant to this and might actually be harmful to national security. I get—I take your point. But, I know the President is very interested, also, in seeing truth come out here, so it may not require Tony or me to tell him that this would be good, to make this as visible as possible.

Senator BRAUN. Well, I think for the American public, if we are relying on the WHO to do it again, even though it seems like they have had somewhat of an epiphany that we need to dig deeper. I think if it does not come from the two of you to ask for simply the release of information, of course, keeping hidden anything that would be something that could not be exposed. But, I am guessing there is a good bulk of that that would be benign in terms of just the information we have about the origin of the disease.

So, I think for many of us, many Americans, with what we have gone through, we ought to at least be willing to look at the information that we have to get people satisfied that we are getting to the bottom of it. So, I would ask each one of you to think about that and see if it makes sense, have our President declassify it so we can see it.

Dr. COLLINS. Thank you.

Senator BRAUN. Thank you.

Senator MURRAY. Thank you. Senator Moran.

Senator MORAN. Chairman, thank you.

Dr. Collins—well, Doctors, welcome. Good to be here with you, and I appreciate your presence and your work.

Let me talk about clinical and translational science, if I could. Under Dr. Austin's prior leadership, the National Center for Advancing Translational Science at NIH has been essential in facilitating clinical and translational research, and I have seen it in Kansas. In fact, I have seen it with the director of that directorate.

CTSA PROGRAM

In Kansas, NCATS' Clinical and Translational Science Award Program has served for a catalyst to bring lots of organizations in the research community and community partners together to advance research.

I have concerns with potential changes that are under consideration for the CTSA Program. In particular, changes that would lower hub awards and limit CTSA partners.

Moving forward, will there continue to be consideration for ensuring that CTSA centers are located in regions in the U.S. which do not already have those hubs? There is already a limited number in the Mid-West, and I would be concerned if any new changes to the program that would make it more difficult for these hubs to compete.

And, then, I would ask the question about partners. At the University of Kansas, for example, they partner with Children's Mercy, Kansas City University of Medicine and Biosciences, Kansas State University, St. Luke's Health, University of Kansas Health System, KU Office of Research, KU School of Medicine in Wichita, and University of Missouri in Kansas City. Since the CTSA Program is focused on partnerships between regional research hubs and community partners, why would NCATS limit the ability of the program, in my view, to accomplish its goal?

Dr. COLLINS. Well, Senator, thank you for the question. I am a big fan of the CTSA Program and enjoyed my opportunity to travel to Kansas with you and see some of the things they were doing a few years ago.

And this is, I think, one of those circumstances where there seems to be some anxiety in the CTSA community about something that has not actually been announced yet, and I would like to be reassuring about this. The real intention of the change that is being proposed is to de-complicate the renewal process, which currently requires an application of about 2,000 pages that I do not think anybody enjoys putting together, and to try to make this more straightforward.

There is no intention to reduce the number of hubs. Certainly, every hub has to compete to show that they are actually using the funds wisely, and we will continue that process. And this notion that somehow the new process will discourage collaborations with other institutions I find a little hard to understand because I have no knowledge that that is at all intended to be the case, and I would personally oppose that.

Senator MORAN. Thank you for your reassurance. My question was more complicated than I wanted it to be, but your answer was very comforting.

Let me ask just a couple of specific questions.

NCATS RARE DISEASE RESEARCH

What can this committee do to support NCATS' efforts to enable and facilitate advanced important research in rare diseases for patients living particularly in rural communities?

Dr. COLLINS. Well, the NCATS is deeply engaged in rare diseases. Our former director, Chris Austin, not only was a personal promoter of that; he was the head of the international committee for rare diseases, and that tradition will continue under Acting Director, Dr. Rutter.

Certainly, the support that this committee has provided to NCATS to make it possible for that kind of investment to happen in rare diseases, for which companies probably are not going to make an investment because the market is too small, is one of the reasons that we have now made really significant progress in dozens of these rare diseases.

We are also engaged right now in a serious conversation with industry about whether there is a way, with gene therapy emerging as an even more attractive opportunity for rare diseases, to make sure that we move that forward at all due speed and not have it held up by such things as a limitation in manufacturing of viral vectors.

So, they are right in the middle of that, and the support that you all have provided has made that possible, particularly through the Cures Acceleration Network, which is part of NCATS.

ALZHEIMER'S DISEASE RESEARCH

Senator MORAN. Can one of the directors talk about the improved science this additional investment in Alzheimer's research will help fund, including a better understanding of risks and protective factors in individuals, again perhaps with a focus on rural populations?

Dr. COLLINS. That is probably me because Dr. Hodes is not here. So, yes, this committee, this Congress, has increased funding for Alzheimer's research by five-fold over the course of the last 7 or 8 years, and that has made possible all kinds of bold approaches we otherwise would not have had.

We now have dozens of new drug targets that have emerged from the very careful analysis of who gets Alzheimer's and who does not. Of course, we are all waiting to see what happens maybe next month when FDA makes a review decision about the monoclonal antibody from Biogen, Aducanumab, and that will make a big difference if they decide there is something there. But, we are not depending on that.

So, yes, I might add, this ARPA–H proposal, which is part of the President's budget, specifically calls out Alzheimer's as an area of great opportunity to do some of these very bold, aggressive, and nimble approaches that would probably not happen so easily by our standard grant mechanism.

Senator MORAN. Dr. Collins, I was confused by what I thought was all the directors were appearing, although just not all of them in person. But, thank you. You can pinch-hit for each and every one of them and you did it——

Dr. COLLINS. I will try.

Senator MORAN [continuing]. This morning. I am going to see if I can get Dr. Sharpless to come to Kansas and join us again on a visit.

Dr. COLLINS. Well, he is listening, so he heard you.

Dr. SHARPLESS. Oh, I look forward to that.

Senator MORAN. All right. Consider yourself invited, and I consider you just accepted.

[Laughter]:

Senator MURRAY. Thank you. Senator Schatz.

Senator SCHATZ. Thank you, Chair Murray and Ranking Member.

PSYCHEDELIC DRUG THERAPIES

Dr. Collins, in 2019, I wrote to you and the then-FDA commissioner requesting an update on efforts by NIH and FDA to research psychedelic drugs to treat mental health illnesses. Since then,

there have been a number of potentially promising, peer-reviewed clinical research on this topic. Can you give me an update on what the next steps may be?

Dr. COLLINS. I appreciate the question. Yes, there has been a resurgence, I think, of interest in psychedelic drugs, which for a while were sort of considered like not an area that researchers legitimately ought to go after. And I think as we have learned more about how the brain works, we have begun to realize that these are potential tools for research purposes and might be clinically beneficial.

I will just mention one, which is Psilocybin, which has now been tried in no less than three randomized, controlled trials for depression, and is showing a signal there of potential interest, and that could be quite exciting because we are looking for new approaches to that.

But, there are other trials going on with MDMA, even with Psilocybin—with LSD. I think at the moment, it is the Psilocybin that has gotten the greatest attention.

Senator SCHATZ. And what are your next steps?

Dr. COLLINS. I have been talking with the Drug Abuse Institute—and I am sorry they are not here—and the Mental Health Institute—and they are not here, so I am pinch-hitting for them, as well—about whether it is a good moment to consider having perhaps a workshop to say, okay, what have we learned so far, and what more might we want to do as far as designing the next generation of clinical trials, to see where these provide benefit going beyond depression to such things as PTSD (Post-Traumatic Stress Disorder).

So, I think over the course of the next year, we are going to want to have a hard look at this.

MARIJUANA RESEARCH

Senator SCHATZ. Thank you. In 2019, you wrote to me that the NIH is committed to advancing research on the risks and potential benefits of marijuana for therapeutic uses. In that letter, you cited a number of barriers to advancing this type of research. Are we making any progress?

Dr. COLLINS. We are making some progress. You may know that, in the past, researchers who wanted to do a clinical study on marijuana had all kinds of limitations. It took generally at least a year to get through the process of paperwork to be allowed to utilize marijuana because it is a Schedule 1 agent.

But, it was also an issue that there was only one source, which was our marijuana farm in Mississippi. When I became NIH director, I was told, hey, you are running a marijuana farm. Who knew? And that, of course, is an issue because it is a limited opportunity for access. DEA (Drug Enforcement Administration) has now given permission to expand the number of suppliers. That will help.

But, frankly, what we really need is to moderate the Schedule 1 limitation. Dr. Volkow and I have been proposing for a while something called Schedule 1–R, which would be basically a different pathway if you are going to use this material for research.

Senator SCHATZ. So, I have a bill with Senators Feinstein and Grassley, which passed the Senate, did not pass the House, to ad-

dress some of these barriers. Do I have your commitment to work with my office on this legislation?

Dr. COLLINS. I would be glad to.

NON-OPIOID ALTERNATIVES TO CHRONIC PAIN

Senator SCHATZ. Thank you. I want to talk to you finally about chronic pain and non-opioid alternatives. I passed a couple of laws in this area to enable research. And I think when people think about alternatives to opioids, they move right to—in their mind, they move right into alternative medicine. And, what I am talking about is a non-opioid, pharmaceutical solution to chronic pain, and I am wondering whether we are making progress in that space.

Because, certainly, if people find other ways to alleviate their pain—physical therapy, yoga, whatever, mindfulness—I am for all of it. But, there is still a space here for a pill that you can take to alleviate chronic pain without getting you hooked on an opioid. Where are we with this?

Dr. COLLINS. That is a critical issue, and this Congress has supported NIH in something we call the HEAL Initiative, which is—stands for Helping End Addiction Long Term. Part of that is about how to better treat people who are addicted to opioids, but a big part of it is coming up with alternatives for chronic pain management that are not addictive, that are not opioids.

As a result of that, we have partnered up with industry to basically identify promising therapeutics that attack different targets in the pain mechanism that might, therefore, be beneficial. Such things as a sodium channel, for instance, called Nav1.7, that is involved in the pain transmission. But, if you block that, it should not give you any risk of addiction. We are making real progress there.

We have something called EPPIC-Net, which is bringing onboard promising compounds, getting them into Phase 2 trials as part of the HEAL Initiative. I could give you a lot more information about that if you would like.

Senator SCHATZ. Thank you. And I will just submit this one that you can consider for the record.

The U.S. has the same Federal trust responsibility for native Hawaiians as it applies to Alaska natives and American Indians, and I am hoping that you will consider expanding the scope of the Tribal Health Research Office to include native Hawaiians. I will get you a more full question for the record and look forward to your response. Thank you.

Dr. COLLINS. Glad to look at that.

Senator MURRAY. Thank you. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Madam Chairman. Thank you for holding the hearing, and thanks to all the witnesses who are participating today, and I certainly appreciate your willingness to serve. That is not lost here, for sure, with the past year that we have had.

FIREARMS RESEARCH AND FIREARM REGISTRIES

Dr. Collins, I wrote to you last November to express my concerns that projects recently funded by NIH disregard the spirit, long-established policies against creation of a Federal firearms registry.

And particularly, an NIH grant to Northwell Health of New York provided Federal funds for the hospital to ask the questions about lawful gun ownership of every patient seeking healthcare for any reason whatsoever at the hospital's emergency department.

Even more concerning, every member of the advisory committee overseeing the grant has been a very outspoken advocate for expansive gun control, including bans on large classes of common and popular firearms.

I have long been concerned about how firearm registries can undermine the ability of law-abiding citizens to exercise their Second Amendment rights. Several provisions of Federal law already prohibit data collection related to lawful gun ownership, and I have introduced legislation to strengthen these provisions even further.

Dr. Collins, given that President Biden is seeking increased funding for grants like the one awarded to Northwell, how are you making sure that such projects do not infringe on Americans' constitutional gun rights or violate Federal statutory prohibitions on gun registries as they stand right now?

Dr. COLLINS. Senator, I recall your letter, and we looked closely at that particular grant from Northwell and what they were proposing to do.

First of all, I think we can all agree that gun violence, which takes about 40,000 lives every year, is something that does deserve close attention and scrutiny as far as the research that we might be able to do to understand what are the causes and how to save those lives if it is possible to do so. So, we will actually be glad to pursue those opportunities.

But, we are mindful of the prohibition that Congress has put forward many years ago about not advocating for gun control, and we have been pretty careful about that. I think in that instance, the particular grant, while you are right that they were asking for this information, it fell somewhat short of what most people would have called a broad concept of a gun registry. And I think that is, if I remember, what we said in the letter in response to you.

But, I want to promise you, we are going to be very sensitive to those issues, as we now, with the President's budget, seek to see if we can do more to try to identify reasons that gun violence is so prominent and what research might teach us about how to save lives.

Senator HYDE-SMITH. Thank you. I appreciate your consciousness of that.

ORIGIN OF COVID–19

And this question may have been asked before. I have been in another hearing. I hope I am not being redundant. But, like many of my colleagues, I firmly believe we need to get to the bottom of the origin of COVID–19, and this seems even more important after this week's Wall Street Journal report that three researchers from China's Wuhan Institute of Virology sought hospital care in November 2019—for symptoms consistent with COVID–19.

First, I want to go down the line for all of our witnesses of how strongly do you believe that it is possible that the origin of the COVID–19 pandemic resulted from a leak of the virus from the Chinese lab?

And second, Dr. Fauci, I would like to ask you specifically, how is your institute working to get to the bottom of the origins of COVID–19, including exploring the laboratory leak theory?

So, I am going to start with the entire panel for the first question of, how strongly do you believe that this is possible?

Dr. COLLINS. Well, I will start, and then others can respond. Again, I will say, I think the most likely reason, mechanism, by which SARS-CoV–2 arose was a natural process of transfer from an animal to humans, but it is certainly possible that other options might have occurred, including a possible lab leak. We just do not have evidence to be able to say what that likelihood is.

Dr. Bianchi.

Dr. BIANCHI. Yes. So, I would agree with Dr. Collins. We have no personal knowledge of anything that might have happened in China at the National Institute of Child Health and Human Development, but we fully support a full investigation of getting at the facts.

Dr. COLLINS. Dr. Gibbons. Dr. Gibbons, are you there?

Dr. GIBBONS. Yes. I concur with my colleagues in terms of transparency is a critical part of this.

Dr. COLLINS. Dr. Sharpless, I think I saw you on the screen.

Dr. SHARPLESS. Sure. Yes, Senator Hyde-Smith, I saw the same report and I found that concerning. I think lab accidents happen and we need to investigate the possibility. Although I think many of us feel zoonotic transfer is perhaps more likely, I think we should investigate all possible explanations.

Dr. COLLINS. Dr. Pérez-Stable.

Dr. PÉREZ-STABLE. I concur with my colleagues. I think of concern, but certainly we need evidence.

Dr. COLLINS. And Dr. Tromberg.

Dr. TROMBERG. Yes, I agree with my colleagues, as well, and would like to see more investigation.

Dr. COLLINS. Dr. Fauci.

Dr. FAUCI. Yes. As I have said many times, I feel the likelihood is still high that this is a natural occurrence. But, since we cannot know 100 percent whether it is or is not, other possibilities exist and, for that reason, I and my colleagues have been saying that we are very much in favor of a further investigation to the next phase from the WHO, who has already done a phase one. And, we are strongly in support of continuing that to a phase two investigation.

Senator HYDE-SMITH. Thank you——

Senator MURRAY. Thank you.

Senator HYDE-SMITH [continuing]. Very much, and I yield my time.

Senator MURRAY. Thank you so much. Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair.

Last week, I had the privilege of joining some of my colleagues on a visit to the National Institutes of Health. While much of our discussion was centered on the response to the COVID–19 pandemic, I was struck by the broad applications of the innovation that we have seen during this time.

ADVANCES IN VACCINE AND THERAPEUTIC DELIVERY SYSTEMS (RADX PROGRAM)

And, I have often spoken about the Wisconsin-based company, FluGen, which is working to make vaccines that can be administered as a nasal spray. I also believe that this type of innovation is key in terms of how we think about our ability to respond to future pandemics.

Dr. Tromberg, it was great to see you on that trip to NIH. I wonder if you could describe how engineering advancements have contributed to our response to COVID–19. And, how are you thinking about the future of delivery and administration of vaccines and therapeutics? And, how will these advancements help us prepare for the future?

Dr. TROMBERG. Thank you, Senator Baldwin, for the question, and it was great to meet you last week, or I guess it was 2 weeks ago when you came to visit.

So, for COVID, we have supported a wide range of technologic advances in medical imaging and artificial intelligence, digital health platforms, PPE (Personal Protective Equipment), ventilators, new therapeutic approaches. Of course, the biggest probably and most impactful has been the RADx testing program, which has delivered, as you have seen, more than 300 million tests, including over-the-counter tests with very advanced technologies from nanoscience.

In terms of vaccines, this is a very exciting area. Another one that we have had in our portfolio, one of the strategies that we have been supporting, are micro needle patches. So, imagine a dime-sized micro needle patch that has got—the needles are entirely soluble in water, and as soon as you put them into your skin, they start to deliver the vaccine. After the delivery, the needles are all gone, and you throw the patch away. You get a new one in the mail. So, this has moved into Phase 1 clinical trials. Efficacy has been shown.

I might, if you have a moment, toss it over to Dr. Fauci because we have collaborated with his institute in the development of these new delivery approaches and they may have some other approaches, as well.

Senator BALDWIN. Please. Dr. Fauci.

Dr. FAUCI. Thank you, Bruce. Yes. We have an active collaboration with Dr. Tromberg's Institute and we are looking towards the future about how we can make it much easier to get people vaccinated. This is of particular relevance right now because, with COVID–19, even though we are doing really very well with vaccination, we still have a group of individuals who were really difficult to get to. And hopefully, when we have a much easier way to administer the way Dr. Tromberg has mentioned, that will make it easier for us.

Senator BALDWIN. Excellent. In April, the University of Wisconsin launched the Center for Health Disparities Research Center, which has a leadership team comprised entirely of women, will focus on how physical environment and social conditions intersect to influence an individual's health.

Their first initiative, funded by the NIH, will use data from 22 Alzheimer's disease research centers throughout the U.S. to examine how social determinants of health throughout a person's lifetime impact their brain health.

The pandemic has made it clear that we need to do more research like this to better understand and respond to health inequities, and I applaud the work of Dr. Amy Kind and the University of Wisconsin. It is imperative that we maintain our commitment to this into the future.

COVID–19 AND HEALTH DISPARITIES

So, Dr. Pérez-Stable, how has the impact of the COVID–19 pandemic on communities of color informed how NIH thinks about studying health disparities going forward? And what additional investments are needed to fill these gaps?

Dr. PÉREZ-STABLE. Thank you, Senator Baldwin, for that question. I think a year ago, when we understood the dimension of the dramatic, disproportionate burden by race, ethnicity, and socioeconomic status on the population, there was sort of an aha moment for all of NIH to say, this problem has been with us for a long time. We have made limited progress. It is time we put our innovation, our efforts, to address this.

Out of this effort, we created the Community Engagement Alliance Against COVID–19. Dr. Gibbons and I are co-chairing that. Dr. Collins mentioned it in his opening statement. And I think to heighten the importance of community engagement, so talk to the people that are affected, bring them in as full partners, identify the problems, and then mobilize all sectors that we can mobilize. Not just the researchers and the healthcare clinicians, but also the housing, transportation, zoning, all the different sectors of society, to see how we can begin to make a difference in this setting.

And I applaud the effort of Dr. Kind. She was a grantee of ours, as well as others, and also applaud the effort of looking at existing data with standardized measures to address problems of this kind, like Alzheimer's disease.

Senator BALDWIN. Yes. Thank you so much.

Madam Chair, I yield back.

Senator MURRAY. Thank you. Senator Rubio.

Senator RUBIO. Thanks, all of you, for being here.

I think I will direct this to Dr. Fauci, but I welcome everybody's answer. I just want to go through, so, what we do know. We have heard a lot about what we do not know.

So, here are the things that we do know, okay?

ORIGIN OF COVID–19

So, SARS–1, we identified the host animal within 4 months.

MERS, I believe, we identified the host animal within 9 months.

It has now been 15 and a half, 16 months, we have still not seen and China has not produced any evidence of the host animal that transmitted COVID–19 to a human.

We know that China has a history of lab accidents. I think, Dr. Fauci, you answered Senator Graham's question. I think he phrased it as, has there ever been a pandemic that came out of a laboratory, and the answer was no.

But, we know of outbreaks that came out of a laboratory. I believe back in 2004, two researchers in Beijing were infected doing research on SARS and it led to an outbreak. China has a history of lab accidents.

This outbreak happened in a city that happened to be the home, coincidentally, of a lab which we know is involved in extensive research. And, what they do is they take this naturally-occurring virus and they manipulate it and they change it to make it infectious to humans. We know that they do that there. They have published about it.

And, it also happened in a city in a lab where a Rutgers biosecurity expert raised concerns about its safety, and our diplomats in 2018 were cabling back to Washington expressing concern about the safety.

So, I take all those facts together, right?

SARS, we knew the host in 4 months.

MERS we knew the host in 9.

We still do not know the host in—for COVID, even though—and China is not being transparent about it even though they have a vested interest in producing the host so they can put all this down.

In a lab that we know is involved in changing viruses synthetically so that they become infectious for humans.

In a lab that diplomats have told us is unsafe.

In a country that had history of lab leaks.

And, by the way, in a virus that we know can be synthetically-created because the Swiss did it. The Swiss created an exact replica of this virus in the lab for purposes of answering it.

All of these facts were available to us last May, last April. Why—I will start with Dr. Fauci. Why did you dismiss the lab leak theory as credible?

Dr. FAUCI. I have always said that the high likelihood is that this is a natural occurrence. I did not dismiss anything. I just said it is a high likelihood that this is a natural occurrence from the environment of an animal reservoir that we have not yet identified, and I still maintain that.

But, as I just mentioned in response to other questions, that since you do not know 100 percent about that, because no one knows, including me, 100 percent what the origin is, is the reason why we are in favor of further investigation.

Senator RUBIO. Well, given everything I have just cited—and if anything I just cited is incorrect, I hope I will be corrected. I am relying—obviously, not my field of study, so I am relying on what other experts have published. What is the basis for this high likely—what is the basis for the conclusion that it is likelier to have been naturally occurring than a lab accident?

I asked a specific question to the Director of National Intelligence, and how I posed it is, is it not true that it is the assessment that they are equally likely, based on our information that we have.

So, as I outline all of these things here, is she wrong when she answered me yes? And, based on everything I have just cited, why the—what is it that we are basing the higher likelihood of naturally occurring? Is it simply because that is all we have ever seen in the past?

Dr. FAUCI. Well, we have historical experience that happened with SARS–CoV–1. It happened with MERS. It happened with HIV. It happened with virtually all the influenza pandemics. So, the historical basis for pandemics evolving naturally from an animal reservoir is extremely strong, and it is for that reason that we felt that something similar like this has a much higher likelihood.

But, again, getting back to what I said—and let me repeat so there is no lack of clarity in that. No one knows, not even I, 100 percent at this point, which is the reason why we are in favor of further investigation.

Senator RUBIO. But, going back to precedent, precedents require them to be similar. The difference between this one and that one is—as I said, 4 months we knew the host for SARS, at 9 months we knew the host for MERS. China has all the incentive in the world to produce this host and has not done so. And, then, you add up all these other things, I mean, is it just a coincidence it happened in the city that is doing this kind of research, which, by the way, is controversial? I know you and others have been supportive of it, but it is controversial. It is not widely accepted as good.

My whole point is there are people out there who had Facebook posts taken down. They are called kooks, conspiracy theorists, for saying publically a year ago what we now say may be possible. I think those people deserve an apology, at a minimum.

Thank you.

Senator MURRAY. Thank you.

COVID–19 AND MIS–C

Dr. Bianchi, thank you. NICHD (National Institute of Child Health and Human Development) is trying to develop ways to identify children at high risk for multi-system inflammatory syndrome in children. It is a rare and life-threatening after effect of COVID–19. Now, while most children who become infected, I know, have mild or no symptoms, some do go on to develop this severe and sometimes fatal condition. I know your research is still in the early stages, but could you describe the NICHD's efforts to develop clinical, predictive models using machine learning to identify children at risk and how physicians are using this testing device and data?

Dr. BIANCHI. Thank you very much for your question, Senator Murray. As you know, there are almost four million children who have been infected with SARS–CoV–2, but the key is to figure out which is the one-in-a-thousand child who is going to get very sick with this MIS–C, and that child could get critically ill, although most do recover. So, as a parent, you would want to know if my child tests positive, what is going to happen.

And, so, as part of the RADx RAD program—NIH is supporting this. It is four different programs CARING for Children with COVID, but the predictive one that is using artificial intelligence and machine learning is called the PreVAIL Kids Program. And what that is, is it is eight different programs around the Country, with some international partners, that are using existing cohorts, as well as prospectively enrolled cohorts, to collect biospecimens and use artificial intelligence in conjunction with the electronic health records.

The program started within the past few months, so we do not have evidence yet. But, the enrollments are on target, and we are expecting to enroll about 12,000—actually, we have already enrolled about 12,000 children out of 16,000 that are expected.

A.I. DETECTION OF CANCERS

Senator MURRAY. Okay. And Dr. Sharpless, artificial intelligence has been shown to help improve the detection of breast cancer in mammograms, and lung cancer in CT scans. And suggesting that AI appears well suited for imaging, are you looking at the potential for AI to help early detection of other cancers?

Dr. SHARPLESS. Oh, yes. This is a very important topic. I think artificial intelligence has really the ability to transform cancer research and cancer clinical care in dramatic ways.

We have a very lively set of collaborations going on with the Department of Energy that has extensive expertise in this topic. To use, you know, AI to try and identify drug targets for medicinal chemistry, or to use AI to read 600,000 pathology reports that we get for the SEER database every year, or to use artificial intelligence for image analysis, both pathology images and radiology images.

So, I think this is a tremendously exciting technology that has real opportunities to advance cancer research and cancer care in many important ways.

I think we were also worried about the ethical issues of AI, and we want to make sure that we use practices that will not reinforce biases that are latent in some of our data sets.

But, overall, I think the promise of AI is very exciting for cancer research.

Senator MURRAY. Interesting. Okay.

CLIMATE CHANGE AND HEALTH

Dr. Gibbons, the request, budget request, includes $110 million to study the impact climate change is having on health. Talk to us about what kind of serious effects have we been seeing from climate change, and what kinds of research do you expect NHLBI (National Heart, Lung, and Blood Institute) to support with this kind of funding?

Dr. GIBBONS. Yes. Thank you for that question. As we know, climate change often involves these changes in our air, in our air quality, particularly it is likely to promote more air pollution. Certainly, the constituents on the West Coast are familiar with the impact of wild fires on air quality.

And although air is all around us, air pollution tends to concentrate and have its greatest impact on certain communities, particularly communities in which those neighborhoods are closer to sources of air pollution, and therefore, the impact is also inequitable in terms of the health consequences of air pollution, and that is falling on the most vulnerable.

We know that it exacerbates certain chronic conditions, certainly cardiopulmonary ones like chronic obstructive pulmonary disease, asthma, heart failure. Heart attacks are increased in the context of higher air pollution promoted by climate change.

And, we anticipate that there will be a need to not only mitigate the impact of climate change, but also to enhance resilience to the effects of air pollution on health, and we anticipate that that will involve enhancing healthy communities that are disproportionately affected by the consequences of air pollution derived from climate change. And our programs that are community-engaged research with that health equity lens should be promising in that regard.

Senator MURRAY. Okay. I think this is really important, and I think we all should recognize that this is an area we need to look at, so I appreciate your work on this and we will be following it closely.

I will turn to——

SEXUAL HARASSMENT AT NIH

Okay. I have one additional question and that is for Dr. Collins. In 2018, the National Academies, as you know, released a report that found that nearly 60 percent of women in academia have experienced—60 percent—have experienced sexual harassment on the job and recommended that Federal research agencies require institutions to notify them when individuals on grants have violated harassment policies or put on administrative leave due to harassment allegation. And other science agencies, like National Science Foundation, have implemented these changes.

Tell me, what is NIH doing to require its research institutes to do the same?

Dr. COLLINS. Senator, I share the sense that this is an extremely important issue. The National Academy report that you mentioned I think really got everybody to recognize how pervasive sexual harassment is and what a significant negative it has been for far too long for women in our scientific workforce.

We conducted our own working group in the Advisory Committee to the Director that reported to me in December of 2019 and made a series of very significant recommendations about how we might change our approach to this. We have been working through those and have already implemented a significant fraction of them. There are some that still require some additional legal authority that is hard for us to be able to do at the present time.

In terms of what you are particularly pointing to, we have had now more than 300 allegations that have been brought to us about sexual harassment in our grantee institutions; others within our own intramural program. Of those 300, about 30 percent of them have turned out to be actually entirely validated. That has resulted in a hundred different changes in grants that—particularly, removal of principal investigators and replacement of those with other individuals.

One hundred and twenty-five individuals have been taken out of our pool of peer reviewers because of this kind of concern about the bias that they bring to that experience.

And we have made it very clear to our institutions that we expect them to report any circumstance——

Senator MURRAY. Well, expecting them does not require them to.

Dr. COLLINS. And, Senator, you and I are in an interesting discussion here that I agree—I wish we were able to simply say require. At the present time, legally, we are told we do not have that

authority. We would have to go through a 2-year rulemaking effort, or we would need statutory assistance.

Senator MURRAY. Well, okay. This is really important, and whatever we need to do, I do not—you know, I know you have worked on it, I know you have focused on it, but I know of women who have left our scientific research institutes because of this. We cannot afford to have that happen for a thousand reasons. So, whatever it is we need to do here, we need to know what it is so we can do it.

Dr. COLLINS. I am so with you. And if there is another iteration we can take at this to try to figure out—I will say that what we have said in terms of the expecting response from our institutions has gotten their attention in a pretty remarkable way. Even without requiring it, we are seeing reporting coming through.

Senator MURRAY. Well, to every one of them that is listening, I am not done with this.

Dr. COLLINS. Okay.

Senator MURRAY. Senator Blunt.

Senator BLUNT. Thank you, Chair.

I have three or four questions. Let me eliminate a couple of other topics by just making a couple of comments on some things that have already been said, one, and one thing that has not been, I do not believe, brought up today.

One is on the CTSA awards. None of the people talking to us that are current recipients think that this simplifying the process makes it more likely that they will get the research bench-to-bedside result that they think you want and they think is the key to this award.

And, you have heard a number of schools mentioned, and University of Washington would be one of them that Senator Murray would be very familiar with. Washington University in St. Louis collaborates through this program with Saint Louis University and the University of Missouri to get to more rural hospital settings and do things. So, I suspect you have heard a number of concerns about that today.

I have not heard brought up one of my concerns, which I am just going to mention. I do not think you need to respond to it. I do think that waiving the intellectual property rights on COVID–19 vaccines is a problem. I think it is a problem because I do not think it actually would increase the number of vaccines, the capacity to produce a vaccine that has efficacy, in the timeframe we need to make it. It probably is not benefitted much by waiving the rights to the research. The WTO (World Trade Organization) has to unanimously agree, which I do not think they do. But, if they do, we give our research to everybody.

And third, when this comes up again, companies would have less willingness, I think, to step forward. At least one of the companies, Dr. Collins that we dealt with in Warp Speed, there was no agreement at all that if they were not successful—we had a contract. We would buy 100,000 doses, but only if they were FDA authorized. So, they were out there totally on their own, as these companies you would expect to be.

I do not think this is likely to happen because of the WTO, but I have some concerns that I suspect are shared by others at NIH.

IMPACT OF COVID–19 PANDEMIC ON CHILDHOOD DEVELOPMENT

Dr. Bianchi, just the title—let's just take the title of your Institute and look at COVID. What do you think the impact on child health and development of COVID and the COVID environment, the pandemic environment, the quarantine environment, has been? And how are we going to be looking at what the long-term ramifications of that might be and what advice we may be able to give to schools and moms and dads and behavioral health and other health providers as it relates to child development impacted by this?

Dr. BIANCHI. Thank you so much for that question, Senator Blunt, because children, you know, have not—I think they are so important in terms of our Nation's future, first of all. But, the fact that children have been home from school has affected the entire family, has affected the workforce, et cetera.

But, because children in general have been asymptomatic or mildly symptomatic, they have not gotten as much attention, and yet being at home, being away from in-person schooling, I think may have significant impact for years to come. And, for that reason, we are trying to get the kids back to school as soon as possible.

And as part of the RADx Underserved Population program, we are also leading an initiative to really develop, evaluate, and implement testing, along with mitigation, of, you know, hand washing, social distancing, et cetera, to get evidence to reassure people to get kids back to school. Two of the sites are actually in Missouri, and one is in Washington State. There is a program in Yakima, and there is a special program in Missouri that is looking at how you deal with kids who have intellectual disabilities and cannot mitigate in the same way.

So, to answer your question, I think there will be long-term effects. I think the answer is to get kids back to school safely, with evidence. And, this program is based on a funded project that was very successful in North Carolina that showed with all the mitigation, with the work with the superintendents of schools, that the secondary infection rate in schools was extremely low compared to the community.

Senator BLUNT. Yes. I would think here that some of the developmental issues, and they will be different with 4 and 5 year olds and kindergarten and first grade than they will people in seventh grade, and those may be different than people——

Dr. BIANCHI. Absolutely.

Senator BLUNT [continuing]. In the eleventh and twelfth grade and how—you know, I think we are going to have to watch this carefully and try to get data and then share that data.

FUTURE OF MRNA TECHNOLOGY

On vaccines—actually, on—maybe more on mRNA than vaccines, what do we think the impact may be as it relates to cancer, to HIV? We will start, Dr. Fauci, with you. Can we look at the flu shot in a different way? And what do we think the mRNA impact, now that we know this different use for it, may have on other healthcare settings? And Dr. Sharpless, I am going to come to you second on this.

Dr. FAUCI. It is going to—I believe, and many of my colleagues believe, that the mRNA technology, as it has been so spectacularly successful with SARS–CoV–2 to develop a vaccine against COVID–19, is already being pursued for other infections, including HIV and including influenza. So, there are a couple of things that are going on now. Even as we see the successes with COVID–19 in using the mRNA technology for the development, for example, of universal flu vaccines, as well as now having HIV vaccine researchers now looking at the possibility of an mRNA platform technology to use for HIV. So, it is already happening.

Senator BLUNT. Dr. Sharpless, on mRNA, I mean, we know the impact in just the last half dozen years of immunotherapy on cancer treatment. What about this mRNA intervention and how it might impact the way we look at fighting cancer?

Dr. SHARPLESS. Yes, this is a very exciting topic. You know, people interested in this space have been working on this, you know, long before the pandemic. So, using mRNA for cancer therapy has many potential applications because you can really get the body to make a protein, and that protein could have a desirable effect against cancer, for cancer therapy, in a lot of ways.

The furthest advance, as you mentioned, is the use of mRNA vaccines, you know, cancer vaccines. And clearly, they tend to be highly personalized, the ideas that you can sequence someone's own tumor and then make the vaccine to their very own tumor in a way that will not cause them autoimmune side effects, and this is an idea to augment other kinds of autoimmune cancer—or anti-immune cancer therapies.

So, it is a very promising area. It is in clinical trials, and we just need to see how this develops.

Senator BLUNT. Thank you. My last question, Chair.

IMPACT OF COVID–19 PANDEMIC ON RESEARCH AND RESEARCHERS

Dr. Collins, in the pandemic, particularly with lab closings, we obviously lost some time, and lost research that is going to take a long time to recreate. Are the lab reopenings happening in the way they need to? And, do you have the flexibility to extend a grant to overcome the disruption? And probably just not this disruption of the time closed, but the research lost by closing, as well.

Dr. COLLINS. I am glad you are asking because this is yet another of the terrible casualties of this terrible pandemic. It has been very hard on researchers, especially those who need a laboratory to do their work or who were running a clinical trial that was very hard to enroll participants. And, yes, we did have to have many of those folks staying away from the workplace for their own safety.

They are coming back. Our own program at NIH, our intramural program, now is up to about 50 percent occupancy, but it is not anywhere near where it was pre-pandemic. We have done everything we can with our flexibilities to try to make sure, particularly, that trainees and early-stage investigators do not get further injured by this by extending the periods of their training; or by allowing grants if they are able to put forward a special request to be extended for an extra year, either without extra funds, or with, if the case is strong.

And yes, I also think we need to be cognizant of the way in which this is affecting people in other ways. We have now come up with a way to provide childcare support for our trainees who otherwise have not had that, and that has been one additional burden on their shoulders.

Our estimates are that it is about a $16 billion loss that has occurred because of the way in which this has affected research in our extramural institutions; that they are in a tough place to try to make up. So, I appreciate your asking the question.

We are going to have a really big challenge getting ourselves back into the place that we were before this happened.

Senator BLUNT. Well, let us know what we need to be thinking about as we think about the rest of this bill on that topic. And thank you, Chair.

Senator MURRAY. Thank you very much. And I want to thank all of our witnesses today for their really—for a really productive hearing. I think we all learned a lot. So, thank you very much.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due one week after the President's budget is delivered at 5 p.m. The hearing record will also remain open until then for members who wish to submit additional materials 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 DR. FRANCIS COLLINS

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. The President's fiscal year 2022 skinny budget proposed a major new biomedical research effort by establishing ARPA–H. While the skinny budget was light on details regarding the structure of the program, the Administration's statement indicated that the initial focus of ARPA–H would be 'on cancer and other diseases such as diabetes and Alzheimer's.'

Assuming Congress and the Administration work together to establish ARPA–H, how would you envision ARPA–H setting priorities for research into additional diseases?

Answer. Over the long term, the proposed structure for the Advanced Research Projects Agency for Health (ARPA–H) is intended to empower the ARPA–H leadership and staff to set and execute on research priorities for a variety of high-risk, high-reward, milestone-driven projects that can lead to novel capabilities, platforms, and resources that are applicable to a range of diseases.

For the initial direction, the Administration is working to set up multiple pathways, both within the government and the broader stakeholder community, for priority setting and for exploring new areas ripe for research at ARPA–H. At the time of this hearing, the White House Office of Science and Technology Policy (OSTP) and the National Institutes of Health (NIH) are in the planning phases of convening multiple listening sessions with key stakeholder groups including patient organizations, industry, venture capitalists and philanthropists, and others from the academic and research communities. During these sessions, stakeholders will be asked to offer their perspective on what they see as the greatest research challenges and opportunities that could be addressed using the ARPA–H model. This input will help refine the scope and provide a wealth of ideas for the first ARPA–H director to consider as they develop the agency's vision.

In mid-July, the Administration established a Joint Fast Track Action Committee (FTAC) to help steer the creation of ARPA–H and lay the groundwork for strong interagency coordination. OSTP and NIH serve as co-chairs of this committee that includes representatives from Department of Agriculture, DARPA, Office of the

Under Secretary of Defense for Research & Engineering, ARPA–E, BARDA, CDC, CMS, FDA, VA, EPA, NSF, and the Smithsonian Institution, among others.

Question. Some of the greatest advances in medical innovation in the last decade have been brought on through genetic analyses and use of sophisticated computer programs that can shorten the time taking drug candidates through clinical studies. In fact, the development of COVID–19 vaccines benefited from the use of 21st century technology like cloud computing and AI to help stop the virus' spread and save lives.

How will the President's budget build on the use of modern tools like cloud computing, AI, and genetic analyses to further accelerate the delivery of cures to patients?

Answer. Over the last decade, pharmacogenetics has advanced the frontier of personalized medicine such that drug therapeutics are developed based on the genetic aberrations of disease. This approach is most notably applied for cancer treatments and also other diseases. Cancers of various types are treated by first knowing the genetic mutations and/or deletion of genes. Then drug candidates are screened and developed by computer modeling of the target sites along with potential drug candidates. Such modeling requires various large datasets and analytics that, if stored in the cloud and interoperable, can be mined to find the best drug candidates that bind to the target sites for treatment. Storing large datasets in the cloud is only the first requirement for cloud computing. Such computation requires new tools, and support for tool development is essential to realize the opportunities for cloud computing.

Artificial intelligence (AI) has advanced the pace of drug discovery and development via predictive models of drug/target interactions and also facilitates clinical trial design based on algorithms for go/no go decisions during the trials.

The President's Budget Request supports the application of AI to improve diagnostics for diseases as diverse as coronavirus disease 2019 (COVID–19) and cancer. In each case, information-rich data sources that are stored, aggregated together, and analyzed in the cloud are used to rapidly train and test these new capabilities. New programs like the Artificial Intelligence/Machine Learning Consortium to Advance Health Equity and Researcher Diversity program, or AIM–AHEAD, and Bridge2AI will harness AI for health by generating AI-ready datasets and best practices for machine learning. This will allow researchers to accelerate data-driven discovery for grand challenges in biomedicine using AI-based technologies. Additionally, NIH's partnership with cloud services providers—Google, AWS and now Microsoft Azure—further enhances researchers' abilities to leverage industry technologies and utilize AI-ready data for drug discoveries and therapeutic treatments.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. I have worked with the Subcommittee Chair and Ranking Member for years on sustained, predictable increases to the NIH budget—with the goal of providing at least 5 percent real growth year-over-year. We have had success, leading to a 42 percent increase over the past 6 years, along with supplemental funding in COVID–19 relief packages. The President's fiscal year 22 budget calls for a 19 percent increase to the NIH overall budget. The vast majority of that comes from the proposed creation of a new advanced research effort, called ARPA–H. When I toured the NIH campus recently with many members of this Subcommittee, you discussed how innovative efforts during the pandemic—such as with the RADx testing program or Warp Speed vaccine development—align with the ARPA-H proposal, incorporation closer partnerships with industry and coordination at different stages in the research and development of promising breakthroughs. Your testimony discusses application of this nimble ARPA–H proposal for cancer, infectious diseases, and autoimmune diseases.

As we evaluate this proposal, what are the core aspects of this ARPA–H policy that you want us to keep in mind?

Answer. We envision that the Advanced Research Projects Agency for Health (ARPA–H) will be able to tackle large-scale challenges using a proven high-risk, high-reward approach that embraces nimbleness and flexibility with the broader goal of delivering rapid breakthroughs that serve all patients. Being successful in this endeavor requires close communication and collaboration across government and with key stakeholders in the external biomedical community. This could include undertaking projects with Federal agencies, private companies, independent research institutes, medical centers, as well as academic institutions—all collaborating to advance innovative health research. NIH deployed similar approaches in response to the COVID–19 pandemic (Accelerating COVID–19 Therapeutic Interventions and

Vaccines, or ACTIV and Rapid Acceleration of Diagnostics, or RADx)—which yielded life-saving results for Americans, and also served as a learning opportunity to appreciate further the value of employing a DARPA—like model to support research. With Congressional support, we believe we can leverage these models in other areas of health research to drive transformative change and impact.

Question. We have spoken in the past about two seemingly divergent issues. On one hand, we talk about the need to invest in medical research to find breakthroughs and cures for patients, so we rightfully appropriate billions into NIH-funded research—sign me up for that. But then these drugs come to market—the vast majority of them benefitting from NIH research (e.g. a study finding that all 210 drugs approved by FDA between 2010 and 2016 benefitted from NIH-funded research in some form)—and too many of them with exorbitant price tags. Recent studies show that high costs contribute to poor medication adherence, including with one-quarter of cancer patients choosing not to fill a prescription due to cost. I know Dr. Sharpless has talked about the "financial toxicity" for cancer patients. Americans pay the highest prices for medications in the world, with a recent GAO report finding that the U.S. pays two- to four-times more for certain medications than other developed countries. It is counterintuitive and an outrage that taxpayers fund cutting-edge research, which leads to drugs, that we often cannot afford once they hit the market. I understand NIH does not set drug prices and does not want to limit the handoff or development of its research to stakeholders that commercialize the discoveries. But the current system does not maximize the benefits for patients.

Given the role of NIH research in contributing to FDA-approved medications, many of which come with extremely high price tags, what specific steps can NIH take to ensure that patients are able to afford the incredible discoveries made at NIH?

The NIH has received several petitions to exercise march-in rights (35 U.S.C. § 203), but has never done so.

—Under what circumstances would NIH consider doing so?

—Under that statutory authority, how does NIH define and evaluate the term "practical application" for the purposes of how a contractor or assignee makes a subject invention funded by NIH available to the public on reasonable terms?

—What are the factors used in such definition and evaluation?

—Can you provide an example of the analysis undertaken in evaluation of a previously filed march-in-petition?

Answer. The National Institutes of Health (NIH) shares your concern about the high price of drugs and the impact on public health. The article you reference shows that all of the 210 drugs approved by U.S. Food and Drug Administration from 2010 to 2016 were based on at least one scientific publication reporting on research funded by the NIH.[1] The researchers reported that 96 percent of the NIH funded projects were identified based on a search for the "target" rather than the drug itself. Identifying a drug target, meaning a protein in a cell that has a function in a disease process, opens the door for any researcher in industry or academia to screen for drugs that bind to the target to slow or arrest disease processes. This research is key to a vibrant drug discovery process in the United States and does not limit discovery to one drug for each target. The development of multiple drugs for a particular disease allows the patient and physician to choose the best one for them and can lead to price competition in the market. Drug pricing is a complex problem that involves various segments of the market, much of which NIH has no control over. A smaller number of important drugs utilize patented inventions funded by the NIH. When NIH has been asked to consider march-in under the Bayh-Dole Act based on the price of such drugs, NIH has stated that the issue of drug pricing is one that should be address by Congress, as it considers these matters in a larger context.[2]

The Bayh-Dole march-in provision (See 35 U.S.C. 203) allows a government funding agency to require a grantee to grant a license to a patent of an invention made under that agency's awarded grants or contracts and allows other "responsible applicants" to obtain the license if one of four circumstances are met:

1. the contractor or assignee has not taken, or is not expected to take within a reasonable time, effective steps to achieve practical application of the subject invention in such field of use

2. to alleviate health or safety needs which are not reasonably satisfied by the contractor, assignee, or their licensees

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[1] Cleary et al., 2018, www.ncbi.nlm.nih.gov/pmc/articles/PMC5878010/.

[2] NIH march-in responses from 1997–2013 at ott.nih.gov/policy/policies-reports under "NIH March-In Response".

3. to meet requirements for public use specified by Federal regulations and such requirements are not reasonably satisfied by the contractor, assignee, or licensees

4. the agreement required by section 204 [a requirement that patented products be manufactured substantially in the United States unless a waiver is granted]

The first two criteria are typically cited in petitions to consider a march-in by the National Institutes of Health (NIH). For example, if a company has rights to a government funded patent for a drug candidate but is not making reasonable efforts to bring it to market, the company may be failing to meet the requirements to achieve practical application of the invention. These criteria are considered on a case-by-case basis by the agency in view of the facts presented in each case.

If NIH were to march-in, the grantee could appeal that decision through the Federal courts. Only after the company had lost all legal appeals could NIH grant a license to a second company, should there be one interested in developing a new version. Additionally, the drug could be covered by other patents that cover certain aspects of the drug, such as methods of making and administering it. In such instances, the march-in could be ineffective, because the original company could stop a new company from making the generic until the other patents expire.

After the court appeals and expiration of any other patents, a company would typically have to conduct clinical trials or otherwise establish equivalency with the brand drug to obtain U.S. Food and Drug Administration approval. The entire process, including administrative hearings, court appeals and new clinical trials, could take years before the new product reached the market. In the meantime, alternative therapies may have become available or the patent subject to march-in may have expired.

NIH has considered march-in on several occasions and was either able to work with parties to reach an agreement to address the issues raised, such as the case with CellPro and Fabrazyme, or decided that the march-in legal requirements were not met to march-in to address the public health and safety issues raised, such as was the case with Norvir.[3]

Question. The COVID–19 pandemic has impacted every major sector of the economy of the United States, including our nation's biomedical research. I have heard from countless universities across the state of Illinois about the impact that this pandemic has had on the medical research pipeline. From shuttered labs, to interrupted or delayed clinical trials, to unforeseen pandemic-related costs, they have estimated that this pandemic has caused over $10 billion in lost research. Last year, Senator Moran and I sent a bipartisan letter to Senate leadership, requesting at least $10 billion in additional funding to help make-up for the unforeseen disruptions and costs to medical research nationwide.

Dr. Collins, I am wondering if you can speak to the toll that the pandemic has taken on medical research nationwide and what Congress might be able to do to help.

Answer. The National Institutes of Health (NIH) remains deeply concerned and mindful about how the spread of coronavirus disease 2019 (COVID–19) has negatively affected the biomedical research enterprise.[4] Last summer, the NIH estimated it would cost at least $10 billion to restart labs which were forced to rapidly close. That original estimate proved overly optimistic as the pandemic subsequently continued, and as such, the NIH now estimates the financial impacts to be approximately $16 billion on the biomedical and behavioral research enterprise.

The estimates considered many factors:

—Key resources, such as animal colonies, cell lines and expired reagents that need to be re-established.

—Access to core facilities that was limited due to a backlog of requests.

—Delicate and complicated equipment that required recalibration and quality control testing prior to returning to routine use.

—Requirements for social distancing to protect staff and clinical trial participants coupled with anticipated reluctance by participants to travel, which slowed the rate of clinical trial accrual and progress and increased the cost of conducting trials.

In addition to the financial estimates, the NIH fielded two online surveys to objectively document COVID–19's impact on the extramural research workforce.[5] The main finding from the surveys was that the majority of respondents noted concerns

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[3] See ott.nih.gov/policy/policies-reports under NIH March-In Response.

[4] https://nexus.od.nih.gov/all/2020/11/04/continued-impact-of-covid-19-on-biomedical-research/.

[5] https://nexus.od.nih.gov/all/2020/10/05/encouraging-participation-in-upcoming-nih-surveys-to-identify-impacts- of-covid-19-on-extramural-research/.

about research functions, research productivity, and financial status.[6] Well into the pandemic, many NIH-supported research labs enforced social distancing, inherently restricting access and severely limiting the ability to generate research results and preliminary data at a crucial time in career development of early stage investigators and trainees. Junior faculty, often with only a single NIH award and unable to access their labs to generate additional data, are at risk of losing all funding and may have insufficient data to write papers while working from home. Some investigators, especially women with dependent care responsibilities, are more negatively affected. Investigators supported by training or career development awards are experiencing hiring freezes and job revocations, jeopardizing the ability of early-stage career investigators to transition to independence, particularly as they come to the end of their current funding. Clinical investigators have been diverted from their research labs to meet the clinical demands of COVID–19 patient care.

Considering these effects, the NIH is concerned about potential pandemic-related losses of scientists exiting the biomedical research workforce and abandoning scientific careers to seek alternative employment. In an effort to address the unanticipated impacts of the pandemic on the career trajectories of early career scientists, the NIH has provided several policy flexibilities, including grant award extensions (both funded and un-funded), opportunities for investigators to extend the timeline for early career status, provided administrative supplements, and more.

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

Question. At the hearing, we discussed psychedelic drug research and the potential of these drugs to treat mental health illness. You stated that the NIH would consider having a workshop on this subject.

What is the current status of NIH-funded clinical trials involving human subjects on the potential benefits of psychedelics combined with psychotherapy?

Are there statutory or regulatory barriers to NIH pursuing or funding human subject research on psychedelic drugs?

When does NIH plan to convene a workshop on psychedelic drug research?

Answer. The National Institutes of Health (NIH) supports research on the development and testing of pharmacological interventions—including the use of hallucinogens such as ketamine, and psychedelic drugs such as psilocybin—for the treatment of illnesses. In particular, the National Institute of Mental Health (NIMH) requires an experimental therapeutic approach for the development and testing of therapeutic interventions for mental illnesses, in which the studies not only evaluate the clinical effect of an intervention, but also generate information about the mechanisms underlying a disorder or an intervention response. Research on psychedelic drugs holds promise for uncovering mechanisms of mental illnesses and possible interventions, ultimately leading to novel treatments with fewer side effects and lower abuse potential. Further research is needed to examine the efficacy and long-term safety of psychedelic drugs, including with repeated exposure and potential interactions with existing treatments.

The dissociative anesthetic ketamine has recently emerged as an effective fast-acting antidepressant.[7] The NIMH Director's Message, "New Hope for Treatment-Resistant Depression: Guessing Right on Ketamine," describes the role of NIMH and other researchers in the development of esketamine, a U.S. Food and Drug Administration-approved, rapid-acting medication that targets treatment-resistant depression.[8] Within the NIMH Intramural Research Program, Dr. Carlos Zarate is now conducting clinical trials to better understand how ketamine rapidly reduces depressive symptoms in people with treatment-resistant depression or bipolar depression.[9,10]

The National Institute on Drug Abuse (NIDA) currently supports a clinical trial which aims to assess the efficacy of ketamine, in combination with behavioral therapy, in the treatment of cocaine use disorders.[11]

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[6] https://nexus.od.nih.gov/all/2021/03/25/the-impact-of-the-covid-19-pandemic-on-the-extramural-scientific-workforce-outcomes-from-an-nih-led-survey/.

[7] pubmed.ncbi.nlm.nih.gov/27839782/.

[8] www.nimh.nih.gov/about/director/messages/2019/new-hope-for-treatment-resistant-depression-guessing-right-on- ketamine.

[9] clinicaltrials.gov/ct2/show/NCT03065335.

[10] clinicaltrials.gov/ct2/show/NCT03973268.

[11] clinicaltrials.gov/ct2/show/NCT03344419.

Additionally, a privately funded clinical trial is assessing the potential efficacy of the psychedelic drug psilocybin for the treatment of obsessive-compulsive disorder.[12] While the NIH is not directly funding this trial, NIMH does support the trial's principal investigator through a Mentored Patient-Oriented Career Development Award.[13]

Further, a number of NIH-funded researchers are conducting basic and preclinical research to investigate the use of psychedelic drugs as potential therapeutic interventions for mental illnesses. For example, NIMH-funded researchers are examining the mechanisms underlying the antidepressant effects of psychedelic drugs in an effort to develop novel, non-hallucinogenic treatment strategies that are both safer and more effective than existing treatment options.[14]

As with all human subjects research, clinical research on psychedelic drugs is governed by several statutes, regulations, and policies intended to protect the rights and welfare of research participants. For example, NIH has specific requirements for research staff and policies regarding research conduct, safety monitoring, and reporting of information about research progress.[15] In accepting an award that supports human subjects research, the recipient institution assumes responsibility for all research conducted under the award, including protection of human subjects at all participating and consortium sites.[16] All human subjects research must also be reviewed, approved, and monitored by an Institutional Review Board.[17]

Because psychedelic drugs are controlled substances, clinical research using psychedelic drugs must also follow Drug Enforcement Administration requirements, including registration, inspection, and certification of the drugs.[18]

From April through June 2021, the Trans-NIH Integrative Medicine Course Organizing Committee hosted a series of research talks on psychedelic drugs.[19] Building on these research talks, NIMH and NIDA are now working together to convene a scientific workshop in winter 2021. This workshop will bring together leading researchers to examine the state of the evidence for the use of psychedelics in the treatment of mental illnesses.

Question. The United States 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. In 2015, NIH established the Tribal Health Research Office within the Office of the Director to coordinate tribal health research activities across NIH. However, no such research office exists for Native Hawaiians.

Would you consider expanding the scope of the Tribal Health Research Office to include Native Hawaiians? Would this help to increase the number of Native Hawaiian researchers and the amount of Native Hawaiian research being conducted across the country?

Has NIH set any goals for the Tribal Health Research Office, and how will you measure its success and impact across NIH's Institutes and Centers?

Some funding opportunities at NIH, such as the Native American Research Centers for Health program, do not permit entities serving Native Hawaiian communities to apply. Why are these entities excluded, and would NIH consider including these entities in the eligibility for these grant opportunities?

Answer. The National Institutes of Health (NIH) Tribal Health Research Office (THRO) does not conduct disparity research on Native American populations. THRO ensures that the NIH fulfills its obligations to Indian Tribes as federally recognized sovereign nations, conducts government to government interactions appropriately, and holds formal Consultations with Tribal governments on policy, regulatory, and legislative issues that have a significant direct impact on Indian Tribes.

The National Institutes of Health (NIH) published the NIH Strategic Plan for Tribal Health Research with input from American Indian/Alaska Native (AI/AN) Communities and the NIH Tribal Advisory Committee (TAC). The plan includes four agency-wide strategic goals: enhancing communication and collaboration; building research capacity for AI/AN communities; expanding research; and enhancing

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[12] clinicaltrials.gov/ct2/show/NCT03356483.
[13] reporter.nih.gov/project-details/10127338.
[14] reporter.nih.gov/project-details/10003396.
[15] grants.nih.gov/policy/humansubjects/policies-and-regulations.htm.
[16] grants.nih.gov/grants/policy/nihgps/html5/section__4/4.1.15__human__subjects__protections.htm.
[17] www.fda.gov/regulatory-information/search-fda-guidance-documents/institutional-review-boards-frequently-asked-questions.
[18] grants.nih.gov/grants/policy/nihgps/html5/section__4/4.1.5__controlled__substances.htm.
[19] events.cancer.gov/nci/psilocybinresearch/agenda.

cultural competency and community engagement. The Tribal Health Research Office (THRO), along with the NIH Institutes and Centers (ICs), developed processes and metrics for evaluating progress on the strategic objectives and their supporting action items to achieve these goals. THRO regularly collects data on AI/AN health research activities from all ICs through an automated process to analyze the NIH research portfolio, assess progress towards the strategic goals, and measure impact across NIH.

The National Institute of General Medical Sciences in conjunction with multiple NIH Institutes, Centers, and Offices (ICOs) partner with Indian Health Service (IHS) to support the Native American Research Centers for Health (NARCH). NARCH grant applications are submitted by and awarded to a tribe or tribal organization, who are sovereign nations with distinct governing bodies. Awarding the grant directly to the tribe or tribal organization allows for the community to dictate and oversee research priorities, while drawing upon necessary expertise from the research community to accomplish its scientific goals.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. West Virginia is consistently ranked last in the nation for health outcomes. In 2020, the America's Health Rankings Report ranked West Virginia 50th for premature deaths, frequent mental distress, and multiple chronic conditions. We also rank last in life expectancy. West Virginia has, in many ways, been left behind as medical advances have saved lives in other places.

What is NIH doing to bridge this gap in health outcomes?

How do you ensure that the medical research that you do benefits people in poor, rural communities?

How can we better expand the access rural Americans have to successful medical treatments, particularly in states like mine where the disease burden is so high?

Answer. The National Institutes of Health (NIH) recognizes the unique health disparities that rural communities face, and as such, rural health is an important area of research for the agency.

Through diverse collaborations and partnerships with communities, academic institutions, and state agencies, NIH supports and conducts rural health research to improve health outcomes and reduce rural health disparities with a special emphasis on the poor in rural communities. In fiscal year 2020, NIH supported more than 1,000 rural health-related grants for approximately $728 million. In 2020, West Virginia received approximately $45.7 million in funding from NIH, of which about $6.4 million supported research and research capacity-building activities related to rural health.

In 2019, NIH held the Inaugural NIH Rural Health Seminar, a collaboration of several NIH Institutes and Centers to explore topics in rural health and opportunities for research collaborations to improve rural health outcomes. In 2020, NIH hosted a virtual rural health conference entitled, NIH Rural Health Seminar: Challenges in the Era of COVID–19. In October 2021, NIH will host the Pathways to Prevention Workshop: Improving Rural Health Through Telehealth-Guided Provider-to-Provider Communication, a virtual event to identify research gaps, explore barriers, and facilitate successful, sustainable implementation of provider-to-provider telehealth in rural settings.

NIH's rural health research focuses on key areas aimed at addressing health disparities that rural populations in West Virginia and around the United States experience. In fiscal year 2020, in response to the disproportionate impact of coronavirus disease 2019 (COVID–19) on racial and ethnic minority, and other vulnerable communities including rural populations, NIH established the Rapid Acceleration of Diagnostics for Underserved Populations (RADx-UP) initiative. The overreaching goal of the RADx-UP initiative is to understand the factors associated with disparities in COVID–19 morbidity and mortality and to lay the foundation to reduce disparities for those underserved and vulnerable populations more impacted by COVID–19. One example of a RADx-UP project in your state, is the Developing Novel Strategies to Increase COVID–19 Testing among Underserved and Vulnerable Populations in West Virginia through Community and State Partnerships. This project will implement collaborative strategies to increase availability and uptake of severe acute respiratory syndrome coronavirus 2 (SARS CoV–2) testing among the medically underserved, rural West Virginia population that includes multiple vulnerable groups at risk for severe COVID–19 and death. This initiative will test whether those implemented strategies, including home test kit and mobile unit mechanisms, successfully increase testing, and if not, determine why the interventions did not work to inform future sustainable testing policy.

In addition, NIH supports the West Virginia University Health Sciences TME CoBRE project, which focuses on the microenvironment of different tumor types, including cancers initiating in the bone marrow, head and neck, breast, and brain. This project will increase understanding of the constant interaction between the tumor and its environment, provide diverse training opportunities and mentoring strategies for junior faculty, and develop critical infrastructure and recruit additional tumor microenvironment focused scientists to West Virginia. Another project, the West Virginia Clinical and Translational Science Institute: Improving Health through Partnerships and Transformative Research (WVCTSI), leads statewide collaborations and innovation in clinical and translational research. This project will build sustainable research infrastructure, recruit clinician scientists and translational researchers that excel in team science, and actively engage with multiple stakeholders that include communities, medical providers, and policy makers to improve the health of West Virginians.

NIH is committed to ensuring that there are opportunities for poor rural Americans to access the benefits of research and that research addresses the unique strengths and challenges of rural communities by supporting several initiatives focused on human immunodeficiency virus (HIV), cardiovascular disease, cancer, drug addiction, and other chronic diseases disproportionately affecting rural communities. First announced in April 2018, the NIH Helping to End Addiction Longterm℠ Initiative, or NIH HEAL℠ Initiative, is an expansive agency-wide effort. It spans basic, translational, clinical, and implementation science and promotes collaborations of all types of research to address the crises of opioid misuse, addiction, and overdose in the United States. Launched in fiscal year 2020, Strategies to Improve Health Outcomes and Reduce Disparities in Rural Populations supports research to promote a greater understanding of the challenges faced by rural populations in developing or adapting evidence-based interventions that can reduce health risks faced by rural Americans. A total of eight awards were funded including: Harnessing the Power of Peer Navigation and mHealth to Reduce Health Disparities in Appalachia which is using a community-based approach to integrate peer navigation and mobile health strategies to develop a culturally congruent, bilingual intervention to increase the use of HIV, sexually transmitted infection, and Hepatitis C prevention and care services among individuals with health disparities living in rural Appalachia. Another study, Heart of the Family: A Cardiovascular Disease and Type 2 Diabetes Risk Reduction Intervention in High-Risk Rural Families is examining the effects of a family focused, lifestyle intervention that is culturally tailored for use with rural Hispanic or Latino and non-Hispanic or Latino adults. In 2020, the National Institute on Minority Health and Health Disparities (NIMHD) funded four rural Resource Hubs to focus on rural health research. These hubs will involve coalitions of researchers and community partners to build research capacity in an identified rural catchment area and offer opportunities to share resources and data across collaborators.

NIH continues to support the Accelerating Colorectal Cancer Screening and Follow-Up Through Implementation Science (ACCSIS) Program, a Cancer Moonshot? Initiative, designed to reduce cancer screening disparities. The aim is to identify evidence-based interventions and identify promising approaches for bringing these interventions to unscreened populations. Researchers test interventions such as mailing programs for home testing, provider education, and clinic-based patient navigation among Medicaid, rural, and racial and ethnic minority groups. In fiscal year 2020, NIH reissued and released the Pragmatic Research in Healthcare Settings to Improve Diabetes and Obesity Prevention and Care funding opportunity announcement. This initiative aims to improve diabetes and obesity prevention and/or treatment that are adapted for implementation in healthcare settings where individuals receive routine medical care. One of the funded grants, Telemedicine for Reach, Education, Access, Treatment and Ongoing Support (TREAT–ON), is a diabetes educator-driven, primary care-based telemedicine model that redesigns primary care practice to provide access to real-time ongoing support and help high risk participants in an underserved rural community to achieve and sustain improvements in clinical, psychosocial and behavioral outcomes. The NIH Minority Health and Health Disparities Strategic Plan 2021–2025 aims to test best practices for dissemination and implementation of minority health and health disparities research in diverse diseases and conditions into rural communities.

Continued collaborations and partnerships with scientists and organizations from rural communities, such as West Virginia, will contribute to NIH's reach in rural communities and support our work to combat rural health disparities.

Question. The NIH funds the WV Clinical and Translational Science Institute at West Virginia University through a 5-year $20 million grant. The Institute provides critical health research across West Virginia and has successfully mentored early

career investigators, established pilot project funding, and created a research network across 27 primary care sites. Their research has focused on important health issues in my state including lung disease in coal miners, opioid addiction, and the hepatitis C epidemic, as well as cancer, heart disease, and stroke. Most recently, the Institute has been on the front line of COVID–19 research, having received a $1.5 million NIH Grant to lead an 8-state effort so that data from COVID–19 patients could be analyzed to develop the most impactful COVID–19 research. They're also responsible for utilizing the NIH RADx grant to scale up COVID–19 testing in WV Communities.

Can you comment on the importance of continued collaboration between the NIH and research institutions like the WV Clinical and Translational Science Institute at West Virginia University?

What more can we be doing to support young researchers, such as those mentored through this Institute?

Answer. One of the core programs supported by the National Institute of General Medical Sciences (NIGMS) Institutional Development Award (IDeA) is the IDeA Networks for Clinical and Translational Research (IDeA–CTRs), which includes the West Virginia Clinical and Translational Science Institute (WV CTSI). The IDeA–CTR network aims to:

—Support the development and/or enhancement of infrastructure and human resources required to address clinical and translational research needs in IDeA-eligible states and jurisdictions;

—Strengthen clinical and translational research that addresses the broad spectrum of health challenges faced by populations in IDeA-eligible regions; and

—Foster and coordinate collaboration in clinical and translational research within an IDeA-CTR network and with other institutions.

Strengthening and expanding the capacity for clinical and translational research in IDeA-eligible states is a pressing need, since health conditions such as obesity, diabetes, cardiovascular diseases, cancer, infectious diseases, chronic obstructive pulmonary disease, maternal health issues, and substance use disorders are disproportionally present in and borne by communities in these states. The IDeA–CTR networks support health research professionals who have first-hand knowledge of these challenges in order to understand and improve the health outcomes of residents in affected jurisdictions. Having the WV CTSI in place during the coronavirus disease 2019 (COVID–19) pandemic, for instance, has allowed it to act as a springboard for West-Virginia-based research aimed at studying and addressing the virus. The $1.5 million supplemental award referenced in this question facilitated the development of an eight-state consortium that created an IDeA State COVID–19 Patient Registry. Through the collaboration between the NIH and WVU, the Registry has become a key component of the National COVID Cohort Collaborative, making important contributions in addressing the unique challenges brought by COVID–19 to traditionally underserved groups such as rural populations. Another supplement to the WV CTSI supports a network for conducting COVID–19 testing in West Virginia that includes the state health department, the national guard, and rural clinics. This collaborative effort is playing a major role in facilitating the state's testing efforts. Finally, the WV CTSI is also a key participant of an NIH-sponsored multisite Post-Acute Sequelae of SARS–CoV–2 (PASC) study of "Long COVID" patients who continue to experience symptoms long after initial infection.

Both NIGMS and NIH remain committed to supporting IDeA–CTR networks like the WV CTSI, given the very important role that such networks play in developing research infrastructure and improving health outcomes within IDeA states.

The National Institutes of Health (NIH) believes that supporting early career researchers is crucial to maintaining a productive, innovative, and diverse biomedical research workforce that can continue to advance the vitality of the scientific research enterprise. NIH's Next Generation Researchers Initiative (NGRI) is developing and implementing strategies to identify, support and retain investigators across early career stages.

As part of the NGRI, NIGMS has prioritized and included several strategies for supporting trainees and early-stage investigators (ESIs) within its 2021–2025 Strategic Plan, along with targets for implementing those strategies that provide accountability and the ability to measure progress. Career development initiatives such as the recently launched Maximizing Opportunities for Scientific and Academic Independent Careers (MOSAIC) program focus on retaining and supporting postdoctoral scholars from diverse backgrounds through the critical point of transitioning them into independent faculty careers. Cooperative agreements with professional organizations support educational activities that equip MOSAIC scholars with professional skills, mentoring, and career networks. At the individual level, grants such as NIGMS' Maximizing Investigators' Research Award (MIRA) offer

support to early-stage investigators (ESIs) by providing them both the opportunity to perform creative and ambitious research as well as the flexibility to follow important new research directions and scientific insights. Since launching this award mechanism in 2015, MIRA has supported 628 early-stage investigators (ESIs), at least two of whom were in West Virginia. In fiscal year 2020 alone, NIGMS funded 200 ESIs through MIRA. As these examples illustrate, both the NIGMS and NIH remain committed to supporting promising early career investigators in every state in the nation.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Collins, I am a big supporter of the Clinical and Translational Science Award (CTSA) program. I believe we should look for ways to strengthen the CTSA program and reinforce the hubs around the country. That is why I am troubled to hear about a possible CTSA reorganization that will be announced in June. This reorganization comes with limited discussion and consultation with the CTSA directors. I am concerned, specifically, with the proposal to break up hub awards into smaller pieces, requiring CTSAs to write several grant applications instead of just one. Dr. Collins, I have two questions. First, as you know, this Committee pays a lot of attention to CTSAs and has been concerned in the past about communication between NCATS and the CTSA community. For example, NCATS emailed relevant stakeholders to combat the rumors about changes to the CTSAs, but did not provide any relevant data to explain what they want to do and why they want to do it. That did nothing but add to the concerns and speculation in the community.

Why haven't these specific changes been discussed broadly within the CTSA community? I believe if there was open dialogue and a stronger partnership between NCATS and CTSAs, there would likely be more buy-in from the community.

Two, how does cutting the hub award and requiring CTSAs to compete for multiple awards strengthen the program? It appears to me that this change would bring uncertainty to the program and jeopardize the stability of the hubs.

Answer. The Clinical and Translational Sciences Award (CTSA) program is indeed a very valuable and important program for the National Center for Advancing Translational Sciences (NCATS), NIH, and the nation. NCATS understands that there are often concerns when there are planned updates to a program, particularly one as large and impactful as the CTSA Program. The planned updates are part of the regular NIH business process for reissuing Funding Opportunity Announcements (FOAs), which is required because FOAs expire after 3–4 years. The planned updates will maintain the structure of the program and reflect the public input received—much of which was provided by the CTSA hub institutions and investigators. The planned updates are designed to strengthen the program, by prioritizing hub strengths, streamlining the overall application process, emphasizing clinical partnerships which are critical to achieving the objectives of this national program, and stabilizing the funding provided to the hub institutions by allowing up to 7 years of funding (rather than the typical five-year award period for NIH awards).

How NCATS Engages with the CTSA Community: NCATS agrees that a strong partnership is extremely important and works closely with the CTSA community on a regular basis.

—*Regular Meetings:* A CTSA Steering Committee[20] including leadership from NCATS and the CTSA Principal Investigator community, meets monthly. A monthly webinar for all CTSA Program investigators also shares information about the program. NCATS CTSA leadership and program officers also routinely engage with investigators and institutional leadership across the CTSA Program as part of their regular duties for implementing a program of this size and complexity. In addition, there are yearly multi-day conferences where the CTSA investigators and NCATS staff engage deeply on important issues related to the CTSA program.

—*Engaging the Community on Updates to the Planned FOA:* To maintain fair and open competition for funding opportunities, NCATS cannot discuss specific details about a draft FOA with select groups of the public, particularly those who already have funding and would be re-competing for the funds. The level of engagement must be framed to ensure that all investigators and institutions, not only the current awardees, have an equal opportunity to compete for the program funds and that NCATS officials act impartially and not give preferential treatment to any organization or individual.[21] In following these NIH policies,

[20] clic-ctsa.org/groups/steering-committee.

[21] ethics.od.nih.gov/principles-ethical-conduct-government-officers-and-employees.

NCATS provided multiple opportunities to ask for and receive input from the broader public, including the CTSA community, on how to improve the CTSA Program.

—A key approach for input was a Request for Information (RFI) released in the Fall of 2019. The comments received, many from the CTSA community, significantly influenced the updates to the CTSA Program that NCATS is planning. (RFI; NOT–TR–19–027 [22])

—General feedback was sought from CTSA application peer reviewers over multiple study sections; many of whom are also CTSA investigators.

—Informal discussions occurred with CTSA Program consortium members, individually and in small group settings, over the course of typical program oversight and interactions.

—Often the first public discussion about a future FOA occurs when NCATS, like other NIH Institutes and Centers, seeks concept approval from its Advisory Council during a session open to the public. This occurs on June 11, 2021. Of note, the NCATS Advisory Council includes three members that are Principal Investigators from the CTSA Program.

—In addition, NCATS has built in additional time after the release of the new FOA—6 months, instead of 2–4 months, prior to the first application receipt date—to familiarize all potential applicants with the new FOA, including hosting of webinars to provide technical assistance to the applicant community.

—NCATS widely shared a communication to address inaccuracies and rumors about changes to the CTSA Program FOA. The letter did not discuss planned changes to the CTSA Program nor provide data, as sharing details about the FOA in a non-public manner prior to its posting is not permissible.

—Summary of Stakeholder Feedback: From the input received through the multiple approaches described above, stakeholder feedback centered around four distinct areas: (1) decreasing application administrative burden, (2) increasing Hub flexibility and Hub specialization opportunities, (3) expanding Hub funding options, and (4) preserving partnerships and collaborations. Three additional areas were identified by NCATS for improvement: (1) ensuring the CTSA Program's sustainability (in terms of avoiding the need to reduce the number of hubs or cut budgets), which requires updates to budget formulas and calculations; (2) increased emphasis towards addressing health disparities; and (3) strengthening clinical research capabilities, which have been critical to the national responses to the opioid epidemic and the coronavirus disease 2019 (COVID–19) pandemic.

Hub Budgeting: NCATS takes the proper stewardship of taxpayer funds very seriously. NCATS does not intend to change the number of hubs or the amount of funding dedicated to the hub core awards. Future award amounts will be based on the amount requested by each applicant and will follow a revised formula for classifying the size of awards from what is currently used. In addition to incorporating feedback from different stakeholders, one of NCATS' objectives is to ensure the long-term sustainability of the program while avoiding a reduction in the number of hubs or reducing hub budgets to stay within the appropriated budget for the program. Requested budgets for CTSA awardees have been increasing to the highest award size under the CTSA graduated award structure, which is not sustainable under current funding for the program, so a restructured award calculation is needed. The total award size of future hubs is anticipated to be similar to the current awards for the vast majority of awardees.

Structure of the Program Applications: NCATS considered extensive public feedback, outlined above, in updating the CTSA Program FOA, including how these updates could contribute to stabilization for the awardees and to sustainability of the program. To date, the application process for institutions applying for CTSA hub awards has been complicated and burdensome, linking up to three separate activities together into one package, the U54 application. Linking the Hub, Career Development, and Training activities together for application submission and peer review is primarily for the benefit of NIH in being able to track these activities. However, based on feedback, it places substantial burden on the applying institution in the form of developing large, complex applications, often containing several areas of duplicate information. The review of three separate activities in one application risks pulling an institution out of funding range, due to one of the activities not faring well in peer review. Applicants that do not successfully compete face a prolonged period of uncertainty for funding, while having to address, revise, and resubmit the

[22] grants.nih.gov/grants/guide/notice-files/NOT-TR-19-027.html; (see this video,www.youtube.com/watch?v=LDBJSl-__QbQ, for an overview presentation of feedback received).

entire U54 application package for a subsequent review cycle. These factors combined with the duration of the awards—five years —raises the stakes of each application and contributes to an environment where applying and awarded institutions are in a constant state of application preparation.

Stakeholder concerns about the complexity of the current application are an important and consistent piece of feedback NCATS received. Separating the applications will streamline the submission process for each component, will reduce duplication of information in an application, will result in less reliance on the success of one part of the application, will avoid the risk of significant delays in awarding a hub if the Training or Career Development components are not strong, and may allow better alignment of Training and Career Development awards with the clinical training calendar. Separating the Hub application from the training and career development applications will also allow the Hub application, which is the key institutional award, to be awarded for up to 7 years, more than the standard 5 years. With this strategy, NCATS intends to provide further stability to an institution's funding by extending the Hub award. Combining all applications together does not allow for that seven-year Hub award option, as NIH limits training and career development awards to 5 years. Separating the applications and providing the additional planned funding opportunities will also give the institutions more control over where they place their priorities based on their own strengths, another key piece of feedback received through stakeholder input.

In closing, we hope that these responses have addressed your concerns. If not, NCATS is happy to provide additional information. NCATS recognizes the significance of the CTSA Program. The pandemic has further served to highlight the importance of this program in responding to emerging clinical and translational needs at local, regional, and national levels. NCATS' intent with the proposed updates to the CTSA FOA is to strengthen the program, provide additional funding stability, and continue to incorporate research to tackle health disparities through this program. NCATS also wants to address important concerns raised by the CTSA community to streamline application and award preparation processes, continue to emphasize the importance of partnerships, and allow institutions more flexibility to leverage their strengths in contributing to this important national resource.

Question. Dr. Collins, the impact of COVID–19 has been significant—both to Americans physical health, but also to their mental health. The fiscal year 2022 budget includes $25 million for focused research on the impact of the pandemic on mental health.

Can you discuss what research areas this funding will be focused on and how the All of Us research initiative will play a role in understanding the full impact of the pandemic?

Answer. The All of Us Research Program's participants come from diverse communities across the United States and generously donate their data and time to drive a wide range of biomedical discoveries, which are vital for informing public health strategies and preparedness. Due to the diverse nature of the program, the All of Us Research Program will play a vital role in understanding the mental and physical impact of the pandemic across the United States and within some of the hardest-hit communities. All of Us began to address the challenge of the coronavirus disease 2019 (COVID–19) pandemic in May 2020 by leveraging its significant and diverse participant base to seek new insights into COVID–19 and its impact through an online COVID–19 Participant Experience (COPE) survey.[23,24] The COPE surveys focused on understanding the mental and physical impacts of the COVID–19 pandemic on participants and included questions on symptoms, stress, social distancing, social determinants of health, and economic impacts. Participants were invited to take the survey in May, June, July, November, and December 2020, and February 2021. This multi-pronged assessment will enable researchers to study the effects of COVID–19 over time and better understand how COVID–19 affects people's mental and physical health differently. To date, over 10,000 participants completed all six COPE surveys and over 100,000 completed at least one COPE survey during the pandemic, with 70 percent of those participants coming from a community that is historically underrepresented in biomedical research.

In addition to COPE, All of Us tested blood samples from over 24,000 participants collected between January 2 and March 18, 2020, for the presence of SARS–CoV–2 antibodies, which provided evidence of infection in five states prior to initial reports. The program anticipates making the full results of this study available in

[23] allofus.nih.gov/news-events-and-media/announcements/all-us-research-program-launches-covid-19-research- initiatives.

[24] www.nlm.nih.gov/dr2/COPE__Survey__NIH__All__of__Us__Clean__4.27.20.pdf.

June 2021.[25] Additionally, All of Us is collecting relevant electronic health record (EHR) information from more than 246,000 participants, some of whom have been diagnosed with COVID–19 or sought healthcare for related symptoms, to help researchers look for patterns and learn more about the physical and mental health impacts of COVID–19 and the effects of different medicines and treatment. As data are made available from all of these efforts, researchers will look for new leads that may bring greater precision to the diagnosis, treatment, and prevention of COVID–19, including those communities that have been hit the hardest. The program will make data gathered through these activities broadly accessible to approved researchers on a rolling basis, in future releases of its secure data platform, the Researcher Workbench.[26] The program will continue to explore additional ways it can leverage its unique and diverse dataset to answer critical research questions to enhance our understanding about the full impact of the pandemic, especially with a focus on mental health.

Question. Dr. Collins, the COVID–19 pandemic highlighted the need to use nonhuman primates (NSP) in research. The budget requests $30 million for NSP infrastructure.

Can you provide further details to the Committee on the need for this funding and details on how this funding would be allocated and to whom?

What types of research would be at jeopardy if NSPs were not replaced or expanded?

Answer. The National Institutes of Health (NIH) remains committed to protecting animal welfare while, at the same time, advancing biomedical research and human health. The budget request for $30 million for nonhuman primate infrastructure would cover facilities used to house nonhuman primates which require continual updates and maintenance to ensure responsible stewardship over these invaluable resources. The funds in the budget request would be distributed by soliciting applications from NIH grantees to improve existing facilities, not to establish new nonhuman primate facilities. Several nonhuman primate facilities have existed for over 60 years and housing enclosures require frequent repair and replacement. New construction for research facilities would include animal holding rooms, necessary equipment such as surgical tables, centrifuge, ultrasound, clinical analyzer, procedure, and veterinary clinical support in order to meet or exceed the current high-level care of the nonhuman primates. Additionally, the COVID–19 pandemic highlighted the need for new construction to expand animal biosafety level 3 areas in order to have biocontainment facilities associated with nonhuman primate facilities. In addition to ethically appropriate housing, nonhuman primates require a proper diet, clinical/veterinary care as well as psychological and environmental enrichment, which necessitates skilled staff and additional resources including supplemental produce, various enrichment devices such as foraging devices for food, various toys, and puzzles.

NIH would support expansion at existing NIH-supported facilities to leverage the investment. The NIH Office of Research Infrastructure and Programs (ORIP) supports a well-coordinated national consortium of seven National Primate Research Centers (NPRCs) and other breeding colonies that collectively address research needs and trends, best husbandry practices, maintenance of genetic diversity, standardization of models, ethics, rigor, and reproducibility. NPRCs are national resources serving not only NIH-funded investigators but other federally funded investigators, foundations, and industry, including many SARS–CoV–2 projects in the last year.

Research with animal species, including nonhuman primates, remains critical for modeling human physiology and is essential for developing new prevention strategies, treatments, and cures for disease beyond the need for responding to emerging infectious diseases. Nonhuman primates have been essential for understanding human biology and developing treatments for diseases, mostly because of our shared anatomy, physiology, and behavior. Importantly, the genetic sequence similarities between nonhuman primates and humans can reach up to 98.77 percent, which has made nonhuman primates models critical for studying neurobiology, transplant tolerance and rejection, infectious diseases, reproductive biology, and regenerative medicine. More recent applications have been in regenerative medicine and gene therapy and editing. There is a rapidly emerging need for marmosets in the neurosciences where recent National Academies of Sciences, Engineering, and Medicine (NASEM) reports and the Brain Research Through Advancing Innovative

[25] The results of this study were announced on June 15, 2021; complete details at: allofus.nih.gov/news-events-and-media/announcements/nih-study-offers-new-evidence-early-sars-cov-2-infections-us.

[26] www.researchallofus.org/.

Neurotechnologies® (BRAIN) Initiative community have pointed out that demand far exceeds supply.[27] Another critical area of intense need and research development is nonhuman primate models of Alzheimer's disease to develop therapies. Nonhuman primate models are commonly used for studies of visual systems, auditory systems, cognitive function, and brain connectivity. The single largest application of nonhuman primates continues to be in developing vaccines and therapies for HIV/AIDS.

Research using animal models, including nonhuman primate models, has led to tremendous advances critical for saving countless lives and extending human life expectancy around the world. Until suitable non-animal models are developed, the complexity of human systems, both in health and in disease, can only be truly understood through complementary model systems with sufficient complexity, and nonhuman primates remain invaluable for this effort. When animal models are required, NIH will only conduct and support research in accordance with the highest scientific and ethical principles. To uphold these principles, the NIH budget includes investments in nonhuman primate facilities, resources, and enrichment.

Question. Dr. Collins, how much funding, broken down by Institute or Center, has NIH repurposed for COVID–19 related lab reopenings or lost research activities?

Answer. To support our recipients affected by the pandemic, the National Institutes of Health (NIH) provided extensions, both funded and unfunded, as well as administrative supplements, to address the unanticipated impacts of the pandemic. The NIH has also issued multiple funding opportunities for current recipients to repurpose existing awards and expand the scope of ongoing research to include coronavirus disease 2019 (COVID–19) research activities.[28] Continued support for these projects is contingent on satisfactory progress, the availability of funds, and NIH Institute and Center (IC) funding priorities, which continue to change as the pandemic, and research on COVID–19 progresses.

Decisions related to individual awards are made by the funding NIH IC on a case-by-case basis, taking into account those critical factors. All requests to change the scope of an NIH grant award require prior approval from the awarding NIH IC, as stipulated in the NIH Grants Policy Statement, section 8.1.2.5.[29]

The NIH continues to analyze the data on the impact of COVID–19 on the biomedical research community, and its potential impact on NIH budget and grant activities.

Question. It is my understanding that one of the main issues NIH faced related to COVID–19 expenses was for post-doctoral candidates finishing their training, research, or fellowship.

How has this issue been addressed and do you expect to see a funding issue related to the extension of some of these grant awards into fiscal year 2022?

Answer. The coronavirus disease 2019 (COVID–19) pandemic, along with extensive mitigation measures, has adversely affected progress in many biomedical research settings. Evidence from multiple sources, including results from a survey during the fall of 2020, indicates legitimate concerns about career trajectory for early career scientists.[30] Hearing these concerns, the National Institutes of Health (NIH) issued a Guide Notice detailing our approach to support early career scientists whose career trajectories may have been significantly affected by the pandemic.[31] Specifically, NIH is providing an opportunity for recipients in their last year of NIH Fellowship (F) and NIH Career Development (K) awards who have been impacted by COVID–19 to request extensions.[32] Such extensions will be considered on a case-by-case basis, within the existing availability of funds.

Generally speaking, the NIH typically makes between 500 to 600 F and K extensions per year, the vast majority (more than 95 percent) of which are no-cost extensions. Only seven funded extensions were awarded in fiscal year 2019. In fiscal year 2020, the NIH awarded 548 extensions, with 75 (14 percent) of these being funded extensions. Thus far in fiscal year 2021, 15 funded extensions are linked to NOT–OD–21–052, but we will have a much better sense of uptake as the fiscal year concludes. Though there appears to be a relative increase in the number of funded extensions commensurate with the pandemic, the absolute numbers remain low.

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[27] www.nap.edu/read/25356/chapter/7.

[28] grants.nih.gov/grants/guide/COVID-Related.cfm.

[29] grants.nih.gov/grants/policy/nihgps/HTML5/section__8/8.1.2__prior__approval__requirements.htm#Change4.

[30] nexus.od.nih.gov/all/2021/03/25/the-impact-of-the-covid-19-pandemic-on-the-extramural-scientific-workforce-outcomes-from-an-nih-led-survey/.

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

[32] https://nexus.od.nih.gov/all/2021/02/08/extensions-for-early-career-scientists-whose-career-trajectories-have-been-significantly-impacted-by-covid-19/.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. What is the fully intended scope of ARPA–H? Will it address diseases beyond cancer, diabetes, and Alzheimer's, such as ones with more challenging markets? Do you have examples?

Answer. The scope of the Advanced Research Projects Agency for Health (ARPA–H) is intended to be broad and, indeed, stretch beyond the areas initially identified by the President. There are a number of areas with substantial unmet needs—some examples include emerging infectious disease, rare and ultra-rare disease, and antimicrobial resistance—and, with targeted investments over time, breakthrough progress could be made. In addition to specific disease areas, ARPA–H intends to build capabilities and explore various platform technological approaches which may have broad applicability across a range of diseases and conditions. A recent commentary in Science [33] outlined some exciting concepts such as developing mRNA vaccines to prevent most cancers; creating molecular "zip codes" to more precisely target tissues and cell types while minimizing side effects; deploying holistic interventions that identify those at high-risk and leverage new telehealth approaches to eliminate racial disparities in maternal morbidity and mortality rates and premature births; and developing small, highly accurate, inexpensive, non-intrusive, wearable 24/7 monitors for blood pressure and blood sugar. While these examples are meant to illustrate the breadth of potential projects that ARPA–H could support, we believe it is projects like these that can have a significant impact for patients who are relying on biomedical research and innovation to live longer, healthier lives.

Question. Additionally, how will ARPA–H fit into the larger health focused R&D structure? How will its role be defined as unique among the various funding programs, and will there be coordination with other entities such as BARDA to ensure cooperation and avoid duplication?

Answer. The Advanced Research Projects Agency for Health (ARPA–H) is meant to become an integral component of the constellation of agencies focused on promoting health and research and development—both within and beyond NIH and HHS. As described in a recently published commentary in Science,[34] ARPA–H should be housed as a new entity within NIH. The rationale for this organizing principle is two-fold. First, the goals of ARPA–H fall squarely within the mission of the NIH, which is "to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability." Second, the NIH offers a rich source of fundamental health research that will be foundational for a constructive, collaborative, and productive relationship with ARPA–H. We envision robust collaborations on synergistic topics with the existing NIH Institutes and Centers, along with organizations both outside and within the government. The added benefit of housing ARPA–H within NIH is that it will create administrative efficiencies so that more resources can be directed toward the mission and help avert duplication of effort.

In mid-July, the Administration launched a Federal Joint Fast Track Action Committee (FTAC) intended to help steer the creation of ARPA–H and lay the groundwork for strong interagency coordination. OSTP and NIH serve as co-chairs of this committee that includes representatives from the Department of Agriculture, DARPA, Office of the Under Secretary of Defense for Research & Engineering, ARPA–E, BARDA, CDC, CMS, FDA, VA, EPA, NSF, and the Smithsonian Institution, among others. Bringing these entities together at an early stage will help ensure strong collaboration and coordination among the various research-focused organizations throughout the Federal Government. The agency personnel who sit on the FTAC will also be a valuable source of insight and advice as ARPA–H is launched.

QUESTIONS SUBMITTED BY SENATOR PATRICK J. LEAHY

Question. I strongly support the Administration's renewed approach to innovation in medical research through the establishment of the Advanced Research Projects Agency for Health (ARPA–H). COVID–19 has shown that a commitment to breakthrough innovation, directed allocation of resources, and collaborative approaches can accelerate how scientific breakthroughs can be transitioned to treatments and cures. The administration has proposed that the agency will focus on innovative treatments in cancer, Alzheimer's disease, and opioid disorders. Several institutions in Vermont are national leaders in these stated research fields despite their smaller and more rural nature. While I strongly support any efforts to accelerate innovation,

[33] science.sciencemag.org/content/373/6551/165.
[34] science.sciencemag.org/content/373/6551/165.

I am concerned that valuable collaborators could be left out or lose out on Federal funding, particularly if there is no traditional grant application process.

What role will smaller and more rural research institutes play in ARPA–H? If projects are funded outside a grant application process, will there be established guidelines to include collaborators from rural or traditionally underrepresented areas?

Answer. Over the long term, the proposed structure for the Advanced Research Projects Agency for Health (ARPA–H) is intended to empower the ARPA–H leadership and staff to set and execute on research priorities for a variety of high-risk, high-reward, milestone-driven projects that can lead to novel capabilities, platforms, and resources that are applicable to a range of diseases. These priorities include the opportunity to fund smaller and more rural research institutes.

For the initial direction, the Administration is working to set up multiple pathways, both within the government and the broader stakeholder community, for priority setting and for exploring new areas ripe for research at ARPA–H. At the time of this hearing, the White House Office of Science and Technology Policy (OSTP) and the National Institutes of Health (NIH) are in the planning phases of convening multiple listening sessions with key stakeholder groups including patient organizations, industry, venture capitalists and philanthropists, and others from the academic and research communities. During these sessions, stakeholders will be asked to offer their perspective on what they see as the greatest research challenges and opportunities that could be addressed using the ARPA–H model. This input will help refine the scope and provide a wealth of ideas for the first ARPA–H director to consider as they develop the agency's vision.

In mid-July, the Administration established a Joint Fast Track Action Committee (FTAC) to help steer the creation of ARPA–H and lay the groundwork for strong interagency coordination. OSTP and NIH serve as co-chairs of this committee that includes representatives from Department of Agriculture, DARPA, Office of the Under Secretary of Defense for Research & Engineering, ARPA–E, BARDA, CDC, CMS, FDA, VA, EPA, NSF, and the Smithsonian Institution, among others.

Soliciting a diversity of perspectives and approaches will be a key tenet of the Advanced Research Projects Agency for Health (ARPA–H). Much like DARPA and ARPA–E, it will do so by supporting the best strategies to solve an identified challenge and by pursuing multiple approaches. Program managers will also have the authority to combine proposals from different institutions to assemble the boldest, most innovative portfolio, allowing each team to build on their strengths while benefiting from the knowledge, expertise, and resources from other institutions. ARPA–H will also provide awards that range in size and mechanism—from smaller, pilot projects to develop a prototype, to complex multi-site trials, to prizes that stimulate healthy competition and ingenuity. Further, ARPA–H will support a Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) program with business development, commercialization, and other resources to provide small businesses with the tools they need to be successful. These approaches are examples of mechanisms that ARPA–H will utilize to support a range of organizations across the country which may include small and/or rural institutions, and its portfolio will be regularly evaluated to ensure there is diversity of perspective. Because ARPA–H will be a nimble, dynamic organization, it will be able to readily pivot to experiment with new approaches.

Question. Chronic pain is a significant public health issue affecting an estimated 50.2 million Americans each year. Based on data from the National Health Interview Survey (NHIS), the total value of lost productivity due to chronic pain is estimated to be nearly $300 billion annually. With little known about alternatives for treating and managing relief from pain, medical providers are often limited to prescribing highly addictive opioids or muscle relaxants to help patients mitigate symptoms from pain. Scientific research suggests that long term use of such medications can result in the body's reduction of its own ability to fight pain. Even for patients who do not experience direct abuse or addiction with long term use, scientists have found that withdrawal symptoms are present when patients stop taking these medications. Unfortunately, research into addiction and alternatives to treatment has historically lagged at NIH. Enhanced research on chronic pain management and treatment, other than through the use of highly addictive opioid painkillers, has the potential to reduce substance abuse and promote better methods for addressing pain.

I strongly support the NIH Heal Initiative to find solutions to curb the national opioid public health crisis by understanding, managing, and treating pain. Please describe any progress made by the HEAL Initiative on medication development to alleviate pain and to treat addiction. What remains the biggest barrier to research to investigate new and alternative options to treat chronic pain?

Answer. The National Institutes of Health (NIH) recognizes the need to improve pain management without risk of addiction and other serious side effects. NIH is taking a multi-pronged approach to develop safe and effective therapies to reduce our reliance on opioids and treat addiction. The NIH Helping to End Addiction Long-term (HEAL) Initiative launched in 2018 has awarded over $1.5 billion for research to discover and accelerate development of non-addictive pharmacological and non-pharmacological pain treatments, as well as treatments for opioid use disorder (OUD) and overdose.

Through the HEAL Initiative, NIH supports over 70 targeted studies to accelerate the development of treatments for OUD, including novel medications and biologic agents, as well as novel formulations of approved medications to treat OUD and prevent opioid overdose. To date, 16 Investigational New Drug Applications were filed with the U.S. Food and Drug Administration and authorized to proceed for human studies. These studies focus on a variety of drug targets, as well as vaccines that could prevent opioids from entering the brain. HEAL currently funds nine opioid vaccine projects including vaccine candidates targeting oxycodone,[35] fentanyl[36] and heroin.[37] This strategy could offer more accessible, manageable treatment through longer-lasting vaccines to reduce the risk of relapse.

HEAL-supported work also includes studies to identify, optimize and test promising molecules, biologics, and devices for treating pain that target non-opioid pathways in the nervous system. Biomarker studies to enhance clinical trials and improve best practices are moving forward. In addition, non-pharmacological approaches to manage many different pain conditions are being evaluated through effectiveness and implementation research approaches.

In these ways, HEAL is providing much needed resources to advance research on new and safe alternatives to opioids for chronic pain. The complexity and diverse nature of chronic pain itself along with a high prevalence of other co-occurring chronic conditions such as diabetes, depression, and autoimmune disorders create an enormous challenge for advancing research.

Mechanisms for the causes of different pain conditions vary, biomarkers for patient response to treatment and likelihood for progression of disease also are characteristic of the disease condition. In addition, treatments for co-morbidities require careful balancing and often long- term multidisciplinary care. These and other factors require an expanded breadth and scope of pain research to better provide personalized care for those with chronic pain. The Federal Pain Research Strategy[38] describes research priorities to relieve the burden of pain. The NIH HEAL initiative provided support to move many of the report's recommendations forward.

Specifically, the NIH HEAL initiative established essential pain research infrastructure to accelerate development of new medications and devices to treat pain. An analgesic screening platform uses animal and human cell-based models such as neural tissue chips for rapid screening of molecules or devices for analgesic-relevant biological and pain behavioral activity. HEAL, with input from academic and industry partners, established an Early Phase Pain Investigation Clinical research network (phase 2 studies) to test safety and efficacy of novel therapeutics and a later stage pain management Effectiveness Research Network (ERN) to compare effectiveness of pharmacological and non-pharmacological approaches in many different pain conditions. The Pragmatic and Implementation Studies for the Management of Pain to Reduce Opioid Prescribing (PRISM) network focuses on clinical trials of non-pharmacologic pain therapies in healthcare systems. The Phase 2 network will launch trials on two new analgesics in late 2021. The ERN is supporting eight large trials for various pain management strategies. PRISM is supporting six large trials in healthcare systems. In addition, HEAL established an analgesic development pipeline to accelerate the development and testing of novel drugs and devices. This comprehensive program uses team-based science coupled with a comprehensive set of research resources to bring new therapeutics rapidly to the clinic. To advance the discovery and validation of new drug targets, HEAL has funded over 30 projects to discover and verify a diverse set of drug target types across multiple pain conditions, six drug optimization studies on new safe and effective pain treatments, and 11 projects to test the effectiveness of implanted devices and noninvasive stimulation of nerves in the brain or throughout the body to reduce perception of pain. In addition, to improve the efficacy of clinical trials for pain treatments, and to increase the chance that new therapeutics will advance along the regulatory path to approval, HEAL tests the development of biomarkers to objectively measure pain,

[35] reporter.nih.gov/search/Pcd2IghkPU6lnJkOT7FlFQ/project-details/9778811.
[36] reporter.nih.gov/search/Wp__sHzUhIUuYqDimSa90iw/project-details/9737173.
[37] reporter.nih.gov/search/GNnJWbYvQUeIlbwhgFofXA/project-details/9734921.
[38] www.iprcc.nih.gov/federal-pain-research-strategy-overview.

including pain associated with sickle cell disease, musculoskeletal disease, nerve pain and headache. Promising biomarkers identified through this program may advance to clinical validation through the Early Phase Pain Investigation Clinical Network (EPPIC-Net). Findings from these studies could improve quality of life for millions of people in the United States who experience pain daily. Recent HEAL accomplishments toward new therapeutics include two patent filings for small molecule modulators of pain receptors involved in chronic pain and migraine.

New directions for HEAL will also continue to pursue goals laid out in the Federal Pain Research Strategy,[39] including demonstration projects to aid in the development of a coordinated approach to pain management in healthcare systems. This effort would assess multi-disciplinary and multimodal approaches to pain management embedded in healthcare systems. Research within systems of pain care would allow for effective interventions to be adopted into the healthcare system and improve access for patients. Focused discussion with select healthcare program leadership would identify pain conditions of greatest opportunity, with an emphasis on effectiveness research, quality management and team-based care. This effort would seek to leverage existing infrastructure through ongoing collaborative and interagency efforts.

Another specific effort in development aims to advance health equity to address the wide disparities in care and treatment for pain and addiction, known to result in both the undertreatment and overtreatment with opioids, increased risk of addiction and overdose, lack of access to effective non-pharmacological options for pain treatment, and lack of access to evidence-based addiction care. Disparities in pain management exist across multiple levels: pain assessment, treatment, and management at the patient, provider, community, and healthcare system levels. Planned expansion to HEAL includes the development and implementation of culturally appropriate interventions for the prevention and management of pain and addiction in diverse populations, with a focus on sustainable and scalable interventions that can be rapidly implemented by healthcare systems.

In addition, recent discoveries in human genetics and molecular biology will be incorporated into the development of a novel team-based platform to rapidly test targets and candidate therapeutics for diverse human pain conditions and share findings with the wider pain research community. This research will address pain systems and allow for a variety of research questions including conditions of chronic analgesic use, other drug use, substance use disorders (SUDs) and other co-morbid conditions, and will enable and accelerate human gene- and cell- based validation of pain therapeutic targets through the HEAL initiative and other pipelines. This will build on existing HEAL research on preclinical and translational research in pain, and ongoing efforts to accelerate the development of novel treatments for pain. Through these and other efforts at HEAL and across the NIH, we aim to continue to improve our understanding of pain and develop non-addictive, effective therapies.

Question. Migraine is currently the second leading cause of all global disability. Unfortunately, due in part to limited research and treatment, inappropriate opioid prescriptions for migraine present Americans with ongoing risks of opioid use disorders and have worsened outcomes in patients. Overall, 6 million Americans living with migraines are active opioid users. I strongly support the NIH Heal Initiative to find solutions to curb the national opioid public health crisis by understanding, managing, and treating pain. While migraine grant proposals are eligible for consideration under the HEAL request for applications (RFAs) issued for pain research, less than 1 percent of HEAL Initiative appropriations have funded headache disorders research—the least funded NIH area among all the nation's burdensome diseases. I am very concerned about the failure to attract enough investigators to this historically under-funded research area.

Does NIH have plans to issue specific RFA programs for headache disorders research, comparable in scope to the Back Pain Consortium (BACPAC) group of RFAs for research on back pain?

Answer. The National Institutes of Health (NIH) recognizes the burden of pain at the individual and population levels and that headache disorders are prevalent and disabling conditions which affect millions of Americans. The NIH launched the HEAL Initiative (Helping to End Addiction Long-term) to improve pain care and better prevent and treat opioid use disorder. Priorities of the HEAL initiative, developed with our stakeholders with expertise in pain research and care, include enhanced understanding of pain, discovery and validation of novel pain therapeutic targets, testing therapies in clinical settings, and accelerating the process to bring new therapies to patients. The initiatives are, or were, open to all pain conditions. The HEAL initiative also established much needed research infrastructure to sup-

[39] www.iprcc.nih.gov/federal-pain-research-strategy-overview.

port innovative science. Headache research fits within the scope of all these initiatives and will benefit from the enhanced infrastructure.

HEAL funding solicitations call for proposals across all pain conditions. NIH staff recognizes the low submission rate of headache applications and broadly disseminates information on HEAL and other funding announcements to the research community to encourage submissions. Most funding announcements specifically cite headache as an area of interest and others are inclusive of headache. Low back pain is an exception among pain conditions in that it has unique research gaps such as lack of diagnostic tools and technologies, no accepted common data elements, poor diagnostic criteria, complex etiology, and lack of an adequate evidence base for effective practice guidelines. The HEAL Back Pain Consortium (BACPAC) initiative was launched to fill these extensive gaps to improve pain care across the spectrum of low back pain.

Migraine and other headache disorders have good classification schemas, a range of effective treatment therapies whose development was supported by NIH research, and evidence-based diagnostic categories and treatment protocols (International Headache Society). Our understanding of migraine etiology is more advanced than that for back pain. NIH has supported transformative basic research that advanced our knowledge of migraine mechanisms, causes, and predictors, biomarker identification, and new therapy development. For example, NIH supported investigators provided the foundation for development of CGRP antibodies now used widely for migraine therapy. NIH sponsored research also contributed to understanding how migraine auras activate nociceptors and initiate a migraine, and the mechanism of action for new migraine therapies such as vagus nerve stimulation. Basic research on potassium channels, delta, or kappa opioid receptors, and TRP channels fundamentally increased our understanding of trigeminal nociceptors and their involvement in initiating a migraine, giving us new targets for potential treatments. An NIH sponsored pivotal pediatric migraine clinical trial changed clinical practice for children with chronic daily headaches.

NIH and HEAL leadership recognize that far too many headache sufferers are prescribed opioids despite clear clinical practice guidelines that call for non-opioid effective alternatives rather than opioids. This practice reflects the sparsity of headache specialists and the lack of and education of our primary care providers who are often the first to treat those with disabling migraines. NIH also recognizes the need to expand the headache research workforce. The HEAL initiative recently released funding announcements to support training and mentorship of early and mid-career researchers in the field of basic, translational, and clinical pain research. We encourage those interested in headache research to benefit from these opportunities.

QUESTIONS SUBMITTED TO DR. ANTHONY FAUCI

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. I have received a lot of questions from Illinois families, who are hoping for more clarity on the CDC's most recent mask guidelines. Many vaccinated parents—with unvaccinated children at home—are wondering if they should be wearing masks when out in public.

What advice would you give to vaccinated parents who have unvaccinated children at home?

When do you think we will have a COVID vaccine approved for children younger than 12 years of age?

Answer. Currently authorized coronavirus disease 2019 (COVID–19) vaccines meet the U.S. Food and Drug Administration's (FDA's) rigorous standards for safety and effectiveness, and current data suggest that fully vaccinated people are less likely to transmit severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2) to others. According to the Centers for Disease Control and Prevention (CDC), fully vaccinated people—including those living with unvaccinated children or adolescents—can resume activities without wearing masks or physically distancing, except where required by Federal, state, local, tribal, or territorial laws, rules, and regulations. Individuals ages 2 and older who are unvaccinated, however, should continue to wear masks in public and when around people who do not live in their household, except when eating or sleeping. CDC will continue to evaluate and update public health recommendations for fully vaccinated people as more information, including on Delta and other new variants, becomes available.

Efforts to evaluate COVID–19 vaccines in children under age 12 currently are underway, and a COVID–19 vaccine may be available for this age group by the end of 2021. On March 16, 2021, Moderna, in collaboration with the National Institute

of Allergy and Infectious Diseases (NIAID) and the Biomedical Advanced Research and Development Authority (BARDA), launched KidCOVE, a Phase 2/3 study to evaluate the safety and efficacy of the Moderna COVID–19 vaccine in children ages 6 months to less than 12 years. Pfizer also is conducting a Phase 1/2/3 trial to evaluate its COVID–19 vaccine in this age group. In addition, other vaccine developers are planning to begin trials to test their vaccine candidates in children. Until a COVID–19 vaccine is available for children under age 12, it will be important for all individuals, especially children and other unvaccinated individuals, to continue to follow all public health measures for COVID–19 advised by the CDC, including frequent hand washing and the use of masks and social distancing in certain settings.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. My home state of West Virginia is battling an epidemic during the middle of a pandemic. My state has been devastated by the drug epidemic, COVID–19, and we now lead the nation in new HIV infection rates. You have spent much of your career focused on the prevention, diagnosis, and treatment of HIV/AIDS. Your research has been instrumental in saving countless lives in the United States and around the world. The National Institute of Allergy and Infectious Diseases supports initiatives focused on diagnosing, treating, preventing and responding to the HIV epidemic in the United States. These efforts represent steps in the right direction, but will not alone end West Virginia's increasing numbers of new HIV infections and other opioid-related infectious diseases.

What is being done to replicate testing and surveillance efforts we saw put into place for COVID–19 for other infectious diseases, like HIV/AIDS?

What public health infrastructure would be required to bring better infectious disease testing and surveillance to fruition?

Answer. The Federal response to coronavirus disease 2019 (COVID–19) relied heavily on the utilization and expansion of existing resources for human immunodeficiency virus (HIV) and other infectious diseases. By leveraging available resources, we have been able to accelerate the development of diagnostic tests and other medical countermeasures, as well as surveillance and community engagement efforts. In turn, knowledge gained from the COVID–19 response may inform strategies to address other infectious diseases such as HIV. This includes efforts undertaken by the U.S. Department of Health and Human Services (HHS) to end HIV in the United States by 2030 through the Ending the HIV Epidemic in the U.S. (EHE) initiative. EHE is coordinating across HHS agencies and with patient, community, academic, and other partners to plan, design, and deliver local HIV prevention and care services. This "whole-of-society" approach is a model for ending both the HIV epidemic as well as the COVID–19 pandemic. Proper diagnosis and treatment of HIV are key components of this initiative, and efforts to improve testing and surveillance for HIV are ongoing.

An important aspect of the response to the COVID–19 pandemic as well as the HIV epidemic is community engagement. The National Institute of Allergy and Infectious Diseases (NIAID), in cooperation with the Department of Defense, established the COVID–19 Prevention Network (CoVPN) by leveraging existing NIAID-funded clinical trials networks, including networks focused on HIV treatment and prevention. The CoVPN built on existing community relationships to enhance trust and meaningful engagement in key racial and ethnic minority communities throughout the United States to promote diverse participation in clinical trials for COVID–19. The community relationships enhanced by the CoVPN may be further leveraged to advance efforts, including testing and surveillance, for HIV and other infectious diseases.

The National Institutes of Health (NIH) also anticipates that the rapid establishment of COVID–19 testing and surveillance may help to address HIV and other infectious diseases. NIH launched the Rapid Acceleration of Diagnostics (RADx) initiative to speed innovation in technologies to test for severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2), in partnership with the Biomedical Advanced Research and Development Agency (BARDA), the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), and the Defense Advanced Research Projects Agency (DARPA). As part of RADx, NIH and CDC are evaluating whether frequent self-administered, at-home SARS–CoV–2 testing helps reduce community transmission of SARS–CoV–2. Efforts to develop and deploy rapid, point-of- need diagnostics for SARS–CoV–2—including at-home testing kits—may inform community-based testing and surveillance strategies for other infectious diseases, including HIV.

NIH and NIAID will continue to build on investments in improved diagnostic tests for SARS- CoV–2 to support the development of novel diagnostic tests for other infectious diseases such as HIV. In addition, lessons learned on the best way to integrate and expand on existing research efforts and infrastructure will be invaluable as we continue to prepare for—and respond to— other existing and emerging infectious disease threats.

As discussed in response to part a of this question, the Federal response to the COVID–19 pandemic has strengthened existing partnerships and coordination mechanisms, as well as established new partnerships that will inform the response to future infectious disease pandemics and existing epidemics, such as the HIV/AIDS epidemic in the United States. The coordinated efforts through RADx and the CoVPN allowed us to leverage the intrinsic strengths from public and private sector partners to achieve an unprecedented level of scientific achievement and community engagement. When the COVID–19 pandemic ends, lessons learned from our experiences with RADx and the CoVPN will continue to help inform efforts to address other infectious disease threats.

NIH and NIAID will continue to work with HHS Operating Divisions and other Federal agencies to identify the actions that were most effective in responding to the COVID–19 pandemic. This information may result in new initiatives, strategic plans, and/or formal assessments of pandemic preparedness.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

Question. As America begins to assist the world to vaccinate all who want it, the current vaccine options can be problematic for countries without the infrastructure to store vials in a cooled or frozen environment.

How beneficial could an effective, intranasal vaccine option be for developing countries that cannot store the current vaccines at frigid temperatures or produce the healthcare workers to give the shot?

Do you see this option benefitting Americans who may be hesitant to receive the current vaccine dosage in a shot?

Answer. Global access to safe, effective vaccines will be critical to address the coronavirus disease 2019 (COVID–19) pandemic. Limiting the spread of the severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2) virus in foreign countries helps to control the pandemic in those countries while also limiting the development and spread of variants that could eventually be introduced into the United States. To enhance vaccine availability in foreign countries, the Biden Administration has supported and contributed to COVAX, a global mechanism for equitable access to COVID–19 vaccines. COVAX has delivered COVID–19 vaccines to more than 100 countries, the majority of which have lower-income economies. The United States also has made millions of doses of COVID–19 vaccines available to other countries to support vaccination campaigns around the world.

Existing COVID–19 vaccines are being successfully administered globally, and several COVID–19 vaccines authorized for emergency use or in clinical testing in the United States can be shipped and stored at refrigerator temperatures (2–8 degrees Celsius). Still, the development of vaccines that can be administered with less skill and/or stored at warmer temperatures have the potential to expand vaccination efforts both in the United States and abroad. The National Institute of Allergy and Infectious Diseases (NIAID) is supporting the development of vaccine candidates and platforms that may be more accessible and convenient than currently available COVID–19 vaccines, including a single-dose intranasal SARS–CoV–2 vaccine candidate called ChAd-SARS–CoV–2–S. NIAID scientists and collaborators recently showed that the intranasal ChAd–SARS–CoV–2–S vaccine candidate limited infection in non-human primates. Novel vaccines with alternative administration strategies, such as intranasal vaccines, may reduce barriers to transporting and administering vaccines in developing countries. It is important to note, however, that these vaccines may still need to be kept at low temperatures or may require administration by a healthcare provider with specialized training to ensure accurate dosing and administration. For example, FluMist Quadrivalent—a U.S. Food and Drug Administration-approved intranasal vaccine against influenza—must be administered by a healthcare provider in the United States.

In addition, National Institutes of Health (NIH) scientists and NIH-supported researchers are studying additional vaccine delivery technologies, including vaccines that can be orally administered or that utilize microneedles in patches placed on the skin to deliver the vaccine. For example, NIH scientists have begun preclinical evaluation of a virus-like-particle-based vaccine candidate for SARS–CoV–2 that can be administered orally, and NIH-supported researchers are evaluating a patch-based

vaccine for SARS–CoV–2. An NIH-supported Phase I trial of a patch-based vaccine candidate for influenza showed that individuals that received the vaccine had a similar immune response to those receiving the influenza vaccine via intramuscular injection. NIH also is supporting the development of another promising patch-based vaccine candidate for influenza that uses biodegradable microneedles originally developed through NIH-supported research to stabilize vaccines and antibiotics outside of the cold chain. Although additional testing will be necessary, orally administered and patch-based vaccines may prove to be an invaluable tool in resource-limited settings as they may require little to no refrigeration, as well as less training to administer correctly.

As we work to address the COVID–19 pandemic, as well as other infectious disease threats, recent innovations in vaccine technology will help make it easier to get vaccines to areas that can be difficult to serve with traditional vaccines. NIH continues to support research on intranasal, oral, and patch-based vaccine platforms, all of which could be highly adaptable for use against a number of infectious pathogens.

Vaccines that can be administered intranasally may be considered less invasive than those that require an injection. Such an option may encourage individuals who are hesitant to receive the COVID–19 vaccines currently authorized for emergency use in the United States, which are all administered via intramuscular injection, to become vaccinated. Additional vaccine delivery technologies, such as oral or patch-based vaccines may also provide additional flexibilities when trying to reach individuals in resource-limited areas or who are vaccine hesitant or needle adverse. As noted in the response to part a of this question, NIAID is supporting and will continue to support the development of vaccine candidates with different delivery technologies to reduce vaccine hesitancy as well as barriers to vaccine access.

QUESTIONS SUBMITTED TO DR. DIANA BIANCHI AND DR. ELISEO PÉREZ-STABLE

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. Our nation continues to struggle with racial disparities, especially in maternal health. The U.S. is one of only 13 countries where our nation's maternal mortality rates are worse now than they were 25 years ago. Every year, 700 women in the U.S. die as a result of their pregnancy—and more than 60 percent of these deaths are preventable. Tragically, African American and Hispanic women are three times as likely as White women to die from pregnancy-related issues. For years, I have introduced the MOMMA's Act with Rep. Robin Kelly, and I'm so pleased that a major component of our bill was recently signed into law as part of the American Rescue Plan. Now states can follow in Illinois' footsteps by allowing new moms to keep their Medicaid coverage for a full year, versus just 60 days.

What research NIH is doing in this space?

How is NIH working to actually improve maternal and infant healthcare?

Answer. Maternal health is a priority for the National Institutes of Health (NIH) and multiple NIH institutes have heavily invested in research to prevent maternal morbidity and mortality (MMM) and improve health for women, before, during, and after pregnancy. In fiscal year 2020 NIH supported $407 million in research on maternal health and $224 million in research on MMM.

In a year that was dominated by both the coronavirus disease 2019 (COVID–19) pandemic and renewed calls to combat health disparities and inequities, NIH ensured these challenges were integrated into efforts to reduce MMM. In March 2020, researchers in the Eunice Kennedy Shriver National Institute of Child Health and Human Development's (NICHD) Maternal-Fetal Medicine Units Network designed the Gestational Research Assessments for COVID–19 (GRAVID) study, which evaluated data from more than 1,200 pregnant women at 33 hospitals across the country and found that pregnant COVID–19 patients with severe disease are at higher risk for cesarean delivery, postpartum hemorrhage, hypertensive disorders of pregnancy, and preterm birth. Data from the study is being shared with a larger registry to inform future studies of COVID–19's effects on pregnancy and maternal health.

Tackling the challenge of reducing maternal MMM requires strong partnerships with and among local communities and resources, particularly with racial and ethnic minority populations that experience stark health disparities. To that end, several NIH Institutes, Centers, and Offices (ICOs) held community engagement activities to hear first-hand how patient communities can inform future research and what engagement strategies might enhance local efforts to improve maternal health. A common refrain was that research conducted in a community should be developed with and vetted by the community to ensure success and improved outcomes. These

engagement activities informed the development of the IMPROVE (Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone) Initiative, which aims to build an evidence base that will improve maternal care and outcomes from pregnancy through 1 year postpartum. IMPROVE is co-led by NICHD and the NIH Office of Research on Women's Health and engages over 30 ICOs to research the leading causes of maternal mortality in the United States—cardiovascular disease, infection, and immunity—as well as contributing health conditions or social factors, such as mental health disorders, diabetes, obesity, substance use disorders, and structural and healthcare system issues that disproportionately affect Black pregnant and postpartum women. IMPROVE prioritizes comprehensive, interdisciplinary research that engages communities with high rates of maternal deaths and complications. This work will help create tailored, evidence-based solutions for pregnant and postpartum women.

NIH research on MMM generates evidence that improves outcomes and clinical care, and several NIH Institutes have strong investments in this space. For example, an NICHD-funded study demonstrated that when hospitals implemented evidence-based recommendations for clinical practice there was a reduction in the risk of severe maternal morbidity from obstetric hemorrhage, a common complication of childbirth. The reduction was more dramatic for Black women more than for White women, reducing disparities and improving outcomes. NICHD is also supporting a machine learning framework to predict severe maternal morbidity. Researchers aim to analyze population-based data from Maryland state databases and hospital surveys to develop techniques that can predict maternal risks early. Identifying key predictors of severe maternal morbidity can help ascertain health disparities, strengths and weaknesses in obstetric care, and prevent adverse maternal and neonatal outcomes.

In fiscal year 2020, the National Institute on Minority Health and Health Disparities (NIMHD) started an initiative entitled Addressing Racial Disparities in Maternal Mortality. This initiative supports multidisciplinary research projects that examine the clinical, social, behavioral, and healthcare system interventions to address racial disparities in MMM in the United States. Additionally, NIMHD funded the Maternal and Developmental Risks from Environmental and Social Stressors (MADRES) project in collaboration with the National Institute on Environmental Health Sciences, to examine prenatal environmental exposures and social stressors in relation to depression and cardiovascular risk factors postpartum.

The National Heart, Lung, and Blood Institute (NHLBI) is weaving together a network of community-engaged researchers who will not only work to improve women's heart health and reduce maternal mortality, but will also address other health disparities. For example, NHLBI's new Maternal Health Community Implementation Program, will fund three or four regional coalitions to pilot test community-based strategies in areas where maternal death rates are high, particularly in the southeast. Additionally, NHLBI's Early Intervention to Promote Cardiovascular Health of Mothers and Children (ENRICH) will tap into existing Federal home health/wellness programs that serve at-risk families to determine if adding a cardiovascular intervention will enhance maternal and early childhood outcomes. Approximately 3,000 mother- child pairs across various sites will be reached as part of this effort.

These are just a few examples of how NIH's broad investment in addressing MMM is improving maternal and infant care.

QUESTIONS SUBMITTED BY SENATOR JEANNE SHAHEEN

Question. I am hopeful that our continued investment in the Special Diabetes Program, and diabetes research at NIH as a whole, can help spur a new wave of breakthroughs, and maybe one day a cure for diabetes.

Now that Congress has secured longer-term funding for the Special Diabetes Program, can you please provide information on NIH's priority areas for Special Diabetes Program research in the years to come?

Answer. The National Institutes of Health (NIH) appreciates the recent extension of the Special Diabetes Program, which will allow us to continue critical ongoing research programs and to support new research to improve the health and quality of life of people with or at risk for type 1 diabetes and its complications. For example, the recent extension will allow the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to continue the Human Islet Research Network, which is working to better understand how insulin-producing cells are lost in type 1 diabetes and to find strategies to replace or protect them in people, toward curing the disease. NIDDK plans to begin new clinical trials through the Type 1 Diabetes

TrialNet network, testing agents to prevent onset of clinical type 1 diabetes. Such research will build on the landmark success of previous TrialNet research demonstrating for the first time ever that early preventive treatment can delay onset of clinical type 1 diabetes in high-risk individuals. NIDDK also plans to support research building on the tremendous recent progress in developing transformative diabetes management technologies, such as artificial pancreas devices. For example, future research is needed to improve components of artificial pancreas devices (e.g., glucose sensors, hormone formulations), develop simpler and more user-friendly devices, and test devices in understudied populations (e.g., older adults, pregnant women, people with poorly controlled blood glucose levels). This type of research will move us closer to our goal of developing multiple different artificial pancreas technologies for people of all ages so that they can choose the technology best suited to their clinical needs. NIDDK also plans to support new research to identify novel ways to detect and monitor type 1 diabetes onset and progression, such as by determining whether "extracellular vesicles" that originate from pancreatic tissue may be useful to detect earlier stages of type 1 diabetes than currently possible. NIDDK is collaborating with the National Heart, Lung, and Blood Institute on new research toward reducing cardiovascular disease in people with type 1 diabetes, as very little is known about how best to prevent and treat this life-threatening complication. To inform other future research directions, NIDDK is spearheading a planning meeting in spring 2022 under the auspices of the statutory Diabetes Mellitus Interagency Coordinating Committee to obtain input from external scientific and lay experts on critical new and emerging research opportunities that could be supported by the Special Diabetes Program.

Question. New Hampshire continues to be one of the hardest-hit states in the substance use disorder epidemic, with one of the highest overdose death rates in the country. I am very supportive of the ongoing work at the National Institute on Drug Abuse (NIDA) to research potential non-addictive alternatives to opioids for pain management.

Could you discuss progress on any research within NIDA to study these types of alternatives?

Answer. The National Institutes of Health (NIH) recognizes the need to improve pain management without risk of addiction and other serious side effects. NIH is taking a multi-pronged approach to develop safe and effective therapies to reduce our reliance on opioids.

To avoid replay of the spike in opioid deaths related to over-use of medical opioids for pain management we need more effective, non-addictive pain medications and data that can inform best practices in pain care. The NIH Helping to End Addiction Long-term (HEAL) Initiative was launched in 2018 and significantly expanded research to discover and accelerate development of non-addictive pharmacological and non-pharmacological pain treatments. HEAL has awarded over $1.5 billion for research to improve pain management and address opioid use disorder and overdose. Studies supported by HEAL, the Blueprint Neurotherapeutics Program, and multiple NIH Institutes, in particular the National Institute for Neurological Disorders and Stroke (NINDS), are underway to identify, optimize and test promising molecules, biologics, and devices that target non-opioid pain pathways in the nervous system. Biomarker studies to help with diagnosis of pain conditions and to identify patients most likely to respond to a particular treatment will enhance pain clinical trials and improve best practices are moving forward. In addition, non-pharmacological approaches to manage many different pain conditions are being evaluated through effectiveness and implementation research approaches.

The NIH HEAL initiative established essential pain research infrastructure to accelerate development of new medications and devices to treat pain. An analgesic screening platform uses animal- and human cell-based models such as neural tissue chips for rapid screening of molecules or devices for analgesic relevant biological and pain behavioral activity. HEAL, with input from academic and industry partners, established an Early Phase Pain Investigation Clinical research network (phase 2 studies) to test safety and efficacy of novel therapeutics and a later stage pain management Effectiveness Research Network (ERN) to compare effectiveness of pharmacological and non-pharmacological approaches in many different pain conditions. The ERN is supporting eight large trials for various pain management strategies. The Pragmatic and Implementation Studies for the Management of Pain to Reduce Opioid Prescribing (PRISM) network focuses on clinical trials of non-pharmacologic pain therapies in healthcare systems.

The Phase 2 network will launch trials on two new analgesics in 2021. The ERN is supporting eight large trials for various pain management strategies. PRISM is supporting six large trials in healthcare systems. In addition, HEAL established an analgesic development pipeline to accelerate the development and testing of novel

drugs and devices. This program uses team-based science coupled with a comprehensive set of research resources to bring new therapeutics rapidly to the clinic. To advance the discovery and validation of new drug targets, HEAL has funded over 30 projects to discover and verify a diverse set of drug target types across multiple pain conditions, six drug optimization studies on new safe and effective pain treatments, and 11 projects to test the effectiveness of implanted devices and noninvasive stimulation of nerves in the brain or throughout the body to reduce perception of pain. This effort greatly expands on NINDS supported studies in these areas.

Recent HEAL accomplishments toward new therapeutics include two patent filings for small molecule modulators of pain receptors involved in chronic pain and migraine. One ongoing study received Investigational New Drug (IND) approval for use of buprenorphine with nonpharmacological treatment to relieve pain in patients undergoing kidney dialysis. Through the NIH Blueprint Neurotherapeutics Program researchers are developing non-addictive kappa opioid receptor antagonists for treatment of migraine and a safe, non-opioid epoxide hydrolase inhibitor to reduce diabetic nerve pain. Earlier, NIH supported basic science research led to calcitonin gene-related peptide therapy for migraine and nerve growth factor therapy for inflammatory pain. Drugs that target these molecules are now approved by the U.S. Food and Drug Administration to treat migraine and osteoarthritis pain. Through the Brain Research through Advancing Innovative Neurotechnologies® (BRAIN) Initiative, which is a major effort to develop tools to map, monitor, and modulate neural circuits, NIH has supported studies that will enhance diagnostics and therapies for chronic pain and other neural circuit disorders.

Question. The Institutional Development Award (IDeA) program at NIH has proven critical in funding New Hampshire researchers, including especially the innovative work at Dartmouth College and Dartmouth-Hitchcock Health. I am hopeful that Congress can continue to support funding for this program.

Can you provide any insight into how NIH is currently making use of Institutional Development Award funds and whether more funding for the program would be helpful?

Answer. The Institutional Development Award (IDeA) supports basic, clinical, and translational research, faculty development, and infrastructure improvements at institutions in states and territories that have historically received a lower aggregate level of NIH funding. The program aims to strengthen biomedical research capacity, enhance the competitiveness of investigators in securing research funding, and enable clinical and translational research that addresses the specific needs of rural and medically underserved communities. Currently, institutions in 23 States and Puerto Rico are eligible for funding through the IDeA Program, the various components of which include:

—*IDeA Networks of Biomedical Research Excellence (INBRE).* INBRE enhances, extends, and strengthens the research capabilities of biomedical research faculty in IDeA states through a statewide program that links a research-intensive institution with primarily undergraduate institutions. INBRE supports institutional research and infrastructure development; research by faculty, postdoctoral scientists, and students at participating institutions; and targeted outreach to build science and technology knowledge within a state's workforce. Only one INBRE award is made per IDeA-eligible state. The New Hampshire INBRE, which is led by Dartmouth and co-led by the University of New Hampshire, is in its twelfth year of operation and has used the program's support to improve and expand research capacity at all eight of its partner institutions, including adding additional labs, cores and instrumentation/infrastructure; establishing fully functional Office of Sponsored Programs for faculty members to competitively seek extramural grants; training and mentoring of both faculty and students; and enhancing a vibrant institutional research culture. In fiscal year 2020, the National Institute of General Medical Sciences (NIGMS) supported 24 INBRE awards.

—*Centers of Biomedical Research Excellence (COBRE—Phases I, II, and III).* COBRE supports the establishment and development of innovative, state-of-the-art biomedical and behavioral research centers at institutions in IDeA-eligible states that: (a) galvanize multidisciplinary research to develop a critical mass of investigators that are competitive for peer-reviewed research funding; (b) provide improvements to research infrastructure; and (c) maintain research cores to sustain a collaborative, multidisciplinary research environment that includes pilot project programs, mentoring, and workforce training. In fiscal year 2020, NIGMS supported 112 COBRE awards. One such example, a Phase I COBRE at Dartmouth's Geisel School of Medicine called iTarget (Institute for Biomolecular Targeting), aims to catalyze the development of new therapeutic approaches to address cancer, chronic obstructive pulmonary disease, and res-

piratory syncytial virus, a common viral infection that can be dangerous to young children and the elderly. This COBRE is providing unique resources to investigators at Dartmouth and its IDeA partners, thus enhancing research productivity and funding competitiveness across the region.

—*IDeA Networks for Clinical and Translational Research (IDeA–CTR).* IDeA–CTRs develop a network infrastructure and capacity in IDeA-eligible states to conduct clinical and translational research focused on health concerns that disproportionately affect rural and medically underserved populations and/or that are prevalent in IDeA states. IDeA–CTR awards support mentoring and career development activities in clinical and translational research. In fiscal year 2020, NIGMS supported 12 IDeA–CTR awards.

—*Regional Technology Transfer Accelerator Hubs.* NIGMS established the Regional Technology Transfer Accelerator Hubs for IDeA states in each of the four IDeA regions (central, northeast, southeast, and western regions). The hubs provide both consulting services and skills development in entrepreneurship, technology transfer, small business finance, and other areas needed to transform important discoveries made in the laboratory into potentially viable commercial products that address human health. In fiscal year 2020, NIGMS supported four accelerator hubs. The northeast hub is located at Celdara Medical in Lebanon, New Hampshire.

—*Research Co-Funding.* NIGMS provides co-funding for applications from IDeA state institutions that have been judged meritorious by NIH peer-review committees and national advisory councils but that may also fall outside the usual range of support by a given NIH Institute or Center (IC). In fiscal year 2020, NIGMS co-funded 42 research project grants at 20 NIH ICs; one of these was at Dartmouth College.

QUESTIONS SUBMITTED TO DR. NED SHARPLESS

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. The American Cancer Society's Annual Report to the Nation on the Status of Cancer highlighted that we are making good progress in the battle against cancer, with the incidence and mortality rates for most cancers have dropped significantly. However, among the 20 most common cancers, relative survival for patients significantly improved since the mid-1970s except for those with uterine cancer.

What plans does the NCI have in fiscal year 2022 to develop a paradigm of increased research to improve hope for survival for patients with uterine cancer?

Answer. The National Cancer Institute (NCI) shares the committee's commitment to research on uterine cancers, including endometrial cancer (cancer of the inner lining of the uterus), and improving outcomes for patients.

Today, nearly 40 percent of adults are obese, and without intervention, the obesity epidemic will result in more cancers. Uterine cancer incidence and mortality have increased in recent years,[40] believed to be partially associated with rising rates of obesity.[41] Women who are obese or overweight are approximately two to four times as likely as normal weight women to develop uterine cancer, including endometrial cancer, making interventions to address weight and obesity vital to combatting uterine cancer incidence and mortality. Examples of NCI-supported research on this topic include a study of how changes in body composition following weight loss impact inflammatory biomarkers in biopsy-collected endometrial tissue and blood samples and whether these processes differ between Black and White women;[42] the development of a weight loss intervention among Appalachian residents;[43] and a study of the Deep South Interactive Voice Response (IVR)-supported Active Lifestyle (DIAL) Intervention to increase physical activity levels among residents of the Deep South.[44]

Researchers at the University of North Carolina Lineberger Comprehensive Cancer Center are directly examining the metabolic and molecular differences of endometrial tumors in obese and non-obese women. In addition, this research team is exploring how metformin, widely used to treat type II diabetes, may also exhibit anti-tumor activity through its effects on a patient's metabolism.[45]

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[40] pubmed.ncbi.nlm.nih.gov/30521505/,seer.cancer.gov/report__to__nation/statistics.html#factors.

[41] www.cancer.gov/about-cancer/causes-prevention/risk/obesity/obesity-fact-sheet.

[42] reporter.nih.gov/project-details/10129305.

[43] reporter.nih.gov/project-details/10065366.

[44] reporter.nih.gov/project-details/10163139.

[45] reporter.nih.gov/project-details/10104456.

Translational research to bridge the gap between basic research on endometrial cancer and potential therapies is also essential to improving outcomes for patients. NCI supports a Specialized Program of Research Excellence (SPORE) focused on translational research for endometrial cancer at the University of Texas/MD Anderson Cancer Center. This SPORE is conducting research aimed at developing therapeutic strategies for advanced/recurrent endometrial cancer and aggressive subtypes, addressing unmet clinical needs in prevention and conservative therapy of high-risk precancerous lesions and low-grade endometrial cancer, and incorporating molecular diagnostics into clinical decisionmaking.[46]

As of July 2021, NCI is supporting over 150 clinical trials with a primary focus on uterine (including endometrial) cancer. Examples of these projects include studies of the use of an immunotherapy agent, in combination with other cancer therapies, to treat high risk endometrial cancer;[47,48] a trial examining a combination therapy to treat endometrial cancers that express the HER2 protein;[49] and a study evaluating the use of the experimental therapy triapine to treat endometrial serous adenocarcinoma, a difficult to treat subtype of uterine cancer.[50] Clinical trials are an integral part of advancing research in this important topic area, and NCI is committed to reaching out to disparate, at-risk communities to explain, educate, and encourage clinical trial participation.

As part of the National Institutes of Health (NIH) efforts to identify future research directions, NCI and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) explored research opportunities into the progression of benign gynecologic conditions to cancers through a collaborative workshop in April 2019. Currently, NICHD funds research on benign gynecologic conditions such as endometriosis and uterine fibroids, while NCI funds research on women's cancers. The workshop sought to bridge the two research areas and identify gaps in the biologic, epidemiologic, and clinical understanding of progression from benign conditions to cancer. The workshop addressed three gynecologic disease types: (1) endometriosis or endometrial cancer and endometrial-associated ovarian cancer, (2) uterine fibroids (leiomyoma) or leiomyosarcoma, and (3) denomyosis or adenocarcinoma. Working groups were formed for each disease type, and key questions and current challenges that emerged from the discussions, along with potential research opportunities to advance understanding of progression of gynecologic benign conditions to cancer, were published. Specific research questions and gaps were identified in all three focus areas, and several cross-cutting topics emerged. The results of this workshop, as well as ongoing horizon- scanning activities, will continue to inform NIH's next steps to address uterine cancer.

Question. Non-Hispanic Black women are two time as likely as non-Hispanic White women to die from uterine or cervical cancer (https://www.ajog.org/article/S0002-9378(16)46212- 5/pdf).

Can NIH/NCI please share with the Committee the research activities the NCI is supporting to address this disparity, particularly with regards to access to care, prevention, early diagnosis, treatment completion and developmental therapeutics?

Answer. The National Cancer Institute (NCI) shares the Committee's concern regarding cervical and uterine/endometrial cancer disparities and is working to support research to eliminate these disparities, as well as cancer disparities more broadly. Examples of research aimed at addressing disparities in uterine and cervical cancer outcomes are provided below.

NCI is a leader in developing and supporting definitive, practice-changing gynecologic (GYN) clinical trials, as well as responding to areas of scientific inquiry that are unaddressed by private industry. The NCI GYN Cancers Steering Committee sets clinical trials strategic priorities that address areas of unmet clinical need, important unanswered clinical questions, and potential new approaches to disease treatment.[51] The Institute has supported and advanced GYN cancer research that will provide greater insight into these cancers, additional options for drug therapies, and improved surgical techniques with the intent of increasing survivorship and quality of life. As of July 2021, NCI is supporting over 150 interventional clinical trials with a primary focus on uterine (including endometrial) cancer, two trials on the rare uterine sarcoma, and nearly 100 trials for cervical cancer patients. NCI also has several trials that are "disease agnostic," meaning that they are open to patients with certain genetic alterations rather than traditional cancer types, cre-

[46] trp.cancer.gov/spores/endometrial.htm.
[47] clinicaltrials.gov/ct2/show/NCT04214067.
[48] clinicaltrials.gov/ct2/show/NCT03914612.
[49] clinicaltrials.gov/ct2/show/NCT04585958.
[50] clinicaltrials.gov/ct2/show/NCT04494113.
[51] www.cancer.gov/about-nci/organization/ccct/steering-committees/nctn/gynecologic.

ating opportunities for patients to potentially benefit from precision medicine and targeted therapy.

A recent study led by NCI intramural researchers used population data from NCI's Surveillance, Epidemiology, and End Results (SEER) database to evaluate trends of hysterectomy-corrected uterine cancer incidence rates for women overall and by race and ethnicity, geographic region, and histologic subtype. Correct estimation of these rates requires accounting for hysterectomy prevalence, which varies by race, ethnicity, and region. The researchers found that incidence rates of common subtypes of uterine cancer were stable in non-Hispanic White women over the study period and increased in women of other racial/ethnic groups. By contrast, incidence rates of aggressive subtypes have been increasing dramatically over time in all racial/ethnic groups; in particular, much higher rates of these aggressive subtypes were observed in Black women than in other racial/ethnic groups. The researchers also observed that survival rates were lower among all women with aggressive subtypes than among women with common subtypes, and Black women had the lowest survival rates within each stage at diagnosis or histologic subtype.

Uterine serous carcinoma (USC) is a rare but aggressive type of endometrial cancer. In about one-third of women with USC, their tumor cells overproduce a protein called HER2 (human epidermal growth factor receptor 2), which is associated with poor prognosis in women with endometrial cancer. Black women with endometrial cancer are more likely than White women to be diagnosed with UCS and are more likely than women of other races/ethnicities to have HER2 overproducing UCS tumors. NCI clinical studies for patients with HER2 overproducing uterine serous cancer and carcinosarcoma are currently in development.

NCI-supported researchers are working to describe additional differences in subtypes of uterine and endometrial cancers, with the eventual goal of targeting therapies to treat each disease subtype. For example, investigators at Brigham and Women's Hospital, using data from the NCI-supported Epidemiology of Endometrial Cancer Consortium (E2C2),[52] are studying genomic variation across the full spectrum of endometrial tumors, distinct risk factor profiles across tumor types, and the role of underlying tumor biology to better understand the disparities in outcomes between African-American and non-African-American women.[53] NCI-supported investigators at Wayne State University are examining aggressive subtypes of high-grade endometrial tumors, including endometrioid, serous, clear cell and mixed carcinomas, by analyzing both clinical and genetic data in 500 women (250 African-American, 250 White) diagnosed with these cancers.[54] In addition, NCI is supporting a planning grant to establish a Specialized Program of Research Excellence (SPORE) at Northwestern University focused on gynecologic cancer disparities. One of the pilot projects will focus on the tumor genomics of endometrial cancer.[55]

To more accurately evaluate the risk of cervical precancer and study novel biomarkers in women undergoing cervical cancer screening, intramural researchers in NCI's Division of Cancer Epidemiology and Genetics have partnered with the University of Mississippi Medical Center and the Mississippi State Department of Health in the STRIDES Study (Studying Risks to Improve Disparities of cervical cancer in Mississippi). This study, based in one of the top five states for cervical cancer incidence and mortality, combines the expertise of clinicians, laboratory scientists, epidemiologists, and implementation scientists to address all aspects of cervical cancer prevention and control.[56]

In 2020, NCI launched the "Last Mile Initiative," with the goal of improving cervical cancer screening coverage to underserved, never screened, and under-screened women. This initiative will evaluate an alternative cervical cancer screening approach: self-collection of samples (self- sampling) by women, which are then sent to labs for human papillomavirus (HPV) testing. This approach aims to identify cervical cancer cases in these groups of women, which account for over half of cervical cancer cases in the United States each year. Self-sampling offers several benefits, including ease of collection at the time and place of the patient's choosing, without the need for a clinic appointment or speculum exam. To conduct this assessment, NCI established a public-private partnership between Federal agencies, industry partners, and professional societies/clinical guidelines organizations, and will support a nationwide, multicentric screening trial in diverse settings, the Last Mile Ini-

[52] epi.grants.cancer.gov/eecc/.
[53] reporter.nih.gov/search/o5KPkwNzZUavBogOfHXfCgproject-details/10156374.
[54] reporter.nih.gov/search/frdhnx__EQkONjxE8GPyxvQ/project-details/9916725.
[55] reporter.nih.gov/search/-UP__KUgEu0G9__0Zt655Nsg/project-details/9961257.
[56] dceg.cancer.gov/research/cancer-types/cervix/cervix-mississippi.

tiative Self-sampling for HPV Testing to Improve Cervical Cancer Prevention Trial (LMI–SHIP Trial).[57]

Additionally, NCI is collaborating with the NIH Office of Research on Women's Health (ORWH) and other NIH Institutes and Centers to participate in an ORWH Advisory Committee on Research on Women's Health Consensus Conference to be held in October 2021. The conference will include a focus on cervical cancer disparities and research opportunities to continue to address disparities in incidence and mortality.

NCI will continue to identify opportunities to better understand and address cancer health disparities, including for cervical and uterine/endometrial cancers.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. Approximately 20,000 people in the United States have germline mutations in the gene RUNX1. Patients with RUNX1-familial platelet disorder are at a heightened risk for developing blood cancers. NCI supports a longitudinal natural history study of patients with such germline mutations and their families. While germline RUNX1 mutations are rare, I understand that NIH-funded research in this area holds promise for the fields of hematology and oncology.

How can deepening our understanding of, and ultimately developing cancer prevention strategies for, inherited blood cancer predisposition syndromes like RUNX1 familiar platelet disorder advance the entire cancer research field forward?

Answer. The RUNX1 gene regulates the development of blood cells (hematopoiesis), controlling other genes that help determine the fate of hematopoietic stem cells, which have the potential to develop into all types of mature blood cells, including platelets. Platelets are cells that help blood to clot. Inherited mutations in the RUNX1 gene cause familial platelet disorder with associated myeloid malignancies (RUNX1–FPDMM) and predispose individuals to some types of blood cancers. Although genetic predisposition to solid tumors such as breast and colon cancers has been widely recognized over the past several decades, the contribution of inherited genetic disorders related to blood cancer is a more recent field of study.

There are many instances where understanding the molecular basis for a rare inherited disease has provided insight into more common forms of a particular disease. For example, BRCA1 and BRCA2 mutations were discovered as hereditary breast cancer genes but are also relevant to sporadic (non-hereditary) breast cancers, ovarian cancers, and some hereditary forms of colon cancer. Similarly, understanding the blood cancers associated with RUNX1–FPDMM may lead to improved understanding of other types of blood cancers as well.

Research efforts across the National Institutes of Health (NIH) are underway to better understand RUNX1–FPDMM. Investigators funded by the National Heart, Lung, and Blood Institute (NHLBI) are studying cells from people with this disorder to better understand key target genes regulated by RUNX1 and their role in hematopoiesis.[58] This work could also yield a better understanding of genetic pathways that lead to blood cancers, as well as the blood clotting mechanisms that contribute to cardiovascular disease. Investigators at the National Human Genome Research Institute (NHGRI), along with intramural scientists at the National Cancer Institute (NCI), are conducting a natural history study at the NIH Clinical Center that is intended to identify and follow patients with RUNX1 mutations to hopefully identify biomarkers that can predict which patients will develop cancers.[59] To date, the study has enrolled 198 patients from 55 families, representing the largest FPDMM cohort being followed prospectively at a single institution in the world.

Studying RUNX1–FPDMM will have broader significance than just this rare disease. Germline (inherited) predisposition to hematopoietic malignancies is often under-diagnosed, with recent studies indicating that 10–30 percent of RUNX1 mutations detected in acute myeloid leukemias are inherited, which is much more common than previously appreciated.[60] In addition, FPDMM can serve as a model to study the development of leukemia, since researchers can monitor individuals with the RUNX1 mutation before they develop leukemia to identify factors associated with cancer risk and to map tumor evolution.

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[57] prevention.cancer.gov/major-programs/nci-cervical-cancer-last-mile-initiative.

[58] reporter.nih.gov/project-details/10083753.

[59] www.genome.gov/Current-NHGRI-Clinical-Studies/hematologic-and-premalignant-conditions-associated-with-RUNX1-mutation;clinicalstudies.info.nih.gov/ProtocolDetails.aspx?id=2019-HG-0059; clinicaltrials.gov/ct2/show/NCT03854318.

[60] pubmed.ncbi.nlm.nih.gov/32315381/.

QUESTIONS SUBMITTED BY SENATOR JACK REED

Question. The fiscal year 2021 Appropriations law included full funding—$30 million—for the Childhood Cancer STAR Act, which I authored.

Could you provide an update on how that funding will be spent in the coming year?

How will that work be coordinated with the childhood cancer data initiative?

Answer. NCI is supporting several new and ongoing Childhood Cancer STAR Act research projects in fiscal year 2021, for a total planned investment of $28 million. The Centers for Disease Control and Prevention continues to support enhancements to expand capacity within the National Program of Cancer Registries (NPCR) to help cancer registries collect and make the data on pediatric cancer cases available more rapidly, a $2 million effort in fiscal year 2021.

Consistent with provisions in Section 101 of the STAR Act, NCI's fiscal year 2021 appropriation for STAR Act activities is supporting new and expanded projects focused on the collection and storage of biospecimens for future research. Several projects are conducted through the NCI-supported Children's Oncology Group (COG) to focus additional attention to rare cancer subtypes that are currently underrepresented in NCI-supported biorepositories, as well as tumor types with a high risk of treatment failure. For example, particularly rare subtypes of pediatric cancers for which COG does not have open clinical trials, tumor tissue collection options are limited. STAR Act appropriations are supporting the COG Rare and Under-Represented Cancer Tissue Banking project to enable tumor tissue and associated germline (e.g., blood) sample collection for specific groups of patients for which current tumor tissue collection is lacking or inadequate, with priority for tumor types such as sarcomas and brain and central nervous system (CNS) tumors, which have high risk of treatment failure.

The COG Rare and Under-Represented Cancer Tissue Banking project was launched in fiscal year 2020 and is expanding in scope in fiscal year 2021. This initiative is collaborating closely with CCDI, and with the use of fiscal year 2021 CCDI funds, tumor tissue will undergo clinically-relevant molecular profiling through the CCDI Molecular Characterization Protocol. The data generated will be returned to treating physicians to help guide the diagnosis and treatment of patients, and the data will additionally be stored and made available to the research community through CCDI data platforms. In addition to rare cancer populations, the CCDI Molecular Characterization Protocol will initially support characterization of tumors from children with CNS tumors and from children with soft tissue sarcomas. The Protocol aims to collect, store, and make available detailed clinical and molecular information for each child participating in the study, including data that will help a pediatric oncologist treat that patient and help researchers learn more about childhood cancers.

NCI is continuing support in fiscal year 2021 for other STAR Act biobanking projects launched in fiscal year 2020. Through the COG Rapid Autopsy Specimen Collection project, NCI and COG are working with patient organizations to support rapid autopsy collection of tumor samples from children and adolescents and young adults (AYAs) who have died of their disease. Foundations and families within the pediatric brain tumor community have been leaders in such programs, and NCI continues to learn from their experiences to expand this model to other childhood cancers. We are incredibly grateful to these parents and caregivers, who amidst unimaginable grief and loss, contribute to future research to advance science and help other families.

NCI is also supporting the COG to continue to expand the collection of specimens taken at the time of relapse, as well as collecting diagnostic samples for children and AYAs who have already submitted samples at relapse through NCI's Pediatric Molecular Analysis for Therapy and Choice (MATCH) Precision Medicine Trial. An important impediment to understanding mechanisms of treatment failure for childhood solid tumors is the limited numbers of paired specimens from both diagnosis and relapse that are available for researchers to study. Specimens at relapse are critical for evaluating biological changes between diagnosis and relapse that can lead to the identification of mechanisms of treatment failure and to the development of strategies for circumventing these mechanisms. Through CCDI, Pediatric MATCH tumor specimens from diagnosis and from relapse are being molecularly characterized to identify the changes in gene mutations and gene expression that occur between diagnosis and relapse, which could inform better treatments.

Consistent with Section 202 of the STAR Act, in fiscal year 2021, NCI will continue to conduct and support childhood cancer survivorship research. NCI has supported two new Requests for Applications (RFAs) since fiscal year 2019 that are directly aligned with survivorship research areas emphasized in the STAR Act. Issued

in fiscal year 2019, RFA CA–19–033:[61] Improving Outcomes for Pediatric, Adolescent and Young Adult Cancer Survivors focused on projects to develop and test interventions that prevent, mitigate or manage adverse outcomes in pediatric and/or AYA cancer survivors and/or evaluate models of care that strengthen coordination, continuity, and quality, or that reduce access barriers to needed services including follow-up care, and that improve outcomes across the survivor's lifespan. Development of interventions to address disparities in outcomes and/or access to needed care, and to address the needs of minority or medically underserved pediatric and/or AYA populations were also prioritized. NCI is supporting seven awards in response to this RFA, and the awards will focus on various patient sub-populations (e.g. disease site), developmental groups, specific late and long-term effects, and the types of interventions (both preventive and supportive care).

Issued in fiscal year 2020, RFA CA–20–027[62] and RFA CA–20–028:[63] Research to Reduce Morbidity and Improve Care for Pediatric, and Adolescent and Young Adult (AYA) Cancer Survivors invite applications for research projects to improve care and health-related quality of life for childhood and AYA cancer survivors, with a focus on six key domains that align with research priorities emphasized in the STAR Act: (1) disparities in survivor outcomes; (2) barriers to follow-up care (e.g. access, adherence); (3) impact of familial, socioeconomic, and other environmental factors on survivor outcomes; (4) indicators for long-term follow-up needs related to risk for late effects, recurrence, and subsequent cancers; (5) risk factors and predictors of late/long-term effects of cancer treatment; and (6) development of targeted interventions to reduce the burden of cancer for pediatric/AYA survivors.

In fiscal year 2021, NCI will support subsequent years for grants initially awarded in fiscal year 2019 and fiscal year 2020, as awards were made for five-year terms, and the Institute will be making several new grant awards through the RFA launched in fiscal year 2020. The first round of applications is in the final stages of review, and awards will be made before the close of fiscal year 2021. The second round of applications are due on July 30, 2021, and awards are anticipated to be made in fiscal year 2022.

NCI also continues to make additional investments in childhood cancer survivorship research beyond the STAR Act appropriation, funding several notable initiatives and projects with resources provided through the Institute's general appropriation. For example, NCI continues to fund long-standing investments in the Childhood Cancer Survivor Study (CCSS),[64] which the Institute has supported continuously since establishing CCSS in 1994. This cohort of more than 38,000 childhood cancer survivors diagnosed between 1970 and 1999 (and 5,000 siblings of survivors who serve as the comparison group for the study) serves as a foundational resource for the survivorship research community.

Additionally, NCI continues to support research projects that investigators develop and submit independent of specific childhood and AYA cancer survivorship funding opportunities such as the STAR Act RFAs described above. These investigator-initiated research projects provide critical contributions to this field, and awards made to date in fiscal year 2021 include a project to compare symptom burdens (toxicity), neurocognitive change, and functional outcomes in children with pediatric brain tumors treated with proton versus photon radiotherapy. Proton beam radiotherapy (PBRT) is often thought to be a promising treatment for children with brain tumors as it may preserve cognitive functioning without sacrificing disease control. This will be the first large-scale study to prospectively compare the two therapies to assess important measures of daily functioning that will quantify the clinical significance of any differences identified between groups in survivorship. This project aims to help physicians and families better understand the relative effect of PBRT on symptoms and neurocognitive functioning to inform treatment decisions.[65] Another award is supporting further study of psychosocial risk in young survivors of pediatric cancer diagnosed in early childhood, including the role of both physical and neurocognitive late effects. This project aims to identify specific medical and neurocognitive late effects that increase psychosocial morbidity, as well as protective factors, to inform more effective interventions to optimize quality of life in children affected by cancers diagnosed in early childhood.[66] In addition, the NCI-supported ASPIRES (Activating cancer Survivors and their Primary care providers to Increase coloREctal cancer Screening) study aims to prevent the development of

[61] grants.nih.gov/grants/guide/rfa-files/RFA-ca-19-033.html.
[62] grants.nih.gov/grants/guide/rfa-files/RFA-CA-20-027.html.
[63] grants.nih.gov/grants/guide/rfa-files/rfa-ca-20-028.html.
[64] cancer.gov/types/childhood-cancers/ccss.
[65] reporter.nih.gov/search/kPIDddsyREmcoShhVEYN4Q/project-details/10146799.
[66] reporter.nih.gov/search/5Nb7PgFn7kyHJnjYOFzMQA/project-details/10122486.

subsequent cancers among childhood cancer survivors treated with abdominal or pelvic radiotherapy, who are almost four times more likely to develop colorectal cancer (CRC) compared to the general population. The study will test a remote intervention aimed at promoting early CRC screening and detection.[67]

NCI remains committed to implementing the research sections of the STAR Act directed toward the Institute, and to ensuring that these efforts continue to complement the Institute's broader portfolio of childhood and AYA cancer research. This includes CCDI, the COG, the CCSS, and many other research programs and projects working together to support much needed progress for children with cancer and their families, including survivors and caregivers facing the challenges of managing the late effects of cancer and its treatments.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Sharpless, one of the goals I had when I was Chairman of this Subcommittee was to increase NIH funding, in an effort to increase the success rates of grants—meaning more research grants would be funded. This is important because the NIH peer review system does not always reward high-risk science or young researchers' grant applications. But, if you have additional funding, you can fund more than just the 'safest' science grants from the most established researchers. NCI has seen an increase of more than 50 percent in the number of grant applications since 2013, keeping your success rates and paylines lower than most NIH Institutes. While the positive aspect of this statistic is that the cancer research community is energized and applying for NCI funding, you can only fund a certain amount of applications because of the significant increase in grant applications. The last two LHHS bills have included specific funding for NCI to increase their Research Project Grants.

How has this allowed you to increase success rates, raise the payline, and make more awards?

Answer. The intense competition and demand for NCI funding reflects incredible scientific opportunities in cancer research and presents a major challenge for the NCI to carefully balance increasing demand for competing grant funding while sustaining previous years' commitments to multi-year grants.

Investigator-initiated research has proven itself to be one of the biggest drivers of progress in cancer research, and accordingly is the biggest driver of NCI's budget, with long-term investments into funding new and continuing awards constituting more than 40 percent of NCI's annual budget. These awards have been the source of some of the most innovative and transformative ideas in cancer research, leading to direct benefits for patients in the form of new oncology drug approvals, the development of immune checkpoint inhibitor therapy (Nobel Laureate Jim Allison), CAR–T (chimeric antigen receptor-T) cell immunotherapy (Carl June), and novel drug design strategies such as PROTACs (proteolysis targeting chimeras)[68] that use normal cellular processes to identify and destroy proteins in cancer cells that drive cancer growth (Raymond DeShais and Craig Crews).

Considering all funding mechanisms, NCI supported 109 additional awards in fiscal year 2020 as compared to fiscal year 2019 (from 6,053 in fiscal year 2019[69] to 6,162 in fiscal year 2020[70]). Across fiscal year 2020 and 2021, the successive funding increases allowed NCI to increase the R01 payline from the 8th percentile in fiscal year 2019 to the 11th percentile in fiscal year 2021. With the fiscal year 2020 budget increase, NCI increased R01 paylines by 25 percent compared to fiscal year 2019 and restored continuing grants to 100 percent of their committed level, providing researchers the full fiscal year 2020 budget approved during the initial grant award. Funding increases in fiscal year 2021 allowed NCI to further raise the payline for R01 research awards, for an overall 35 percent increase compared to 2019, as well as to keep funding continuing awards at 100 percent. In addition, for those two consecutive years (fiscal year 2020 and fiscal year 2021), NCI also raised the payline for Early-Stage Investigators, reflecting NCI's commitment to developing and supporting early career scientists to build the next generation of cancer researchers.

We have the final success rate and total number of awards results for fiscal year 2020, the year when Congress targeted an additional $212.5 million for new and

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[67] reporter.nih.gov/search/5Nb7PgFn7kyHJnjYOFzMQA/project-details/10096080.

[68] www.cancer.gov/research/annual-plan/scientific-topics/protac-infographic.

[69] www.cancer.gov/about-nci/budget/congressional-justification/fy2021-nci-congressional-justification.pdf.

[70] www.cancer.gov/about-nci/budget/congressional-justification/fy2022-nci-congressional-justification.pdf.

continuing grants, but we will not have final results for fiscal year 2021 until after the first quarter of fiscal year 2022. Our fiscal year 2020 results show that NCI increased the number of competing R01s we issued within the payline by more than 100 awards, a jump of more than 15 percent from the prior year. The funding increase also allowed us to pay other meritorious R01 applications that scored just outside the payline. Overall, our success rate for fiscal year 2020 rose to 12.7 percent, from 11.6 percent in the prior year.

The targeted increases that Congress has provided allows NCI to increase paylines, achieve a corresponding increase in the overall NCI application success rate, and issue more grant awards. This funding has been critical to awarding new grants, while also allowing NCI to support ongoing research and the breadth of core NCI research investments, such as NCI's designated cancer centers, Specialized Programs of Research Excellence (SPOREs), and large national networks of clinical trials. All of these awards and programs will continue to fuel broad, sustained progress that serves the needs of individuals with cancer and those at risk of cancer, leading to a deeper understanding of the biology of cancer and new strategies to prevent, screen, diagnose, and treat cancer, in all its forms.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. The NCI is doing tremendous work in implementing the new Childhood Cancer Data Initiative, which holds the promise of vastly improving the treatment of childhood cancer and the quality of life for survivors. The Childhood Cancer STAR Act calls for a major investment in biorepository and bio-specimen collection.

Can you tell us how these two vital initiatives are working together? NIH Response:

Answer. The National Cancer Institute (NCI) agrees that it is vital for biospecimen collection and storage efforts supported through the STAR Act and data generation, analysis, and sharing supported through Childhood Cancer Data Initiative (CCDI) to continue to contribute to and enhance each initiative's progress in a complementary manner. To that end, NCI is utilizing STAR Act appropriations to support the Children's Oncology Group (COG) Rare Tumor Populations Biobanking project, which enables tumor tissue and germline (e.g., blood) collection for specific groups of patients for which current tumor tissue collection is lacking or inadequate, with priority for tumor types such as sarcomas and brain and central nervous system tumors, which often have the highest risk of treatment failure.

The COG Rare Tumor Populations Biobank was launched in fiscal year 2020 and is expanding in scope in fiscal year 2021. This initiative is collaborating closely with CCDI, and with the use of fiscal year 2021 CCDI funds, tumor tissue will undergo clinically-relevant molecular profiling through the CCDI Molecular Characterization Protocol. The COG Rare Tumor Populations Biobank provides a critical foundation for these characterization efforts within CCDI. The data generated will be returned to treating physicians to help guide the diagnosis and treatment of patients, and the data will be stored and made available to the research community through CCDI data platforms. In addition to rare cancer populations, the CCDI Molecular Characterization Protocol will initially support characterization of tumors from children with Central Nervous System (CNS) tumors and from children with soft tissue sarcomas. The Protocol aims to collect, store, and make available detailed clinical and molecular information for each child participating in the study, including data that will help a pediatric oncologist treat that patient and help researchers learn more about childhood cancers.

NCI is also supporting a STAR Act biobanking project through the COG to continue to expand the collection of specimens taken at the time of relapse, as well as collecting diagnostic samples for children and adolescents and young adults (AYAs) who have already submitted samples at relapse through NCI's Pediatric Molecular Analysis for Therapy and Choice (MATCH) Precision Medicine Trial. An important impediment to understanding mechanisms of treatment failure for childhood solid tumors is the limited numbers of paired specimens from both diagnosis and relapse that are available for researchers to study. Specimens at relapse are critical for evaluating biological changes between diagnosis and relapse that can lead to the identification of mechanisms of treatment failure and to the development of strategies for circumventing these mechanisms. Through CCDI, Pediatric MATCH tumor specimens from diagnosis and from relapse are being molecularly characterized to identify the changes in gene mutations and gene expression that occur between diagnosis and relapse, which could inform better treatments.

These are specific examples of early and ongoing collaboration between STAR Act and CCDI- supported projects, and more broadly, there will be additional opportuni-

ties for data generated through STAR Act specimen collection and survivorship research efforts to contribute to the CCDI data ecosystem. For example, other STAR Act biobanking projects have supported additional biospecimen collection within the NCI-supported Childhood Cancer Survivor Study (CCSS), focused on subsequent cancers and chronic health conditions. CCDI funds were used to molecularly characterize specimens from patients who developed second cancers to enhance understanding of the genetic factors that lead to increased risk of second malignant tumors. Additionally, CCDI funds have supported submission and management of CCSS data to NCI and other NIH repositories so that they can be linked within the CCDI data ecosystem and more easily shared with the broader research community.

As NCI's CCDI continues to link data resources across the childhood cancer research field, we envision these linkages and the data ecosystem they create serving as a resource for continued research, and as a growing repository for all types of data generated through NCI and other funded childhood and AYA cancer research. Similar to the CCSS, individual research projects, including preclinical studies and clinical trials, will have the opportunity to contribute data to CCDI, linking this additional data to CCDI resources such as the Molecular Characterization Protocol and the National Childhood Cancer Registry, two foundational CCDI initiatives.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. I, along with many members of the committee remain concerned with the lack of targeted therapies for rare cancer patients. It is my understanding that rare cancers account for 380 of 400 distinct forms of cancer and almost 1/3 of all diagnoses and include all pediatric cancers. A recent analysis showed that 80 percent of all patients who lacked an FDA-targeted therapy were rare cancer patients. In addition, of the 3,994 clinical trials in phases 1, 2, and 3 from January 1, 2012 to January 1, 2017, almost 75 percent did not include a rare cancer by name. While rare cancer affects every population, translational research and commercial drug development has traditionally neglected small patient populations. Each subtype of cancer requires a targeted therapy in order to save a life or to significantly improve lifespan.

What is NIH's plan to ensure there are adequate investments for treatments for rare cancer patients and what can Congress and this committee do to help?

Answer. The National Institutes of Health (NIH) remains committed to supporting research to advance the understanding of all cancers, including rare cancers, and to inform the development of targeted cancer therapies for rare cancers and rare subtypes of cancers, including pediatric cancers (all types and subtypes of pediatric cancers are considered "rare" by definition).

The cancer research community—thanks to NIH-supported developments in understanding the specific genes, proteins, and other unique molecular characteristics driving certain cancer subtypes—continues to recognize that cancer is made up of a collection of hundreds, if not thousands, of subtypes defined by these characteristics. As a result of National Cancer Institute (NCI)-supported efforts and other relevant research, "cancer" is increasingly becoming a collection of rare cancer subtypes.

This evolved understanding of cancer is reflected in NCI's current clinical trials portfolio and investments in translational and basic research, including several initiatives in the intramural Center for Cancer Research (CCR).

Increasingly, clinical trials are examining targeted therapies based on molecular subtypes. For example, NCI's National Clinical Trials Network (NCTN) is currently supporting trials assessing therapies to treat gliomas with certain genetic alterations [71] and pancreatic cancers with specific gene alterations.[72,73] NCI also supports trials that are dedicated to patients with rare tumors, including the NCTN-supported Dual Anti-CTLA–4 and Anti-PD1–Blockade in Rare Tumors (DART) Trial [74] and the Rapid Analysis and Response Evaluation of Combination Anti-Neoplastic Agents in Rare Tumors (RARE CANCER) Trial,[75] which is supported by NCI's Experimental Therapeutics Clinical Trials Network.

To ensure that researchers have a strong pipeline of therapy candidates to consider for use in clinical trials, NCI supports several initiatives to support the preclinical stage of development of therapeutics to treat rare cancers, including the NCI

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[71] www.clinicaltrials.gov/ct2/show/NCT00887146.
[72] www.clinicaltrials.gov/ct2/show/NCT04858334.
[73] www.clinicaltrials.gov/ct2/show/NCT04548752.
[74] www.clinicaltrials.gov/ct2/show/NCT02834013.
[75] www.clinicaltrials.gov/ct2/show/NCT04449549.

Experimental Therapeutics (NeXT) Program and the Pediatric Preclinical Testing Consortium (PPTC). The mission of NeXT is to advance clinical practice and bring improved therapies to patients with cancer by supporting the most promising new drug discovery and development projects. The PPTC addresses key challenges associated with the development of new therapies for children with cancer by developing reliable preclinical testing data for pediatric drug candidates that can be used to inform new agent prioritization decisions.

The first step in identifying new therapeutic targets, however, is elucidating the basic biological mechanisms that give rise to cancers. To further these research efforts, NCI supports the development of resources for broad use across the cancer research community. These resources include cell lines, organoid models, patient derived xenograft (PDX) models, biospecimens, and other biological samples. NCI makes drug information summaries available on its website, along with extensive cancer treatment summaries. Additional resources include the Developmental Therapeutics Program, the National Clinical Trials Network (NCTN) Navigator, Patient-Derived Xenograft (PDX) Centers, PDX Finder, the NCI Mouse Repository, and the Physician Data Query (PDQ) Database.[76]

The Rare Tumor Patient Engagement Network, launched in fiscal year 2018 and part of NCI's CCR, leverages the resources of the NCI intramural research program and the NIH Clinical Center to bring together investigators, patients, and advocacy groups to study rare tumors. Under the umbrella of this effort, NCI launched the My Pediatric, Adolescent, and Adult Rare Tumor (MyPART) Network, a collaboration of scientists, patients, family members, advocates, and healthcare providers to find treatments for rare cancers. The MyPART Network collects samples like blood, saliva, and archived biopsy tissue from people with rare solid tumors as part of the Natural History Study of Rare Solid Tumors. The purpose of the study is to engage rare tumor patients and their families in the research process, study how rare tumors grow, track participants' health history over a long period of time, share data with other scientists, build new ways of testing new treatments, and design new clinical trials for rare cancers. MyPART scientists also hold clinics on rare tumors to facilitate collaborations between researchers, patients, and advocacy organizations; to date, MyPART has hosted clinics on chordomas, SDH-deficient gastrointestinal stromal tumors, and medullary thyroid cancer, and more clinics are in the planning stages. Additionally, the NCI Comprehensive Oncology Network Evaluating Rare CNS Tumors (NCI–CONNECT) program aims to advance the understanding of rare adult central nervous system (CNS) cancers by establishing and fostering patient-advocacy-provider partnerships and networks to improve approaches to care and treatment; seven clinical studies and trials are currently open through NCI–CONNECT.[77]

Because of these and similar investments, the U.S. Food and Drug Administration (FDA) has approved a number of therapies in recent years for patients with rare cancer subtypes and related conditions. For example, in May 2021, the FDA granted accelerated approval to sotorasib (Lumakras) for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with alterations in the KRAS G12–C gene, a mutation which is present in only 13.8 percentsa of NSCLC patients. Similarly, the FDA approved selumetinib (Koselugo) in 2020 for the rare tumor condition neurofibromatosis type 1, in patients over the age of two, as the first approved treatment for this condition. In 2018, the FDA granted accelerated approval to larotrectinib (Vitrakvi) for adult and pediatric patients with solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion. NTRK gene fusions are prevalent in nearly all cases of certain rare cancer subtypes, including secretory carcinoma of the breast or salivary gland and infantile fibrosarcoma; they have also been observed in some patients with more common types of cancer, such as glioma, melanoma, and carcinomas of the thyroid, lung, and colon.[78]

NIH will continue to support research efforts that reflect the scientific understanding of the many subtypes of cancers, including work that will enable the development of therapies for rare tumor subtypes.

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[76] A more extensive list is available at www.cancer.gov/research/resources/.
[77] www.cancer.gov/rare-brain-spine-tumor/refer-participate/clinical-studies.
[78] www.ncbi.nlm.nih.gov/pmc/articles/PMC6859817/.

QUESTIONS SUBMITTED TO DR. GARY GIBBONS

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Gibbons, we have all heard about the plight of COVID–19 "long-haulers" who have symptoms after their acute COVID–19 infection has subsided. A growing number of studies suggest that many patients experience some type of heart damage after contracting the infection, even in those not sick enough to be hospitalized. According to the American Heart Association, nearly one-fourth of those hospitalized with COVID–19 have been diagnosed with cardiovascular complications. A study in the Journal of the American Medical Association stated that researchers found abnormalities in the hearts of 79 percent of recovered patients and "ongoing myocardial inflammation" in 60 percent.

Who is most at-risk of this type of heart damage, and is there indication that this damage is permanent?

With heart damage appearing to be widespread, will screenings to detect cardiovascular damage be included as routine follow-up care for COVID–19 patients?

Do you have any sense of how long longitudinal studies should last to follow long-haulers?

Answer. While severe acute respiratory syndrome coronavirus 2 (SARS–CoV–2) enters the body through the respiratory tract, the virus also infects many other cell types and can damage multiple organs and tissues, including the heart and blood vessels. In rare cases, acute infection has been associated with cardiovascular complications including acute myocardial injury, myocarditis (heart inflammation), and arrhythmias (irregular heartbeat). This is not surprising given that viruses frequently trigger inflammation, and as the body's immune system fights off the virus, the inflammatory process can damage healthy tissues, including the heart. Many different viruses are known to cause myocardial injury and myocarditis.

Many patients with coronavirus disease 2019 (COVID–19) experience damage to their blood vessels, leading to the formation of blood clots (thrombosis) that can develop in or travel to vital organs, including the heart. Blood clots in the coronary arteries can starve the heart of oxygen and damage the heart muscle. NIH's ACTIV–4 Antithrombotics adaptive master protocols have made progress in evaluating the safety and effectiveness of various types of blood thinners (e.g., aspirin, heparin, apixaban) for treating adults with signs of blood vessel damage and thrombosis from COVID–19, known as COVID–19-associated coagulopathy.[79] Clinical trials are ongoing across three patient populations (inpatient, outpatient, and convalescent or patients recovering from COVID–19). These trials are providing valuable information about how to help prevent moderately ill patients with COVID–19 from progressing to intensive care, and could perhaps help mitigate future cardiac complications. For example, ACTIV–4 has shown that full-dose heparin is safe and effective at preventing blood clots in moderately ill hospitalized patients and reduced the need for life support.

Studies have shown that patients with COVID–19 may show signs of cardiac injury, detected by a release of the cardiac muscle protein troponin into the bloodstream.[80] Such injury is associated with worse short-term outcomes and higher mortality. An analysis of more than 40 studies involving more than 8,000 COVID–19 patients found that venous thromboembolism (VTE; blood clots originating in a vein) occurred in approximately 21 percent of patients.[81] Among COVID–19 patients admitted to intensive care, the VTE rate was as high as 31 percent. A review of myocarditis associated with acute COVID–19 estimated that the incidence is less than five percent; although less than previously thought, this could still mean a large number of patients with acute myocarditis given that COVID–19 cases in the United States have surpassed 33 million.

The incidence of continuing or new cardiac problems after COVID–19 or asymptomatic SARS–CoV–2 infection remains unknown. Although most people with COVID–19 get better within weeks of illness, some people experience post-acute sequelae, including chest pains, shortness of breath, exhaustion, heart palpitations, and chest pain. In addition, patients diagnosed with cardiac injury, thrombosis, or myocarditis during acute COVID–19 could sustain damage to the heart that persists long after the acute illness has passed. There is still much to be learned about the long-term cardiovascular consequences of SARS–CoV–2 infection.

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[79] www.nih.gov/research-training/medical-research-initiatives/activ/covid-19-therapeutics-prioritized-testing-clinical-trials#activ4.

[80] www.heartrhythmjournal.com/article/S1547-5271(20)30625-1/fulltext#tbl1.

[81] pubmed.ncbi.nlm.nih.gov/33251499/.

NIH's Researching COVID to Enhance Recovery (RECOVER) initiative seeks to understand, and ultimately to prevent and treat, long COVID and other post-acute sequelae of SARS–CoV–2 (PASC) across the lifespan.[82] At the center of the Initiative is an observational study that will include adults and children recruited from ongoing studies of COVID–19, long COVID clinics, and other cohorts. RECOVER is designed to significantly expand both our knowledge about the full clinical spectrum, long term outcomes, and underlying biology of PASC; as well as our ability to provide safe and effective therapeutic interventions.

Current diagnostic protocols generally include physical, cognitive, and psychological assessments. The evaluation of patients hospitalized with COVID–19 includes elements of a cardiovascular evaluation, including assessment of known cardiovascular disease and risk factors for cardiovascular disease, assessment of symptoms that may be caused by respiratory or cardiac disease, laboratory testing (including a complete blood count and complete metabolic panel), chest radiograph, electrocardiogram (ECG), and troponin testing (which is followed if elevated). A more targeted cardiac evaluation may be needed depending on the patient's symptoms. Patients who develop new onset heart failure, for example, may need an echocardiogram (echo) to determine the best course of action. One of the goals of the RECOVER meta-cohort study is to develop core defining characteristics and diagnostic criteria for long COVID and other forms of post-acute sequelae of SARS–CoV–2 infection (PASC), including understanding the impact the virus has on the cardiovascular system.

NIH plans to, and has support to follow the RECOVER meta-cohort for at least 3 years. In addition to addressing the public health impact of SARS–CoV–2 infection, RECOVER also has the potential to enhance our understanding of other chronic syndromes theorized to have a viral origin, at least in some individuals, such as chronic fatigue syndrome and postural orthostatic tachycardia syndrome (POTS).

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. Pulmonary fibrosis (PF) means scarring in the lungs. Over time, the scar tissue can destroy the normal lung and make it hard for oxygen to pass through the walls of the air sacs into the bloodstream. PF is not just one disease—it is a group of more than 200 different lung diseases that all look very much alike.

The most recent studies show that more than 200,000 Americans are living with PF today. Approximately 50,000 new cases are diagnosed each year and as many as 40,000 Americans die each year. With no known cure, certain forms of PF, such as idiopathic pulmonary fibrosis, (IPF), may take the lives of patients within three to 5 years from diagnosis.

PRECISIONS is the first-ever clinical trial to apply the principles of precision medicine to the diagnosis and treatment of idiopathic pulmonary fibrosis. PRECISIONS is supported by a $22 million grant from the National Institutes of Health (NHLBI grant number HL145266) and Three Lakes Foundation, a philanthropic organization.

PRECISIONS is designed as a double-blind, multi-center, randomized, placebo-controlled trial investigating the safety and efficacy of NAC in patients with IPF who have a specific genetic variant which is present in 25 percent of IPF patients. The trial will enroll 200 patients from approximately 20 PFF Care Center Network (CCN) sites. Initial recruitment into the study is being facilitated by looking at phenotypic data from patients that are enrolled in the PFF Registry.

Can you provide an update on the NHLBI-funded PRECISIONS grant, which seeks to shed more light on the role of genetics in pulmonary fibrosis?

How has the COVID pandemic affected this study?

Answer. The National Heart, Lung, and Blood Institute (NHLBI) is committed to supporting research on pulmonary fibrosis, which leads to progressive scarring of the lungs that makes it increasingly more difficult to breathe. PRECISIONS[83] is a five-year study that aims to enroll 200 patients with idiopathic pulmonary fibrosis (IPF) and use genetic testing to identify those patients most likely to respond to an experimental treatment, an antioxidant known as N-acetylcysteine or NAC. This first-of-its-kind precision medicine trial builds on an earlier study suggesting that a gene called TOLLIP influences how patients respond to NAC, such that it might be helpful only for a subgroup of patients who have a particular version of the gene.

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[82] recovercovid.org/.

[83] reporter.nih.gov/project-details/9822535.

The trial will enroll only that subgroup, in order to increase the likelihood of detecting a benefit.

PRECISIONS is co-funded by the Three Lakes Foundation, a non-profit philanthropy that supports education and research efforts to improve the time to diagnosis and accelerate new therapies for IPF. The study also involves a partnership with the Pulmonary Fibrosis Foundation, whose patient registry is being leveraged to perform molecular analyses on biospecimens obtained from patients with IPF. These analyses are intended to uncover novel genetic risk factors that will improve IPF diagnosis, predict its clinical course, and understand its underlying disease mechanisms—all of which could yield further insight into potential targeted therapies.

The study was delayed in the latter half of fiscal year 2020 due to COVID–19-related institutional research restrictions, which led to NHLBI approval of a six-month interim no-cost extension. By December 2020, the investigators had successfully completed all pre-specified project milestones for the first phase of their biphasic research plan, including enrollment of the first study participant. NHLBI approved the transition to the second phase of the project in March 2021. To date, six study sites have been activated, the percentage of eligible participants who meet the study's genotype inclusion criteria has been exactly as expected, and recruitment has proceeded on target.

During COVID–19-related delays and uncertainty regarding the feasibility of in-person lung function assessments (spirometry), PRECISIONS initiated an ancillary study to understand the utility of home spirometry to monitor patients with IPF. The study also intends to add a COVID–19—specific questionnaire to baseline and follow-up visits in the clinical trial as a means of leveraging this existing patient cohort to capture additional data on the epidemiological and clinical characteristics of COVID–19.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. Concerned about other countries' ability to obtain vaccines quickly for their populations, the Administration recently announced that it will support a waiver of the World Trade Organization TRIPS Agreement, which would waive intellectual property protections for COVID–19 vaccines. It is my understanding, however, that there are no guarantees that the companies or countries who seek to use vaccine manufacturer's intellectual property to make copies will be able to deliver safe and effective vaccines, or that their manufacturing processes will meet the strict regulatory standards necessary for authorization. Furthermore, there are already reports of counterfeit vaccines being used to exploit vulnerable populations in the U.S. and around the world.

Are you concerned that giving away intellectual property via a TRIPS waiver could make worse the problem of counterfeit and low-quality vaccines in the market? What effect could this have on endangering lives and undermining public confidence in the vaccines that have been proven safe and effective?

Answer. The National Institutes of Health (NIH) is concerned about counterfeit and low-quality vaccines; however, NIH does not have the expertise or authority to investigate these matters. The degree to which any TRIPS waiver addresses these issues of concern will not be known unless and until the terms are agreed upon.

Question. The Administration recently endorsed the idea of waiving intellectual property (IP) protections for COVID–19 vaccines, in the hopes that it will speed up manufacturing of the vaccines around world. However, it is my understanding that some vaccine developers are already experiencing constraints in everything from raw materials to fill-finish capacity critical to producing and administering vaccines.

Are you concerned that diverting critical supplies from manufacturers with proven track records for delivering high-quality, safe and effective vaccines could actually worsen the supply chain constraints we're currently seeing, and not just for COVID vaccines, but also non-COVID–19 medicines such as oncology and other infectious diseases?

Answer. The National Institutes of Health (NIH) fully supports efforts to ensure reliable supply chains for vaccines and other medicines; however, NIH is not directly involved in these efforts.

QUESTIONS SUBMITTED TO DR. PÉREZ-STABLE

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Pérez-Stable, we typically talk about getting researchers into the NIH field and staying there as a pipeline. However, when we look at the pipeline

for minority researchers, it can easily be called a funnel. We have a lot of work to do in increasing the diversity of NIH researchers. And as the COVID–19 pandemic has highlighted, NIH must also focus on health disparities research. The problems to these two solutions may go hand-in-hand. I know that Dr. Collins has started the UNITE program to look at racial inequities within the NIH community and has started a Common Fund program to fund transformative research into health disparities. While I commend these steps, many of the fundamental issues these programs are trying to address are reasons we started the Institute you fund—the National Institute for Minority Health and Health Disparities.

Can you provide your perspective on how we get more minority scientists into the NIH community?

And, specifically, what role should NIH take in making sure minorities have the educational background necessary to go into STEM fields—which often starts at the high school level, if not earlier?

Answer. The National Institutes of Health (NIH) is committed to diversifying the research workforce and will continue to identify opportunities to increase its focus on building and supporting a diverse scientific workforce. The NIH UNITE initiative was developed to address inequity in biomedical research and will help NIH to identify more strategies and opportunities to strengthen its efforts to diversify the research workforce and attract and prepare more students from underrepresented backgrounds for STEM careers. The NIH already has several efforts to diversify the STEM pipeline and to train students at all levels of education as described below.

NIH supports several initiatives to attract and recruit more minority scientists into the NIH intramural community. For example, the NIH Equity Committee systematically tracks and evaluates diversity, inclusion, and equity metrics in the intramural research program. In addition, the Distinguished Scholars Program (DSP) enhances the diversity of principal investigators in the NIH Intramural Research Program (IRP) by supporting first year tenure-track investigators with supplemental funds to start their research lab and engaging in activities designed to foster a sense of belonging and to promote research and career success. Moreover, the IRP provides a diverse environment for NIH-wide scientific recruitments through the Stadtman Tenure-Track Investigators, Lasker Clinical Research Scholars, and Early Independent Scientists recruitment programs. This approach has led to a greater proportion of women and scientists from underrepresented backgrounds recruited to NIH. The 2019 DSP cohort was comprised of approximately 7 percent Hispanics or Latinos, 27 percent African Americans or Blacks, 27 percent Asians, 40 percent White, and 73 percent female. Among the fiscal year 2020 cohort, 21 percent was African American or Black, 21 percent Hispanic or Latino, 21 percent Asian, 36 percent White, and 50 percent female. Of the 15 Distinguished Scholars selected in the 2019 cohort, nine were Stadtman Tenure-Track Investigators, and two were Lasker Clinical Research Scholars. Of the 14 Distinguished Scholars selected in the 2020 cohort, 10 were Stadtman Investigators, and three were Lasker Scholars.

Extramurally, NIH has dedicated efforts to recruit diverse scientists from underrepresented groups to prepare successful NIH grants. NIH provides Diversity Research Supplements to enhance the diversity of the research workforce by recruiting and supporting graduate students, post-doctoral fellows, and eligible investigators from diverse backgrounds, including those from groups that have been shown to be underrepresented in health-related research. These supplements to existing grants provide a pathway to career success for scientists from diverse backgrounds and remains relatively underutilized. There are several other NIH programs that promote diversifying the research workforce and some are highlighted below. First, the NIH/National Institute on Minority Health and Health Disparities Loan Repayment Program (NIMHD LRP), which aims to increase the pool of qualified researchers who conduct health disparities research. Over a 15-year period, recipients of an LRP award from NIMHD are more likely to be awarded a subsequent NIH grant than their counterparts who were not successful. The LRP Health Disparities applications have now been extended to all NIH Institutes as of 2019. Second, the Native American Research Centers for Health promote a cadre of scientists and health research professionals interested in American Indian/Alaska Native health research. Third, NIMHD established the NIMHD Health Disparities Research Institute to support the research career development of promising early-career minority health and health disparities research scientists. Fourth, the NIH's Faculty Institutional Recruitment for Sustainable Transformation (FIRST) program, announced in 2020, will increase the participation of researchers dedicated to inclusive excellence, including minority researchers, in biomedical research at NIH-funded institutions. The aim of the program is to enhance institutional inclusive excellence, with diversity and equity at its core enabling biomedical research institutions to hire a diverse cohort of early-stage research faculty committed to inclusive excellence and diver-

sity. The current pipeline of underrepresented scientists is not empty with about 14 percent of new U.S.-granted Science, Technology, Engineering and Math (STEM) PhDs awarded to underrepresented groups and similarly 14 percent of current medical students are from these groups.Lastly, the Science Education Partnership Award (SEPA) Program funds innovative pre-kindergarten to grade 12 science, technology, engineering, and mathematics (STEM) and Informal Science Education (ISE) educational projects. SEPA projects create partnerships among biomedical and clinical researchers and teachers and schools, museums and science centers, media experts, and other educational organizations. The NIH will continue to identify opportunities to increase its focus on building and supporting a diverse scientific workforce.

SUBCOMMITTEE RECESS

Senator MURRAY. The meeting is adjourned. Thank you.

[Whereupon, at 12:08 p.m., Wednesday, May 26, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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 than 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 longstanding 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

[1] Centers 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've 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.

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-

sissippi, 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 2200 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 refuges.

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 my 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 the 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 stetting the public's expectations around COVD–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 rule [1] 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.Ss 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.

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[2] The 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 significant 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 management[8] 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

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[3] Sharma 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.

[4] Goedel 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.

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

[9] Aarons 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-

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[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.

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[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.

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 Recuse 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–19 [21]
—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 shutdowns [22]
—Temporary extensions of eligibility for select NIH programs, including the NIH K99/R00 Pathway to Independence Award [23]
—Flexibilities for NIH-funded clinical trials and human subjects for the duration of the declared public health emergency [24]
—Flexibilities for assured institutions for activities of institutional animal care and use committees [25]

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

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[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] 25 NOT-OD-20-088.

[26] 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.

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[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 $1billion 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 onshore 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 overwhelming 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–19–128[29] and updated in NOT–OD–19–137[30] 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.]

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

WEDNESDAY, JUNE 16, 2021

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

The subcommittee met at 10 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.

Present: Senators Murray, Durbin, Reed, Shaheen, Manchin, Blunt, Moran, Hyde-Smith, and Braun.

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

STATEMENT OF HON. MIGUEL CARDONA, 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 please come to order.

Today we are having a hearing on the Biden administration's fiscal year 2022 budget request for the Department of Education. Senator Blunt and I will each have an opening statement. And then I will introduce our witness, Secretary Cardona. After his testimony, Senators will each have 5 minutes for a round of questions. And while we are unable to have the hearing fully open yet 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 Cardona, after years of proposed budget cuts and school privatization from your predecessor, this budget would increase education funding by 40 percent to $103 billion, and it is a much-needed breath of fresh air. It proposes bold investments to help our schools and students as they respond to and recover from this pandemic, and addresses long-standing inequities in education, which COVID–19 has made even more damaging.

LOST LEARNING TIME AND DISPARITIES

One of the biggest issues facing our Nation is getting our students back on track and addressing the lost learning time that they have experienced. We know students of color, students with disabilities, students in rural and Tribal communities, and students from families with low incomes have borne the brunt of this pandemic.

One study, for example, found the pandemic set students of color back 3 to 5 months from where they would be in a typical year, and set white students back 1 to 3 months. We need to make sure every student, no matter who they are, or where they live, or how much money they or their family make, can receive the supports they need to thrive despite this pandemic.

So I am glad this budget takes the task of reckoning with these inequities seriously, with investments across a range of programs to help ensure all students can get a quality public education. It invests $20 billion in a new initiative intended to reduce disparities in public, elementary, and secondary education in our country, and proposes to use this funding to help public schools address a variety of issues, including inequities in State and local education funding, expanding high quality preschool programs, and improving outcomes for all of our students.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Of course, improving outcomes for students means we must also do more to support students with disabilities. This budget takes an historic step on that front by proposing a $3 billion increase for the Individuals with Disabilities Education Act. Over the years, Congress has fallen short of its promise to use 40 percent of the funding to support the education of students with disabilities through IDEA (Individuals with Disabilities Education Act).

Currently only 13 percent is provided and struggling States and districts have been left to fill in the gaps. President Biden's proposal will help us better keep this promise and help schools across the country, address the shortage of teachers for students with disabilities, and provide early intervention services so students can get the support they need to succeed as soon as possible.

And when it comes to supporting students' academic, social, emotional, and mental health needs, this budget proposes a $413 million increase for full-service community schools, an increase of $120 million for English Language Acquisition Grants, and a new $1 billion initiative to ensure students have access to school counselors, nurses, and mental health professionals.

This is especially critical, given the mental health challenges students, educators, and school staff have faced during the pandemic. These challenges will persist well into the next school year. We need to make investments to support student and staff wellbeing, and we need to bring in more counselors, nurses, and psychologists. In Washington State we only have one school psychologist for every 1,000 students. This budget will help us tackle inequities in higher education as well, and significantly expand support for students pursuing a postsecondary education, including by increasing the maximum Pell Grant by almost a third.

HIGHER EDUCATION

This is so important. Federal support like Pell Grants allowed my six brothers, and sisters, and I, to all go to college. But Pell has gone from covering 75 percent of the average cost of a 4-year degree at its peak to less than 30 percent today. We have to strengthen and expand Pell. And this budget is a clear step in the right direction. Ultimately, we need to do even more to double the maximum Pell award over the next 6 years, protect Pell from being cut by budget shortfalls, and expand Pell Grants to more students.

Today, I join colleagues in the House and Senate to introduce legislation to accomplish all of that. And I hope to work with you, Secretary Cardona, and my colleagues here in Congress to get this done. And increased Pell Grants are just one of several investments, this budget proposes to make higher education more accessible and affordable for all students, provides funding to help implement the Bipartisan FAFSA (Free Application for Federal Student Aid) Simplification Bill I worked to pass last December.

This will make it easier for all students to apply for financial aid, including Pell Grants, expand the number of students eligible for support, and increase financial aid to students with low incomes. It increases funding for TRIO programs, which help first-generation college students, students with disabilities, and students from families with low incomes to get to and go through college successfully.

It nearly doubles funding for quality campus-based childcare to support student and parents under the CCAMPIS (Child Care Access Means Parents in School) Program. And it provides increased funding for historically under-resourced colleges and universities, including $345 million, which is a 44 percent increase, in funding for minority serving institutions, like Historically Black Colleges, and Universities, and other institutions predominantly serving low-income students, like community colleges. And finally, this budget increases funding for the Department's Office for Civil Rights.

TITLE IX

Between this budget and the public hearings, the Department started last week on the previous administration's inadequate Title IX Rule, it is clear we have a President who is focused on protecting students, no matter their race, ethnicity, religion, sex, including sexual orientation, and gender identity, or disability.

I will be watching your work in this space closely, and encourage the Department to continue its efforts, to hear, acknowledge and address the stories and concerns of survivors of sexual assault.

EDUCATION FOR HOMELESS CHILDREN AND YOUTHS

I will say, one area where I would like to see an increased investment, is funding to support education for children and youth who are experiencing homelessness. But overall, this budget is night-and-day different from the previous administration. I always say a budget is a reflection of your values. And this budget shows President Biden understands the money we spend on schools, students, and public education is an investment in our future. What our Nation accomplishes in the years ahead will be determined by the op-

portunities and support we are able to give children across the country, now.

I look forward to working with the administration and with my colleagues on this committee to make the investments in education we need to make so we have a brighter future for our families.

With that, I will turn it over to Senator Blunt for his remarks.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Well, thank you, Senator Murray. And welcome to the hearing, Secretary Cardona. I know this is your first time to appear before this committee, and I am sure by the end of the hearing, you will be looking forward to next year when you get to come back, and the other discussions we will have between now and then. I am just glad we had a chance to talk, not only during the confirmation process, but again yesterday, and look for more opportunities to do that.

Certainly, the last year has been one of the most challenging years for students, for parents, for school administrators, for teachers, for everybody in the education field, including cafeteria workers, and bus drivers who, in a virtual setting, wound up without a job while everybody else's jobs became maybe even longer in a day to get ready for the new challenges of virtual education, where that occurred, and to try to get back to school, as quickly as they could.

You know, you and I are both first-generation college graduates, and we have both been classroom teachers, and so I think because of that, hopefully, we have an understanding of just how important education is, and what a difference, just a slight change it points along the way of your trajectory of where you think your life can take you, can make for the people we taught, just like we both saw happen with us.

We also understand the critical role education plays in our society. Our ability to compete around the world, the values that we transmit from one generation to another, all very important. I am a proud supporter of many of the programs we are going to be talking about today, career and technical education, state grants, IDEA, Title I, the TRIO Programs, school-based mental health, that you and I talked about yesterday.

Now I am concerned about the spending level. I just heard the Chair mentioned the importance of this huge increase of about 41 percent in spending. I think that increase on top of the $280 billion in COVID–19 supplemental funding for education, last year, is a lot of input into the system in a very short period of time. In fact, last year's spending was about four times as much as the Department normally receives in annual appropriations each year. This year the request is $102.8 billion, which is almost $30 billion, or 41 percent greater than last year's spending.

It is a lot of money to try to put into the system all at once. I look forward to hearing your plans and, hopefully, some of your concerns about how that much new funding going into the system would go in, in the best possible way. As a former university president, I am particularly concerned about the proposal to make community college tuition free for all students. As, you know, my view

is if you want to make a college education really expensive, make it free, but we will talk about that.

We will talk about what we are doing now to make it possible for people to go to college and what you are proposing in terms of making those first 2 years free at community colleges. I would point out that in the average community college in America, if you qualify for the full Pell Grant, you have more money in that grant than books, fees, and tuition. I think the average Pell Grant recipient was $3,946, the average tuition and fees at community colleges was $3,700. I think there may be other ways to make it possible for more people to go to community college, and all other schools without cost. But we are going to talk about that today, and as we move forward with this budget.

Many States across the country already have programs that make up the difference, and at a community college in Missouri the A+ scholarship pays the community college tuition for eligible students for up to 2 years. I do think those colleges play an incredibly important role in the country. Both as an access point for education, but also as a way to get people ready for jobs that are available, or could be available, in a specific community.

I am concerned that free community college for everybody unfairly subsidizes higher-income students. And if it is community college only, it creates an incentive for students to attend schools that may not be the best fit for them. Through the Pell Grant limited taxpayer dollars have targeted students in the most need. It maintains the ability of students to Pell Grant, and most of our other programs, to pick institutions that best meet their individual needs.

Since this committee worked to reinstate year-round Pell Grants, with Senator Murray and I working hard to lead on that effort, students have the flexibility to accelerate their post-secondary studies and complete their programs more quickly.

I am pleased to see that the budget does not include widespread loan forgiveness. However, the Department has not outlined a plan at the same time for borrowers to get back into the repayment process. Federal student loan borrowers have gone for over a year without being required to make a payment on their loans. And I think it is important that the Department begins communicating to those borrowers early and often to ensure that all borrowers understand their responsibilities, and their repayment options when a payment or a loan comes due October 1 of this year. I don't see any discussion about that in the comments you are making today, and something I would like to see more thought given to.

I am also concerned that the Department has not announced how long the student loan servicing will be handled moving forward, once the legacy servicing contracts end later this year. We have spent a lot of time in this committee looking at past proposals on changing that system. As you and I discussed yesterday, I look forward to hearing your thoughts as to how that system moved forward.

We both support increased educational opportunities in every State, such as Title I and IDEA. It is my goal to find ways we can work together. This budget proposes a 10 percent increase, or $120 million in discretionary funding for career and technical education,

teamed with $1 billion in mandatory funding for a New Career Pathways Program. I do think it is critically important we provide students with meaningful information about the jobs that are out there with the work-based learning opportunities and exposure to different career paths early in high school.

We have been talking about that for some time. There is a lost decade for so many people from the time they graduate until the time they really settle in, to the career that provides the most promise and the most satisfaction for them.

So I look forward to working together on this. I know we are going to have a number of questions and concerns about this budget, but it is a critically important part of how people move forward in our country, giving them those opportunities and the information they need. And I look forward to working with you to find the appropriate balance between fiscal responsibility and meaningful investment that supports access to quality education for all students.

Thank you, Chair.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Good morning. Thank you, Chair Murray. And thank you, Secretary Cardona, for appearing before the Subcommittee today to discuss the Department of Education's FY2022 budget request.

This has been a long and challenging year for all Americans, but it has been particularly difficult for students, parents, teachers, school administrators, and all those in the education field. You and I are both first generation college graduates and classroom teachers, we know how much education can change the trajectory of a person's life, because we saw it in our own lives and in the lives of the people we taught. We also understand the critical role education plays in our society and its impact on our nation's ability to compete in a global economy.

Because of that, I am proud to support key programs that the Department of Education administers such as career and technical education state grants, IDEA, and Title I, Part A. However, I am concerned with the unprecedented level of spending proposed in this budget request, particularly at a time when Congress has already provided almost $280 billion in COVID–19 supplemental funding for education in the last year. For reference, that is about four times as much as the Department receives in annual appropriations each year.

The FY2022 budget request for the Department of Education is $102.8 billion, which is $29.8 billion, or 41 percent, more than FY2021. Future generations can't afford this budget. It also invests the majority of new funding in new programs—and the budget provides few details on how these programs will work and who will benefit.

As a former university president, I am particularly concerned about the proposal to make community college tuition "free" for all students. As the saying goes, if you think college is expensive now, wait until you see what it costs when it's free.

First, for most low-income students who receive a Pell Grant, community college tuition is already free. Last school year, the average Pell Grant recipient at a community college received $3,946, while the average tuition and fees at these schools were only $3,700.

Second, many states across the country already have programs to make up the difference between a student's Pell Grant and the cost of community college if there is one. In Missouri, the A+ Scholarship pays the community college tuition for an eligible student for up to two years.

Finally, while community colleges play a crucial role in our diverse higher education system in America, they may not be the best choice for every student.

Rather than subsidizing higher income students and incentivizing students to attend schools that may not be the best fit for them, we should instead focus our investments in programs that make a student's choice in college affordable. And the best way to do so is through the Pell Grant program and other programs like the GI bill, work study and SEOG.

Through the Pell Grant program, limited taxpayer dollars are targeted toward students most in need. It maintains the ability of students to pick the institutions that best meets their individual needs. And since this Subcommittee reinstated year-round Pell Grants in FY2017, students have the flexibility to accelerate their postsecondary studies and complete their programs more quickly. This Subcommittee has boosted the maximum Pell Grant award for the past four years, and I hope we can do so again this year.

While I am pleased to see that the budget request does not include widespread loan forgiveness, I am concerned that the Administration has not outlined a plan to transition borrowers back into repayment when the student loan pause ends this fall. Federal student loan borrowers have gone over a year without making a payment on their loans.

It is absolutely imperative that the Department begins communicating with borrowers early and often to ensure that all borrowers understand their responsibilities and their repayment options when a payment or loan come due on October 1, 2021.

As borrowers begin to repay their loans after such a long pause, student loan servicing will be more important than ever. However, I am concerned that the Department has not announced how student loan servicing will be handled moving forward once legacy servicing contracts end later this year and early next year. This Subcommittee has worked closely with the Department over the past several years as it continues to reform and modernize the Federal student loan servicing system, and I hope that will continue.

Mr. Secretary, while there are issues on which we disagree, we have many shared priorities that are reflected in the budget request. I know we both share a strong desire to fund programs that are proven and benefit all students, and I know we both support increased educational opportunities in every state, such as Title I and IDEA. It is my goal for us to work together on many of these and other important issues.

In particular, the budget proposes a 10 percent increase, or $128 million, in discretionary funding for career and technical education, teamed with $1 billion in mandatory funding for a new career pathways program. While this Subcommittee will only consider the discretionary request, I am interested in your ideas for how this and other efforts could improve educational opportunities for students beginning in high school, or earlier, to pursue the full-range of post-secondary college and career opportunities.

Providing students meaningful work-based learning opportunities and exposure to different career paths early in high school, or even middle school, can help them identify interests that lead to well-paying jobs and careers. Too often individuals only find opportunities through apprenticeships or high-quality credential programs later in life, in their late twenties or thirties.

I call this the Lost Decade and have provided the Department $10 million each of the past two years to work toward addressing these issues. I think giving more students access to these opportunities earlier on is an area of interest for us both, and I hope it is something we can work on together.

Mr. Secretary, I look forward to working with you this year to find the appropriate balance between fiscal responsibility and meaningful investments that support access to quality education for all students.

Thank you again for being here today.

Senator MURRAY. Thank you, Senator Blunt.

Our witness is today, is Miguel Cardona, Secretary of the Department of Education. Secretary Cardona, thank you for joining us today. And I am so glad you could be here. I look forward to your testimony, and you may begin now.

SUMMARY STATEMENT OF HON. MIGUEL CARDONA

Secretary CARDONA. Thank you. Good morning, Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee.

I recently attended an International Thespian Induction ceremony at a high school where students were being inducted for their commitment to theater after this long year. My daughter was one of those students. I can tell you, it was the first time we came to-

gether as a school community in over a year. So the room was filled with a lot of emotion.

FULFILLING OUR ROLES TO IMPROVE THE EDUCATION SYSTEM

One thing caught my eye, there was a banner hanging that had a quote from the renowned poet, Alexander Pope, and the banner read, "Act well your part, there all the honour lies." In other words, do your part, and that is where you will find the honor.

I come to you today representing the Department of Education, as we boldly do our part to serve the students across the country. That is our responsibility and our privilege. And that is where our collective honor lies.

To that end, I am proud to testify today about President Biden's fiscal year 2022 budget request for the Department of Education, because it makes good on the President's campaign commitment to invest in education. It also begins to address the significant inequities that students, primarily students of color, confront every day in schools, in pursuit of higher education, and career technical education. I want to thank members of the subcommittee and your staff who have helped ensure the passage of the American Rescue Plan, bringing vital resources to our schools and colleges across the country. The American Rescue Plan funds will ensure that school buildings reopen for full-time in-person instruction safely and quickly.

EDUCATION AS AN EQUALIZER

I come to you today with a great sense of urgency about the work we have to do. Generations of inequity have left far too many students without equitable access to high-quality, inclusive learning opportunities, including in our rural communities. Education can be the great equalizer like it was for me and for many of you, but we have to prioritize, replicate, and invest in what works for all students. Not just some.

We must do more to level the playing field, including providing a strong foundation from birth, improving diversity among the teacher workforce, creating learning pathways that work for all students. To that end, the budget proposal calls on Congress to invest nearly $103 billion in the Department of Education's programs, a 41 percent increase over the fiscal year 2021 appropriation to support students' success.

OVERVIEW OF THE BUDGET REQUEST

The fiscal year 2022 request also makes a meaningful down payment toward the Biden-Harris administration's goal of reversing inequities. That is what is at stake here, reversing inequities. The centerpiece is a proposal for a new $20 billion Title I equity grants program that would address inequities and disparities between under-resourced schools and their wealthier counterparts.

It would support competitive compensation for teachers and Title I schools, expand access to pre-kindergarten, and increase preparation for, access to, and success in rigorous coursework. Our requests would put the Nation on a path to double the number of school counselors, nurses, and mental health professionals in our

schools, and significantly expand support for community schools to help increase the availability of wraparound service services to students and families in underserved schools and communities.

The pandemic reinforced the need for this. We also think it is past time for the Federal Government to make good on its commitment to students with disabilities, and their families, and the request makes a significant move toward full funding of IDEA, proposing a 20 percent increase for IDEA State grants of $2.6 billion.

Turning to higher education, an area that needs immediate attention. Our budget proposal begins the Biden-Harris administration's critical work to increase access and affordability for students. The budget proposal coupled with increased proposals—proposed in the American Families Plan would be the largest increase to Pell Grant ever, helping millions of students and families pursue their goals. Importantly, our proposal would ensure that Dreamers may also receive Pell Grants if they meet current eligibility requirements.

The fiscal year 2022 request paints a bold picture for the future of our institutional and student support programs. The budget increases institutional capacity and student supports at minority-serving institutions, with additional funding for HBCUs (Historically Black Colleges and Universities), Hispanic-Serving Institutions, Asian-American, and Native-American Pacific Islander-serving Institutions, and Tribally Controlled Colleges and Universities, as well as our beloved TRIO and GEAR UP programs to help ensure underserved students succeed and graduate from college.

Finally, we would prioritize efforts to enforce civil rights laws related to education through a 10 percent increase for the Office for Civil Rights, to protect students and advance equity and educational opportunity, and delivery in preschool through college. This is a fundamental right we are committed to for all students.

Working together with stakeholders, including students and educators, we can and will heal, learn, and grow together, during this challenging time. I am committed to working collaboratively with each of you to strengthen our schools, and campuses, and to help improve opportunities, pathways, and outcomes for students across the country, including students in our rural communities.

Thank you. And I look forward to answering any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF HON. MIGUEL CARDONA

Good morning Chairwoman Murray and Ranking Member Blunt.

I am pleased to join you today, and I am proud to testify on behalf of President Biden's fiscal year 2022 Budget Request for the Department of Education. The full fiscal year 2022 Budget Request, which was released a little over two weeks ago, makes good on President

Biden's campaign commitment to reverse years of underinvestment in Federal education programs and would begin to address the significant inequities that millions of students—primarily students of color—and teachers confront every day in underserved schools across America. These inequities in opportunity and access continue to be experienced by students pursuing higher education and career and technical education credentials as well.

AMERICAN RESCUE PLAN ACT

Before I begin, I want to thank the Members of the Subcommittee—and your staff—who helped carry the American Rescue Plan Act to the finish line. I can tell

you from immediate experience that the ARP funds will make all the difference in ensuring that schools re-open for full-time, in-person instruction as safely and soon as possible. In addition, ARP funds will enable schools to address the mental health, social, and emotional needs of students that the pandemic has laid bare, and to fully recover from the massive impact of lost instructional time on student achievement during the pandemic.

The plans to reopen are bold—and will require coordination among key stakeholders at the Federal, State, and local levels. But they match the urgency the challenges before us demand. It's important to remember that once we fully reopen schools, we still have work to do. Our job will not be done. Generations of inequity have left far too many students without equitable access to high-quality, inclusive learning opportunities. Education can be the great equalizer—it was for me—if we prioritize, replicate, and invest in what works for all students, not just some.

We must do more to level the playing field, including providing a strong foundation from birth, improving diversity among the teacher workforce, and creating learning pathways that work for all students. To that end, the fiscal year 2022 budget proposal for the Department of Education provides strong investments in key areas to ensure students of all ages have what they need to succeed.

DEPARTMENT OF EDUCATION FUNDING LEVELS

The President's fiscal year 2022 request calls for a significant and long-overdue increase in Federal support for education from birth through college and career. The proposed discretionary request of $103 billion for Department of Education programs, an increase of almost $30 billion over the fiscal year 2021 enacted level, would be complemented by additional mandatory investments under the American Jobs Plan and the American Families Plan. We understand that some have raised questions about the unprecedented increase in Federal education funding proposed by President Biden, particularly coming on top of emergency appropriations over the past year to address the impact of the COVID–19 pandemic on our schools. However, it's important to recognize that these bold proposals follow a decade of virtually no funding growth in real terms for Department programs, a significant under-investment in light of the rising needs of students and families.

The $73.5 billion that Congress appropriated for the Department for the current fiscal year, fiscal year 2021, is about 8 percent more than the fiscal year 2011 total of $68.3 billion. Title I funding did a little better, up 10 percent, or 1 percent a year, over the same period of time. The total Federal investment in elementary and secondary education grew at the same rate—just 1 percent annually over the past 10 years—not even keeping up with inflation.

FUNDING INEQUITIES IN STATE AND LOCAL EDUCATION SYSTEMS

This underinvestment in K–12 education matters because of the dramatic and longstanding inequities in State and local education funding systems, which despite more than half a century of litigation and reform, too often continue to provide significantly less funding for high-poverty districts and schools, which are more likely to serve students of color, resulting in a disproportionate impact on these students. Reversing these funding inequities, as well as immediately addressing the negative impact of those inequities in service of students, are critical goals of the Biden-Harris Administration's racial equity agenda, and the President's fiscal year 2022 request for the Department of Education would make a meaningful down payment toward these goals. Addressing these inequities are critical to our nation's future. Our country and our economy will be stronger when every child is prepared to succeed in tomorrow's economy, regardless of race, zip code, their family's income, or disability.

INVESTMENT IN TITLE I GRANTS TO LOCAL EDUCATIONAL AGENCIES

The centerpiece of that request is $20 billion for a new Title I Equity Grants program—part of the President's commitment to dramatically increase funding for Title I schools—that would help address long-standing funding disparities between under-resourced school districts and their wealthier counterparts; ensure teachers in Title I schools are paid competitively; support expanded access to preschool; and increase preparation for, access to, and success in the rigorous coursework needed to prepare for postsecondary education and high-paying, in-demand careers. This proposal will further the goals of Title I as outlined by President Johnson in partnership with Congress back in 1965 as part of the War on Poverty, to help ensure that all students—especially students from low-income backgrounds and students of color in underserved communities—receive the high-quality education they need to thrive and achieve their dreams.

INVESTMENT IN IMPROVING STUDENTS' PHYSICAL AND MENTAL HEALTH

Long before the COVID–19 pandemic there was increasing evidence that the conditions of poverty—especially concentrated poverty—take a tragic toll on the physical and mental health of students. This warrants significant investments in mitigating the impact of this toll in order to improve student outcomes. Congress recognized this problem, in part, through the creation and rapid increase in funding for the Title IV–A Student Support and Academic Enrichment program. Our request would build on these efforts through a $1 billion investment for a new School-Based Health Professionals program to support the mental health needs of our students by increasing the number of counselors, nurses, and mental health professionals in our schools, and building the pipeline for these critical staff, with an emphasis on underserved schools.

COMMUNITY-BASED PROGRAMS

In addition, the President's request would help increase the availability of a broad range of wrap-around services to students and families in underserved schools and communities through a significant expansion of the Full-Service Community Schools program, from $30 million in fiscal year 2021 to $443 million in fiscal year 2022. This program recognizes the role of schools as the centers of our communities and neighborhoods, and funds efforts to identify and integrate the wide range of community-based resources needed to support students and their families, expand learning opportunities for students and parents alike, support collaborative leadership and practices, and promote the family and community engagement that can help ensure student success. The request would support implementation of the community schools model at roughly 800 additional schools serving up to 2.4 million students, family members, and community members.

Our request also would help strengthen communities by fostering diverse schools through renewed efforts to improve school racial and socioeconomic diversity. We would provide $100 million for a new Fostering Diverse Schools program that would help communities develop and implement strategies that will build more racially and socioeconomically diverse schools. Research suggests that diverse learning environments benefit all students and can improve student achievement, serve as engines of social and economic mobility, and promote school improvement. Our proposal also would build evidence around effective practices for addressing the growing concern that our Nation's schools are becoming less diverse and more segregated each year.

SUPPORT FOR SPECIAL EDUCATION

We also think it is past time for the Federal Government to make good on its commitment to students with disabilities and their families, as expressed in the Individuals with Disabilities Education Act. The President's request makes a significant move toward full funding of the IDEA with a $2.6 billion, or 20 percent, increase for IDEA Part B Grants to States above the regular fiscal year 2021 appropriation, for a total of $15.5 billion. Notably, this increase would raise the Federal share of the excess cost of serving students with disabilities for the first time in 8 years-demonstrating that IDEA has been yet another casualty of the Federal underinvestment in education over the past 10 years.

In addition, we would increase funding for the IDEA Part C Grants for the Infants and Families program by more than 50 percent, or $250 million above the regular fiscal year 2021 appropriation level, for a total of $732 million to expand access to early intervention services for infants and toddlers with disabilities. We would pair this increased funding with reforms to strengthen the Part C program, particularly for children who have been historically underrepresented in the program, including children of color.

The President's Request would also boost the Preschool Grants program by $105 million over the 2021 appropriation, to aid in the provision of special education and related services for children with disabilities aged 3 through 5.

TEACHER TRAINING AND SUPPORT

The Title I Equity Grants proposal is just one demonstration of President Biden's strong commitment to teachers. Other key investments, split between discretionary and mandatory American Families Plan funding, include $412 million ($132 million in discretionary funding and an additional $280 in mandatory authority for fiscal year 2022) for Teacher Quality Partnerships to address teaching shortages, improve training and supports for teachers, and boost teacher diversity, particularly through investment in teacher residencies and Grow Your Own programs; $340 million ($250

million in discretionary funding and an additional $90 million in mandatory authority for fiscal year 2022) for Special Education Personnel Preparation to ensure that there are adequate numbers of personnel with the skills and knowledge necessary to help children with disabilities succeed educationally; and $60 million ($20 million in discretionary funding and an additional $40 in mandatory authority for fiscal year 2022) to fund for the first time the Hawkins Centers of Excellence program designed to increase the quality and number of new teachers of color. In addition, the American Families Plan would make a one-time mandatory investment of $1.6 billion to support additional certifications at no cost for more than 100,000 educators in high-demand areas like special education, bilingual education, career and technical education, and science, technology, engineering, and mathematics. We are also requesting, through the American Families Plan, $200 million in mandatory authority for a new Expanding Opportunities for Teacher Leadership and Development program to support opportunities for experienced and effective teachers to lead and have a greater impact on their school community while remaining in the classroom (and be compensated for additional responsibilities) through such activities as high-quality teacher mentorship programs and job-embedded coaching. Lastly, the American Families Plan would double TEACH Grants from $4,000 to $8,000 for future teachers while earning their degrees.

IMPROVING CAREER PATHWAYS

The President's Request also recognizes that a skilled workforce is critical for both strong communities and a strong economy by proposing to make targeted investments that would help build the capacity of our workforce development system. These investments include an increase of $108 million in Career and Technical Education National Programs to support an innovation grants initiative focused on youth work-based learning and industry credential attainment, along with a $25 million increase under Adult Education National Leadership Activities to expand college bridge programs for low-skilled adults without a high school degree. In addition, the American Jobs Plan would provide $1 billion in mandatory funding in fiscal year 2022 ($10 billion total over 10 years) to expand career pathways for underserved middle and high school students that include partnerships with employers, community colleges and other partners and allow students to earn credentials or college credit while still in high school; and also would invest $100 million annually over the next 10 years to help connect job-seeking adults to employment opportunities by focusing on foundational skills and embedded career services.

POSTSECONDARY EDUCATION INVESTMENTS

Turning to higher education, our budget proposal would make postsecondary education more affordable for students from low-income households through a $400 increase to the maximum Pell Grant. In combination with the $1,475 increase to the maximum Pell Grant proposed in the American Families Plan, the increase in 2022 would be the largest increase to the Pell Grant ever. This historic increase is just a first step in a more comprehensive proposal to double the grant. Importantly, our proposal also would ensure that postsecondary students who are DACA recipients may receive Pell Grants and other federal aid if they meet current eligibility requirements.

Through the American Families Plan, our budget proposal would provide two years of free community college to first-time students and those wishing to reskill. It would also make college more affordable for low- and middle-income students at four-year Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), and Minority Serving Institutions (MSIs) such as Hispanic-Serving Institutions (HSIs) and Asian American and Native American Pacific Islander-Serving Institutions (AANAPISIs).

The fiscal year 2022 request also would increase institutional capacity and student supports at HBCUs, TCUs, and MSIs, and other under-resourced institutions, such as community colleges. The discretionary request includes more than $600 million in additional funding for institutional supports programs and programs like TRIO and GEAR UP, to help ensure underserved students succeed in and graduate from college. The American Families Plan also provides historic mandatory investments over ten years in college access and success, including $46 billion for HBCUs, TCUs, and MSIs, and $62 billion for a new Completion Grants program that would make formula grants to States to support the use of evidence-based strategies to strengthen completion and retention rates at institutions that serve students from our most disadvantaged communities like community colleges.

SCHOOL INFRASTRUCTURE

Too many students attend schools and child care centers that are run-down, unsafe, and pose health risks. These conditions are dangerous for our kids and exist disproportionately in schools with a high percentage of low-income students and students of color. We can't close the opportunity gap if low-income kids go to schools in buildings that undermine health and safety, while wealthier students get access to safe buildings with labs and technology that prepare them for the jobs of the future. Accordingly, the American Jobs Plan would provide $10 billion in mandatory funding in 2022, and $50 billion over five years, for grants to upgrade existing school facilities and build new public elementary and secondary schools. Outside of the Department of Education, funding would leverage an additional $50 billion in investments in school infrastructure through bonds. The American Jobs Plan would also provide $2.4 billion in mandatory funding in 2022, and $12 billion over five years, for grants to invest in community college facilities and technology in order to help protect the health and safety of students and faculty, address education deserts (particularly for rural communities), grow local economies, improve energy efficiency and resilience, and narrow funding inequities.

STUDENT AID ADMINISTRATION

In addition to making college more affordable, our budget proposal will improve the services we provide students and families to help them pay for college. We are requesting $2.1 billion to administer the Federal student aid programs in fiscal year 2022, an increase of $200 million over the fiscal year 2021 appropriation. The requested funds are necessary to implement the FAFSA(r) Simplification Act and FUTURE Act, which together will greatly ease the process of applying for student aid and accessing affordable, income-driven repayment options; provide high-quality loan servicing to more than 40 million student loan borrowers; and protect the personally identifiable information of around 75 million students and parents.

ENFORCEMENT OF CIVIL RIGHTS LAWS

Finally, we would prioritize efforts to enforce the Nation's civil rights laws, as they relate to education, through a 10 percent increase for the Office for Civil Rights to protect students, providing a total of $144 million to advance equity in educational opportunity and delivery at Pre-K through 12 schools and at institutions of higher education.

CLOSING REMARKS

Thank you again for this opportunity to share more about the President's plan to invest in students of all ages and the institutions that serve them. I look forward to hearing your reactions to this historic budget request, and to learning more about your individual interests and priorities related to Department of Education programs and activities. I am committed to working collaboratively with each of you, to the greatest extent possible, to help improve educational opportunities and outcomes for all students.

Thank you, and I will do my best to respond to any questions you may have.

RESOURCE ALLOCATION

Senator MURRAY. Thank you so much, Mr. Secretary. We will now begin around a 5-minute questions of our witness, and I ask our colleagues to, please, keep track of your clock. Stay within those 5 minutes.

Mr. Secretary, the President's budget calls for major investments in our Nation's public schools, acknowledging the significant resource disparities between schools serving more students from families with low incomes and their wealthier peers. These resource discrepancies contribute to the achievement gap between students of color who represent more than half of our students served in Title I schools and white students. One of the key provisions we included in the Reauthorization of the Elementary and Secondary Education Act, is a requirement to review the resource inequities in schools which have been identified for support and improvement.

And we also included a requirement for per pupil expenditure reporting for all States and school districts in the Nation, a requirement that still has not been fully implemented years after we passed the law. I believe that combination of additional Federal education investments, accurate and timely reporting, and thoughtful review of how all education funds are being allocated and used in schools needing additional support would improve the quality of education services for all of our students and families.

I know the pandemic has likely impacted the implementation of these resource allocation reviews, but can you share your plans for supporting and monitoring State and local agencies conducting these reviews, as well as your plans for ensuring States and school districts do comply with the SEA's (State Educational Agencies) fiscal equity reporting requirements?

Secretary CARDONA. Thank you, Senator Murray. And you start with an issue that is critically important that we must address together. The opportunity gaps and achievement disparities and outcomes are significant, so much so that I have been an educator for over 20 years, it has almost become normalized. And we have an opportunity here to address it, with the budget proposal, and the American Families Plan, there is a transformational opportunity for our country, to not only recover from the pandemic, but to be better than we ever were before in education.

And I look forward to ensuring that every penny that is allocated is used to support our students in a way that is equitable. You know, we talk a lot about education being the great equalizer, well, this budget proposes strategies to get there. And it is important for me to make sure that while the resources are there, we have equal amounts of accountability to make sure that the funds are being used for what they were intended.

So, absolutely, to me, the work that we do at the agency to ensure that the funds are being used for what they were intended for is critically as important as providing resources. We can't get to equalizing the playing field if the resources are not being used where they are supposed to.

So I, and the team at the Department of Education, will be very vigilant, especially with this new American Rescue Plan, and the funding that has been provided over the last year. We are going to be vigilant to make sure that the funds are being used for what they are intended to be used for. And I will add that as we rolled out the American Rescue Plan, we required States to provide transparent reports on how they were going to use the money, and engage stakeholders, so they are a part of the process early and ensure that equity is at the heart of the plan.

I envision this being something that is going to help lift our students. And I look forward to working with you and others to make sure it happens.

INVESTMENTS TO SUPPORT HIGHER EDUCATION

Senator MURRAY. Okay. Thank you. And on higher Ed, the pandemic really exacerbated, as we know, the financial challenges a lot of our students face pursuing a post-secondary education. Congress, as you know, responded by providing significant relief to students and borrowers, including flexible funding to address students' basic

needs during this pandemic. But as our country begins to recover from this pandemic, many of the financial strains that are facing students who are low-income, students of color, student parents, and first-generation students are really out there for them.

This is not just the cost of tuition and fees I am talking about, but housing, food, childcare, unexpected bills that can quickly derail a student's plans. And as we turn this corner on COVID, we should redouble our efforts to help all students pursuing a post-secondary education. And this budget I think is a positive step in that direction. But can you speak for a moment about the increases for Pell Grants, and childcare, for students, parents, TRIO, why those investments are so critical right now?

Secretary CARDONA. Thank you, Senator. We recognize now that if we don't act with urgency, we are going to lose many of our students who are thinking about higher education as an opportunity to continue their growth. The increase in Pell Grants, which is significant under the American Families Plan, $1,400, and $400 increase here in this budget show the commitment that the President has toward ensuring equitable access to higher education for our students.

And we recognize that that, with other supports, are going to allow for our students to continue to engage in college, free community college for students, talk about giving an opportunity to students who might not even think of higher education, because it is too far off, or the fear of being in debt for the rest of their lives. With that said, the pause on loan repayment has provided—saved over $5 billion a month for over 41 million borrowers. So we know how critically important that is. It has covered 1.1 million borrowers in the process, but programs like the Pell increase provide access to college for many more students. And we were confident with support of programs like that, and programs like TRIO, more and more students will look at higher education as an option for themselves.

Senator MURRAY. Okay. Thank you very much.

Senator Blunt.

Senator BLUNT. Thank you, Chairman.

FREE COMMUNITY COLLEGE

Secretary, let's talk a little about the first 2 years of college education being free, or at least if you choose to go to a community college. I am much more inclined to be receptive to your arguments about increasing the Pell Grant, increasing even the level of maybe whether you qualify for that maximum Pell sooner. What are you thinking about in terms of 2 years of free community college education?

I am a big supporter of the community college system, every community college in my State, I believe, understands that, but I don't quite understand, one, why we want to make community college free for everybody regardless of need. And then my second question is going to be: Why just community colleges? But how do you expect this plan to work? And would all students who choose the community college have no cost of going to that college?

Secretary CARDONA. Thank you, Senator. I recognize that there are many States that are doing amazing work providing access to

higher education institutions. I was in Michigan recently, and I saw amazing efforts there to make college affordable and accessible to students in Michigan. But this plan would allow 5.5 million students to have access to higher education who might not have had it previously.

And we know that not only is it a benefit for these students, but it is a benefit for their families, their community, and there is an economic benefit. Graduates of 2-year colleges, on average, earn 21 percent more than students with a high school diploma. We know that the skills that are needed in the workforce today are skills that would require some level of training.

So with good coordination, our free community colleges connecting with our high schools, connecting with the workforce and 4-year colleges, which stand to gain because there is going to be a wider net of students seeking higher education. We do feel that this is a step forward for the country.

Senator BLUNT. Good. I don't disagree with any of those thoughts, except your point that there would be, I think you said 5 million students that would not have access to community college, otherwise. What about all the students that could go to community college, otherwise, that we are—are we now paying that tuition as well?

Secretary CARDONA. Many of those students are benefiting from supports now. What we are doing is leveling.

Senator BLUNT. No, no. That is not what I am asking. What I am asking is if any student at any income level wants to go to community college, can they go for free under this program?

Secretary CARDONA. Yes, it would be accessible to all who want to study in a community college.

EXPANDING FREE COLLEGE PROPOSAL TO ALL ACCREDITED INSTITUTIONS

Senator BLUNT. So why would—so let's go to a second question. Why would you focus that first 2 years on a community college when students might want—that even qualify for, for instance, the Pell Grant now, they can take that Pell Grant money and go to any college, any accredited institution, public or private, they want to, and many of those institutions now with fully qualified Pell students, figure out how there is no other costs beyond Pell. Why would you not allow them to continue to have that same ability to go free to those schools as well, if they are students in real economic need?

Secretary CARDONA. Under this proposal, students will still have the choice to attend the college that they would like, benefiting from Pell Group programs if they are eligible. So it does not limit options. If anything it provides more options, and provides more opportunity for students who might not have considered higher education an option for them due to the costs.

Senator BLUNT. What about, generally, to continue this discussion, we should have free first 2 years of college, or free college for everybody, but that almost always talks about a college in a public school setting, as opposed to an accredited school setting. I think one of the real strengths of the American higher education system since World War II has been virtually all of our programs, whether

they were the GI benefit, or Pell Grants, or any other Federal Government program, you had the ability to use that at any accredited, post-secondary institution.

What is your view on that? As we continue to discuss how access to various levels of grants and fundings public—versus both public and private competing with each other after high school?

Secretary CARDONA. Thank you, Senator. You know, I look forward to continuing conversations with you and others to find the right pathway. What we want to do is provide access to higher education for students across the country; we know that access to higher education affords students the opportunities to better options in life, higher earning potential. And that is good, not only for the student, but for the community and the economy, as I said earlier. So I am a big proponent of providing options for students who want to pursue different careers, or different educational institution based on their choice. And I would be in support of exploring options to make sure that that is accessible under this plan.

Senator BLUNT. Well, the current system, as you know, creates lots of options to accredited institutions. I hope that continues to be the case, and certainly something you and I will continue to talk about. Thank you, Secretary.

Secretary CARDONA. Thank you.

Senator BLUNT. Thank you, Chair.

Senator MURRAY. Senator Shaheen.

Senator SHAHEEN. Thank you, Madam Chairwoman.

ACCESS TO AND USE OF COVID RELIEF FUNDS

Mr. Secretary, we are delighted to have you here today. I want to start with a challenge that we are having in New Hampshire. As you know, Congress has provided nearly $200 billion for emergency relief for elementary and secondary schools as a result of the COVID pandemic. This funding was intended to assist schools during this emergency, and Congress was very clear when we passed that legislation, that the intent of these funds is to be—allow them to be at the school's discretion to meet a wide variety of local needs, including for construction projects, such as HVAC (Heating, Ventilation, and Air Conditioning) repairs and improvements.

I am very concerned about the delays that many New Hampshire schools have experienced when trying to access this relief funding. And I have been troubled by the Department's delay in issuing clear implementation guidance that regards regulatory requirements on States and school districts. Now I appreciate the guidance that was just provided to—by the Department to New Hampshire yesterday.

I hope it resolves some of this uncertainty, but there are still questions that schools have, and in order for them to benefit from this money, we have a limited time for construction during the summer, and so it would be really important to have the Department be very clear on the use of these funds. So can you talk a little bit about how the Department is working to allow expeditious access to the funds that have been approved and appropriated by Congress?

Secretary CARDONA. Thank you, Senator. You are absolutely right. The importance of being expedient in the use of funds to get

them into the schools, to provide the resources that are needed, to get the students what they need to be in the classroom quickly and as safely as possible. And with the distribution of funds, we recognize that different parts of the country have different needs. I was in Philadelphia recently, and I learned how the ventilation issues in those schools prevented students from coming in at the same rate as communities that had schools that were a bit newer and had better ventilation. So in that particular area, the issue was ventilation.

So what we want to do is balance flexibility around how the funds are used with ensuring that the funds are being used to safely reopen schools, and address inequities that were exacerbated during the pandemic. And by the strategies that we are taking is becoming accessible, and making sure we are working with States on their individual needs, and their individual challenges. We worked closely with various States, meeting with them and having conversations with not only their educators, but their elected officials, to ensure that maintenance of effort is being kept, and that the funds are being moved quickly to help the schools, and getting out to the LEAs (Local Education Agency) as soon as possible, and we will continue to do that.

Senator SHAHEEN. Well, I appreciate that, but that hasn't happened as expeditiously in New Hampshire, as the school districts really need it to happen. The ventilation systems, the HVAC systems are clearly an issue in many of our schools, and again, when Congress passed these funds, we tried to make it very clear that we wanted them to be as flexible as possible for use by the schools. So as you point out, the more the Department can be accommodating, and working with States on their needs as quickly as possible, the better.

Secretary CARDONA. Thank you, Senator.

Senator SHAHEEN. So do I have your commitment that the Department will continue to work with the State of New Hampshire?

Secretary CARDONA. We will be on the phone with New Hampshire today, Senator.

STUDENT LOAN REPAYMENT

Senator SHAHEEN. Thank you. All right. I am going to hold you to that. You and Senator Murray talked a little bit about the student loan program, and the effort to help address the challenge that many students are facing. This moratorium is scheduled to end September 30. I just wonder if the Department considers the final date of the moratorium, are you looking at a further extension? One of the challenges we have heard from people is needing certainty, as they are thinking about going back to school, and both loan agencies and students themselves.

Secretary CARDONA. Yes. You know, we are aiming to provide as much of an on-ramp for these borrowers as possible. And the date in September payments are—we are starting in October is something that we have, but we are continuing conversations about if that is the best time. No announcements today, but we continue to have those conversations. We recognize that for many families the recovery of this pandemic will come around the same time. Students are going to be returning to schools, mortgages have to start

getting paid, and loans have to start getting paid. So we want to make sure we are sensitive to the needs of the borrowers and aware of the other challenges that they have.

We are going to continue to do as much as we can with our authorities. Just today we are announcing $500 million in new discharges for, over 18,000 borrowers who attended ITT technical college just to make—technical institutes, excuse me, just to make sure that every authority that we have currently, we are taking advantage of it to support our borrowers who are in need. And we do want to provide timely information, as Senator Blunt also mentioned, and make sure we have as long an on ramp for these borrowers to start repayment.

Senator SHAHEEN. Well, thank you. I appreciate that. And I know that it is a huge concern for borrowers, but the sooner decisions can be made, I think the better people can plan.

Secretary CARDONA. Thank you.

Senator SHAHEEN. So thank you. Thank you, Madam Chair.

Senator MURRAY. Thank you.

Senator Moran.

Senator MORAN. Thank you, Chairwoman.

INDIVIDUALS WITH DISABILITIES ACT

Mr. Secretary, thank you for your presence today. Let me just highlight a couple of things that I am pleased with, and that would be IDEA. The increased funding support for that is valuable, commitments were made a long time ago, and those commitments have not been kept for a long time. And a significant component of our success in education will be our ability to educate those who need the IDEA aspect of our public education system.

IMPACT AID

And I look forward to working with you to see that we continue to provide additional support for those students. I also want to highlight the importance of Impact Aid; Kansas with Fort Riley and Fort Leavenworth, they are hugely important to assist our school districts that have a large presence of public lands. And I look forward to working with you to see we support Impact Aid and its ability to level the playing field in the finance of education in my State.

TRIO

Let me ask a question about TRIO. The Biden Administration proposed investing $62 billion in new college retention and completion services. This, to me, seems unnecessary spending on a duplicative program when we have TRIO programs. And I noticed in your comments you bragged about the significance and value of TRIO, but what is the circumstance that suggests that this is not duplicative or that the resources that you are putting into new programs could not be utilized in the TRIO programs to achieve the same outcome?

Secretary CARDONA. Thank you, Senator. And I do agree that the investment in special education is so needed. I have spoken to families of children with disabilities, in particular, families with chil-

dren with autism, who have said, "you know, the laptop alone is not going to cut it." So I am hopeful that our students with disabilities are going to get the support that they need, and that we are on a path to fully funding it.

With regard to the TRIO programs, you know, one thing we have heard is, students who are in our community colleges or in our 4-year colleges, due to the pandemic have had to leave. And there is a lot of concern whether or not they are going to be able to come back. And we also know that this translates into high school students who were maybe once thinking about going to college, not having that opportunity, or having to work now to supplement the income of the home, and have other factors that are pulling them in a different direction.

So the $200 million increase in the TRIO programs, to me, addresses what we know to be the case. What we are hearing from educators, what we are hearing from families, what we are hearing from students is that going to college for some students who might have been considering it, it seems a little bit further removed. And we want to make sure we are addressing that, so that we do continue to have students in colleges across the country.

Senator MORAN. Well, my concern is not that you are increasing the TRIO program by $200 million; it is if TRIO is a valuable program, which I believe it is, why would we create new programs with new funding, the $62 billion, without further utilizing the TRIO programs that already exist? We have a habit I think in Congress, and I can't imagine that is—an administration that is immune. We in politics and public policy have a habit, when we try to highlight the value or the importance we place on something, we create a new program.

And my suggestion is, my request is an understanding of why current programs, such as TRIO, would not be the vehicle by which you deliver new assistance. There are lots of schools in Kansas and across the country that would love to have a TRIO program, would love to expand the number of TRIO programs they have. Those are restrained in many instances because of lack of funding, and yet we are putting significant new dollars into a new program, which I would suggest has a pretty similar objective as TRIO.

Secretary CARDONA. Thank you, Senator. Well, we want to make sure we have opportunities for all students. And I agree with you, the TRIO program is successful when it is able to get students into college. And I hear your question. You are saying, why are we duplicating services if TRIO does similar? I look forward to working with you to discuss this further. And we would be happy to have conversations about where you feel we should be looking at things, and combining them instead of setting a new programs.

Senator MORAN. I look forward to working with you. And I was particularly interested in your response to Senator Blunt's question, which I—the answer at least to me, was incomplete. And I would be welcoming to see why, that the ideas that Senator Blunt suggested are ones that don't, in your view, have merit. Thank you.

Secretary CARDONA. Thank you.

Senator MURRAY. Senator Durbin.

Senator DURBIN. Thanks Madam Chairman.

Mr. Secretary, thanks for being here.

Secretary CARDONA. Glad to be here.

FOR-PROFIT COLLEGES

Senator DURBIN. This is not a trick question, but do you have any idea what percent of post-secondary students in America enroll in for-profit colleges and universities?

Secretary CARDONA. Off the top of my head, sir, I don't, but I can get you that information.

Senator DURBIN. I will tell you what it is. I will give you the answer, and it is not to trick you. It is 8, 8 percent post-secondary students in America enroll in for-profit colleges and universities.

Next question, what percent of student loan defaults in America are accounted for by for-profit college students?

Secretary CARDONA. I have a feeling you are going to share that answer with me, sir. So, I will, turn it back to you.

Senator DURBIN. As I said, I am not trying to trick you, 30.

Secretary CARDONA. Thirty.

Senator DURBIN. Eight percent of the students, 30 percent of the student loan defaults. What does it tell us? It tells us they are enrolling students who cannot finish, won't finish. It tells us also they are charging money that students cannot repay even if they are employed, 8 percent, 30 percent. As often as I meet you here each year, I am going to ask you the same question, because the numbers don't change.

But here is what is interesting, in the COVID–19 situation, colleges and universities across America are generally struggling for enrollment, except for the for-profit schools. They have seen a 3 percent increase in students. How can that be? Are they that good? They market and advertise constantly. You don't have to turn on television, or look into the news except to see the latest ad for them. Now, the reason I raise that is because I think that raises a serious policy question about a branch of higher education that is failing so many students and yet receives such a handsome Federal subsidy.

Now you have many roles, a Secretary of Education, educator, principal, president of the university, all these things, all of the above, and you certainly have the background for it, but there is one aspect of your responsibility then I want to delve into that is not often brought up. You are the Nation's—one of the Nation's biggest bill collectors. You are a credit agency, you are a banker. And I want to tell you the record that was written by your predecessor in this field is not one that I think we want to see continue. For example, if I might. Public service loan forgiveness. Are you familiar with it?

Secretary CARDONA. Sure.

STUDENT LOANS

Senator DURBIN. Do you know what the DeVos administration did with public service loan forgiveness? I will tell you. 99 percent of those who applied were denied, that is just outrageous. And then Congress tried to extend the program with a new version. That was ignored as well. So Secretary DeVos was channeling Henry Potter and not George Bailey many, many times. When it came to borrower defense of 108,000 students who applied, and said that they

were the victims of fraud by for-profit colleges and universities, the DeVos Education Department, as they were leaving town, denied 80,000 of them after waiting month after month, and year after year. The lives of these borrowers have been compromised.

Now, I don't know how familiar you are with ECMC (Educational Credit Management Corporation). Has your staff given you a briefing on your collection agency?

Secretary CARDONA. Yes. I have heard it.

Senator DURBIN. They have?

Secretary CARDONA. Yes.

Senator DURBIN. Well, I will tell you, the last point I want to make before I turn it over for your response is this. They are outrageous. The policies that they use to collect on student loans, I don't think any of us want to try to defend in public. If someone goes into bankruptcy court and tries with the one narrow exception to the bankruptcy code for student loans, undue hardship, they don't have a chance. ECMC is going to beat them back, whether or not you are dealing with veterans, who are so disabled that they can't pay back their loans, people subsisting on Social Security Disability, people with terminal illness, they are all beaten back and denied by your collection agency. So, open question: What would you like to do about it?

Secretary CARDONA. Thank you, Senator Durbin, for bringing out the facts, on something, that I will be very frank with you is the top priority at the agency. We have done a disservice and it is time to act. It is time to have our students at the center of the conversations there. It is a high priority for me to make sure that we correct that, it is unacceptable to have a 98–99 percent refusal with public service loan forgiveness.

I had a conversation with students who had to go through that process and were given the run around. I was frustrated after that call. They had to hold on and go through different hoops to try to get an answer. And then the answers were not accurate, and they had to go somewhere else. So, there is a lot of work that has to be done.

I recently hired Richard Cordray. He was recently appointed by the President. And we need to have a consumer protection mentality, we need to put the students at the center of the conversation, and we need to make sure that what we are doing at the agency, is a model for what we expect. And we have to put our loan providers on notice that we are going to put the students first.

We have not been sitting around waiting either though, we have provided a $1.5 billion in relief through borrower defense, by delivering a billion in full relief to 72,000 borrowers, and approving 500 million in discharges, as I mentioned with ITT. So, we are taking every opportunity now to change the culture there. And the message is very clear to Richard. Fix this. Fix this, and move quickly, and be transparent, and change the culture that people perceive.

As you pointed out, we have a culture to change and we have better—we have to implement strategies better. Our students cannot wait, and we are contributing to the problem, you will see a turnaround in that. That is a priority for me.

Senator DURBIN. Thank you. Channel George Bailey. Thank you very much.

Senator MURRAY. Thank you.

I will turn to myself, and then Senator Blunt for a second round. I would just notify all committee—members and staff to please tell your members to be here, because if there is no one else to present at after that time we will wrap up this hearing. I know Mr. Secretary, you are sad to hear that.

Secretary CARDONA. I know.

RATIONALE FOR ADDITIONAL FUNDING

Senator MURRAY. Mr. Secretary, the President's budget calls for major new investments in our Nation's public, elementary, and secondary schools, totaling $66 billion. That is an increase of $25 billion more than last year's, LHHS (Labor, Health and Human Services) bill, now Republican and Democrats were able to work together on COVID relief in our regular appropriations bills last year. The $125 billion in K–12 education investments included in the American Rescue Plan Act passed earlier this year did not have bipartisan support. And some of our Republican colleagues expressed concern that those funds would not be spent quickly or were unnecessary.

Tell us why you think the additional K–12 investments proposed in the President's budget are needed on top of the significant COVID supplemental appropriations that are already enacted into law?

Secretary CARDONA. The technical support that the allocations provide are critical, and I will get into that, but let me first talk about how important it is that the President signal a transformational change in how we view education as the foundation of our country's growth.

As the First Lady said, any country that out-educates us outperforms us. So, this administration understands the important investment in education. And I don't have to remind you, because you mentioned it in your opening comments, years of underinvestment in education. I have seen that. I was a principal when we were asked to do more with less. I had class sizes that were very high, with teachers who were doing their very best to meet the needs of students, and those needs kept increasing, but the funds kept decreasing.

There is a realization here, that if we don't get this right, so much else is going to suffer. So, when we talk about what this investment can turn into, it can turn into smaller class sizes. It can turn into better teacher preparation. Students are coming back from a trauma-filled year. I spoke to a student at Harvey Milk School 2 days ago, in New York, who told me his grandmother and his significant other died in the last year.

This student is going back to school. If we are not investing in additional trauma support, training to make sure everyone, including our school bus drivers, our cafeteria aides who have been heroes this past year, have the support and training to help meet the needs of these students when they come in, then we don't stand a chance. If we are not providing funds to give students access to digital devices and broadband so that they can have access to learning wherever they are, then we lost an opportunity.

The pandemic exacerbated the need. You mentioned it in your opening comments, the impact that it is having on our poor communities, in our rural communities students didn't have access to broadband during the entire pandemic. We cannot continue underinvesting in education and think that we are going to continue to produce students that are going to lead the world. We have an opportunity here, an obligation, a privilege to make sure we are funding our schools, and giving our educators the tools that they need to be successful. More importantly, giving our students the tools that they need to be successful.

Imagine our country, when students don't have to worry about not having a teacher in front of their classroom, enough materials, or access to technology so that they could get access to basic deliverables in education. That is where we are going. And this bill does that. The American Family Plan boldly communicates that. And I am excited about supporting it moving forward.

SIMPLIFICATION OF FREE APPLICATION FOR FEDERAL STUDENT AID

Senator MURRAY. Thank you. I really appreciate that response. Mr. Secretary, too many students miss out on college financial aid that they are eligible for, like Pell Grants, in part because the application process has been so cumbersome. Last December we were able to finally reach a bipartisan agreement to significantly simplify the Federal Student Aid Application process with the passage of FAFSA Simplification Act, and that law, by the way, also expands eligibility for Federal financial aid.

The administration's budget request does include a significant increase in funding to implement those and other related changes. But unfortunately, the Department announced last week, as you know, that some of those changes cannot be implemented quite as fast as all of us had really hoped. This is not a criticism of the Department. Everyone wants the law implemented as quickly as possible, but tell us what the Department is doing to implement FAFSA as quickly as possible, including moving forward with key benefits for students on time?

Secretary CARDONA. Thank you. And I recognize it is not a criticism, but, but we need to get moving on this. And I thank you, and Senator Blunt, and others who have really pushed this, and understand the importance of that simplification process. I have talked to students who said, you know what, that is too much. Or families, I can't do that. And they have missed out on opportunity.

So, the simplification process is critically important, but the reality is we walked into a system that doesn't have the capacity. As I mentioned in the previous statement, you know, under-investment leads to results. Well, we have a 45-year-old computer system that can't handle the changes that are needed, and that you voted for.

So, we need to move quickly, swiftly, to make sure we are prioritizing that, that is critically important, the FAFSA simplification. We are on it. We are going to prioritize that, again, another area that Richard is really prioritizing. And we are going to keep you updated. You deserve to be updated on what progress we are making, what challenges we have, that is a priority for the agency, and for me as Secretary.

Senator MURRAY. Thank you very much.
Senator Blunt.

TRANSPARENCY OF COVID RELIEF SPENDING

Senator BLUNT. Thank you. Thank you, Chair. On the topic of new money to schools, Congress provided in the American Rescue Plan and the COVID supplementals, a total of $190 billion to K through 12 education. Data provided to us by the Department as of June 4, less than $9 billion of that has actually been spent by schools. What can we do to ensure that that money gets spent, and there is more transparency about how and where it is being spent?

Secretary CARDONA. Thank you for that question. And it gives me an opportunity to share that as the commissioner of education, during the beginning of the pandemic and throughout most of the pandemic, we also had to develop systems that did not exist before, to distribute money in this unprecedented time, to make sure that LEAs had the support they needed. And as the Senator mentioned earlier, in some places that process is slower than we would like.

So we are in communication with our districts, our State LEAs, and we recognize, however, and I can tell you from experience that, you know, a good portion, sometimes 80 percent of budget is human resources, right? So that money is drawn down as the contract, or the year goes by. And we recognize also that this is a 3- to 4-year process where the funds are going to be used to provide services for multiple years. Also, contracts that are signed off on are not paid for until the services are provided. And in many cases that extends years.

So, we recognize the need. I think the transparency, what you brought up is critically important. We asked that any planning that is being done for funds with the American Rescue Plan have transparency that are posted on websites and that engage stakeholders, so that folks know how the money is being used. We have a responsibility to ensure every dollar of taxpayer money is being used to support what it was intended to use.

Senator BLUNT. Right. Now I certainly agree with that. And I think we actually assumed that more of that money would be spent on technical support and things that wouldn't have been part of the normal education system that districts had in place, as opposed to long-term contracts with individuals, and things that probably were in their normal and regular budget.

IN–PERSON INSTRUCTION

I hope we are looking carefully to see that that money is spent, to be more ready for virtual education when we need it, and different kinds of communication when we need it. Obviously, as Senator Murray has pointed out, and others have, the loss of learning in many cases to people who couldn't go to school, either they didn't engage in a virtual class, or that wasn't the right way for them to learn. Where do you think we are going to be in the fall in terms of in-person learning? What percentage of American public school students do you think we will be back in school in the fall in person?

Secretary CARDONA. Some of the expenditures that take time, as you mentioned, are critical, virtual learning access, broadband ac-

cess, and that does take some time. With that said, I do expect 100 percent of the students across the country to have access to in-person learning. April data shows that 96 percent of the K–8 students had an opportunity to learn in person. But I would argue that hybrid isn't a great option.

In many cases families can't do the hybrid option because parents have to work. It is all or nothing. I am pushing really hard to make sure that we are addressing, and we are working with States, and local LEAs to address whatever factors might be preventing them from offering full in-person learning, full-time for all students in the fall.

That is my expectation. And we are having conversations regularly with different State leaders, and local education leaders to make sure that that is—the message is clear, and that the expectation is there. The funds are there. We have to make it happen for our students, Senator.

STUDENT LOAN SERVICING

Senator BLUNT. Let's talk about loan servicing for just a minute. Certainly, as you pointed out, and I was pleased to be in involved in trying to simplify those loan forms. Senator Murray and Senator Alexander and the Authorizing Committee, last year, did a great job of leading there. Now there has been a discussion with the Title IV additional servicers, how we connect better with students—with individuals who have student loans.

This committee was not supportive of the last plan for the next generation of student loans. We are about to run out of the current framework of contracts. I think the current not-for-profit servicers contracts, and between December of this year and March of next year, there appears to be no plan to replace the current system. What I am asking is: Will you use the authority you have in the fiscal year 2021 labor bill to extend these legacy of servicing contracts while you work on a long-term servicing solution? Or do you expect to have a long-term service solution in place by December of this year?

Secretary CARDONA. We are working aggressively to make sure we have a system that has very high standards for loan servicers. We have to put the students at the center, while I don't have an announcement to make today, I will tell you that we plan on having an update, and we will update you within the next month or so to share what the plans are with that.

Senator BLUNT. Well, I will tell you. I have been very involved in this discussion. I would like to be updated, and would hope to be updated before you absolutely have a plan you are ready to announce. And then if, for whatever reason, that plan can't be put in place by the time these servicing and agreements run out I hope you are thinking about the authority that we gave you to extend those agreements if that was the best thing to do.

Thank you, Chair.

Secretary CARDONA. Thank you, Senator. We will be in touch.

Senator MURRAY. Thank you.

Senator Braun.

Senator BRAUN. Thank you, Madam Chair. I remember in our first or second conversations along the way, we have had a—kind

of a spirited discussion on resources that we put beyond education, in general. And in my opinion education, along with one's healthcare, we ought to be doing that as well as possible, not only through public, but through the private arena as well.

RETURN ON INVESTMENT IN POST-SECONDARY EDUCATION

And post-secondary education now has the dubious distinction of being the place where costs are going up more per year than any other significant sector of our economy. Just eclipsed a few years ago, the rate of increase in healthcare, which is a place I have, since I have been here wanted to reform and try to fix, because I think it is a broken system there in terms of what we do through the private sector, and through government, because we have got the entity itself, the system that doesn't deliver, it has cost us in healthcare twice as much as what it does in other countries.

So, I think it is silly to pour more resources in anything that is not delivering outcomes that look like they are at least headed in the right direction. So do you think when it comes to the results, and let us look at post-secondary education, I will come back to secondary in a moment. Do you think we have been getting a good bang for our buck?

Secretary CARDONA. There is always room for improvement, Senator. And I can assure you that the team that we are assembling recognizes the importance, and the moment that we have to make sure we are improving access and affordability. Again, I mentioned earlier, the American Families Plan provides opportunities for students to access community colleges for free. We know how important that is to give them an opportunity to join the workforce with skills that they need to be successful. And that the earning potential of graduates of community colleges can be up to 21 percent higher.

We have work to do and we are going to be aggressive to make sure that students are getting a good return on investment in post-secondary education. And we are addressing the issues that exist, where students are being taken advantage of, or sold a bill of goods and never delivered on. We are on that. And that is a priority for me.

Senator BRAUN. So my observation before I got here is that you generally don't pour resources into something until you look at what you have got, that you are trying to rebuild, re-energize, or make better. And 41 percent increase over fiscal 2021 levels is embedded in this budget proposal. And my observation, from being on a school Board for 10 years, to wrestling with education at the State level as a State legislator, it is not about spending more money, it is really more about finding how we change the system.

To me it is analogous to healthcare. And as long as we are here, since we live with no constraints, now added in the two-and-a-half years I have been here, nearly $10 trillion in national debt. The need to be a little more entrepreneurial, a little more concerned about changing the paradigm. And here I see most of this just pouring more resources into something that doesn't need to tell us any more clearly, that it is not delivering the goods.

SECONDARY EDUCATION ALIGNMENT WITH JOB MARKET

Before I run out of time, let me pivot back to, the same point would be made in secondary education, before you get to college. College is runaway with costs that even parents are really scratching their heads. Is it worth it to send my kid into a system that 50 percent of the kids that go there don't pursue it, and many get a misguided degree, and employers don't have a market for?

Why don't we try to get it better at the secondary level and match training and skills with the high-demand, high-wage jobs that all of us have out there? My State of Indiana, checked with my kids, I think we have got 70 to 80 job openings in our own company, out of a total employment of 1200. We don't need any more 4-year degrees, because the jobs that we have in a State like Indiana, where we ship out twice as many 4-year degrees as we use in the State, we need better skills that are being delivered out of high school.

I look at a place like Garrett High School, west of Fort Wayne that catches kids and, obviously, parents, when they are fifth graders, before they go to middle school. That is something that would cost no more money, but would change the dynamic of where we need to change our emphasis in how we do things. And until education does that, until healthcare does that, I really think we are just going to be borrowing more money and putting it down a dubious hole. I won't refer to the word that comes to mind. So, a quick comment on that.

Secretary CARDONA. Thank you. I agree with you. If we do what we have done, we are going to get what we have gotten. So, you know, the plans discussed CTE (Career and Technical Education) changes. We really, if you recall, my hearing, one of my goals as Secretary of Education is to make sure we evolve our secondary schools to meet the demands of the workforce, and the careers that are available today, as you mentioned, in your own community.

So, this is something that I am eager to work with. Not only in the budget do we see that in there. And it is not just resources, it is the change in mindset. We are going to get there. And I look forward to working with you on that. I know the Jobs Plan has funds for that, the Families Plan. I know the President gets it, it is in the budget, and we are going to make it happen. And I look forward to working with you on that.

Senator BRAUN. Thank you. And I would invite you to take a road trip to Indiana and visit some of the places that are setting the trend on what we, as employers, need which is a better elementary and especially secondary education, before you start pushing kids into a broken system after that. Thank you.

Secretary CARDONA. Look forward to working with you on that.

Senator MURRAY. Senator Reed.

Senator REED. Thank you very much, madam Chairwoman.

SCHOOL INFRASTRUCTURE

Welcome, Mr. Secretary. Your experience as a State Commissioner of Education is, I think, invaluable because you have seen these issues up close and personal, as they used to say on television. And one of the issues I hope is not debatable is the poor sta-

tus of school infrastructure, and this is not just an urban issue, it is a national issue.

I have been working very hard to get resources in for infrastructure repairs in schools, and also in the context of infrastructure repairs, you can do a lot of things like, change the heating system to be more efficient. We discovered in the pandemic, in Providence they had to teach all winter with the windows open, because the HVAC system, and you probably had the same situation in Connecticut, the HVAC system would not support a safe instruction, and was probably built in 1930, et cetera.

I am pushing very hard to get $100 billion in the Jobs Plan for the schools. And I hope you can assist me in doing that, with the President and with my colleagues.

Secretary CARDONA. Thank you, Senator. Part of the "Help Is Here Tour" we visited about nine or ten different States, and visited about ten different schools. And as I mentioned in an earlier response, the needs in different communities, post-pandemic, were different. And one really stood out to me. I was in Philadelphia, and I visited schools that were over 120 years old. You know, where the windows are shut with paint.

Senator REED. Lead paint?

Secretary CARDONA. Yes. The students, they need better. And it really just brought to the surface what educators have known for years; that facilities do matter, but what is the first thing that goes in local budgets when there is not enough funds, the facilities' maintenance. I remember as commissioner of education, talking to district leaders who said, our system hasn't been touched in years, the maintenance of the system hasn't been touched in years, the filters haven't been changed out.

I learned more about MERV 13, MERV 15, more than I ever thought I needed to know. But the point is there has been negligence on facilities for years. And what we are finding is, in order to get students back into school safely and ensure a safe learning environment where the community could feel confidence in their schools. When we talk about reopening schools, we have to take that into account. So, I agree with you. Part of the Jobs Plan has the upgrade and building new public schools where it is needed, the $50 billion over 5 years.

But the community colleges also need the support, and the $12 billion over 5 years there, is a commitment to making sure that our facilities are safe places for our learners, for our educators. So that kids go to school, they attend regularly, and they have a learning environment where they can grow. So, I agree with you there, wholeheartedly, Senator.

Senator REED. Well, thank you. And I must confess part of my passion is the fact that my father was a school custodian. And so he would get to—in fact supervisor custodian—so he would get those calls in the middle of a winter night to go fix the boiler that was installed in 1927 or something like that.

Secretary CARDONA. Exactly.

LITERACY

Senator REED. A further question. I had an interesting discussion with adult education providers, and they reported that 95 percent

of the students that they are serving, come to them with virtually no literacy skills. They can't read, they might graduate from high school, or at least going the length of time they have to, but they can't read. And if they can't read, it is very difficult to train someone for a job, particularly in the sophisticated, post-industrial economy.

Secretary CARDONA. Right.

Senator REED. One issue I think is if making sure we know what at least the rates are. And I have just wondered, do you have national, local, and States' reliable statistics about literacy?

Secretary CARDONA. We do, we have data that we are tracking in terms of where the States are. But we have to do more. We have to do more to make them transparent, and to ensure that the funds that are being used through the American Rescue Plan are aimed at addressing those literacy gaps. I will tell you; we know in education that if a student is not reading by 3rd grade, you are going to be intervening for the rest of that student's school career.

And in the process, probably disengaging that student in ways where they can't take the courses that they want to select, or think about college as early as they need to, to make sure they have the same opportunities as other students. But that is where I also believe, sir, that the American Family Plan and the commitment on early childhood education.

Three- four-year-old programs, I saw as a principal, when 5-year-olds walked into the kindergarten classroom on day one, we knew which students had access to high quality programs. We could tell which students didn't, and we knew, day one, kindergarten, which students were going to need intervention and support. So you pay now or pay later, we really need to focus on early childhood education, and literacy skills early, science-based, research-based practices, to make sure that we are allowing our students to have the best opportunity in life by reading by 3rd grade.

Senator REED. I agree, but we also have to pay attention to adults who will miss these prospective reforms but still have low literacy skills.

Secretary CARDONA. Right.

Senator REED. Thank you. My time has expired.

Secretary CARDONA. Thank you. Thank you, sir.

Senator MURRAY. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Madam Chairman. And thank you, Mr. Secretary, for being here. I absolutely loved the background that you have, and it is very obvious that you really get it.

Secretary CARDONA. Thank you.

Senator HYDE-SMITH. And I appreciate that, because I can tell by your passion that you know exactly what these students are going through. So that I truly want you to know how much I appreciate that.

Secretary CARDONA. Thank you.

FLEXIBILITY IN USE OF COVID FUNDING

Senator HYDE-SMITH. As we know from COVID, so many kids got just really far behind in so many areas, and great concern, not just in Mississippi, but everywhere. But Mississippi has recently received significant American Rescue Plan funding to help reopen our

schools. The reality is that most Mississippi schools have been open for in-person learning for nearly 10 months, as many Mississippi schools resumed classroom instructions last August. We really got back in quick with good results, and made some good decisions there that our leaders made. But the school year for most Mississippi schools ended in early May, and students are already out for their summer break.

In your submitted testimony you stated that the plans to reopen are bold, and will require coordination among key stakeholders at the Federal, State, and local levels. However, this statement, and several others from the Department, seem to ignore the fact that many other States, like Mississippi, have been opened since fall of 2020. So, we have this money, but we have already been open, but how much flexibility are schools being given to use the American Rescue Plan funding? Because that is the calls that I get, and that is the questions that I get, from my schools and my educators.

Secretary CARDONA. Yes. Thank you, for first of all, for your comments, and for the thoughts that you are bringing up on behalf of the constituents you serve. And like you, my own children have attended since August, and I have been fortunate that some of the students in Mississippi that were able to attend in person, early, safely. That is critical.

So, we know, as I mentioned in a previous response that the impact of COVID effected some regions differently than other regions. And we have to be aware of that and provide the flexibilities where needed. We recognize that in some places, while students have been in school, it might have been in a hybrid model, or some students have had access more than other students, due to, whether it is confidence, or trauma with the pandemic, some students will still need support even if they are going into school, maybe half-time, or full-time even.

We also know that summer learning will help bridge those gaps of learning that we experienced through the disruption of COVID–19. So, flexibility is important. And what we are trying to do is balance flexibility while making sure that the impacts of COVID–19 are being addressed with the American Rescue Plan, as was the expectation from Congress.

So, we are working closely with States to communicate flexibilities, and we are available, if there are questions in Mississippi, to discuss how their plans are being rolled out, and questions that they might have around flexibilities, or adherences to specific requirements that might have come out of the agency.

Senator HYDE-SMITH. So, all we have to do is really contact your Department and for these individual questions, because I know they have some really good ideas, but we want to make sure we are following the guidelines the way that we are supposed to be doing that.

Secretary CARDONA. Sure. Senator, you know, we do encourage innovation also. So, we look forward to hearing it. As matter of fact, we will reach out, just to make sure that we are partnering with Mississippi to make sure that their questions are answered, and that we can promote as much flexibility to meet the needs of the students as needed.

CHARTER SCHOOLS

Senator HYDE-SMITH. Thank you. And I have a little time left. We have seven charter schools operating in Mississippi and, you know, charter schools have given parents the flexibility to decide which schools best fits their child's needs, individually, and not the government. In some instances, charter schools also have the freedom to adapt their classrooms as they see fit. And over the years, charter schools have seen increases in academic gains. We have had a lot of success there, which allow children more opportunities as they continue in their academic career.

And with your commitment to ensuring all students have access to a quality education, how will you support school choice in order to expand access to higher quality charter schools?

Secretary CARDONA. I am a big proponent of high-quality schools for all students across the country. And I recognize that students have options and, public charter schools are options for students. And I feel that all schools should be held to similar standards of accountability. And I think that is where I stand with that. I have seen examples of schools that needed a lot of intervention, but I have also seen examples of schools that really met the needs of the student and the families in a charter school.

Senator HYDE-SMITH. Because we really had some good luck. We had a Senator Michael Watson, State Senator at the time, really worked on this a long time. He is Secretary of State right now. But it really proved that we made a lot of ground there that were good decisions and beneficial. So, you will continue to support funding for the charter school program? Is that what you are saying?

Secretary CARDONA. Yes. The President made it very clear. You know, we don't—we are not going to be promoting a private charter school growth, but we are endorsing the programs that exist now where students are taking advantage of public charter schools.

Senator HYDE-SMITH. Great. Thank you very much.

Thank you, Madam Chairwoman.

Senator MURRAY. Thank you. My understanding is Senator Manchin is going to walk in the door behind me at any moment. He will be our last questioner.

STATE PLANS FOR ESSER FUNDING

While we are waiting for him. Mr. Secretary, I just wanted to thank you and your staff for all the hard work implementing the American Rescue Plan Act and other COVID–19 Relief Legislation, and the fiscal year 2021 Appropriations Bill. I know you got a lot on your plate. And I know the processes—the Department is really in the process of reviewing the State plans that are being submitted for each State's final one-third share of ESSER (Elementary and Secondary School Emergency Relief Fund) allocations under the American Rescue Plan.

But one of my priorities really is, is that the legislation—in the legislation is the required State and school district set asides for evidence-based interventions that address the academic, and social, and emotional needs of students of color, students experiencing homelessness, underserved students.

Secretary CARDONA. Yes, right.

Senator MURRAY. And I really appreciate the Department's template for State plans that include descriptions of state strategies, for carrying out these required activities, and strategies for States to support these district plans. Can you just assure us that the Department will only approve high-quality plans that effectively address the requirements of the law?

Secretary CARDONA. Yes. As I said at the beginning, that is where the honor lies, making sure that we are serving our students. And on behalf of the 50 million students, when we review those plans, we want to ensure that we are building back better, and that the plans are addressing the inequities that were exacerbated by the pandemic, that the plans engage our stakeholders in different ways, because that is critically important. Many folks who were already struggling in school prior to the pandemic are now further away. So, we need to engage them to make sure that the schools that we are reopening are welcoming places that are able to meet their needs as well.

Senator MURRAY. Well, thank you. I really appreciate that commitment. And I just ask that you keep my staff updated on the review of those plans. As you know, high quality plans are only successful if they are effectively implemented. And I know your Department has hosted webinars, and established a clearinghouse, and taken some other actions, which I really appreciate.

And while we are waiting for Senator Manchin, share some thoughts on how the Department will support and monitor those plans.

Secretary CARDONA. Senator, I appreciate you mentioning the actions that we have taken. We have—take your time. This is something I want to talk about. So, we do have a best practices clearinghouse, innovation doesn't come from Washington, D.C., alone. In fact, across the country, we have over 1,100 submissions of innovative practices to reopen schools, and engage those students that were hardest to engage during the pandemic.

So, we are lifting our best practices from across the country. And, you know, I always say, we are going to heal together, we are going to learn together, we are going to grow together. And the tools that we have are at the disposal of the districts now are tools that were developed with them, not for them, with them. And I have to say that, you know, we are continuing that conversation. We are having an equity summit next week, where we are inviting everyone to come take a look at what it means to rethink addressing inequities, and be bold. Our students deserve it. Looking forward to that.

Senator MURRAY. Thank you. Thank you.

Senator Manchin.

Secretary CARDONA. Senator.

Senator MANCHIN. Did I interrupt you?

Secretary CARDONA. No. Not at all.

HOMELESS EDUCATION

Senator MANCHIN. Thank you so much. Let me, a few things. And I appreciate so much, Secretary, on the difficult job you have. And I want to go through a few things because a lot of it either makes sense or doesn't make sense. But the main thing is, I have really a problem with homelessness with children. And I noticed

that the budget hadn't been increased for that. But I know that we put, myself and Murkowski, and all of our colleagues on both sides of the aisle supported $800 million going into that. But if the base doesn't move because, if it hasn't moved, it has been flat.

Secretary CARDONA. Right, right.

Senator MANCHIN. It is growing. I hope you would show attention to that. I know we were able to meet it this year, but we won't be able to meet a year after that.

Secretary CARDONA. Right.

Senator MANCHIN. Okay? So, if you can.

Secretary CARDONA. Sure. And I appreciate that. I recall experiences with students in the district where I worked before, who were experiencing homelessness. And I was always amazed at how they were able to engage in learning, and be a part of extracurriculars with housing instability, not knowing where they were going to go.

And that reduces the bandwidth for learning when you are thinking about where am I going to sleep tonight? So, the money, the $800 million for homeless education through ARP (American Rescue Plan) is critically important. But I also want to share that the focus on community schools—the focus on community schools, and the vast proposal in the American Families Plan, is also intended to address some of these issues that lead to homelessness, right?

Senator MANCHIN. And I think homelessness, and I was just asking, we need to describe it make sure we are all on the same page.

Secretary CARDONA. Right.

Senator MANCHIN. McKinney-Vento describes homelessness one way, and the Department describes it another way. So, they might show in West Virginia we don't have that many. We know we have because we are basically talking to the schools. We know kids have been disrupted, things like that.

Secretary CARDONA. Right.

Senator MANCHIN. We need to get that definition on the same wavelength. And let me go through a few more.

Secretary CARDONA. Sure.

Senator MANCHIN. So, on that one there, and the second tranche of money is going to supposed to come out for them, the McKinney-Vento. These are very, very important. The other thing I wanted to talk about is community college. Okay. First of all, I will talk about pre-K 3 and 4, which I agree one million percent.

Secretary CARDONA. Yes.

Senator MANCHIN. We have been doing it when it wasn't even popular.

Secretary CARDONA. Right.

Senator MANCHIN. Let me tell you why we did it. Just on nutrition, just giving kids some stability in life. And we had a challenge in Appalachia. So, we had to. And I did it when I was governor, we have done it, and it has worked out great. So, I am glad the whole Nation, because you cannot get ahead of the curve if you don't start at 3 and 4 years of age.

Secretary CARDONA. Right.

FREE COMMUNITY COLLEGE PROGRAM

Senator MANCHIN. God bless you on that. Where I disagree a little bit on community and technical colleges, and I disagree on free.

Secretary CARDONA. Mm-hmm.

Senator MANCHIN. And I said, let me earn it. I have told people this and, you know, someone said free college. I said, I have a child, who is up 30–40 years of age. If they had had free college, they would still be in college. They never left, they loved it so much. That is just a little tidbit on that.

But on community, here is the thing. Community technical colleges usually trained to skills, skill sets. It is not the same as a 4-year baccalaureate, or it gives them a segue, because their grades might not have been good enough. Okay. I understand all that. But most of it is skill sets.

If we could determine the skill sets we need in different categories, in different parts of our country. So, if our community colleges are training for one thing in West Virginia, you are training for another thing in California, another thing in different parts of the country. If those skill sets are met by someone who is going, and we have a Stafford loan that we basically guarantee federally, you take the loan out. You, you accomplish that within a 2-year period of a community college, and you have that associate degree, then it should be forgiven.

Let them earn it. Don't give it on the front end, earn it on the back end. You be surprised how much more they respect and appreciate something they have earned, than something you have given them. That is the only thing I have said about that, because I can tell you, as a parent, it works and works very well. And it is very efficient. You know, that would be like the same as a kid getting it: Where is my allowance, dad? And he is 35 years old. Do you understand where I am coming from?

Secretary CARDONA. Yes. Thank you, Senator. And I look forward to hearing more, and working with you, too. We need to make sure that all students have access.

Senator MANCHIN. Right.

Secretary CARDONA. We need to make sure that all students have either access to the skilled development that you mentioned. And you are absolutely right, the workforce needs——

Senator MANCHIN. And for a time, either way.

Secretary CARDONA. But also, it might be an opportunity for students who don't think that they have the potential to go to college, to get access to a 2-year college and then continue on to a 4-year school.

Senator MANCHIN. No problem.

Secretary CARDONA. So, we are widening the net, and we know the earning potential is greater when you graduate college. And I can tell you, 21 percent for community college graduates, I believe this is good for the economy in the long term. It is really creating a workforce with higher earning potential, better discretionary income, and I do think it is——

FINANCIAL LITERACY

Senator MANCHIN. What is the dropout rate? You ever look at the dropout rate? Do you know why student loans are so high? Because we cannot even demand that they have financial literacy. They come in, we cannot even have a registrar say, no, you are not getting that much, Miguel, you don't, you only need $4,000. I know you qualify because your family is for $11,004, but $4,000 is going to be fine. They cannot say that. So, end up stacking up debt, 2 years they flunk out or they quit because they haven't had to pay any payments out. And all of a sudden it comes tumbling down.

Secretary CARDONA. Yes.

Senator MANCHIN. We do a horrible job of managing student debt, but we are talking about, eliminated before you have people responsible for it.

Secretary CARDONA. We are going to be aggressive on the student debt, and making sure that we are communicating, that we are advocating for students, working with students, putting the students at the center. I am eager to get going on that and get started.

Senator MANCHIN. I cannot wait to work—I cannot wait to work with you.

Secretary CARDONA. Same here.

Senator MANCHIN. There are so many good things—and I would love to——

Secretary CARDONA. Same here. Thank you, Senator.

Senator MURRAY. Thank you.

Senator MANCHIN. Thank you.

Senator MURRAY. That will end our hearing today. I want to thank all of our fellow committee members for their participation. Secretary Cardona, thank you for your very thoughtful answers today, and to talk about the President's budget. I do look forward to continuing to work with you, to support students and families in our country.

ADDITIONAL COMMITTEE QUESTIONS

For any senators who wish to ask additional questions, questions for the record will be due Friday, June 25, at 5 p.m. The hearing record will also remain open until then for any member who wishes to submit additional materials for the record.

Secretary CARDONA. Thank you.

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

QUESTIONS SUBMITTED TO HON. MIGUEL CARDONA

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. I'd like to follow-up on our discussion during the hearing about implementation of fiscal equity requirements under current law. These requirements include resource allocation reviews by states, school districts and schools identified for support and improvement. Earlier this year, the Government Accountability Office (GAO) reported most states (43 of 51) indicated helping districts identify resource inequities as somewhat or very challenging based on survey results prior to the pandemic.

Please share the Department's plans in fiscal year 2021 and fiscal year 2022 for supporting, enhancing and monitoring resource allocation reviews by state and local education agencies and schools?

Answer. Section 1111(d)(3)(A)(ii) of the Elementary and Secondary Education Act of 1965 (ESEA) requires a State educational agency (SEA) to periodically review resource allocation to support school improvement in each local educational agency (LEA) in the State serving a significant number of schools identified for support and improvement. This requirement is part of the Department's monitoring protocol for Title I, Part A (available at: https://oese.ed.gov/files/2020/08/SEA-Protocol-Title-I.docx, under "Support for LEA and School Improvement"). Specifically, the protocol asks each SEA to describe how it periodically reviews resource allocation to support school improvement in each LEA serving a significant number or percentage of schools identified for comprehensive or targeted support and improvement.

In addition, the Department has been providing on-going technical assistance to States regarding this requirement. For example, the State Support Network, created by the Department in 2016 to provide technical assistance to support the transition to the Every Student Succeeds Act (ESSA), hosted a community of practice (CoP) with 13 States in 2019 that focused on planning for school resource allocation reviews. Please find more information and several resources here: https://oese.ed.gov/resources/oese-technical-assistance-centers/state-support-network/resources/resource-allocation-reviews-community-practice-summary/. The State Support Network also created a number of tools to assist with school improvement planning, including Tools for School Improvement Planning, a CoP for "Implementing Needs Assessments" and other resources for developing needs assessments. It also published several blogs about using school financial data in decisionmaking, including "Going Beyond Finances in Resource Allocation Decisions".

Further, the Department's Comprehensive Centers have provided individualized technical assistance to several States on this topic. In the past 2 years (since the 2019 competition established new TA providers), the Comprehensive Centers have been supporting States in their implementation of ESEA requirements. Two centers specifically have provided assistance to States on resource allocation reviews. The Region 15 Comprehensive Center is supporting Utah in the State's work. WestEd and the Region 15 Comprehensive Center have worked on an equity driven resource allocation framework during another State collaborative session. The Region 13 Comprehensive Center has worked with the Oklahoma State Department of Education to design a Resource Allocation Review toolkit. The Region 2 Comprehensive Center is supporting efforts in Connecticut and Rhode Island to develop a process to conduct resource allocation reviews.

The fiscal year 2022 request would build on these efforts to strengthen fisal equity through the Title I Equity Grants proposal, which would require each State to collect and make publicly available detailed data on the allocation of State and local education funding to school districts and schools. The proposal also would require the use of a consistent definition of per-pupil expenditures to support identification and mitigation of disparities in funding for high-poverty districts and schools, along with goals, interim targets, and timelines for closing identified gaps.

In addition, our proposal would encourage States to undertake a comprehensive review of their school finance systems through a $50 million reservation for voluntary State School Funding Equity Commissions that would (1) identify funding and educational opportunity gaps based on measures of equity and adequacy; (2) through extensive community engagement, develop detailed action plans for addressing existing gaps that include goals, interim targets, and timelines for closing identified gaps; and (3) report on progress toward these goals and targets.

Question. The Every Student Succeeds Act (ESSA) established a policy requiring the reporting of actual personnel and nonpersonnel expenditures, disaggregated by Federal, state and local source of funds for each school and school district in each State. Transparently providing this information would allow a range of uses from parents seeing easily how their school's spending compares to other schools in the district to other stakeholders using the information to participate in equity conversations on differences within and between states.

What is the Department's plan for ensuring states and school districts comply with ESSA's policy requiring the reporting of actual personnel and nonpersonnel expenditures, disaggregated by Federal, state and local source of funds for each school and school district and such information is made available to the public in an accessible and understandable manner?

Answer. The Department will ensure that SEAs and LEAS meet the report card requirements in ESEA section 1111(h), including the requirement to report per-pupil expenditure data. As you are aware, to help facilitate compliance with these requirements, the Department released non-regulatory guidance on State and local report cards in September 2019 (available at: https://oese.ed.gov/files/2020/03/report-card-guidance-final.pdf). This document includes detailed guidance for SEAs and LEAs regarding how to calculate per-pupil expenditures. The guidance encourages

SEAs to establish uniform statewide procedures for calculating per-pupil expenditures so that that data are uniform, understandable, and comparable across each LEA and school in a State.

To help ensure SEAs and LEAs comply with applicable requirements, including reporting per-pupil expenditures, a complete review of State and local report cards is included in the Department's Title I, Part A monitoring protocols, which are found at: https://oese.ed.gov/offices/office-of-formula-grants/school-support-and-accountability/performance-review/). An important aspect of our consolidated monitoring is a thorough review, for each State monitored in a particular year, of the State's report card to ensure that it includes all required elements. In addition, each January, the Department reviews each State website to determine if States and districts were in compliance with certain report card requirements, including reporting per-pupil expenditure data. The Department shares the results of its review with each State.

Over the past few years, the Department has initiated several technical assistance activities through the State Support Network, a four-year technical assistance contract begun in 2016 to support States and districts as they transitioned to the new ESSA requirements. Some of the technical assistance initiatives focused on State and local report cards, several of which have had a particular focus on per-pupil expenditure data. For example, in 2018 a community of practice involving Arkansas, Montana, North Dakota, New Mexico, Nevada, and Oklahoma focused on improving financial transparency. Other relevant communities of practice have focused on data quality, State and local report cards, and resource allocations. Information about these communities of practice can be found at: https://oese.ed.gov/resources/oese-technical-assistance-centers/state-support-network/resources/. The Network also created the "Financial Transparency and Reporting Readiness Assessment Tool." This tool can help States and districts meet the ESSA reporting requirements by identifying and analyzing school level expenditure data. This tool contains two components—a self-diagnostic framework and an analysis tool—that are designed to help districts and States understand the dynamics of school-level per-pupil reporting in their own district financial data. The tool can be found at: https://oese.ed.gov/resources/oese-technical-assistance-centers/state-support-network/resources/financial-transparency-reporting-readiness-assessment-tool/.

The Department is also funding the National Comprehensive Center's work with Georgetown University's Edunomics Lab to improve the quality and utility of school-level per-pupil expenditure data that is reported on State and local report cards as required under ESSA. Edunomics' initial work through this project involved analyzing the utility and usefulness of the school-level per-pupil expenditure data reported by each State (https://edunomicslab.org/state-data-tracker/). The current phase of the National Comprehensive Center's project with Edunomics is focused on working with a little under 20 school districts across different States to analyze each district's school-level expenditure data and build staff capacity to use data to drive decisionmaking for school improvement and equitable allocation of resources. After piloting tools and communication materials with these school districts, Edunomics will create a data visualization tool that all districts will be able to access to analyze their school-level per-pupil expenditure data and use it for finance decisionmaking.

Additionally, the Department's National Center for Education Statistics (NCES) has been working with over 20 States to improve the quality of expenditure data reported through a voluntary data collection. Recently, NCES issued a report on highlights of school-level finance data that were previously reported (https://nces.ed.gov/pubs2021/2021305.pdf).

The Department looks forward to expanding and building upon these efforts.

Question. I appreciate the Secretary's commitment to properly implementing the American Rescue Plan Act of 2021, including required state and school district set-asides for evidence-based interventions that address the academic, social, and emotional needs of students of color, students experiencing homelessness and other underserved student groups disproportionately impacted by the pandemic.

Please describe in detail how the Department will support, monitor and enforce requirements of the Elementary and Secondary School Emergency Relief Fund (ESSER) related to these set-asides and implementation of State and district ESSER plans related to these state and district learning loss requirements.

Answer. We support these requirements through the State plan process that the Department established, technical assistance efforts, non-regulatory guidance documents, and ongoing communication with States through our program officers.

The ARP ESSER State plan template requires grantees to describe how they will use each required set-aside under the ARP Act. We will monitor grantees against their approved ARP ESSER State plans as well as statutory requirements. As need-

ed, the Department will issue any findings and develop corrective action plans to address those findings. We are committed to working with grantees to resolve any findings.

In July, the Department issued a notice inviting comment related to data submission requirements for the ESSER (including ESSER I, ESSER II, and ARP ESSER) annual performance report (APR). The public is asked to comment on data quality and burden-related concerns related to collecting data on evidence-based summer learning or summer enrichment programs, evidence-based afterschool programs, and extended instructional time, among other items. After the data collection instrument is finalized and APR data is submitted, the Department will review grantee submissions to identify technical assistance needs and inform future monitoring of grantees.

Question. Department regulations state the Secretary may make a continuation award for a direct grant for a budget period after the first budget period of an approved multi-year project if Congress has appropriated sufficient funds for that purpose and the grantee is making substantial progress toward meeting the goals of the project, among other factors. The regulations further state "In deciding whether a grantee has made substantial progress, the Secretary may consider any information relevant to the authorizing statute, a criterion, a priority, or a performance measure, or to a financial or other requirement that applies to the selection of applications for new grants."

For fiscal year 2018 and 2019, how many direct grantees did not receive a continuation award for any reason? How many of such denials were related to the lack of substantial progress on performance? How much total funding was associated with such denial of a continuation award due to lack of substantial progress on performance?

Answer. In fiscal years 2018 and 2019, 11 grantees received a continuation award of $1, which is equivalent to a denial of a continuation award but is the amount required to keep the grant award active so grantees can complete work already funded. Of those, 10 were at least in part because of issues related to substantial progress. The total amount impacted grantees requested in their initial grant applications for the budget period not funded is approximately $38 million. In addition, the Department reduced continuation awards for other grantees if appropriate based on lack of substantial progress or other considerations. Further, some grantees asked for their continuation award to be reduced or for the grants to end early due to their concerns about not being able to implement their projects

Question. What policies or criteria have the Department adopted for considering information in making a determination of substantial progress? If none, how does the Department consistently evaluate substantial progress?

Answer. The Department follows the procedures for non-competing continuation awards as set forth in 34 CFR 75.253 and has internal policy about how to determine substantial progress, including what should be included in documentation for non-competing continuation award documents. The policy includes considerations to support decisionmaking, including program- and grantee-specific context, monitoring grantee performance, and discussing performance concerns with grantees. There are also internal discussions across offices to share about office practices and lessons learned, particularly in light of the COVID–19 pandemic and how best to consider associated disruptions to the project activities in making substantial progress determinations.

Question. Earlier this year, the Department withdrew a notice inviting applications for equity assistance centers (EACs) issued by the previous administration and extended existing contracts for 1 year. Equity Assistance Centers can play an important role in addressing racial and other equity concerns and designing and implementing school desegregation plans.

What are the Department's plans for the new notice inviting applications?

Answer. The Department plans to publish a notice inviting applications for new awards in the Federal Register in early 2022.

Question. How does the Department evaluate the resources needed for EACs to carry out this important work? Please share any analysis completed that supports the sufficiency of the $6.5 million requested for EACs to delivery timely and effective services across the entire United States.

Answer. We have not carried out any detailed analysis of EAC resource needs, but we do ask the EAC grantees to tell us in their annual performance reports the percentage of technical assistance requests received from organizations that they accepted during the performance period. Annually across 2017 to 2020, the EACs were able to accept between 95 percent and 98 percent of the technical assistance requests they received from the field.

Question. As of June 11, more than sixty percent of the CARES Elementary and Secondary School Emergency Relief (ESSER) funds ($8 billion of $13.2 billion) have been recorded as spent and outlaid from the Federal Treasury, while $2.1 billion of $54.3 billion provided through ESSER in the Coronavirus Response and Relief Supplemental Appropriations (CRRSSA) Act, 2021 and $25 million of $81 billion obligated from ESSER funds in the American Rescue Plan (ARP) Act of 2021 have been so reported. The Department also is in the process of reviewing state plans for the obligation of the remaining one-third of the ARP ESSER funds. However, earlier this year the Government Accountability Office reported "Federal spending data alone provide an incomplete picture of states' and school districts' spending" noting "there is often a significant gap between when a district uses the funds and when those funds are reported as spent in state and Federal reporting systems".

Please describe actions taken and planned by the Department to provide a more complete reporting of the use and status of ESSER funds.

Answer. Section 15011 of the CARES Act specifies the reporting requirements for covered programs. Existing reporting requirements, established under the Federal Funding Accountability and Transparency Act of 2006 (FFATA), Public Law No. 109—282, as amended by the Digital Accountability and Transparency Act (DATA Act), Public Law No. 113—101, were deemed sufficient to meet many of the reporting requirements for ESSER fund program. Specifically, States were required to report to the General Services Administration's FFATA Subaward Reporting System (FSRS), the amount of ESSER funds granted to school districts. These data are required to be reported directly from States and are made available to the Department and the public through USAspending.gov.

To further meet the Section 15011 reporting requirements and additional reporting requirements described within the ESSER Certification and Agreements, the Department created an annual reporting process for ESSER grantees (States). The annual report captures the following information (1) award and outlay information from the Department to ESSER grantees (States); (2) award and outlay information from ESSER grantees to their subgrantees (school districts/LEAs); and (3) subgrantee expenditure data. States were required to provide these data for district awards/expenditures made March 13, 2020—September 30, 2020 to the Department in early 2021. States will be required to provide additional reports on ESSER funds annually thereafter. The current ESSER reporting form is available for review through: https://api.covid-relief-data.ed.gov/collection/api/v1/public/docs/ESSER__Data__Collection__Final.pdf.

The Department acknowledges the importance of collecting and publicly reporting information on school districts' financial commitments (obligations), as well as outlays in order to more completely reflect the status of their use of Federal COVID–19 relief funds. Earlier this year, the Department proposed modifications to its ESSER annual report on State and school district spending data to include obligations data in subsequent reporting cycles. The proposed modifications, in accordance with the Paperwork Reduction Act, are currently available for public comment on the Federal Register: (https://www.Federalregister.gov/documents/2021/07/02/2021-14200/agency-information-collection-activities-comment-request-education-stabilization-fund-elementary-and).

Question. The Department's fiscal year 2022 Annual Performance Plan includes plans to identify opportunities to further build and use evidence in both formula and competitive grant programs.

How many competitive grant programs will include an evidence priority in fiscal year 2021?

Answer. In fiscal year 2021, 19 competitions required the use of evidence through a requirement or an absolute priority and 6 competitions included a competitive priority for evidence, and 18 encouraged applicants to rely on evidence by including it in selection criteria. An additional 2 competitions encouraged the use of evidence, such as through an invitational priority. Note that two competitions included evidence in more than one way and are thus counted in multiple categories. An unduplicated total of 43 competitions, or almost 60 percent of all competitions in fiscal year 2021, included evidence in at least one of these ways.

Question. How many competitive grant programs does the Department plan to include an evidence priority in fiscal year 2022?

Answer. The Department is discussing how best to use and build evidence in fiscal year 2022 competitions in alignment with statutory requirements, the body of available evidence, and lessons learned from previous competitions.

Question. Please identify the formula programs in which evidence building and use will be promoted and supported and the specific strategies to accomplish these goals.

Answer. The Department is supporting evidence building and use in the ESEA formula grant programs under Titles I, II, and IV. Evidence is also important within the context of IDEA formula grant programs. The Department works with the Comprehensive Centers, the Regional Educational Laboratories, and the technical assistance centers funded by the Office of Special Education programs to identify and share resources related to evidence building and use. To further support the identification of evidence-based practices, The Institute of Education Sciences' What Works Clearinghouse has recently added a new feature to its website—evidence tier "badges"—making it easier for users to know whether a given approach meets regulatory definitions of strong, moderate, or promising evidence. The WWC has also produced a series of technical assistance materials supporting the use of this feature and of the site overall. In addition, the Department is providing resources related to the evidence-based strategies required under the Elementary and Secondary School Education Relief Fund (ESSER Fund) under the American Rescue Plan. Within the context of safely reopening all schools, the Department has created the Safer Schools and Campuses Best Practices Clearinghouse. The Clearinghouse provides resources for practices that can be leading examples of how best to provide support to students and educators.

Question. Please describe efforts the Department has undertaken to build the internal capacity of staff in the use and implementation of evidence in activities funded through formula and competitive grant programs.

Answer. Measuring Skills. In 2020, ED developed and fielded the inaugural Data and Evidence Use Survey to measure staff skills. In Q3, the Office of the Chief Data Officer and the National Center for Educational Evaluation finalized the survey to respond to requirements of the Evidence Act and the Federal Data Strategy. CDOs in other agencies, including DHS, Commerce, Labor, and the Air Force have requested and received ED's survey to support their efforts. The results of the ED Survey are used to target staff training to improve data literacy and the capacity to use evidence.

The Evidence Act requires ED to assess its evaluation activities and agency capacity to support the development and use of evaluation. Congress explicitly made this requirement an agency-wide focus by instructing the Evaluation Officer to coordinate activities with agency officials in carrying out the functions of the Evaluation Officer in section 313(d) of title 5. Additionally, the Open Government Data Act requires the Chief Data Officer to support the Evaluation Officer in identifying and using data to carry out their statutory functions (§ 3520(c)(9)). The Evaluation Officer and the Chief Data Officer share common interest and authority in carrying out these functions and collaborate to field the annual Data and Evidence Use Survey.

Enhancing Skills. In 2021 ED launched its new Data Literacy Program, an intentional commitment to upskilling and continual learning. The program's goal is to develop a data culture at ED which enables all staff to speak a shared language around data and evidence. An expert-based approach was designed with support from The Data Lodge to provide a comprehensive corpus of flexible training to reach 3,500 staff. A partnership among ED's data office, research office, and human resources office resulted in a committee of 5 SES and GS15 leaders (including ED's Evaluation Officer) who developed the program blueprint. The blueprint mapped out a programmatic approach over 3 years, engaging ED offices in waves of customized, highly interactive sessions. Learning pathways were developed using Skillsoft. ED also developed plans for its own developed content and OCDO-led introductory workshops. Current training consists of four major components: (1) a hallmark initial, interactive 2-hour session "Exploring Data Literacy," (2) a one-hour ED-specific session, "Data Literacy 101" (3) four self-paced Learning Pathways of SkillSoft and external courses around evidence, decisionmaking, visualization, and analytics and (4) Learning Bytes, 15 min interactive topics recorded for easy use.

As ED staff begin to build data literacy, we continue our efforts to ensure that all staff are increasingly well-versed in the role of evidence in the work of schools, States, districts, and institutions of higher education. This past year, the Institute of Education Sciences and the Office of Planning, Evaluation, and Policy Development's Grants Policy Office (GPO) began offering "Evidence 101: Evidence Use at the Department of Education" to all new hires each quarter. As part of that training, new staff are introduced to statutory and regulatory requirements related to evidence use, the history of evidence use at the Department, and Department resources that can support their work. IES and GPO have also worked to build a virtual "community of practice" focused on evidence use based on a monthly newsletter to staff and associated website, the Evidence Connection. Approximately 250 staff across the Department are currently members and receive regular updates about resources that can support their efforts to use evidence in their own work and support the work of Department grantees.

Question. What is the Department's plan for continuing to build this capacity in the coming year?

Answer. In 2022, the ED Data Literacy Program will advance general staff ability to use, understand, and apply data and evidence to support decisionmaking around programs, policy, and operations. In 2022, the program will mature current engagement, curriculum, and resources. First, our engagement will broaden and deepen. Current Data Literacy Ambassadors for the first wave of ED offices participating in the program will customize and deliver existing program resources for relevant and actionable professional development. We will onboard additional offices to reach all 3,500 staff. Second, we will expand our current curriculum and add new courses, both interactive and virtual, asynchronous training. In 2022, we would like to add 4 major ED-specific courses featuring ED leaders, data processes, core data collections, and projects and tools. Lastly, we plan to augment and enhance resources around data language (e.g., Glossary), expertise (e.g., Directory) best practices and technology. To address the specific capacity-building needs of ED data professionals who support the production of evidence for grant programs, ED launched its new Data Professionals Community of Practice (DPCoP) in August 2021. In alignment with ED Data Strategy Objective 2.3 "Establish clear career paths and training curriculums for data professionals", the DPCoP will be a member-driven collaborative forum open to all ED data professionals. It will provide opportunities to share resources, tools, and successful practices in ED, inform leadership of data-related issues or concerns, and establish workgroups to address specific topics and challenges.

Question. How will the Department measure the growth of this capacity and expected improved targeting of resources to activities authorized by current law and aligned with evidence of effectiveness?

Answer. Evidence Use. As noted above, the Department is currently fielding the second iteration of its Data and Evidence Use Survey. The survey provides repeated cross-sectional estimates of ED staff capacity to use evidence in their work in areas including: (1) designing performance measures, (2) providing technical assistance on evidence definitions and requirements, and (3) monitoring grantees for effective evidence use. These data can be used to inform professional development opportunities for ED staff and the production of new resources for both staff and stakeholder use.

Resource Targeting. The Department will continue to work with SEAs, LEAs, institutions of higher education and other entities to support and increase the use of evidence to inform decisionmaking.

Question. How does the Department support and monitor SEA and LEA decisionmaking related to reasonably available determinations for evidence use under provisions of ESEA? What are the Department's plan to monitor and further support such determinations?

Answer. To support States, local educational agencies (LEAs), and schools in understanding the levels of evidence and interventions that meet them, the Department continues to disseminate information and provide technical assistance that highlights the evidence levels associated with a wide range of interventions, strategies, and approaches. Specifically, the Institute of Education Sciences What Works Clearinghouse (WWC) provides information on the evidence levels of interventions, strategies, and approaches on a wide range of topics through both Intervention Reports and Practices Guides, as well as individual studies. These user-friendly resources describe the level of evidence demonstrated, the characteristics of students, and the setting (urban, rural, suburban) of the research studies included. When evaluations produced through discretionary grant programs are submitted to the WWC for review to determine if they meet the evidence levels as defined in the ESSA, they can be highlighted in the WWC for use in supporting formula grantees. In addition, the Department's technical assistance network also produces resources to support their respective target audiences in understanding and using evidence. For example, this resource from the Regional Education Laboratory West provides important considerations for using evidence-based interventions.

With respect to monitoring use of evidence consistent with statutory and regulatory requirements, the Department includes questions regarding State and local compliance with evidence requirements as relevant in its monitoring protocols. In addition to understanding compliance with these requirements, these monitoring protocol questions allow program officers to identify areas for future technical assistance to support States, LEAs, and schools in their efforts to support student achievement.

Question. Last year, Congress removed a limitation on Federal education funds that prevented the use of such funds for transportation costs associated with school integration efforts.

How will the Department and its technical assistance providers work with state educational agencies (SEAs), local educational agencies (LEAs) and schools to inform and support them in this use of funds?

Answer. While Congress has removed certain limitations on the use of Federal education funds for transportation costs related to school integration plans, section 8526(2) of the Elementary and Secondary Education Act of 1965 (ESEA; 20 U.S.C. 7906(2)) prohibits ESEA funds from being used for transportation unless otherwise authorized by the ESEA. Most ESEA programs, including Title I Grants to LEAs and Title IV–A Student Support and Academic Enrichment Grants, do not authorize the use of funds to transport students to or from the regular school day.

In addition, section 802 of the Education Amendments of 1972 (20 U.S.C. 1652), titled "Prohibition against busing" includes a restriction for the use of funds under ED programs for the transportation of students or teachers to carry out a plan of racial desegregation of any school system, subject to certain contingencies.

Question. The previous administration failed to hire sufficient staff at the Office for Civil Rights, despite increases in appropriations and direction to do so.

Please describe the impact of each staff member having such a large caseload on their ability to thoroughly investigate complaints for associated evidence of systemic discrimination, timely process complaints, conduct compliance reviews, and monitor corrective actions.

Answer. A critical component of OCR's mission is the prompt investigation and resolution of complaints. A large per-staff caseload hinders OCR's ability to discharge this responsibility in a timely manner, which is also unacceptable to both complainants and recipients. OCR enforcement staff are required to conduct investigations and make determinations that are factually accurate and legally sound. Ensuring that these standards are met is a process that requires careful consideration of evidence provided by complainants and recipients. There are no "short cuts" to fulfilling OCR's mission. Current caseload numbers may impact OCR's ability to pursue proactive enforcement activities—compliance reviews and directed investigations—as well as effectively address an anticipated increase in complaints. In short, large caseloads can slow the delivery of justice for complainants and disserve school districts and postsecondary institutions that need guidance from the Department to ensure that they provide all students with an environment that is free from discrimination.

Question. How would the additional staff requested in the budget be utilized to enable OCR to more effectively fulfill its mission?

Answer. The majority of the additional staff will be utilized to resolve complaints and proactive activities (compliance reviews and directed investigations). OCR also requested additional legal staff that will develop policy guidance and regulatory materials for civil rights enforcement. Additional administrative staff will respond to Freedom of Information Act (FOIA) requests and help reduce the FOIA backlog and support Civil Rights Data Collection. Requested administrative staff are also needed to provide oversight of OCR's IT security, systems operations, website and records management.

Question. With respect to the Charter School Grants program, the fiscal year 2022 Congressional Justification indicates: "The Department will work to ensure that Charter Schools Grants funds support schools that are opened and operated with demonstrated family and community support, serve students from diverse racial and socioeconomic backgrounds, provide meaningful access to instruction for students with disabilities and English learners, maintain diverse educator workforces, and are subject to strong accountability, transparency, and oversight." The document also indicates that 14 state entity grantees provide or plan to provide technical assistance to charter school subgrantees in meeting the needs of students with disabilities, while 13 provide or plan to provide technical assistance to subgrantees in meeting the needs of English learners.

Please describe how the Department will accomplish each of the objectives outlined above.

Answer. The Department looks forward to working with you and with other stakeholders to address these important priorities.

Question. What does the Department know about the evidence base supporting the state entity technical assistance strategies for students with disabilities and English learners? With which tier, if any, of the definition in section 8101(21)(A) of the Elementary and Secondary Education Act (ESEA) do they align?

Answer. The program statue does not require applicants to propose evidence-based technical assistance strategies, as such, information regarding the evidence base for specific state entity (SE) technical assistance strategies implemented by SE grantees to support students with disabilities and English learners was not examined as part of the review referenced in the program's Congressional Justification.

Question. Please describe how the Department would use national activities funds available in fiscal year 2022 or supported by fiscal year 2022 appropriations for each of the national activities authorities available under the ESEA.

How would these plans be informed by evidence of effectiveness and the needs of those served by each of the authorities?

Answer. The Department does not yet have detailed plans for national activities in fiscal year 2022, since most planning for discretionary grant programs, including national activities authorities, takes place in the summer and fall prior to the beginning of the fiscal year. In addition, such plans depend in part on completion of final appropriations action, which includes both final funding levels and any applicable Congressional priorities for the use of national activities funds. Consideration of the needs of those served by our programs, as well as maximizing the use of evidence-based practices in meeting those needs, is the starting point for the Department's planning process.

Question. Under the Every Student Succeeds Act, SEAs and LEAs were required to develop plans for how they will identify and address the disparities of low-income and minority children being disproportionately taught by ineffective or inexperienced teachers.

How does the Department plan to support the timely implementation of such plans, including through the use of funds appropriated and requested for Title II–A of ESEA and other current law authorities?

Answer. ESEA section 1111(g)(1)(B) requires each SEA to describe how low-income and minority children enrolled in Title I, Part A schools are not served at disproportionate rates by ineffective, out-of-field, or inexperienced teachers, and the measures the SEA will use to evaluate and publicly report the progress of the SEA with respect to such description. Consistent with ESEA section 8302, the Department determined that this description was required as part of the consolidated State plan. Thus, each SEA was required to provide a description and how it will publicly report its progress in addressing any identified disparities. This provision does not require each SEA to submit a plan to the Department regarding how it will address those disparities. Information about the ESSA Consolidated State Plan, including each State's plan, can be found at: https://oese.ed.gov/offices/office-of-formula-grants/school-support-and-accountability/essa-consolidated-state-plans/.

The Department includes a review of this requirement in our monitoring protocols for Title I, Part A (available at: https://oese.ed.gov/files/2020/08/SEA-Protocol-Title-I.docx). The Department requires each SEA monitored to describe how it evaluated its progress toward ensuring that low-income and minority children in Title I schools are not served at disproportionate rates by ineffective, out-of-field, and inexperienced teachers and requests updated educator equity data. The Department also requires each SEA to describe how it publicly reported its progress toward meeting this requirement and asks for documentation of public reporting. Finally, the Department asks each SEA to describe how it supports LEAs in meeting this requirement. The SEA must describe how it ensures each LEA receiving a Title I, Part A subgrant identifies and addresses disparities resulting in low-income and minority students having disproportionate access to ineffective, out-of-field, and inexperienced teachers and requests that the SEA provide the following documentation, if applicable: LEA plan template reflecting this requirement; SEA guidance for LEAs related to equitable access to educators; and/or SEA monitoring protocol that demonstrates the SEA is verifying compliance with this requirement.

In our review of States over the past several years, the Department has issued two monitoring findings related to these requirements. In 2020, the Department cited Kentucky for two issues: 1) the State publicly reported inaccurate educator equity data; and 2) the State did not adequately document how it ensures that each LEA receiving a Title I subgrant identifies and addresses disparities resulting in low-income and minority students having disproportionate access to ineffective, out-of-field, and inexperienced teachers. In 2019, the Department issued a finding for New Jersey because although the State provides LEAs with multiple sources of related data, NJDOE is not currently evaluating or publicly reporting its progress in ensuring that low-income and minority children in Title I, Part A schools are not served at disproportionate rates by ineffective, inexperienced, and out-of-field teachers. The Department also issued a recommendation that New Jersey incorporate the requirement in ESEA section 1112(b)(2) in the State's subrecipient monitoring protocol to ensure that LEAs are meeting the statutory requirements to ensure that low-income and minority children in Title I, Part A schools are not served at disproportionate rates by ineffective, inexperienced, and out-of-field teachers. The reports for Kentucky and New Jersey (and all information related to the Department's consolidated monitoring, can be found at: https://oese.ed.gov/offices/office-of-formula-grants/school-support-and-accountability/performance-review/).

Regarding the use of Title II, Part A funds, the ESEA consolidated State plan asks each State to describe how it will use Title II, Part A funds to address this requirement, if it chooses to do so. In addition, the Department conducts an annual use-of-funds survey that asks SEAs to account for how State-level Title II, Part A funds are used. In school year (SY) 2019–2020, the most recent year for which survey data are available, 20 States indicated that they had spent at least some of their State-level Title II, Part A funds on activities to improve equitable access to effective teachers. The Department also conducts an annual survey on how LEA-level Title II, Part A funds are used; this survey is distributed to a nationally- and State-level-representative sample of LEAs in the country. In the survey covering expenditures in SY 2029–2020, 34 percent of responding LEAs indicated that they had spent at least some of their Title II, Part A funds on strategies to recruit, hire, and retain effective educators, although it is not clear if these expenditures specifically focused on ensuring equitable access effective educators in the districts. Additional detail on the results of the 2019–2020 surveys on how Title II, Part A funds were used is available at https://ies.ed.gov/ncee/pubs/2021011/index.asp.

The Department looks forward to expanding and building upon these efforts.

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

Answer. The Department is working to support HHS/CDC in the dissemination of guidance on vaccination of children and youth in the following manner:

—Collaborated and hosted a number of webinars to share mitigation strategies and guidance with the educators, school personnel, families, education stakeholders, and public

—Participated in bi-weekly ED/CDC planning calls to coordinate and organize scheduled webinars with HHS/CDC and the Department

—Posted resource materials on the Department of Education website, federally supported National Technical Assistance websites, as well the newly launched Safer Schools and Campuses Best Practices Clearinghouse (https://Bestpracticesclearinghouse.ed.gov)

—Participated in weekly established ED/CDC K–12 Touchbase calls to share information/research/guidance/upcoming agency planned activities

—Released Guidance Handbooks for the education community and included information on the topic

Question. The Department is developing supplemental priorities that may be applied to fiscal year 2022 and future grant competitions. The fiscal year 2022 Congressional Justification cites building and enhancing the instructional skills of a more diverse educator workforce as one possible supplemental priority.

What other supplemental priorities may be applied in fiscal year 2022 competitions?

Answer. The Department published a Notice of Proposed Priorities on June 30, 2021. There are six draft priorities: (1) Addressing the Impact of COVID–19 on Students, Educators, and Faculty; (2) Promoting Equity in Student Access to Educational Resources, Opportunities, and Welcoming Environments; (3) Supporting a Diverse Educator Workforce and Professional Growth to Strengthen Student Learning; (4) Meeting Student Social, Emotional, and Academic Needs; (5) Increasing Postsecondary Education Access, Affordability, Completion, and Post-Enrollment Success; and (6) Strengthening Cross-Agency Coordination and Community Engagement to Advance Systemic Change.

Question. Please identify the programs in which supplemental priorities will be applied.

Answer. The public comment period on the Notice of Proposed Priorities closed on July 30. The Department is reviewing the comments received and is considering how best to incorporate the Secretary's priorities in fiscal year 2022 competitions once the priorities are finalized.

Question. The budget includes $180 million, an increase of $15 million more than the fiscal year 2021 LHHS bill, for the National Assessment of Educational Progress (NAEP). The requested funds would maintain the current assessment schedule and provide funding for initial research and development investments intended to improve assessment quality and reduce future program costs. Over the past year, staff of the Department, National Center for Education Sciences and National Assessment Governing Board have provided informative updates on COVID–19-induced changes to the NAEP schedule and cost increases. Please provide:

A description of the policies and procedures implemented to ensure sufficient oversight and monitoring of contracts, including cost controls.

Answer. All Institute of Education Sciences (IES) acquisition activities, including NAEP, adhere to the Department's internal control strategies, policies, and procedures, with support from the Department's Contracts and Acquisition Management (CAM) team and Budget Service:

—Budget Service reviews every planned and on-going contract over $100k. The Budget Service team reviews, approves, and allots funds in the Department's payment management system before funds can be obligated to support payments to vendors (by CAM).

—CAM ensures that new and current contracts are legal and consistent with the Federal Acquisition Regulations (FAR). Contracting Officers (who possess warrants to sign off on new acquisitions and day-to-day commitments) independently review every invoice submitted by vendors before payment to ensure that costs are allowable. CAM also partners with IES to validate that FAR requirements are maintained across the lifecycle of every individual Assessment contract.

In the Department's most recent A–123 internal control entity level review of IES, completed in Fall 2020, IES (including the Assessment Division) provided evidence that IES meets and effectively implements all 17 GAO Green Book principal areas across all five GAO Internal Control component areas. IES recognizes that we need to do more to better anticipate the challenges of increased cost and uncertainties related to our assessment activities and unforeseeable events such as COVID–19.

IES recently established an Acquisition Program Management Office (PMO) that is focused on modernizing IES acquisition practices to better align with our business model and improve outcomes for customers. IES also recently awarded a small contract to conduct an independent validation and review of our current controls and funds management practices for the Assessment program. We initiated this contract in part due to the rising costs of assessments, reflected in the 2019 NAEP Alliance contracts, and in part due to the recent volume of unplanned and unforeseen task revisions and cost adjustments within the NAEP Alliance contracts resulting directly from COVID–19. We expect the results of this quick-turnaround review at some point early in the 2022 calendar year.

Question. The amount and descriptions of additional funding needed in each of fiscal year 2022, fiscal year 2023 and fiscal year 2024 for research and development investments;

Answer. The requested $15 million increase would support NAEP operations to fiscal year 24 and beyond for the current assessment schedule and would begin to support necessary R&D investments. However, we anticipate that additional investments would be needed in future years both to maintain NAEP as the gold standard of large-scale assessments and to produce cost savings and efficiencies in program administration costs over time (see responses to 1d and e below).

We also note that while this response is based on the most accurate budgetary estimates currently available, there may be adjustments to these estimates based on additional modifications to NAEP alliance contracts in response to the impact of COVID–19 on NAEP activities.

Estimated Allocations to Operations and R&D based on increase of $15 million per year (as of 8.4.21)

Funding stream	FY22	FY23	FY24	FY25	FY26	FY27	FY28	Total approp
Operational	$14M	$10M	$12M	$12M	$12M	$12M	$12M	$84M
Current R&D*	$1M	$5M	$3M	$3M	$3M	$3M	$3M	$21M
Total	$15M	$15M	$15M	$15M	$15M	$15M	$15M	$105M

*See response to question 1d below for current R&D activities.

Question. The amount of additional funding needed in each of fiscal year 2022, fiscal year 2023 and fiscal year 2024 for operating costs;

Answer. Please see the response to 1b. above. Based on the best estimates available at this time, the requested $15 million increase would support operational funding needs through fiscal year 2024; however, as noted above, it may not fully support currently planned R&D efforts.

Question. Studies planned and other actions necessary for maintaining the continuity and integrity of NAEP in any changes implemented to reduce future program costs;

Answer. We have a number of actions planned to achieve efficiencies, starting in 2022. These include (i) transitioning to online assessments, (ii) transitioning from

Surface Pro tablets to more cost-efficient devices in the short term and to school-owned devices in the longer term, (iii) introducing automated scoring, (iv) reducing the number of field staff needed to conduct the assessments, and (v) implementing design changes, including adaptive testing and two-subject design. Each change will be carefully studied in multiple rounds of reviews to first explore feasibility and examine effect(s), if any, on student performance. If any effect on student performance is detected, IES will need to implement a bridge study to account for the effect and maintain trends.

Question. Expected savings and supporting information by fiscal year associated with research and development investments for reducing future program costs; and

Answer. We expect to realize savings beginning in fiscal year 2024 as currently funded R&D efforts in automated scoring and the eNAEP test platform take effect. These savings, which are measured against estimated costs on the current NAEP platform in the absence of proposed R&D-based modernization efforts, will grow through fiscal year 2030 assuming IES is able to implement fully its planned R&D investments on eNAEP, which would enable NAEP to be administered on less costly devices, including school equipment (device agnostic), and with reduced NAEP field staff. We also note that the capacity to test individual students in multiple subjects using such devices should dramatically reduce student and school sample sizes, yielding further savings. Estimated savings by two-year NAEP cycle are in the table below. Total expected savings associated with current (and planned future R&D) investments over the period are approximately $98 million. Note that these estimated savings assume increased R&D funding in future years.

Two-year cycle	Expected Savings
FY23—24	$4M
FY25—26	$20M
FY27—28	$42M
FY29—30	$32M
Total	$98M

Question. Potential additional reductions to future program costs or program enhancements resulting from recommendations made under current contract with National Academies of Sciences, Engineering, and Medicine.

Answer. An independent expert panel convened by the National Academies of Sciences, Engineering, and Medicine (NASEM) is currently underway. This 17-month study focuses on how NAEP might modernize its operations and reduce costs through innovations such as those mentioned in (d) above. We expect that NASEM's recommendations, once released in February 2022, will help further refine current plans for modernization. Some of the innovations under consideration by NASEM are not expected to result in cost savings (e.g., adaptive testing), but could improve measurement quality, especially for students scoring at below NAEP Basic level.

Question. The current NAEP assessment schedule outlines plans to conduct the Long-Term Trend (LTT) assessment for 17 year-olds in 2022 as a result of the delay caused by the COVID–19 pandemic. However, also repeating the LTT for 9-year-olds in 2022 would provide nationally representative information on the impact of COVID–19 on reading and math learning, including for students of color. This kind of information would be one type of information and research on learning loss intended to be funded by the $100 million provided to the Institute of Education Science by the ARP.

Will the assessment schedule be changed to collect this important information?

Answer. Yes. NCES and NAGB agreed that the NAEP schedule should be changed to collect this important information for age 9-year-olds in 2022, while canceling the LTT for 17-year-olds. NAGB will take an official vote on the change to the schedule at the August meeting. Additionally, preparation for both LTT age 9 and age 17 would be unsustainably expensive given available funding and the expected $8m cost for each of these age groups. That is, preparation for paper booklets, quality control reviews, printing, and distribution could not be done for both cohorts given anticipated budget shortfalls in 2024. Accordingly, we put preparations for LTT age 17 on hold in June based largely on cost considerations. NCES has also confirmed that it is too late to restart preparation work for age 17, even if funds were made available.

Question. If the LTT for nine year olds was not paid for with funds available to IES in the ARP, how would such a change impact the NAEP 2021 operating plan? How would such an additional cost for LTT impact the rest of the currently approved assessment schedule? Please provide a revised operating plan.

Answer. The Department considered using ARP funds for LTT but decided against doing so because of legal concerns with using ARP funds for research. Regarding the impact on the NAEP budget, since the data collection costs for the two cohorts are comparable, changing from an assessment of 17-year-olds to 9-year-olds would have no real effect on anticipated outlays. The anticipated shortfall in 2024 would remain the same if the requested $15 million increase in fiscal year 2022 is not enacted.

We note that in 2025 the schedule calls for all three ages, 9, 13, and 17 to be collected again as part of a bridge study to transition the assessments from paper to digital formats.

Question. ESEA contains provisions on parent and family engagement under ESEA programs and authorizes support for Statewide Family Engagement Centers. These ESEA provisions include a 1 percent set-aside of LEA Title I–A allocations for effective parent and family engagement activities, along with requirements for parent, family and community engagement activities using English Language Acquisition funds.

What are the Department's plans for supporting SEAs and LEAs in implementing parent and family engagement requirements under section 1116 of ESEA, including in identifying and overcoming barriers to greater participation by parents who have limited English proficiency or are of any racial or ethnic minority background?

Answer. The Department administers the Statewide Family Engagement Centers program which is authorized under Title IV, Part E of the Elementary and Secondary Education Act of 1965, as amended. The purpose of the SFEC program is to provide financial support to organizations that provide technical assistance and training to SEAs and local educational agencies LEAs in the implementation and enhancement of systemic and effective family engagement policies, programs, and activities that lead to improvements in student development and academic achievement. For those families from diverse background and who have limited English proficiency, there are 12 statewide family engagement centers across the country that (1) carry out parent education and family engagement in education, programs and (2) provide comprehensive training and technical assistance to SEAs, LEAs, schools identified by SEAs and LEAs, organizations that support family-school partnerships and other such programs.

In addition, the Department administers the Comprehensive Centers program, which is authorized under Title II, Sec. 203, of the Educational Technical Assistance Act of 2002. The Comprehensive Centers address needs identified by SEAs in meeting ESEA student achievement goals, as well as priorities established by states. As part of this work, Comprehensive Centers have developed resources on various topics (e.g., literacy instruction) to support SEAs, LEAs, and educators. Building SEA and LEA capacity to engage parents and families is a key element of this support (e.g., Evidence Based Literacy Instruction: Families as Partners). Comprehensive Centers have also developed resources that specifically focus on establishing and nurturing successful school-family relationships. Finally, parent and family engagement has played an important role in the Summer Learning and Enrichment Collaborative (SLEC). Several SLEC sessions have provided SEAs, LEAs, and other participants with support on developing partnerships for family engagement in high-needs communities, creating authentic partnerships with marginalized families and communities, and meeting whole student and family needs through collaborative partnerships at school.

The Department looks forward to expanding and building upon these efforts.

Question. How does the Department monitor and support the coordination and integration of parent and family engagement strategies under Title I–A with other relevant Federal programs?

Answer. Under ESEA section 1116, an LEA receiving Title I, Part A funds must develop a written parent and family engagement policy in collaboration with parents and family members of participating students. Among other things, the policy must describe how, to the extent feasible, the agency will coordinate and integrate Title I parent and family engagement strategies with strategies under other relevant Federal, State, and local laws and programs. An LEA's policy also must describe how it will annually evaluate of the content and effectiveness of the parent and family engagement policy, including identifying barriers to participation, with particular attention to parents who are economically disadvantaged, disabled, have limited English proficiency, have limited literacy, or are of any racial or ethnic minority background. The Department monitors ESEA section 1116, Parent and Family Engagement, as part of the Title I, Part A monitoring protocol (available at: https://oese.ed.gov/files/2020/08/SEA-Protocol-Title-I.docx). Within the protocols, the Department specifically asks each SEA it monitors to describe how it reviews LEA parent and family engagement policies and practices to ensure the LEA meets the require-

ments of section 1116, including those referenced above. In addition, the Department asks each SEA to describe how, in its review of the LEA's parent and family engagement policies and practices, it ensures that the LEA's parent and family engagement policies provides opportunities for the participation of all parents and family members (including parents and family members who have limited English proficiency, parents and family members with disabilities, and parents and family members of migratory children) and provides information and school reports, in a format and, to the extent practicable, in a language that parents understand. The Department asks that each SEA submit its process to review LEA policies and procedures for family engagement as evidence during the monitoring review.

Additionally, the Department of Education has an Office of Communications and Outreach that has a Family and Community Engagement Team. The goal of the Team is to expand efforts to help schools, districts, and states better engage families in education. This team works to monitor and support the coordination and integration of parent and family engagements strategies under Title I, Part A (and other Titles) with other relevant Federal programs.

Question. The fiscal year 2022 Annual Performance Plan identifies a goal of improving access to quality educational programs in correctional settings.

Please identify the programs and strategies involved in improving access to quality educational programs in correctional settings.

Answer. The Office of Career, Technical, and Adult Education's Integrated Education and Training (IET) in Corrections Project will identify, develop, and document IET in corrections models to demonstrate how to extend existing secondary-postsecondary pathway models to include the corrections system. The project is intended to provide strategies that can be disseminated and replicated.

Second Chance Pell (an Experimental Site Initiative) launched in 2016 and allowed 67 colleges and universities enroll incarcerated students using Pell Grants on an experimental basis. In 2020, the program was expanded to allow an additional 67 colleges and universities to serve even more students. On July 30, 2021, the Department announced a further expansion of Second Chance Pell to gain critical insights about how to reinstate Pell Grant eligibility within correctional facilities, consistent with the implementation of the provisions of the Consolidated Appropriations Act of 2021 that will expand Pell Grant eligibility for all eligible incarcerated students on July 1, 2023. The Department has announced plans to publish regulations on the program prior to its implementation and held public hearings in June of 2021 to that end.

The Department has already taken steps to implement changes to the Free Application for Federal Student Aid (FAFSA), which incarcerated students and education institutions alike have reported as a major stumbling block in implementing college-in-prison programming. For example, for the 2021–2022 award year FAFSA, the Department has removed the impact of responses to questions about Selective Service registration and requirements around drug convictions. These questions will be removed entirely from future FAFSAs.

Question. How will the Department work with relevant Federal agencies on this goal?

Answer. The Department currently staffs interagency working groups including the Federal Advisory Committee on Juvenile Justice, the Legal Aid Interagency Roundtable, and the Interagency Working Group for Youth Programs. The Department liaises on a regular basis with other Federal agencies including the Departments of Justice, Labor, Health and Human Services, and the Consumer Financial Protection Bureau to update these agencies on Departmental initiatives, such as Pell reinstatement, that are focused on quality educational program in correctional settings. The Department also works collaboratively with these agencies as they implement programming for incarcerated.

Question. CRDC data from the 2017–18 school year survey show that Black students represented 15 percent of student enrollment but 38 percent of students who received one or more out-of-school suspensions. Such discipline contributes to lost instructional time and negative life outcomes.

Please describe planned activities for how the Department will support a reduction in racial disparities in school discipline.

Answer. The Department is aware of these and other disparities in the administration of school discipline nationwide—and the adverse impacts that these disparities have on students—and is actively planning to address these issues. The Department anticipates issuing new guidance following its 2018 rescission of the Dear Colleague letter on Nondiscriminatory Administration of School Discipline and related materials, which provided guidance to schools on how to identify, avoid, and remedy discrimination based on race, color, or national origin in the design and administration of school discipline and create a positive school climate. As part of that process,

on May 11, 2021, the Department's Office for Civil Rights (OCR) and the Civil Rights Division of the U.S. Department of Justice organized a virtual convening session, Brown 67 Years Later: Examining Disparities in School Discipline and the Pursuit of Safe and Inclusive Schools, where students, educators, school administrators, civil rights lawyers, and researchers considered the impact of exclusionary school discipline policies and practices on our nation's students, particularly students of color, students with disabilities, and LGBTQ+ students. As a follow up to the convening, on June 8, 2021, OCR published a Request for Information (RFI), seeking public comments on what guidance schools and school districts need to ensure all students attend welcoming, supportive, and safe schools. As stated in the RFI, OCR recognizes that students may experience multiple forms of discrimination at once and encourages commenters to identify and address individual and intersectional discrimination as appropriate. OCR expects that the public comments in response to the RFI will inform future decisions about what policy guidance, technical assistance, or other resources would assist schools that serve students in pre-K through grade 12 with designing and administering school discipline in a nondiscriminatory manner and improving school climate and safety. The comment period for the RFI closed on July 23, 2021, and OCR is in the process of reviewing the comments received.

Question. The fiscal year 2022 President's budget proposes to continue authority for performance partnership pilot and proposes a priority for such pilots to include communities disproportionately impacted by COVID–19.

What are the Department's plans for inviting new applications for performance partnership pilots?

How will these pilots be informed by the national evaluation released earlier this year, including the recommendations for more planning time, additional guidance and technical assistance, and support of systems change through developing and implementing related metrics?

Answer. The Department, as part of the ongoing Administration transition, is continuing to evaluate the lessons learned from previous Performance Partnership Pilots for Disconnected Youth (P3), including recommendations from the national evaluation, and how best to position the program for maximum impact in the context of State and local needs arising from the COVID–19 pandemic (including any flexibilities that could facilitate more effective use of ARP funds), as well as other Administration priorities.

Question. The "Foundations for Evidence-Based Policymaking Act of 2018" includes key provisions related to developing a multi-year learning agenda, evaluation plan, improving coordination of data government at the Department, and improving accessibility of education data.

What is the Department's timeline for release of its multi-year learning agenda? Please describe stakeholder consultations that have occurred or will occur during its development.

Answer. Per OMB guidance, the Department will publish its multi-year Learning Agenda for fiscal year 22–26 in February 2022, concurrent with the release of the President's fiscal year 2023 Budget. Consultation with stakeholders will include a broad Request for Information published in the Federal Register, along with targeted outreach to specific communities based on their role (e.g., chief state school officers) or area of emphasis (e.g., researchers focused on, or advocacy organizations related to, Federal student aid).

Question. When will the Department release its evaluation plan?

Answer. Per OMB guidance, the Department will publish its fiscal year 2023 Annual Evaluation Plan in February 2022, concurrent with the release of the Presidents' fiscal year 2023 Budget. The Department's fiscal year 22 Annual Evaluation Plan, which was delayed so that elements of the document could be better aligned to the Secretary's priorities and the Department's strategic planning efforts, will be posted in August 2021 to https://ed.gov/data.

Question. What is the Department's timeline for implementing other provisions of the Act?

Answer. ED's implementation of the Evidence Act is informed by the recommendations of the Commission on Evidence-Based Policymaking, the Federal Data Strategy's Principles and Practices, and the Office of Management and Budget's Phase 1 guidance on Evidence Act implementation (M–19–23). Our implementation also is informed by discovery and assessment activities in our own agency that led to a coherent ED Data Strategy that now serves as ED's roadmap to data maturity.

The ED Data Strategy—the first of its kind for the U.S. Department of Education—was released in December of 2020. The four ED Data Strategy goals are highly interdependent with cross-cutting objectives requiring a highly collaborative effort across ED's offices.

—The strategy calls for strengthening data governance to administer the data it uses for operations, answer important questions, and meet legal requirements. To that end, we are developing a holistic agency-wide framework with established data governance structures, functions, roles, policies, and procedures and developing a comprehensive data quality framework for the agency.
—To accelerate evidence-building and enhance operational performance, it requires that ED make data more interoperable and accessible for tasks ranging from routine reporting to advanced analytics. To inform decisionmaking processes, we are working to connect fragmented data from disparate sources, so we can answer critical questions, and strengthen grant programs' performance and accountability measures.
—The high volume and evolving nature of ED's data tasks necessitates a focus on developing a workforce with skills commensurate with a modern data culture in a digital age. We are developing an ED data workforce plan to support long-term planning for our data-related human capital needs; we are also building the capacity of our data workforce while we increase data literacy among all staff.
—At the same time, safely and securely providing access for researchers and policymakers helps foster innovation and evidence-based decisionmaking at the Federal, state, and local levels. Aligned with these efforts, we are developing an Open Data Plan, while awaiting OMB guidance on final requirements for that plan; we are also building toward a comprehensive data inventory to catalog data assets for both external open data and internal sources and will incrementally expand the number of Department data assets listed in the Federal Data Catalog.

Achieving the four ED Data Strategy goals requires a concerted effort to address short-term challenges and thoughtfully set a course for long-term data maturity. Each Goal includes a set of objectives—designed to be completed in the next 12 to 18 months—that form an action plan for tackling short-term challenges to continue building the foundation of a data-driven culture. Future objectives under the four goals will iteratively represent the next set of implementation challenges to raise ED offices and the agency as a whole to an even higher level of data maturity.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

Question. The Department notified me and other Members of Congress on February 13, that Secretary DeVos had decided not to extend the closed school discharge look-back period for students who attended schools owned by Education Corporation of America (ECA). As the Department has previously stated, "during the months of March, April, and May 2018, ACICS placed many locations of ECA on either campus-level show-cause or campus-level compliance warning due to student achievement rates" and on "May 8, 2018, ACICS placed ECA on show-cause due to adverse action by another agency."

Actions toward the removal of accreditation are a clear example of exceptional circumstances as provided under 34 CFR §685.214. Will you reconsider this decision?

Answer. Question answered elsewhere in this document.

Question. In that same February notification, the Department noted that Secretary DeVos had not yet made a decision on the request from me and other Members of Congress made on December 21, 2018, to extend the look back period for Vatterott students—which also met the exceptional circumstances bar in the law.

Will you look into this matter and render a decision?

Answer. The Department is cognizant of the significant harm to students that occurs when a college suddenly closes. We are reviewing a number of school closures to determine whether an extension of the look-back window is appropriate, and hope to be able to share more on the results of that review soon.

Question. On June 23, 2021, the Department provided a response to a letter I sent on October 29, 2020, with several colleagues to then-Secretary DeVos. Secretary DeVos failed to respond. Your Department's response mentioned the announced rulemaking in several of the areas mentioned in the letter—including closed school discharge.

While I'm pleased the Department is taking up many of these issues in rulemaking, when can we expect a decision from you to the specific requests in the letter—related to extending closed school look-back dates?

Answer. We are reviewing a number of school closures to determine whether an extension of the look-back window is appropriate, and hope to be able to share more on the results of that review soon.

Question. Since June 2018, the Department has released borrower defense data on a quarterly basis:

Please provide a breakdown of "total denied" borrower defense claims to date by institution.

Answer. Beginning in December 2019, the term "total denied" was no longer used in the quarterly borrower defense reports. The term "total ineligible" is used to refer to applications in which the borrower has been notified that their claim does not meet the requirements for a borrower defense to repayment discharge.

Question. Please provide a breakdown of "total ineligible" borrower defense claims to date by institution.

Answer. An Excel file providing the requested data as of June 30, 2021, is enclosed.

Ineligible Borrower Defense Applications by Institution as of 06/30/2021

Note: Totals may not sum due to rounding.

OPEID	School Name	School Type	Rounded Ineligible Case Count
02098800	University of Phoenix	Proprietary	20,030
02291504	ITT TECHNICAL INSTITUTE	Proprietary	6,410
01072700	DeVry University	Proprietary	6,210
02606202	Everest College	Private, Nonprofit	5,570
00458600	Purdue University Global	Public	3,710
00149901	Everest University - Orlando South	Private, Nonprofit	3,290
00748100	SANFORD-BROWN COLLEGE	Proprietary	2,880
03022600	LE CORDON BLEU COLLEGE OF CULINARY ARTS	Proprietary	2,050
03010600	Virginia College	Proprietary	1,790
00450700	ALTIERUS CAREER COLLEGE	Private, Nonprofit	1,600
00188100	ASHFORD UNIVERSITY	Proprietary	1,450
00149904	Everest University - Tampa	Private, Nonprofit	1,380
00709100	EVEREST INSTITUTE	Private, Nonprofit	1,370
02346200	WyoTech	Private, Nonprofit	1,310
02113600	AMERICAN INTERCONTINENTAL UNIVERSITY	Proprietary	1,190
02075400	DEVRY UNIVERSITY - DOWNERS	Proprietary	930
01014800	COLORADO TECHNICAL UNIVERSITY	Proprietary	900
00853200	HEALD COLLEGE - HAYWARD	Proprietary	890
00747000	Art Institute of Pittsburgh (The)	Proprietary	840
00915705	WyoTech - Blairsville	Proprietary	740
00723401	HEALD COLLEGE - HONOLULU	Proprietary	710
00814604	Everest University - Pompano	Private, Nonprofit	700
00112300	BROOKS INSTITUTE	Proprietary	660
00809300	HEALD COLLEGE - FRESNO	Proprietary	650
00723410	HEALD COLLEGE - STOCKTON	Proprietary	640
00723404	HEALD COLLEGE - CONCORD	Proprietary	630
00723405	HEALD COLLEGE - MILPITAS	Proprietary	630
02504200	WALDEN UNIVERSITY	Proprietary	610
00464600	MINNESOTA SCHOOL OF BUSINESS	Proprietary	580
02300104	Altierus Career College - Tacoma	Private, Nonprofit	580
02599801	Everest University - Largo	Private, Nonprofit	570
02362100	FULL SAIL UNIVERSITY	Proprietary	560
01151002	EVEREST INSTITUTE - EVEREST COLLEGE	Proprietary	550
00907906	EVEREST COLLEGE- EVEREST INSTITUTE	Private, Nonprofit	540
00982800	Altierus Career Education	Private, Nonprofit	510
02262300	HEALD COLLEGE	Private, Nonprofit	510
02263100	ANTHEM COLLEGE	Proprietary	510
02593100	HEALD COLLEGE - ROSEVILLE	Proprietary	500
02151900	KEISER UNIVERSITY	Private, Nonprofit	490
03267300	Capella University	Proprietary	470
03395307	ICDC College	Proprietary	470
00747700	HEALD COLLEGE - RANCHO CORDOVA	Proprietary	460
02596600	ATI CAREER TRAINING CENTER	Proprietary	450
00145900	STRAYER UNIVERSITY	Proprietary	440
00464200	GLOBE UNIVERSITY	Proprietary	440
02237500	Las Vegas College	Proprietary	440
00723603	ARGOSY UNIVERSITY - THE ART INSTITUTE OF CALIFORNIA - LOS ANGELES	Proprietary	430
01185802	EVEREST COLLEGE - BURR RIDGE	Private, Nonprofit	410
02295000	EVEREST COLLEGE PHOENIX	Proprietary	410
00753100	ACADEMY OF ART UNIVERSITY	Proprietary	400
01019500	Art Institute of Fort Lauderdale (The)	Proprietary	400
03003200	Everest University - Everest Institute - Kendall	Private, Nonprofit	400
03034000	HEALD COLLEGE - SALINAS	Proprietary	400
00835000	Art Institute of Philadelphia (The) -	Proprietary	390
01185803	EVEREST COLLEGE - MELROSE PARK	Private, Nonprofit	390
01014805	COLORADO TECHNICAL UNIVERSITY - ON LINE	Proprietary	370
01049000	REGENCY BEAUTY INSTITUTE	Proprietary	350
01287302	WYOTECH - EVEREST COLLEGE	Proprietary	350
00723402	HEALD COLLEGE - PORTLAND	Proprietary	340
02591100	CAREER POINT COLLEGE	Proprietary	340
00450303	Altierus Career College - Fort Worth South	Private, Nonprofit	320
00512727	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC CINCINNATI	Proprietary	320
00915706	WyoTech - West Sacramento Campus	Proprietary	300
00926701	EVEREST COLLEGE - CHESAPEAKE	Private, Nonprofit	300
02174900	INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY - COLLINS COLLEGE	Proprietary	300
02179907	Argosy University - Phoenix	Proprietary	300

03072700	WESTWOOD COLLEGE - LOS ANGELES	Proprietary	300
00149902	Everest University - Melbourne	Private, Nonprofit	290
00832200	DEVRY INSTITUTE OF TECHNOLOGY	Proprietary	290
02300103	EVEREST COLLEGE - EVERETT	Private, Nonprofit	290
02121800	Everest University - Everest Institute - Miami	Private, Nonprofit	280
01162600	WESTWOOD COLLEGE - SOUTH BAY	Proprietary	270
02078900	Art Institute of Colorado (The)	Proprietary	270
02261302	EVEREST INSTITUTE - HOUSTON GREENSPOINT	Private, Nonprofit	270
02305800	FLORIDA CAREER COLLEGE	Proprietary	270
00450701	EVEREST COLLEGE- EVEREST COLLEGE, AURORA	Private, Nonprofit	260
00982801	EVEREST INSTITUTE- DEARBORN	Private, Nonprofit	260
00977700	KAPLAN COLLEGE	Proprietary	250
01206100	BRYMAN COLLEGE	Proprietary	250
02261303	Altierus Career College - Houston Hobby	Private, Nonprofit	250
02609200	Vatterott College	Proprietary	250
03832300	DADE MEDICAL COLLEGE	Proprietary	250
01035601	EVEREST INSTITUTE - DECATUR	Proprietary	240
02352200	LE CORDON BLEU COLLEGE OF CULINARY ARTS IN CHICAGO	Proprietary	240
03549300	Ultimate Medical Academy	Private, Nonprofit	240
01102401	EVEREST COLLEGE - CHICAGO	Proprietary	230
03115100	HERITAGE COLLEGE	Proprietary	230
00380700	MOUNTAIN STATE UNIVERSITY	Private, Nonprofit	220
00822100	Universal Technical Institute	Proprietary	220
01258400	Illinois Institute of Art (The)	Proprietary	220
02327600	Argosy University - The Art Institute of California - San Diego	Proprietary	220
02617506	Altierus Career College - Tigard	Private, Nonprofit	220
03006800	LE CORDON BLEU INSTITUTE OF CULINARY ARTS	Proprietary	220
02300105	EVEREST COLLEGE - EARTH CITY	Private, Nonprofit	210
03076400	BRYMAN SCHOOL OF ARIZONA (THE)	Proprietary	210
00927000	Art Institute of Atlanta (The)	Proprietary	200
00982804	Altierus Career Education - South Plainfield	Private, Nonprofit	200
01303900	South University	Proprietary	200
02100401	EVEREST INSTITUTE - KALAMAZOO	Proprietary	200
03035800	HERITAGE INSTITUTE	Proprietary	200
00888700	Concorde Career College	Proprietary	190
02291300	Art Institute of Seattle (The)	Proprietary	190
02617507	EVEREST COLLEGE - EVEREST INSTITUTE - BENSALEM	Private, Nonprofit	190
04051311	Art Institute of Las Vegas (The)	Proprietary	190
00736200	MEDTECH COLLEGE	Proprietary	180
00982803	EVEREST INSTITUTE - DETROIT	Private, Nonprofit	180
01024800	ART INSTITUTES INTERNATIONAL MINNESOTA (THE)	Proprietary	180
02296605	DEVRY UNIVERSITY - ADDISON	Proprietary	180
00153410	EVEREST UNIVERSITY - EVEREST COLLEGE - MILWAUKEE	Proprietary	170
01072714	DEVRY UNIVERSITY - DECATUR	Proprietary	170
00458300	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC SOUTH BEND	Proprietary	160
01005700	AMERICAN COMMERCIAL COLLEGE	Proprietary	160
02117100	Art Institute of Houston (The)	Proprietary	160
02121801	EVEREST INSTITUTE - HIALEAH	Proprietary	160
02179900	Argosy University	Proprietary	160
02614201	Miller - Motte Technical College	Proprietary	160
03084602	Art Institute of Phoenix (The) - Art Institute of Las Vegas (The)	Proprietary	160
03390300	LINCOLN TECHNICAL INSTITUTE	Proprietary	160
00266700	DOWLING COLLEGE	Private, Nonprofit	150
00267800	BRYANT & STRATTON COLLEGE	Proprietary	150
00781900	Art Institute of Portland (The)	Proprietary	150
00450301	EVEREST COLLEGE - MCLEAN	Private, Nonprofit	140
00748600	NEW ENGLAND INSTITUTE OF ART (THE)	Proprietary	140
00780400	STAR CAREER ACADEMY	Proprietary	140
00974800	Carrington College	Proprietary	140
02075700	Briarcliffe College	Proprietary	140
02525600	ART INSTITUTE OF NEW YORK CITY (THE)	Proprietary	140
03062300	WESTECH COLLEGE	Proprietary	140
03426400	ANTHEM INSTITUTE	Proprietary	140
00499203	Miller-Motte Technical College	Proprietary	130
00754802	WESTWOOD COLLEGE - ANAHEIM	Proprietary	130
02120700	SAN JOAQUIN VALLEY COLLEGE	Proprietary	130
02158400	Harrison College	Proprietary	130
02202300	PITTSBURGH CAREER INSTITUTE	Proprietary	130
02539600	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN - ART INSTITUTE DALLAS	Proprietary	130
03534300	JONES INTERNATIONAL UNIVERSITY	Proprietary	130
00467300	Baker College	Private, Nonprofit	120

00723407	HEALD COLLEGE - MODESTO	Proprietary	120
00754803	WESTWOOD COLLEGE - INLAND EMPIRE	Proprietary	120
01072706	DeVry University - Ontario	Proprietary	120
02110500	Miami International University of Art & Design - Art Inst of Charlotte	Proprietary	120
03031402	SANFORD-BROWN COLLEGE - ORLANDO	Proprietary	120
00149905	Everest University - Brandon	Private, Nonprofit	110
00450702	EVEREST COLLEGE- EVEREST COLLEGE, ARLINGTON	Private, Nonprofit	110
00489800	McCann School of Business & Technology	Proprietary	110
01072720	DEVRY UNIVERSITY - COLUMBUS	Proprietary	110
01072724	DEVRY UNIVERSITY - IRVING	Proprietary	110
01157400	BAUDER COLLEGE	Proprietary	110
02053000	LIBERTY UNIVERSITY	Private, Nonprofit	110
02065500	BROOKS COLLEGE	Proprietary	110
02179902	Argosy University - Atlanta	Proprietary	110
02298501	EVEREST COLLEGE - FORT WORTH	Proprietary	110
02532100	BUSINESS CAREER TRAINING INSTITUTE	Proprietary	110
02576900	CHARTER COLLEGE	Proprietary	110
03031403	SANFORD-BROWN COLLEGE - LE CORDON BLEU COLLEGE OF CULINARY ARTS	Proprietary	110
03162300	FOUR-D COLLEGE	Proprietary	110
03903500	SOUTHERN TECHNICAL COLLEGE	Proprietary	110
00158300	MORRIS BROWN COLLEGE	Private, Nonprofit	100
00270400	College of New Rochelle (The)	Private, Nonprofit	100
00927002	Art Institute of Atlanta (The) - Art Institute of Washington (The)	Proprietary	100
00972200	Empire Beauty School	Proprietary	100
01035602	EVEREST INSTITUTE - EAGAN	Proprietary	100
02217100	PIMA MEDICAL INSTITUTE	Proprietary	100
02332900	DEVRY INSTITUTE OF TECHNOLOGY-POMONA	Proprietary	100
02605501	REMINGTON COLLEGE - MOBILE	Private, Nonprofit	100
02616703	LE CORDON BLEU COLLEGE OF CULINARY ARTS - LAS VEGAS	Proprietary	100
03026500	Remington College	Private, Nonprofit	100
03031409	SANFORD-BROWN COLLEGE - INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY	Proprietary	100
03304300	Centura College	Proprietary	100
00450302	EVEREST COLLEGE - SANTA ANA	Private, Nonprofit	90
00472900	MOUNT WASHINGTON COLLEGE	Proprietary	90
00767800	SPARTAN COLLEGE OF AERONAUTICS AND TECHNOLOGY	Proprietary	90
00822103	Universal Technical Institute - California	Proprietary	90
02100505	UNIVERSAL TECHNICAL INSTITUTE -UNIVERSAL TECHNICAL INST OF N. CA, INC.	Proprietary	90
02116011	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - NEW YORK	Proprietary	90
02152100	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY - MIAMI-JACOBS CAREER COLLEGE	Proprietary	90
02218700	NUC University - Florida Technical College - Orlando	Proprietary	90
02293202	ATI CAREER TRAINING CENTER - ATI COLLEGE OF HEALTH MIAMI	Proprietary	90
03003201	EVEREST INSTITUTE - FT. LAUDERDALE	Proprietary	90
03022601	LE CORDON BLEU COLLEGE OF CULIANRY ARTS - ATLANTA	Proprietary	90
03125400	Argosy University - The Art Institute of California - Hollywood	Proprietary	90
00150900	Nova Southeastern University-Davie	Private, Nonprofit	80
00293700	King's College	Proprietary	80
00458608	Purdue University Global - Omaha	Public	80
00458612	Purdue University Global - Hagerstown	Public	80
00844300	ITT TECHNICAL INSTITUTE - SEATTLE	Proprietary	80
00888900	LEHIGH VALLEY COLLEGE	Proprietary	80
01258401	Illinois Institute of Art (The) - The IL Institute of Art - Schaumburg	Proprietary	80
02113601	AMERICAN INTERCONTINENTAL UNIVERSITY - LOS ANGELES	Proprietary	80
02205203	SANFORD-BROWN COLLEGE - ST. PETERS	Proprietary	80
02616203	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC FINDLAY	Proprietary	80
03076402	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM COLLEGE - ORLANDO	Proprietary	80
03380301	STAR CAREER ACADEMY - STAR PHILADELPHIA	Proprietary	80
00258000	Southern New Hampshire University	Private, Nonprofit	70
00736202	MEDTECH COLLEGE - GREENWOOD	Proprietary	70
00922800	DEVRY COLLEGE OF TECHNOLOGY	Proprietary	70
01072711	DEVRY UNIVERSITY - ORLANDO	Proprietary	70
01091300	Madison Media Institute	Proprietary	70
01164700	SBI CAMPUS - AN AFFILIATE OF SANFORD-BROWN	Proprietary	70
02055200	Harrington College of Design	Proprietary	70
02116001	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - TREVOSE	Proprietary	70
02127900	SOJOURNER-DOUGLASS COLLEGE	Private, Nonprofit	70
02218800	BROOKLINE COLLEGE	Proprietary	70
02241800	AMERICAN CAREER COLLEGE	Proprietary	70
02611004	HERITAGE COLLEGE-KANSAS CITY	Proprietary	70
02617508	EVEREST COLLEGE - WOODBRIDGE	Private, Nonprofit	70
03095500	ASA COLLEGE	Proprietary	70
03232304	Lincoln Technical Institute - Lincoln	Proprietary	70

03756300	ANAMARC COLLEGE	Proprietary	70
00144800	HOWARD UNIVERSITY	Private, Nonprofit	60
00149912	Everest University - Everest College - Kansas City	Private, Nonprofit	60
00319100	CONCORDIA UNIVERSITY	Private, Nonprofit	60
00364200	Texas Southern University	Public	60
00750601	LINCOLN TECHNICAL INSTITUTE - UNION	Proprietary	60
00758600	REMINGTON COLLEGE - TAMPA	Private, Nonprofit	60
00780401	STAR CAREER ACADEMY - STAR BRICK	Proprietary	60
00784400	SBI CAMPUS - AN AFFILIATE OF SANFORD-BROWN - SANFORD-BROWN INSTITUTE	Proprietary	60
00887800	Miami International University of Art & Design	Proprietary	60
00962100	HERZING UNIVERSITY	Private, Nonprofit	60
00998200	VICTORY UNIVERSITY	Proprietary	60
01021700	INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY - NASHVILLE	Proprietary	60
01072702	DEVRY UNIVERSITY - PHOENIX	Proprietary	60
01077900	PORTER AND CHESTER INSTITUTE	Proprietary	60
02100502	UNIVERSAL TECHNICAL INSTITUTE- MOTORCYCLE MECHANICS INSTITUTE DIVISION	Proprietary	60
02116006	SANFORD-BROWN COLLEGE - FT. LAUDERDALE	Proprietary	60
02171500	WESTERN INTERNATIONAL UNIVERSITY	Proprietary	60
02266200	HELMS CAREER INSTITUTE	Private, Nonprofit	60
02283800	BEAUTY SCHOOLS OF AMERICA	Proprietary	60
02559300	UNITED EDUCATION INSTITUTE	Proprietary	60
02559400	INTERCOAST COLLEGES	Proprietary	60
02599705	Vatterott College - Sunset Hills	Proprietary	60
02611005	HERITAGE COLLEGE - WICHITA	Proprietary	60
03006801	PENNSYLVANIA CULINARY INSTITUTE - LE CORDON BLEU COLLEGE OF CUL ARTS	Proprietary	60
03022602	LE CORDON BLEU COLLEGE OF CULINARY ARTS - MINNEAPOLIS/ST. PAUL	Proprietary	60
03115102	HERITAGE COLLEGE - LITTLE ROCK	Proprietary	60
03380302	STAR CAREER ACADEMY - STAR NEWARK	Proprietary	60
03809400	MICROPOWER CAREER INSTITUTE	Proprietary	60
03819300	AMERICAN PUBLIC UNIVERSITY SYSTEM	Proprietary	60
00108100	ARIZONA STATE UNIVERSITY	Public	50
00140100	POST UNIVERSITY	Proprietary	50
00149906	Altierus Career College - Orange Park	Private, Nonprofit	50
00174600	Roosevelt University - State Street	Private, Nonprofit	50
00422002	Purdue University Global - Cedar Rapids	Public	50
00458605	Purdue University Global - Des Moines	Public	50
00464601	MINNESOTA SCHOOL OF BUSINESS - BROOKLYN CENTER	Proprietary	50
00464605	MINNESOTA SCHOOL OF BUSINESS - ROCHESTER	Proprietary	50
00675500	BROWN MACKIE COLLEGE (THE -)	Proprietary	50
00736205	MEDTECH COLLEGE - LEXINGTON	Proprietary	50
00740500	WOOD TOBE - COBURN SCHOOL	Proprietary	50
00748800	KAPLAN CAREER INSTITUTE	Proprietary	50
00777700	REMINGTON COLLEGE - CLEVELAND	Private, Nonprofit	50
00822101	Universal Technical Institute - Illinois	Proprietary	50
00822104	Universal Technical Institute - NASCAR Technical Institute	Proprietary	50
00974801	CARRINGTON COLLEGE - SAN LEANDRO CAMPUS	Proprietary	50
00982808	Altierus Career College - Atlanta	Private, Nonprofit	50
01035100	PSI INSTITUTE	Proprietary	50
01072704	DEVRY UNIVERSITY - NEWARK	Proprietary	50
01072717	DEVRY UNIVERSITY - KANSAS CITY	Proprietary	50
01072719	DEVRY COLLEGE OF NEW YORK	Proprietary	50
01111200	FASHION INSTITUTE OF DESIGN & MERCHANDISING -	Proprietary	50
02078905	ART INSTITUTE OF COLORADO (THE) - PHOENIX BRANCH	Proprietary	50
02113604	AMERICAN INTERCONTINENTAL UNIVERSITY - DUNWOODY	Proprietary	50
02116005	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - LANDOVER	Proprietary	50
02116009	SANFORD-BROWN COLLEGE - MIDDLEBURG HEIGHTS	Proprietary	50
02148300	MANHATTAN BEAUTY SCHOOL	Proprietary	50
02179901	Argosy University - Twin Cities	Proprietary	50
02179918	Argosy University - Sarasota	Proprietary	50
02263104	ANTHEM COLLEGE - ANTHEM CAREER COLLEGE - NASHVILLE	Proprietary	50
02301300	PRISM CAREER INSTITUTE	Proprietary	50
02599701	Vatterott College - Kansas City	Proprietary	50
02614900	SANFORD-BROWN INSTITUTE	Proprietary	50
02616401	SANFORD-BROWN INSTITUTE - TAMPA	Proprietary	50
03030600	CORTIVA INSTITUTE	Proprietary	50
03076405	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM CAREER COLLEGE - MEMPHIS	Proprietary	50
03077700	DECKER COLLEGE	Proprietary	50
03079900	CITY COLLEGE	Proprietary	50
03089700	CAREER INSTITUTE OF HEALTH AND TECHNOLOGY	Proprietary	50
03091100	ACT COLLEGE	Proprietary	50
03339400	WESTERN GOVERNORS UNIVERSITY	Private, Nonprofit	50

03348400	MATTIA COLLEGE	Proprietary	50
03426300	COLLEGE OF HEALTH CARE PROFESSIONS (THE)	Proprietary	50
03969600	UEI COLLEGE	Proprietary	50
00132800	UNIVERSITY OF SOUTHERN CALIFORNIA	Private, Nonprofit	40
00146700	BETHUNE COOKMAN UNIVERSITY	Private, Nonprofit	40
00149700	JONES COLLEGE	Private, Nonprofit	40
00149908	Everest University - Lakeland	Private, Nonprofit	40
00149909	Everest University - Jacksonville	Private, Nonprofit	40
00149911	Everest University - Everest College - Merrionette Park	Private, Nonprofit	40
00219300	MOUNT IDA COLLEGE	Private, Nonprofit	40
00224900	Davenport University	Private, Nonprofit	40
00241000	JACKSON STATE UNIVERSITY	Public	40
00252100	WEBSTER UNIVERSITY	Private, Nonprofit	40
00262900	Rutgers, the State University of New Jersey	Public	40
00275100	LONG ISLAND UNIVERSITY	Private, Nonprofit	40
00332900	Pennsylvania State University (The)	Public	40
00340400	JOHNSON & WALES UNIVERSITY	Private, Nonprofit	40
00473000	MCINTOSH COLLEGE	Proprietary	40
00473100	DANIEL WEBSTER COLLEGE	Proprietary	40
00479900	Monroe College	Proprietary	40
00520307	REMINGTON COLLEGE - LAFAYETTE	Private, Nonprofit	40
00730306	LINCOLN TECHNICAL INSTITUTE - EAST WINDSOR	Proprietary	40
00736204	MEDTECH COLLEGE - FORT WAYNE	Proprietary	40
00739400	BERKELEY COLLEGE	Proprietary	40
00822105	Universal Technical Institute - Massachusetts	Proprietary	40
00869410	RASMUSSEN COLLEGE - OCALA	Proprietary	40
00887805	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN - ART INST. OF TAMPA	Proprietary	40
00963500	FLORIDA INTERNATIONAL UNIVERSITY	Public	40
01072718	DeVry University - Iselin	Proprietary	40
01072723	DEVRY UNIVERSITY - FEDERAL WAY	Proprietary	40
01287200	NORTH-WEST COLLEGE	Proprietary	40
02075702	Briarcliffe College - Bohemia	Proprietary	40
02112300	Ridley - Lowell Business & Technical Institute	Proprietary	40
02115100	BUTLER BUSINESS SCHOOL	Proprietary	40
02116008	SANFORD-BROWN COLLEGE - ATLANTA	Proprietary	40
02131600	PENNCO TECH	Proprietary	40
02158410	Harrison College - East	Proprietary	40
02179919	Argosy University - Dallas	Proprietary	40
02180100	ROSS MEDICAL EDUCATION CENTER	Proprietary	40
02202301	SANFORD-BROWN INSTITUTE - SANFORD-BROWN INSTITUTE	Proprietary	40
02263105	ANTHEM COLLEGE - HIGH-TECH INSTITUTE - ATLANTA	Proprietary	40
02294900	INSTITUTE OF AUDIO RESEARCH	Proprietary	40
02295002	EVEREST COLLEGE PHOENIX - MESA CAMPUS	Proprietary	40
02295700	NATIONAL ACADEMY OF BEAUTY ARTS	Proprietary	40
02361101	ITT TECHNICAL INSTITUTE -	Proprietary	40
02541200	Stratford University	Proprietary	40
02599710	Vatterott College - Vatterott Career College - Memphis	Proprietary	40
02614205	Miller - Motte Technical College - Miller - Motte College - Greenville	Proprietary	40
02616402	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - ISELIN	Proprietary	40
02616403	SANFORD-BROWN INSTITUTE - SANFORD-BROWN COLLEGE - WEST ALLIS	Proprietary	40
02617503	EVEREST COLLEGE - VANCOUVER	Private, Nonprofit	40
03010602	Virginia College - Huntsville	Proprietary	40
03010603	Virginia College - Jackson	Proprietary	40
03042700	LAURUS TECHNICAL INSTITUTE	Proprietary	40
03076403	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM COLLEGE - IRVING	Proprietary	40
03076404	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM INSTITUTE - LAS VEGAS	Proprietary	40
03123900	SOUTHEASTERN COLLEGE	Proprietary	40
03399300	BRYAN COLLEGE	Proprietary	40
03523300	Aviation Institute Of Maintenance	Proprietary	40
03813300	Northcentral University	Proprietary	40
04121500	COLUMBIA SOUTHERN UNIVERSITY	Proprietary	40
04190000	RADIANS COLLEGE	Proprietary	40
00108300	University of Arizona (The)	Public	30
00148000	FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY	Public	30
00152600	SAINT LEO UNIVERSITY	Private, Nonprofit	30
00152800	ST. PETERSBURG COLLEGE	Public	30
00166500	Columbia College Chicago	Private, Nonprofit	30
00167100	DEPAUL UNIVERSITY	Private, Nonprofit	30
00228400	MARYGROVE COLLEGE	Private, Nonprofit	30
00232900	Wayne State University	Public	30
00245600	Columbia College	Private, Nonprofit	30

00277200	MERCY COLLEGE	Private, Nonprofit	30
00278200	NEW YORK INSTITUTE OF TECHNOLOGY	Private, Nonprofit	30
00278500	New York University	Private, Nonprofit	30
00304300	CHANCELLOR UNIVERSITY	Proprietary	30
00305100	KENT STATE UNIVERSITY	Public	30
00312300	UNIVERSITY OF AKRON (THE)	Public	30
00342000	BENEDICT COLLEGE	Private, Nonprofit	30
00458607	Purdue University Global - Cedar Falls	Public	30
00458609	Purdue University Global - Lincoln	Public	30
00458615	Kaplan University - Portland	Public	30
00461700	National College	Proprietary	30
00462500	DELGADO COMMUNITY COLLEGE	Public	30
00464606	MINNESOTA SCHOOL OF BUSINESS - BLAINE	Proprietary	30
00486600	STAUTZENBERGER COLLEGE	Proprietary	30
00489300	DUBOIS BUSINESS COLLEGE	Proprietary	30
00489804	McCann School of Business & Technology - Hazelton Campus	Proprietary	30
00675000	VALENCIA COLLEGE	Public	30
00675501	BROWN MACKIE COLLEGE	Proprietary	30
00716400	BRYAN UNIVERSITY	Proprietary	30
00747001	ART INSTITUTE OF PITTSBURGH (THE) - SANTA MONICA	Proprietary	30
00748400	Newbury College	Private, Nonprofit	30
00779100	WILFRED ACADEMY OF HAIR & BEAUTY CULTURE	Proprietary	30
00780402	STAR CAREER ACADEMY - STAR EGG HARBOR	Proprietary	30
00793100	PACIFIC TRAVEL TRADE SCHOOL - MAIN CAMPUS	Proprietary	30
00927003	Art Institute of Atlanta (The) - Art Institute of Tennessee-Nashville	Proprietary	30
00940700	Lincoln College of New England	Proprietary	30
00945103	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC TUCSON	Proprietary	30
00972100	Bradford School	Proprietary	30
00974804	CARRINGTON COLLEGE - CITRUS HEIGHTS	Proprietary	30
00974807	CARRINGTON COLLEGE - SAN JOSE	Proprietary	30
00982810	EVEREST INSTITUTE - EVEREST COLLEGE- BEDFORD PARK	Private, Nonprofit	30
01005901	AMERICAN COMMERCIAL COLLEGE - AMERICAN COMMERCIAL COLLEGE	Proprietary	30
01014200	Touro College	Private, Nonprofit	30
01019800	ECPI UNIVERSITY	Proprietary	30
01063300	Houston Community College	Public	30
01072712	DEVRY UNIVERSITY - MIRAMAR	Proprietary	30
01072722	DEVRY UNIVERSITY - FORT WASHINGTON	Proprietary	30
01072754	DEVRY UNIVERSITY - HOUSTON	Proprietary	30
01087700	AMERICAN BUSINESS INSTITUTE	Proprietary	30
01146000	National University - La Jolla	Private, Nonprofit	30
01164400	University of Maryland Global Campus	Public	30
01248200	ATI TECHNICAL TRAINING CENTER	Proprietary	30
01289100	ANTONELLI COLLEGE	Proprietary	30
02055500	DELTA SCHOOL OF BUSINESS AND TECHNOLOGY	Proprietary	30
02103200	BROWN MACKIE COLLEGE-MERRILLVILLE	Proprietary	30
02106600	AMERICAN INSTITUTE	Proprietary	30
02112301	RIDLEY - LOWELL BUSINESS & TECHNICAL INSTITUTE - POUGHKEEPSIE	Proprietary	30
02113606	AMERICAN INTERCONTINENTAL UNIVERSITY (THE) - PLANTATION	Proprietary	30
02113609	AMERICAN INTERCONTINENTAL UNIVERSITY - WESTON	Proprietary	30
02128000	SUPERIOR TRAINING SERVICES	Proprietary	30
02179903	Argosy University - Washington D.C. Area	Proprietary	30
02179909	Argosy University - Tampa	Proprietary	30
02179914	Argosy University - Nashville	Proprietary	30
02179928	Argosy University - Los Angeles	Proprietary	30
02179948	Argosy University - The Art Institute of California - Inland Empire	Proprietary	30
02205207	SANFORD-BROWN COLLEGE - MILWAUKEE	Proprietary	30
02215100	HALLMARK INSTITUTE OF PHOTOGRAPHY	Proprietary	30
02219500	Mildred Elley	Proprietary	30
02239202	ANTHEM COLLEGE - METRO SOUTH	Proprietary	30
02250603	EVEREST COLLEGE - ARLINGTON	Private, Nonprofit	30
02253900	Miller-Motte College - Berks Technical Institute	Proprietary	30
02263101	ANTHEM COLLEGE - SACRAMENTO	Proprietary	30
02305801	Florida Career College - Pembroke Pines	Proprietary	30
02337800	COLLEGE OF OFFICE TECHNOLOGY	Proprietary	30
02362002	UNIVERSAL TECHNICAL INSTITUTE - PENNSYLVANIA	Proprietary	30
02491500	Southwest University of Visual Arts	Private, Nonprofit	30
02538900	INTERNATIONAL BUSINESS COLLEGE-	Proprietary	30
02546800	MTA SCHOOL, RESIDENT SCHOOL	Proprietary	30
02557800	ART INSTITUTE OF YORK (THE) - PENNSYLVANIA	Proprietary	30
02572800	VISTA COLLEGE	Proprietary	30
02576200	MID-CONTINENT UNIVERSITY	Private, Nonprofit	30

02580100	IVERSON INSTITUTE	Proprietary	30
02588904	MEDTECH INSTITUTE- MEDTECH COLLEGE	Proprietary	30
02599702	Vatterott College - Springfield	Proprietary	30
02606800	Miller-Motte College - McCann - Monroe	Proprietary	30
02611007	HERITAGE COLLEGE - COLUMBUS	Proprietary	30
02615001	SANFORD-BROWN COLLEGE - DALLAS	Proprietary	30
03010607	Virginia College - Mobile	Proprietary	30
03010616	Virginia College - Montgomery	Proprietary	30
03031405	SANFORD-BROWN COLLEGE - LAS VEGAS	Proprietary	30
03031406	SANFORD-BROWN COLLEGE - SEATTLE	Proprietary	30
03067500	Institute of Technology	Proprietary	30
03071801	ITT TECHNICAL INSTITUTE - EVERETT	Proprietary	30
03079200	WESTWOOD COLLEGE - DUPAGE	Proprietary	30
03108100	Summit College	Proprietary	30
03108500	EVERGLADES UNIVERSITY	Private, Nonprofit	30
03110000	ACADEMY OF HEALING ARTS	Proprietary	30
03128700	MT. SIERRA COLLEGE	Proprietary	30
03172400	CALIBER TRAINING INSTITUTE	Proprietary	30
03196300	Lincoln Technical Institute - Somerville	Proprietary	30
03368300	MIDWEST TECHNICAL INSTITUTE	Proprietary	30
03448300	BUSINESS INDUSTRIAL RESOURCES	Proprietary	30
03595400	ANGLEY COLLEGE	Proprietary	30
03789300	UNITECH TRAINING ACADEMY	Proprietary	30
03866300	GALIANO CAREER ACADEMY	Proprietary	30
04116000	VIDEO SYMPHONY ENTERTRAINING	Proprietary	30
04122300	Grantham University	Proprietary	30
04137900	BRENSTEN EDUCATION	Proprietary	30
04148000	NEW LIFE BUSINESS INSTITUTE	Proprietary	30
00100200	ALABAMA AGRICULTURAL & MECHANICAL UNIVERSITY	Public	20
00100500	ALABAMA STATE UNIVERSITY	Public	20
00111700	AZUSA PACIFIC UNIVERSITY	Private, Nonprofit	20
00113900	CALIFORNIA STATE UNIVERSITY, LONG BEACH	Public	20
00115000	CALIFORNIA STATE UNIVERSITY - SACRAMENTO	Public	20
00115300	CALIFORNIA STATE UNIVERSITY, NORTHRIDGE	Public	20
00115400	SAN FRANCISCO STATE UNIVERSITY	Public	20
00115500	SAN JOSE STATE UNIVERSITY	Public	20
00131500	University of California, Los Angeles	Public	20
00136000	METROPOLITAN STATE UNIVERSITY OF DENVER	Public	20
00136300	REGIS UNIVERSITY	Private, Nonprofit	20
00146900	FLORIDA INSTITUTE OF TECHNOLOGY	Private, Nonprofit	20
00148900	FLORIDA STATE UNIVERSITY	Public	20
00150000	BROWARD COLLEGE	Public	20
00150400	State College of Florida, Manatee-Sarasota	Public	20
00152000	Seminole State College of Florida	Public	20
00152100	SOUTHEASTERN UNIVERSITY	Private, Nonprofit	20
00154400	Albany State University	Public	20
00155900	CLARK ATLANTA UNIVERSITY	Private, Nonprofit	20
00157400	GEORGIA STATE UNIVERSITY	Public	20
00157700	KENNESAW STATE UNIVERSITY	Public	20
00169400	CHICAGO STATE UNIVERSITY	Public	20
00173700	NORTHERN ILLINOIS UNIVERSITY	Public	20
00175800	SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE	Public	20
00180500	INDIANA INSTITUTE OF TECHNOLOGY	Private, Nonprofit	20
00181300	Indiana University - Purdue University Indianapolis	Public	20
00183300	SAINT JOSEPH'S COLLEGE	Private, Nonprofit	20
00184200	VALPARAISO UNIVERSITY	Private, Nonprofit	20
00198300	ST. CATHARINE COLLEGE	Private, Nonprofit	20
00200600	Grambling State University	Public	20
00202500	SOUTHERN UNIVERSITY AND AGRICULTURAL & MECHANICAL COLG AT BATON ROUGE	Public	20
00208300	Morgan State University	Public	20
00213000	Boston University	Private, Nonprofit	20
00220500	QUINCY COLLEGE	Public	20
00221100	Springfield College	Private, Nonprofit	20
00225900	EASTERN MICHIGAN UNIVERSITY	Public	20
00229000	MICHIGAN STATE UNIVERSITY	Public	20
00233000	WESTERN MICHIGAN UNIVERSITY	Public	20
00236200	MINNEAPOLIS COMMUNITY AND TECHNICAL COLLEGE	Public	20
00240700	Hinds Community College	Public	20
00244100	UNIVERSITY OF SOUTHERN MISSISSIPPI	Public	20
00256900	UNIVERSITY OF NEVADA - LAS VEGAS	Public	20
00261700	MONTCLAIR STATE UNIVERSITY	Public	20

00273200	HOFSTRA UNIVERSITY	Private, Nonprofit	20
00279100	PACE UNIVERSITY	Private, Nonprofit	20
00290500	NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY	Public	20
00290900	BARBER-SCOTIA COLLEGE	Private, Nonprofit	20
00295000	North Carolina Central University	Public	20
00296800	Saint Augustine's University	Private, Nonprofit	20
00301800	BOWLING GREEN STATE UNIVERSITY	Public	20
00302600	CENTRAL STATE UNIVERSITY	Public	20
00309000	OHIO STATE UNIVERSITY	Public	20
00312500	UNIVERSITY OF CINCINNATI	Public	20
00313100	UNIVERSITY OF TOLEDO	Public	20
00319600	LANE COMMUNITY COLLEGE	Public	20
00319900	Marylhurst University	Private, Nonprofit	20
00321300	Portland Community College	Public	20
00324900	COMMUNITY COLLEGE OF PHILADELPHIA	Public	20
00325600	DREXEL UNIVERSITY	Private, Nonprofit	20
00344800	UNIVERSITY OF SOUTH CAROLINA - COLUMBIA	Public	20
00350900	UNIVERSITY OF MEMPHIS (THE)	Public	20
00351000	MIDDLE TENNESSEE STATE UNIVERSITY	Public	20
00352200	TENNESSEE STATE UNIVERSITY	Public	20
00352400	PIEDMONT INTERNATIONAL UNIVERSITY - CHATTANOOGA CAMPUS	Private, Nonprofit	20
00359400	UNIVERSITY OF NORTH TEXAS	Public	20
00363000	Prairie View Agricultural & Mechanical University	Public	20
00371200	TIDEWATER COMMUNITY COLLEGE	Public	20
00372800	OLD DOMINION UNIVERSITY	Public	20
00373900	SAINT PAUL'S COLLEGE	Private, Nonprofit	20
00374900	GEORGE MASON UNIVERSITY	Public	20
00376400	VIRGINIA STATE UNIVERSITY	Public	20
00376500	NORFOLK STATE UNIVERSITY	Public	20
00382700	West Virginia University	Public	20
00386600	Milwaukee Area Technical College	Public	20
00389600	UNIVERSITY OF WISCONSIN - MILWAUKEE	Public	20
00395400	UNIVERSITY OF CENTRAL FLORIDA-MAIN CAMPUS	Public	20
00396900	University of Minnesota - Twin Cities	Public	20
00399300	Midlands Technical College - Airport Campus	Public	20
00449402	EVEREST COLLEGE - ONTARIO	Proprietary	20
00458606	Purdue University Global - Mason City	Public	20
00458610	Kaplan University - Council Bluffs	Public	20
00458616	Purdue University Global - Lewiston	Public	20
00464602	MINNESOTA SCHOOL OF BUSINESS - PLYMOUTH	Proprietary	20
00464603	MINNESOTA SCHOOL OF BUSINESS - SHAKOPEE	Proprietary	20
00464604	MINNESOTA SCHOOL OF BUSINESS - ST. CLOUD	Proprietary	20
00472901	MOUNT WASHINGTON COLLEGE - NASHUA CAMPUS	Proprietary	20
00472905	MOUNT WASHINGTON COLLEGE - SALEM CAMPUS	Proprietary	20
00489805	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY - SCRANTON	Proprietary	20
00492000	TRIDENT TECHNICAL COLLEGE	Public	20
00493800	South College	Proprietary	20
00520800	COLLEGE OF WESTCHESTER (THE)	Proprietary	20
00673100	Casa Loma College	Private, Nonprofit	20
00686700	COLUMBUS STATE COMMUNITY COLLEGE- MAIN CAMPUS	Public	20
00697500	Lincoln University	Private, Nonprofit	20
00712000	Des Moines Area Community College	Public	20
00722900	WESTERN BEAUTY INSTITUTE	Proprietary	20
00740100	Mandl School	Proprietary	20
00743900	Fountainhead College of Technology	Proprietary	20
00751800	Apex Technical School	Proprietary	20
00757200	AMERICAN MUSICAL & DRAMATIC ACADEMY	Private, Nonprofit	20
00758602	REMINGTON COLLEGE - FORT WORTH CAMPUS	Private, Nonprofit	20
00775900	LINCOLN TECHNICAL INSTITUTE - ALLENTOWN	Proprietary	20
00781400	BROOKSTONE COLLEGE OF BUSINESS	Proprietary	20
00781401	BROOKSTONE COLLEGE OF BUSINESS - GREENSBORO	Proprietary	20
00784500	NEW ENGLAND INSTITUTE OF TECHNOLOGY	Private, Nonprofit	20
00787000	HILLSBOROUGH COMMUNITY COLLEGE	Public	20
00793803	LINCOLN COLLEGE OF TECHNOLOGY - NASHVILLE	Proprietary	20
00821700	Paul Mitchell the School Green Bay	Proprietary	20
00827000	WILFRED ACADEMY	Proprietary	20
00841700	STENOTYPE INSTITUTE OF JACKSONVILLE	Proprietary	20
00850101	Rasmussen College	Proprietary	20
00863500	IBMC COLLEGE	Proprietary	20
00902200	ASSOCIATED TECHNICAL COLLEGE	Proprietary	20
00904300	ELMIRA BUSINESS INSTITUTE	Proprietary	20

00926800	KELSEY-JENNEY COLLEGE	Private, Nonprofit	20
00927004	Art Institute of Atlanta (The) - The Art Institute of Charleston	Proprietary	20
00943200	ESS COLLEGE OF BUSINESS	Proprietary	20
00961800	TULSA WELDING SCHOOL	Proprietary	20
00974802	CARRINGTON COLLEGE - PLEASANT HILL CAMPUS	Proprietary	20
00974803	CARRINGTON COLLEGE - STOCKTON	Proprietary	20
00974806	CARRINGTON COLLEGE CALIFORNIA - ANTIOCH/WALNUT CREEK	Proprietary	20
00974808	CARRINGTON COLLEGE CALIFORNIA - EMERYVILLE	Proprietary	20
00982807	EVEREST INSTITUTE - MARIETTA	Private, Nonprofit	20
01014804	COLORADO TECHNICAL UNIVERSITY - SIOUX FALLS BRANCH CAMPUS	Proprietary	20
01014814	COLORADO TECHNICAL UNIVERSITY - NORTH KANSAS CITY	Proprietary	20
01027900	Hickey College	Proprietary	20
01036200	COLLEGE OF SOUTHERN NEVADA	Public	20
01040500	PINNACLE CAREER INSTITUTE	Proprietary	20
01057700	UNITED COLLEGE OF BUSINESS	Proprietary	20
01072709	DEVRY UNIVERSITY - WESTMINSTER	Proprietary	20
01083100	NEW COLLEGE OF CALIFORNIA	Private, Nonprofit	20
01088100	STARK STATE COLLEGE	Public	20
01093000	SUBURBAN TECHNICAL SCHOOL	Proprietary	20
01103100	TECHNICAL CAREER INSTITUTES	Proprietary	20
01112200	SAWYER COLLEGE	Proprietary	20
01114500	LONE STAR COLLEGE SYSTEM	Public	20
01116600	Broadview College	Proprietary	20
01162601	WESTWOOD COLLEGE - SOUTH BAY - ARLINGTON BALLSTON	Proprietary	20
01162602	WESTWOOD COLLEGE - SOUTH BAY - ANNANDALE	Proprietary	20
01197900	BLAKE BUSINESS SCHOOL	Proprietary	20
01202700	GALEN COLLEGE OF CALIFORNIA	Proprietary	20
01226200	USA TRAINING ACADEMY HOME STUDY	Proprietary	20
01234600	BERKELEY COLLEGE - CLIFTON	Proprietary	20
01246104	Lincoln Technical Institute - Center City	Proprietary	20
01246105	Lincoln Technical Institute - Northeast	Proprietary	20
01258405	Illinois Institute of Art (The) - The Art Institute of Michigan	Proprietary	20
01284601	BRANCH CAMPUS	Proprietary	20
02069200	PACIFIC COAST COLLEGE	Proprietary	20
02074100	CAPITOL CITY TRADE & TECHNICAL SCHOOL	Proprietary	20
02098814	UNIVERSITY OF PHOENIX - ONLINE CAMPUS	Proprietary	20
02100607	Carrington College -Tucson	Proprietary	20
02100608	CARRINGTON COLLEGE - WESTSIDE	Proprietary	20
02100611	Carrington College - Mesa	Proprietary	20
02103201	BROWN MACKIE COLLEGE-MERRILLVILLE - BROWN MACKIE COLLEGE-MICHIGAN CITY	Proprietary	20
02110700	Cleveland Institute of Dental - Medical Assistants	Proprietary	20
02116012	SANFORD-BROWN COLLEGE - HOUSTON NORTH LOOP	Proprietary	20
02119200	COURT REPORTING INSTITUTE OF ST LOUIS	Proprietary	20
02120800	YORKTOWNE BUSINESS INSTITUTE	Proprietary	20
02120901	ITT TECHNICAL INSTITUTE - HAYWARD	Proprietary	20
02131500	NORTHWESTERN COLLEGE	Private, Nonprofit	20
02141500	SAVANNAH COLLEGE OF ART AND DESIGN	Private, Nonprofit	20
02151100	ATI COLLEGE OF HEALTH	Proprietary	20
02158401	Harrison College - Columbus	Proprietary	20
02158402	Harrison College - Lafayette	Proprietary	20
02158405	Harrison College - Terre Haute	Proprietary	20
02158407	Harrison College - Anderson	Proprietary	20
02158409	Harrison College - Evansville	Proprietary	20
02158412	Harrison College - Fort Wayne	Proprietary	20
02160304	INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY - SCHAUMBURG	Proprietary	20
02161800	MUSICIANS INSTITUTE	Proprietary	20
02164200	FOREST INSTITUTE OF PROFESSIONAL PSYCHOLOGY	Private, Nonprofit	20
02177500	RIO SALADO COMMUNITY COLLEGE	Public	20
02179905	Argosy University - Hawaii	Proprietary	20
02179926	ARGOSY UNIVERSITY - ORANGE COUNTY	Proprietary	20
02179932	Argosy University - Inland Empire	Proprietary	20
02179943	Argosy University - The Art Institute of California - San Francisco	Proprietary	20
02179944	Argosy University - The Art Institute of California - Orange County	Proprietary	20
02179945	Argosy University - The Art Institute of California - Sacramento	Proprietary	20
02202500	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF CONN	Proprietary	20
02205204	SANFORD BROWN COLLEGE-NKC	Proprietary	20
02205300	SAVANNAH RIVER COLLEGE	Proprietary	20
02206300	BEAUTY INSTITUTE (THE)	Proprietary	20
02239203	ANTHEM COLLEGE - BEAVERTON	Proprietary	20
02241801	AMERICAN CAREER COLLEGE - ANAHEIM	Proprietary	20
02244900	Goodwin University	Private, Nonprofit	20

02245200	MTI COLLEGE OF BUSINESS AND TECHNOLOGY	Proprietary	20
02255200	PENNSYLVANIA SCHOOL OF BUSINESS	Proprietary	20
02263106	ANTHEM COLLEGE - ANTHEM COLLEGE - KANSAS CITY	Proprietary	20
02277400	South Coast College	Proprietary	20
02280800	Lincoln College of Technology - West Palm	Proprietary	20
02293203	ATI CAREER TRAINING CENTER - ALBUQUERQUE	Proprietary	20
02296500	MASTERS INSTITUTE	Proprietary	20
02304000	MISSOURI TECHNICAL SCHOOL	Proprietary	20
02305802	FLORIDA CAREER COLLEGE - WEST PALM BEACH	Proprietary	20
02305804	FLORIDA CAREER COLLEGE - LAUDERDALE LAKES	Proprietary	20
02311200	AMERICAN SCHOOL OF TECHNOLOGY	Proprietary	20
02313900	WESTWOOD COLLEGE - O'HARE AIRPORT	Proprietary	20
02317300	Tricoci University of Beauty Culture	Proprietary	20
02338500	Glendale Career College	Proprietary	20
02362003	UNIVERSAL TECHNICAL INSTITUTE - NORTHERN TEXAS	Proprietary	20
02490800	HAIR FASHIONS BY KAYE BEAUTY COLLEGE	Proprietary	20
02491100	Beckfield College	Proprietary	20
02539900	STAR TECHNICAL INSTITUTE	Proprietary	20
02540000	Tennessee Academy of Cosmetology	Proprietary	20
02547600	FLORIDA NATIONAL UNIVERSITY	Proprietary	20
02559000	University of Advancing Computer Technology	Proprietary	20
02559301	UNITED EDUCATION INSTITUTE - SAN BERNARDINO	Proprietary	20
02559303	UNITED EDUCATION INSTITUTE - SAN DIEGO	Proprietary	20
02559304	UNITED EDUCATION INSTITUTE - ONTARIO	Proprietary	20
02559305	UNITED EDUCATION INSTITUTE - ENCINO	Proprietary	20
02559309	United Education Institute - Chula Vista	Proprietary	20
02569306	LE CORDON BLEU COLLEGE OF CULINARY ARTS - SANFORD-BROWN COLLEGE	Proprietary	20
02586200	FLORIDA CAREER COLLEGE - CLEARWATER	Proprietary	20
02588902	MEDTECH INSTITUTE - SILVER SPRING	Proprietary	20
02596400	SPARTAN COLLEGE OF AERONAUTICS & TECHNOLOGY	Proprietary	20
02596502	ATI- CAREER TRAINING CENTER - OKLAHOMA CITY (#037)	Proprietary	20
02598200	UNIVERSITY OF SOUTHERNMOST FLORIDA	Proprietary	20
02599703	Vatterott College - Joplin	Proprietary	20
02599706	Vatterott College - Tulsa	Proprietary	20
02599712	VATTEROTT COLLEGE - ST. CHARLES	Proprietary	20
02608900	PINNACLE COLLEGE	Proprietary	20
02617501	EVEREST COLLEGE - FIFE	Private, Nonprofit	20
03009701	HARRISON COLLEGE - MUNCIE	Proprietary	20
03010604	Virginia College - Austin	Proprietary	20
03010606	Virginia College - Chattanooga	Proprietary	20
03010608	Virginia College - Pensacola	Proprietary	20
03010610	Virginia College - Biloxi	Proprietary	20
03010611	Virginia College - Golf Academy of America - Carlsbad	Proprietary	20
03010619	Virginia College - Augusta	Proprietary	20
03012500	NEW WAVE HAIR ACADEMY	Proprietary	20
03023500	Carnelot College	Proprietary	20
03025800	Dawn Career Institute	Proprietary	20
03026501	REMINGTON COLLEGE - NORTH HOUSTON CAMPUS	Private, Nonprofit	20
03035300	Southern Careers Institute	Proprietary	20
03039900	Fremont College	Proprietary	20
03042501	Carrington College - Spokane	Proprietary	20
03062701	PLATT COLLEGE - ONTARIO	Proprietary	20
03067300	METROPOLITAN COLLEGE	Private, Nonprofit	20
03068200	OHIO MEDIA SCHOOL	Proprietary	20
03071606	College of Business & Technology	Proprietary	20
03076401	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM COLLEGE	Proprietary	20
03089702	CAREER INSTITUTE OF HEALTH AND TECHNOLOGY - BROOKLYN	Proprietary	20
03104300	Career Technical Institute	Proprietary	20
03108700	ROYAL BEAUTY CAREERS	Proprietary	20
03109000	SCHOOL OF COMMUNICATION ARTS OF NORTH CAROLINA	Proprietary	20
03110300	SALON ACADEMY (THE)	Proprietary	20
03113100	MARIC COLLEGE	Proprietary	20
03115000	ARIZONA COLLEGE	Proprietary	20
03126400	CENTURA COLLEGE -	Proprietary	20
03138400	AMERICAN COLLEGE OF MEDICAL TECHNOLOGY	Proprietary	20
03197300	INSTITUTE FOR HEALTH EDUCATION (THE)	Proprietary	20
03294300	BLUE CLIFF COLLEGE	Proprietary	20
03294306	BLUE CLIFF COLLEGE - SHREVEPORT	Proprietary	20
03316300	LINCOLN TECHNICAL INSTITUTE - HARTFORD	Proprietary	20
03380303	STAR CAREER ACADEMY - STAR CLIFTON	Proprietary	20
03380304	STAR CAREER ACADEMY - STAR AUDUBON	Proprietary	20

03394300	REMINGTON COLLEGE - SAN DIEGO CAMPUS	Proprietary	20
03400300	Quest College	Proprietary	20
03425400	CENTRAL FLORIDA INSTITUTE	Proprietary	20
03525300	BLUE CLIFF COLLEGE - GULFPORT	Proprietary	20
03549301	ULTIMATE MEDICAL ACADEMY -	Private, Nonprofit	20
03625300	PERFORMANCE TRAINING INSTITUTE	Proprietary	20
03627400	JACKSONVILLE BEAUTY INSTITUTE	Proprietary	20
03676400	HEALTHY HAIR ACADEMY	Proprietary	20
03698400	CALIFORNIA COLLEGE OF VOCATIONAL CAREERS	Proprietary	20
03706300	Hollywood Institute	Proprietary	20
03812300	OMNITECH INSTITUTE	Proprietary	20
03875300	MCI INSTITUTE OF TECHNOLOGY	Proprietary	20
03973300	SAE EXPRESSION COLLEGE	Proprietary	20
04051304	Art Institute of Phoenix (The) - Art Institute of Indianapolis (The)	Proprietary	20
04127900	TRIDENT UNIVERSITY INTERNATIONAL	Proprietary	20
04134500	SAN DIEGO COLLEGE	Proprietary	20
04135900	Orion College	Proprietary	20
04141400	LAURUS COLLEGE	Proprietary	20
04149300	PARK WEST BARBER SCHOOL	Proprietary	20
04152300	Georgia Beauty Academy	Proprietary	20
04161800	BRANDMAN UNIVERSITY	Private, Nonprofit	20
04162500	HOLLYWOOD INSTITUTE OF BEAUTY CAREERS	Proprietary	20
04184800	VANTAGE COLLEGE	Proprietary	20
00102800	MILES COLLEGE	Private, Nonprofit	10
00104400	Stillman College	Private, Nonprofit	10
00104700	Troy University	Public	10
00105100	UNIVERSITY OF ALABAMA	Public	10
00105200	UNIVERSITY OF ALABAMA AT BIRMINGHAM	Public	10
00105700	UNIVERSITY OF SOUTH ALABAMA	Public	10
00107700	MESA COMMUNITY COLLEGE	Public	10
00107800	PHOENIX COLLEGE	Public	10
00108200	NORTHERN ARIZONA UNIVERSITY	Public	10
00108700	Arkansas Baptist College	Private, Nonprofit	10
00109003	Arkansas State University	Public	10
00109200	UNIVERSITY OF CENTRAL ARKANSAS	Public	10
00110100	UNIVERSITY OF ARKANSAS AT LITTLE ROCK	Public	10
00113800	California State University, East Bay	Public	10
00114000	CALIFORNIA STATE UNIVERSITY, LOS ANGELES	Public	10
00114200	California State University, San Bernardino	Public	10
00114700	CALIFORNIA STATE UNIVERSITY, FRESNO	Public	10
00116400	Chapman University	Private, Nonprofit	10
00132500	UNIVERSITY OF SAN FRANCISCO	Private, Nonprofit	10
00134201	WHITTIER COLLEGE - COLLEGE OF LAW	Private, Nonprofit	10
00137800	CENTRAL CONNECTICUT STATE UNIVERSITY	Public	10
00141600	UNIVERSITY OF BRIDGEPORT	Private, Nonprofit	10
00142800	DELAWARE STATE UNIVERSITY	Public	10
00143400	AMERICAN UNIVERSITY	Private, Nonprofit	10
00144100	UNIVERSITY OF THE DISTRICT OF COLUMBIA	Public	10
00144400	George Washington University	Private, Nonprofit	10
00147500	Daytona State College	Public	10
00147700	FLORIDA SOUTHWESTERN STATE COLLEGE	Public	10
00148100	Florida Atlantic University	Public	10
00148400	FLORIDA STATE COLLEGE AT JACKSONVILLE	Public	10
00148600	FLORIDA MEMORIAL UNIVERSITY	Private, Nonprofit	10
00150600	MIAMI DADE COLLEGE	Public	10
00153500	UNIVERSITY OF FLORIDA	Public	10
00153600	University of Miami	Private, Nonprofit	10
00153700	University of South Florida	Public	10
00156200	GEORGIA STATE UNIVERSITY - PC-DECATUR	Public	10
00157200	Georgia Southern University	Public	10
00158000	MERCER UNIVERSITY	Private, Nonprofit	10
00159900	VALDOSTA STATE UNIVERSITY	Public	10
00169200	ILLINOIS STATE UNIVERSITY	Public	10
00177500	University of Illinois Urbana-Champaign	Public	10
00177600	University of Illinois at Chicago	Public	10
00180700	Indiana State University	Public	10
00180900	Indiana University - Bloomington	Public	10
00182200	INDIANA WESLEYAN UNIVERSITY	Private, Nonprofit	10
00182500	PURDUE UNIVERSITY	Public	10
00191700	BARCLAY COLLEGE	Private, Nonprofit	10
00194800	UNIVERSITY OF KANSAS	Public	10

00196200	UNIVERSITY OF THE CUMBERLANDS	Private, Nonprofit	10
00196800	KENTUCKY STATE UNIVERSITY	Public	10
00198900	University of Kentucky	Public	10
00199900	UNIVERSITY OF LOUISVILLE	Public	10
00200200	WESTERN KENTUCKY UNIVERSITY	Public	10
00201500	UNIVERSITY OF NEW ORLEANS (THE)	Public	10
00202400	SOUTHEASTERN LOUISIANA UNIVERSITY	Public	10
00210300	UNIVERSITY OF MARYLAND, COLLEGE PARK	Public	10
00219900	NORTHEASTERN UNIVERSITY	Private, Nonprofit	10
00221800	SUFFOLK UNIVERSITY	Private, Nonprofit	10
00224300	CENTRAL MICHIGAN UNIVERSITY	Public	10
00227000	Henry Ford College	Public	10
00227800	Lansing Community College	Public	10
00232300	University of Detroit Mercy	Private, Nonprofit	10
00236000	Minnesota State University, Mankato	Public	10
00239600	Alcorn State University	Public	10
00239700	Belhaven University	Private, Nonprofit	10
00242400	Mississippi Valley State University	Public	10
00244000	University of Mississippi	Public	10
00248000	LINDENWOOD UNIVERSITY	Private, Nonprofit	10
00250300	MISSOURI STATE UNIVERSITY	Public	10
00254000	College of Saint Mary	Private, Nonprofit	10
00256800	UNIVERSITY OF NEVADA , RENO	Public	10
00257900	New England College	Private, Nonprofit	10
00260700	FAIRLEIGH DICKINSON UNIVERSITY	Private, Nonprofit	10
00261300	NEW JERSEY CITY UNIVERSITY	Public	10
00262200	KEAN UNIVERSITY	Public	10
00263200	SETON HALL UNIVERSITY	Private, Nonprofit	10
00265700	NEW MEXICO STATE UNIVERSITY	Public	10
00266300	UNIVERSITY OF NEW MEXICO	Public	10
00267808	BRYANT & STRATTON COLLEGE - PARMA	Proprietary	10
00267813	Bryant & Stratton College - Milwaukee Downtown	Proprietary	10
00277700	MEDAILLE COLLEGE	Private, Nonprofit	10
00279000	Nyack College	Private, Nonprofit	10
00280600	ROCHESTER INSTITUTE OF TECHNOLOGY	Private, Nonprofit	10
00282300	Saint John's University	Private, Nonprofit	10
00283400	EXCELSIOR COLLEGE	Private, Nonprofit	10
00284200	SUNY COLLEGE AT BUFFALO	Public	10
00287200	MONROE COMMUNITY COLLEGE	Public	10
00287300	NASSAU COMMUNITY COLLEGE	Public	10
00292300	East Carolina University	Public	10
00296200	SHAW UNIVERSITY	Private, Nonprofit	10
00303000	OHIO CHRISTIAN UNIVERSITY	Private, Nonprofit	10
00303200	CLEVELAND STATE UNIVERSITY	Public	10
00304000	Cuyahoga Community College	Public	10
00304600	Franklin University	Private, Nonprofit	10
00314500	YOUNGSTOWN STATE UNIVERSITY	Public	10
00315700	LANGSTON UNIVERSITY	Public	10
00321600	PORTLAND STATE UNIVERSITY	Public	10
00325800	DUQUESNE UNIVERSITY OF THE HOLY SPIRIT	Private, Nonprofit	10
00327300	HARRISBURG AREA COMMUNITY COLLEGE	Public	10
00331500	BLOOMSBURG UNIVERSITY OF PENNSYLVANIA	Public	10
00331700	CHEYNEY UNIVERSITY OF PENNSYLVANIA	Public	10
00339400	WILKES UNIVERSITY	Private, Nonprofit	10
00344600	SOUTH CAROLINA STATE UNIVERSITY	Public	10
00347800	AUSTIN PEAY STATE UNIVERSITY	Public	10
00348000	Bethel University	Private, Nonprofit	10
00349400	Hiwassee College	Private, Nonprofit	10
00349700	KNOXVILLE COLLEGE	Private, Nonprofit	10
00350100	LEMOYNE-OWEN COLLEGE	Private, Nonprofit	10
00353006	University of Tennessee	Public	10
00357700	HUSTON - TILLOTSON UNIVERSITY	Private, Nonprofit	10
00358500	LON MORRIS COLLEGE	Private, Nonprofit	10
00359000	MCLENNAN COMMUNITY COLLEGE	Public	10
00359300	NAVARRO COLLEGE	Public	10
00359900	University of Texas Rio Grande Valley	Public	10
00360600	Sam Houston State University	Public	10
00361200	UNIVERSITY OF HOUSTON - DOWNTOWN	Public	10
00361500	Texas State University	Public	10
00362600	Tarrant County College District	Public	10
00363400	TEXAS STATE TECHNICAL COLLEGE	Public	10

00364400	Texas Tech University	Public	10
00365200	UNIVERSITY OF HOUSTON	Public	10
00365600	UNIVERSITY OF TEXAS AT ARLINGTON	Public	10
00366100	University of Texas at El Paso	Public	10
00369200	Norwich University	Private, Nonprofit	10
00372700	Northern Virginia Community College	Public	10
00373500	VIRGINIA COMMONWEALTH UNIVERSITY	Public	10
00375200	VIRGINIA INTERMONT COLLEGE	Private, Nonprofit	10
00379800	UNIVERSITY OF WASHINGTON	Public	10
00380000	WASHINGTON STATE UNIVERSITY	Public	10
00393803	INTER AMERICAN UNIVERSITY OF PUERTO RICO - SAN GERMAN CAMPUS	Private, Nonprofit	10
00394100	Universidad Ana G. MÃ©ndez - Carolina Campus	Private, Nonprofit	10
00396500	BAY STATE COLLEGE	Proprietary	10
00398500	ORAL ROBERTS UNIVERSITY	Private, Nonprofit	10
00399100	GREENVILLE TECHNICAL COLLEGE	Public	10
00407200	NORTHWOOD UNIVERSITY	Private, Nonprofit	10
00449200	WATTERSON COLLEGE	Proprietary	10
00464201	GLOBE UNIVERSITY - EAU CLAIRE	Proprietary	10
00484400	WAKE TECHNICAL COMMUNITY COLLEGE	Public	10
00485200	Clark State College	Public	10
00489807	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY - CARLISLE	Proprietary	10
00492500	HORRY GEORGETOWN TECHNICAL COLLEGE	Public	10
00494700	WEST TENNESSEE BUSINESS COLLEGE	Proprietary	10
00554100	Minnesota State Community and Technical College	Public	10
00575300	OWENS COMMUNITY COLLEGE	Public	10
00696100	JEFFERSON COMMUNITY AND TECHNICAL COLLEGE	Public	10
00729701	WESTWOOD COLLEGE OF TECHNOLOGY - O'HARE	Proprietary	10
00737200	AUSTIN'S SCHOOL OF SPA TECHNOLOGY	Proprietary	10
00743000	ANTONELLI INSTITUTE	Proprietary	10
00743700	PITTSBURGH TECHNICAL COLLEGE	Private, Nonprofit	10
00754900	COYNE COLLEGE	Proprietary	10
00758604	REMINGTON COLLEGE-LARGO CAMPUS	Private, Nonprofit	10
00758605	REMINGTON COLLEGE-JACKSONVILLE CAMPUS	Private, Nonprofit	10
00760500	ACADEMY PACIFIC TRAVEL COLLEGE	Proprietary	10
00764800	DENVER TECHNICAL COLLEGE	Proprietary	10
00768600	SOUTHERN UNIVERSITY AT SHREVEPORT - BOSSIER CITY	Public	10
00783200	LINCOLN TECHNICAL INSTITUTE - PHILADELPHIA	Proprietary	10
00812300	ADVANCED CAREER TRAINING	Proprietary	10
00831000	AUBURN UNIVERSITY MONTGOMERY	Public	10
00869407	RASMUSSEN COLLEGE - BLOOMINGTON	Proprietary	10
00869411	RASMUSSEN COLLEGE - NEW PORT RICHEY	Proprietary	10
00869413	RASMUSSEN COLLEGE - FORT MYERS	Proprietary	10
00903200	EMPIRE COLLEGE	Proprietary	10
00903400	CATHERINE COLLEGE	Proprietary	10
00907700	UTICA SCHOOL OF COMMERCE	Proprietary	10
00908200	INTERNATIONAL BUSINESS COLLEGE	Proprietary	10
00923000	WAYNE COUNTY COMMUNITY COLLEGE DISTRICT	Public	10
00926803	KELSEY - JENNEY COLLEGE-	Private, Nonprofit	10
00943100	NATIONAL EDUCATION CENTER NATIONAL INSTITUTE OF TECHNOLOGY CAMPUS	Proprietary	10
00944700	WEBSTER CAREER COLLEGE	Proprietary	10
00974100	University of Texas at Dallas	Public	10
00976900	METROPOLITAN COLLEGE OF NEW YORK	Private, Nonprofit	10
00978400	NATIONAL EDUCATION CENTER-BAUDER COLLEGE CAMPUS	Proprietary	10
00991700	IVY TECH COMMUNITY COLLEGE OF INDIANA	Public	10
01003500	SOUTHERN COLLEGE	Proprietary	10
01011500	UNIVERSITY OF TEXAS AT SAN ANTONIO	Public	10
01014802	COLORADO TECHNICAL UNIVERSITY - DENVER BRANCH CAMPUS	Proprietary	10
01028600	SUNY EMPIRE STATE COLLEGE	Public	10
01034500	CINCINNATI STATE TECHNICAL & COMMUNITY COLLEGE	Public	10
01037200	ADELPHI BUSINESS COLLEGE	Proprietary	10
01046300	NATIONAL TECHNICAL SCHOOLS	Proprietary	10
01050300	WICHITA TECHNICAL INSTITUTE	Proprietary	10
01050900	Hallmark University	Private, Nonprofit	10
01055400	Concordia College Alabama	Private, Nonprofit	10
01072725	DEVRY UNIVERSITY - ARLINGTON	Proprietary	10
01084700	Miller-Motte College - Arizona Automotive Institute	Proprietary	10
01099800	PENNSYLVANIA INSTITUTE OF TECHNOLOGY	Private, Nonprofit	10
01121900	COLUMBIA SCHOOL OF BROADCASTING, HOME STUDY	Proprietary	10
01171900	Universidad Ana G. MÃ©ndez - Gurabo Campus	Private, Nonprofit	10
01174500	OHIO TECHNICAL COLLEGE	Proprietary	10
01181000	Taylor Business Institute	Proprietary	10

01191100	BRICK COMPUTER SCIENCE INSTITUTE	Proprietary	10
01191600	DRAKE BUSINESS SCHOOL	Private, Nonprofit	10
01201500	Austin Community College	Public	10
01202600	BELLUS ACADEMY	Proprietary	10
01242500	Stone Academy	Proprietary	10
01289600	North Coast College, The	Proprietary	10
01291200	MTI COLLEGE	Proprietary	10
01300500	OLYMPIAN ACADEMY OF COSMETOLOGY	Proprietary	10
01303904	SOUTH UNIVERSITY - WEST PALM BEACH CAMPUS	Proprietary	10
01303906	SOUTH UNIVERSITY - MONTGOMERY	Proprietary	10
01303907	SOUTH UNIVERSITY - COLUMBIA	Proprietary	10
01303908	SOUTH UNIVERSITY - TAMPA	Proprietary	10
02054300	TRUMBULL BUSINESS COLLEGE	Proprietary	10
02055100	HAWAII BUSINESS COLLEGE	Proprietary	10
02060900	BROWN COLLEGE OF COURT REPORTING	Proprietary	10
02065501	BROOKS COLLEGE - SUNNYVALE	Proprietary	10
02066200	New School, The	Private, Nonprofit	10
02092400	RIDLEY-LOWELL SCHOOL OF BUSINESS	Proprietary	10
02098300	WESTERN TECHNICAL COLLEGE	Proprietary	10
02100612	Carrington College - New Mexico	Proprietary	10
02104000	HARRIS SCHOOL OF BUSINESS	Proprietary	10
02113602	AMERICAN INTERCONTINENTAL UNIVERSITY - LONDON	Proprietary	10
02113610	AMERICAN INTERCONTINENTAL UNIVERSITY - HOUSTON	Proprietary	10
02120600	SAYBROOK UNIVERSITY	Private, Nonprofit	10
02128300	INSTITUTE FOR BUSINESS & TECHNOLOGY	Proprietary	10
02128301	INSTITUTE FOR BUSINESS & TECHNOLOGY - NATIONAL CAREER EDUCATION	Proprietary	10
02147400	CLEVELAND CHIROPRACTIC COLLEGE	Private, Nonprofit	10
02151906	KEISER UNIVERSITY - LAKELAND	Private, Nonprofit	10
02151908	KEISER UNIVERSITY - MIAMI CAMPUS	Private, Nonprofit	10
02152700	CENTER FOR THE MEDIA ARTS	Proprietary	10
02157800	AMERICAN HI-TECH BUSINESS TECHNOLOGY	Proprietary	10
02158417	Harrison College - Columbus, OH	Proprietary	10
02160700	WILFRED ACADEMY OF HAIR DESIGN & BEAUTY CULTURE	Proprietary	10
02165400	TRAINCO BUS SCHOOL	Proprietary	10
02178500	Eagle Gate College	Proprietary	10
02179908	Argosy University - San Francisco Bay Area	Proprietary	10
02179913	Argosy University - Seattle	Proprietary	10
02179921	Argosy University - Schaumburg	Proprietary	10
02188400	SIERRA VALLEY COLLEGE OF COURT REPORTING	Proprietary	10
02216800	CALIFORNIA INSTITUTE	Proprietary	10
02219600	OMEGA INSTITUTE	Proprietary	10
02234200	KEYSTONE TECHNICAL INSTITUTE	Proprietary	10
02241400	BARCLAY CAREER SCHOOL	Proprietary	10
02261301	NATIONAL INSTITUTE OF TECHNOLOGY - HOUSTON GALLERIA	Private, Nonprofit	10
02270200	INTERNATIONAL AVIATION AND TRAVEL ACADEMY	Proprietary	10
02275100	Concorde Career Institute	Proprietary	10
02284300	INTERACTIVE COLLEGE OF TECHNOLOGY	Proprietary	10
02284700	CHICAGO INSTITUTE OF TECHNOLOGY	Proprietary	10
02295200	UNITED SCHOOLS	Proprietary	10
02295900	AMERICAN CAREER TRAINING TRAVEL SCHOOL	Proprietary	10
02305803	FLORIDA CAREER COLLEGE -HIALEAH	Proprietary	10
02312400	LA COLLEGE INTERNATIONAL	Proprietary	10
02317800	American Institute of Trucking	Proprietary	10
02320900	Tidewater Tech	Proprietary	10
02321901	ITT TECHNICAL INSTITUTE - SANTA CLARA	Proprietary	10
02326800	MERIDIAN COLLEGE	Proprietary	10
02330100	Pioneer Pacific College	Proprietary	10
02334200	SOUTHEASTERN ACADEMY	Proprietary	10
02334402	CENTURA COLLEGE - NEWPORT NEWS	Proprietary	10
02339800	SOUTHERN INSTITUTE OF COSMETOLOGY	Proprietary	10
02340500	ST. LOUIS COLLEGE OF HEALTH CAREERS	Proprietary	10
02353200	AMERICAN BUSINESS INSTITUTE (CLOSED)	Proprietary	10
02360800	Provo College	Proprietary	10
02532101	BUSINESS COMPUTER TRAINING INSTITUTE - SEATTLE	Proprietary	10
02546400	MTI Business College	Proprietary	10
02559310	UNITED EDUCATION INSTITUTE - WEST COVINA	Proprietary	10
02572008	Vista College - Beaumont	Proprietary	10
02577900	SANTA BARBARA BUSINESS COLLEGE	Proprietary	10
02581200	CC'S COSMETOLOGY COLLEGE	Proprietary	10
02584400	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF MASSACHUSETTS	Proprietary	10
02596500	ATI- CAREER TRAINING CENTER	Proprietary	10

02599714	Vatterott College - ex'treme Institute by Nelly	Proprietary	10
02599718	Vatterott College - L'Ecole Culinaire	Proprietary	10
02609500	Career Training Academy	Proprietary	10
02612800	LOS ANGELES RECORDING SCHOOL	Proprietary	10
02614901	SANFORD-BROWN INSTITUTE - SPRINGFIELD	Proprietary	10
02617200	AMERICAN COLLEGE	Proprietary	10
02621500	CAREER COLLEGE OF NORTHERN NEVADA	Proprietary	10
02622001	SOUTHWEST ACUPUNCTURE COLLEGE -ALBUQUERQUE	Proprietary	10
03006802	PENNSYLVANIA CULINARY INSTITUTE - LE CORDON BLEU COLLEGE BOSTON	Proprietary	10
03010612	Virginia College - Golf Academy of America - Apopka	Proprietary	10
03010617	Virginia College - Greenville	Proprietary	10
03010618	Virginia College - Jacksonville	Proprietary	10
03010620	Virginia College - Charleston	Proprietary	10
03019800	PCI HEALTH TRAINING CENTER	Proprietary	10
03027400	Avalon School of Cosmetology	Proprietary	10
03031408	SANFORD-BROWN COLLEGE - SAN ANTONIO	Proprietary	10
03031600	DPT BUSINESS SCHOOL	Proprietary	10
03044501	MARIC COLLEGE - PANORAMA CITY	Proprietary	10
03065400	PROFESSIONAL CAREERS INSTITUTE	Proprietary	10
03078000	MIAMI MEDIA SCHOOL	Proprietary	10
03079202	WESTWOOD COLLEGE - ATLANTA MIDTOWN	Proprietary	10
03083700	Galen Health Institutes	Proprietary	10
03091300	REGENT UNIVERSITY	Private, Nonprofit	10
03113104	MARIC COLLEGE - LOS ANGELES	Proprietary	10
03122600	EASTERN INTERNATIONAL COLLEGE	Proprietary	10
03126401	CENTURA COLLEGE - WEST	Proprietary	10
03162302	FOUR-D COLLEGE - VICTORVILLE	Proprietary	10
03173300	ATLANTA'S JOHN MARSHALL LAW SCHOOL	Proprietary	10
03275300	COSMETOLOGY CAREER INSTITUTE	Proprietary	10
03294303	BLUE CLIFF COLLEGE - LAFAYETTE	Proprietary	10
03367400	COMMUNITY CARE COLLEGE	Proprietary	10
03416500	Chicago School of Professional Psychology - College of Nursing	Private, Nonprofit	10
03427500	UNIVERSITY OF ANTELOPE VALLEY	Proprietary	10
03445500	FAYETTE BEAUTY ACADEMY	Proprietary	10
03479300	PCI College	Proprietary	10
03513400	APEX SCHOOL OF THEOLOGY	Private, Nonprofit	10
03639300	WEST COAST ULTRASOUND INSTITUTE	Proprietary	10
03750300	PROSPECT COLLEGE	Proprietary	10
03786300	ADVANCED COLLEGE	Proprietary	10
03838500	NORTHWEST CAREER COLLEGE	Proprietary	10
03852500	CIT COLLEGE OF INFOMEDICAL TECHNOLOGY	Proprietary	10
03910400	NATIONAL POLYTECHNIC COLLEGE	Proprietary	10
03915300	Career Quest Learning Centers	Proprietary	10
03939400	CENTURA INSTITUTE	Proprietary	10
03969601	UEI COLLEGE-RIVERSIDE	Proprietary	10
04038300	ATA COLLEGE	Proprietary	10
04057300	ASHER COLLEGE	Proprietary	10
04115700	REGINA'S COLLEGE OF BEAUTY	Proprietary	10
04124500	MYCOMPUTERCAREER.COM /TECHSKILLS	Proprietary	10
04131700	SOUTHWEST UNIVERSITY AT EL PASO	Proprietary	10
04143100	PROFESSIONAL HANDS INSTITUTE	Proprietary	10
04147700	Lake Lanier School of Massage	Proprietary	10
04150000	CENTRAL NURSING COLLEGE	Proprietary	10
04158700	HOLLYWOOD BEAUTY COLLEGE	Proprietary	10
04177200	Real Barbers College (The)	Proprietary	10
04189200	SALON PROFESSIONAL ACADEMY (THE)	Proprietary	10
04189300	ALLIED AMERICAN UNIVERSITY	Proprietary	10
04221800	Toni&Guy Hairdressing Academy	Proprietary	10
	All Other Schools with Less than 10 Ineligible Applications		12,650
TOTAL			137,410

Question. Please provide a breakdown of "total closed" borrower defense claims to date by institution.

Answer. An Excel file providing the requested data as of June 30, 2021, is enclosed.

Closed Borrower Defense Applications by Institution as of 06/30/2021

Note: Totals may not sum due to rounding.

OPEID	School Name	School Type	Rounded Closed Case Count
	No School Listed		2,640
02606202	Everest College	Private, Nonprofit	1,100
00149901	Everest University - Orlando South	Private, Nonprofit	870
02291504	ITT TECHNICAL INSTITUTE	Proprietary	760
02346200	WyoTech	Private, Nonprofit	370
00709100	EVEREST INSTITUTE	Private, Nonprofit	310
00723401	HEALD COLLEGE - HONOLULU	Proprietary	260
02098800	University of Phoenix	Proprietary	220
00809300	HEALD COLLEGE - FRESNO	Proprietary	180
02262300	HEALD COLLEGE	Private, Nonprofit	180
00723404	HEALD COLLEGE - CONCORD	Proprietary	160
00853200	HEALD COLLEGE - HAYWARD	Proprietary	160
00450700	ALTIERUS CAREER COLLEGE	Private, Nonprofit	150
00149904	Everest University - Tampa	Private, Nonprofit	140
00723405	HEALD COLLEGE - MILPITAS	Proprietary	140
00723410	HEALD COLLEGE - STOCKTON	Proprietary	130
01287302	WYOTECH - EVEREST COLLEGE	Proprietary	120
02593100	HEALD COLLEGE - ROSEVILLE	Proprietary	120
00915705	WyoTech - Blairsville	Proprietary	100
00747700	HEALD COLLEGE - RANCHO CORDOVA	Proprietary	90
00723402	HEALD COLLEGE - PORTLAND	Proprietary	80
01072700	DeVry University	Proprietary	80
03034000	HEALD COLLEGE - SALINAS	Proprietary	80
00814604	Everest University - Pompano	Private, Nonprofit	70
00982800	Altierus Career Education	Private, Nonprofit	70
02295000	EVEREST COLLEGE PHOENIX	Proprietary	70
01035602	EVEREST INSTITUTE - EAGAN	Proprietary	60
01206100	BRYMAN COLLEGE	Proprietary	60
00458600	Purdue University Global	Public	50
00723407	HEALD COLLEGE - MODESTO	Proprietary	50
00748100	SANFORD-BROWN COLLEGE	Proprietary	50
01151002	EVEREST INSTITUTE - EVEREST COLLEGE	Proprietary	50
02338700	MARINELLO SCHOOL OF BEAUTY	Proprietary	50
00926701	EVEREST COLLEGE - CHESAPEAKE	Private, Nonprofit	40
01102401	EVEREST COLLEGE - CHICAGO	Proprietary	40
02300103	EVEREST COLLEGE - EVERETT	Private, Nonprofit	40
02300105	EVEREST COLLEGE - EARTH CITY	Private, Nonprofit	40
03022600	LE CORDON BLEU COLLEGE OF CULINARY ARTS	Proprietary	40
00149905	Everest University - Brandon	Private, Nonprofit	30
00153410	EVEREST UNIVERSITY - EVEREST COLLEGE - MILWAUKEE	Proprietary	30
00188100	ASHFORD UNIVERSITY	Proprietary	30
00754800	WESTWOOD COLLEGE - DENVER NORTH	Proprietary	30
00915706	WyoTech - West Sacramento Campus	Proprietary	30
00982804	Altierus Career Education - South Plainfield	Private, Nonprofit	30
01035601	EVEREST INSTITUTE - DECATUR	Proprietary	30
02113600	AMERICAN INTERCONTINENTAL UNIVERSITY	Proprietary	30
02121800	Everest University - Everest Institute - Miami	Private, Nonprofit	30
02237500	Las Vegas College	Proprietary	30
02261303	Altierus Career College - Houston Hobby	Private, Nonprofit	30
02300104	Altierus Career College - Tacoma	Private, Nonprofit	30

02599801	Everest University - Largo	Private, Nonprofit	30
03072700	WESTWOOD COLLEGE - LOS ANGELES	Proprietary	30
03771300	AMERICAN CAREER INSTITUTE	Proprietary	30
00145900	STRAYER UNIVERSITY	Proprietary	20
00449402	EVEREST COLLEGE - ONTARIO	Proprietary	20
00450303	Altierus Career College - Fort Worth South	Private, Nonprofit	20
00450701	EVEREST COLLEGE- EVEREST COLLEGE, AURORA	Private, Nonprofit	20
00450702	EVEREST COLLEGE- EVEREST COLLEGE, ARLINGTON	Private, Nonprofit	20
00747000	Art Institute of Pittsburgh (The)	Proprietary	20
00982801	EVEREST INSTITUTE- DEARBORN	Private, Nonprofit	20
01185802	EVEREST COLLEGE - BURR RIDGE	Private, Nonprofit	20
01185803	EVEREST COLLEGE - MELROSE PARK	Private, Nonprofit	20
02100401	EVEREST INSTITUTE - KALAMAZOO	Proprietary	20
02121801	EVEREST INSTITUTE - HIALEAH	Proprietary	20
02179907	Argosy University - Phoenix	Proprietary	20
02261302	EVEREST INSTITUTE - HOUSTON GREENSPOINT	Private, Nonprofit	20
02263100	ANTHEM COLLEGE	Proprietary	20
02298501	EVEREST COLLEGE - FORT WORTH	Proprietary	20
02539100	Brightwood College	Proprietary	20
02591100	CAREER POINT COLLEGE	Proprietary	20
02617507	EVEREST COLLEGE - EVEREST INSTITUTE - BENSALEM	Private, Nonprofit	20
03003200	Everest University - Everest Institute - Kendall	Private, Nonprofit	20
03010600	Virginia College	Proprietary	20
04051311	Art Institute of Las Vegas (The)	Proprietary	20
00107400	Grand Canyon University	Proprietary	10
00112300	BROOKS INSTITUTE	Proprietary	10
00149902	Everest University - Melbourne	Private, Nonprofit	10
00149911	Everest University - Everest College - Merrionette Park	Private, Nonprofit	10
00907906	EVEREST COLLEGE- EVEREST INSTITUTE	Private, Nonprofit	10
00982803	EVEREST INSTITUTE - DETROIT	Private, Nonprofit	10
00982808	Altierus Career College - Atlanta	Private, Nonprofit	10
01014800	COLORADO TECHNICAL UNIVERSITY	Proprietary	10
01014805	COLORADO TECHNICAL UNIVERSITY - ON LINE	Proprietary	10
01162600	WESTWOOD COLLEGE - SOUTH BAY	Proprietary	10
02075400	DEVRY UNIVERSITY - DOWNERS	Proprietary	10
02223900	DRAKE COLLEGE OF BUSINESS	Proprietary	10
02313900	WESTWOOD COLLEGE - O'HARE AIRPORT	Proprietary	10
02590900	WRIGHT CAREER COLLEGE	Private, Nonprofit	10
02596600	ATI CAREER TRAINING CENTER	Proprietary	10
02617506	Altierus Career College - Tigard	Private, Nonprofit	10
03003201	EVEREST INSTITUTE - FT. LAUDERDALE	Proprietary	10
03076400	BRYMAN SCHOOL OF ARIZONA (THE)	Proprietary	10
03267300	Capella University	Proprietary	10
03832300	DADE MEDICAL COLLEGE	Proprietary	10
	All Other Schools with Less than 10 Closed Applications		1,730
TOTAL			11,960

Question. How many schools are being investigated for misconduct due to borrower defense claims filed by their students?

Answer. The Department does not comment on deliberative, preliminary, or ongoing investigative work, including disclosing a number or list of institutions that may be subject to such work until the outcomes of any investigations have been issued to the institutions or entities. Nevertheless, the Department notes that it has opened numerous investigations in 2021 and will be holding schools accountable where appropriate. For schools with findings of misrepresentation or misconduct, the Department will use evidence in connection with our borrower defense fact-finding process.

Question. Please provide a list of for-profit colleges for which the Department is aware of pending state or Federal investigations or lawsuits—and the corresponding state or Federal entities.

Answer. The Department does not maintain a formal list of for-profit colleges with pending state or Federal investigations or lawsuits. However, the Department collaborates closely with law enforcement partners where appropriate and requests evidence and input when their investigations of for-profit colleges result in evidence that the Department may consider in connection with its efforts to hold schools accountable.

Question. For how many borrowers whose borrower defense applications have been approved has the Department or its agents made corrected reports to credit reporting agencies? What percentage?

Answer. FSA requires our vendors to remove the credit tradeline for any loans that are approved for 100 percent borrower defense relief.

Question. How many and which institutions is the Department currently investigating for purposes of making findings related to borrower defense?

Answer. The Department does not comment on deliberative, preliminary, or ongoing investigative work, including disclosing a number or list of institutions that may be subject to such work until the outcomes of any investigations have been issued to the institutions or entities. To the extent that a Department investigation results in obtaining evidence that may be relevant to borrower defense claims, the evidence will be given to FSA's Borrower Defense Group for use in its fact-finding process. Additionally, the Department is in the process of increasing staffing within FSA's Investigations Group to advance these efforts.

Question. Since the 2014 collapse and 2015 bankruptcy of Corinthian Colleges, Inc., many for-profit colleges have followed suit—closing their doors as part of a planned teach-out or shuttering precipitously. In these cases, students are eligible for Federal closed school discharges. Many are also eligible for Federal student loan discharges through the Higher Education Act's borrower defense provision as a result of their institution's fraud and misconduct. We cannot let students be left holding the bag. At the same time, the Department's enforcement failures, failures to hold accreditors accountable, attempts to roll back the Gainful Employment and Borrower Defense rules—including provisions allowing students to hold institutions directly accountable in court for misconduct—mean that taxpayers are ultimately on the hook.

Please provide the cumulative cost of approved closed school and borrower defense discharges (including automatic closed school discharges under the 2016 Borrower Defense rule) associated with for-profit colleges since 2014.

Answer. As of June 30, 2021, the cumulative effectuated closed school and borrower defense discharges amount is approximately $2.2 billion. This includes almost $1.1 billion in borrower defense discharges and more than $1.1 billion in closed school discharges, including automatic closed school discharges. The Department is continuing to process the discharges of the roughly 91,800 borrower defense approvals that have been announced in press releases in recent months.

Question. Please provide the cumulative amount that the Department has recouped from institutions for closed school discharge costs associated with for-profit colleges since 2014.

Answer. The Department's recoupment of loan discharge liabilities is a trailing process which follows the Department's quantification of actual discharged loan amounts and assertion of liabilities. In general, when an institution closes, it is required to submit a "Close-Out Audit" report to the Department. When FSA resolves a close-out audit, it quantifies closed school loan discharges and asserts liabilities in the final audit determination for the close-out audit report. FSA may also pursue additional recovery of liabilities arising after the close-out audit is resolved. In all cases, the Department must provide institutions with appeal rights to challenge asserted liabilities and the Department does not pursue collections while an appeal is pending. In addition, the circumstances of some school closures may require the Department to pursue recoveries through protracted bankruptcy proceedings. To that end, the Department has recouped more than $10.4 million from institutions for closed school discharge costs associated with for-profit colleges since 2014.

Question. Please provide the cumulative amount that the Department has recouped from institutions for borrower defense discharge costs associated with for-profit colleges since 2014.

Answer. The Department has not recouped any costs associated with borrower defense discharges from institutions. All approved claims to date relate to closed schools.

Question. According to the April 2021 borrower defense report, the Department currently has nearly 108,000 pending borrower defense claims. Please provide:

The average length of time the 108,000 claims have been pending;

Answer. The average length of time that all applications have been pending as of June 30, 2021, is 748 days. This is not specific to the 108,000 claims referenced, but rather the total number of pending applications, which includes those in the Awaiting Adjudication and Pending Notification categories, as of June 30, 2021.

Question. The percentage of pending claims related to for-profit institutions (including institutions that have been for-profit institutions within the past 10 years), public institutions, and private not-for-profit institutions respectively;

Answer. As of June 30, 2021, 88 percent of total pending applications were related to for-profit institutions; 4 percent were related to public institutions; and 8 percent were related to private not-for-profit institutions. A small number of applications

(less than 1 percent) include those without a school assigned and those involving foreign institutions.

Question. A breakdown of the 108,000 pending claims by institution; and

Answer. An Excel file providing the requested data as of June 30, 2021, is enclosed. Please note that institutions may appear on the list several times because the data was pulled based on the institutions' 8-digit OPEID.

Pending Borrower Defense Applications* by Institution as of 06/30/2021

Note: Totals may not sum due to rounding.

OPEID	School Name	School Type	Rounded Pending Case Count
02291504	ITT TECHNICAL INSTITUTE	Proprietary	28,880
01072700	DeVry University	Proprietary	11,020
02098800	University of Phoenix	Proprietary	8,200
04051311	Art Institute of Las Vegas (The)	Proprietary	2,300
00747000	Art Institute of Pittsburgh (The)	Proprietary	1,830
02539100	Brightwood College	Proprietary	1,740
00754800	WESTWOOD COLLEGE - DENVER NORTH	Proprietary	1,470
02338700	MARINELLO SCHOOL OF BEAUTY	Proprietary	1,340
00149901	Everest University - Orlando South	Private, Nonprofit	1,320
00748100	SANFORD-BROWN COLLEGE	Proprietary	1,280
02606202	Everest College	Private, Nonprofit	1,250
00458600	Purdue University Global	Public	1,220
00188100	ASHFORD UNIVERSITY	Proprietary	1,080
04143500	CHARLOTTE SCHOOL OF LAW	Proprietary	1,010
02504200	WALDEN UNIVERSITY	Proprietary	930
00149904	Everest University - Tampa	Private, Nonprofit	920
01014800	COLORADO TECHNICAL UNIVERSITY	Proprietary	890
03072700	WESTWOOD COLLEGE - LOS ANGELES	Proprietary	890
02113600	AMERICAN INTERCONTINENTAL UNIVERSITY	Proprietary	830
00107400	Grand Canyon University	Proprietary	780
00723603	ARGOSY UNIVERSITY - THE ART INSTITUTE OF CALIFORNIA - LOS ANGELES	Proprietary	780
03022600	LE CORDON BLEU COLLEGE OF CULINARY ARTS	Proprietary	640
00464600	MINNESOTA SCHOOL OF BUSINESS	Proprietary	630
03267300	Capella University	Proprietary	600
02179907	Argosy University - Phoenix	Proprietary	530
02346200	WyoTech	Private, Nonprofit	520
03010600	Virginia College	Proprietary	520
03125400	Argosy University - The Art Institute of California - Hollywood	Proprietary	500
01258400	Illinois Institute of Art (The)	Proprietary	480
00450700	ALTIERUS CAREER COLLEGE	Private, Nonprofit	470
02313900	WESTWOOD COLLEGE - O'HARE AIRPORT	Proprietary	470
02327600	Argosy University - The Art Institute of California - San Diego	Proprietary	460
00466600	American College for Medical Careers	Proprietary	440
02223900	DRAKE COLLEGE OF BUSINESS	Proprietary	440
00835000	Art Institute of Philadelphia (The) -	Proprietary	430
00853200	HEALD COLLEGE - HAYWARD	Proprietary	430
02590900	WRIGHT CAREER COLLEGE	Private, Nonprofit	430
00709100	EVEREST INSTITUTE	Private, Nonprofit	420
01303900	South University	Proprietary	420
02075400	DEVRY UNIVERSITY - DOWNERS	Proprietary	420
00464200	GLOBE UNIVERSITY	Proprietary	410
01019500	Art Institute of Fort Lauderdale (The)	Proprietary	410
03079200	WESTWOOD COLLEGE - DUPAGE	Proprietary	410
00723404	HEALD COLLEGE - CONCORD	Proprietary	370
00778100	Brightwood Career Institute	Proprietary	370
00367400	Stevens Henager College	Private, Nonprofit	360
00748600	NEW ENGLAND INSTITUTE OF ART (THE)	Proprietary	360
02596600	ATI CAREER TRAINING CENTER	Proprietary	340
00723405	HEALD COLLEGE - MILPITAS	Proprietary	330
00927000	Art Institute of Atlanta (The)	Proprietary	330
00814604	Everest University - Pompano	Private, Nonprofit	320
00941200	Fortis College	Proprietary	320
01048900	AMERICAN NATIONAL UNIVERSITY	Proprietary	320
02078900	Art Institute of Colorado (The)	Proprietary	320
00512727	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC CINCINNATI	Proprietary	310
00747700	HEALD COLLEGE - RANCHO CORDOVA	Proprietary	300
02179900	Argosy University	Proprietary	290
02262300	HEALD COLLEGE	Private, Nonprofit	290
02609200	Vatterott College	Proprietary	290
00145900	STRAYER UNIVERSITY	Proprietary	280
00723410	HEALD COLLEGE - STOCKTON	Proprietary	280
02599801	Everest University - Largo	Private, Nonprofit	280
03034000	HEALD COLLEGE - SALINAS	Proprietary	280
00809300	HEALD COLLEGE - FRESNO	Proprietary	270
00844300	ITT TECHNICAL INSTITUTE - SEATTLE	Proprietary	270
02074000	BRANFORD HALL CAREER INSTITUTE	Proprietary	270

02291300	Art Institute of Seattle (The)	Proprietary	270
02295000	EVEREST COLLEGE PHOENIX	Proprietary	270
02525600	ART INSTITUTE OF NEW YORK CITY (THE)	Proprietary	270
03084602	Art Institute of Phoenix (The) - Art Institute of Las Vegas (The)	Proprietary	270
01258401	Illinois Institute of Art (The) - The IL Institute of Art - Schaumburg	Proprietary	260
02593100	HEALD COLLEGE - ROSEVILLE	Proprietary	260
02110500	Miami International University of Art & Design - Art Inst of Charlotte	Proprietary	250
00793800	LINCOLN COLLEGE OF TECHNOLOGY	Proprietary	240
01103100	TECHNICAL CAREER INSTITUTES	Proprietary	240
02362100	FULL SAIL UNIVERSITY	Proprietary	240
03416300	COMPUTER SYSTEMS INSTITUTE	Proprietary	240
00405700	NATIONAL AMERICAN UNIVERSITY	Proprietary	230
01024800	ART INSTITUTES INTERNATIONAL MINNESOTA (THE)	Proprietary	220
02596500	ATI- CAREER TRAINING CENTER	Proprietary	220
00927002	Art Institute of Atlanta (The) - Art Institute of Washington (The)	Proprietary	210
01248200	ATI TECHNICAL TRAINING CENTER	Proprietary	210
02616203	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC FINDLAY	Proprietary	210
00458300	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC SOUTH BEND	Proprietary	200
00723401	HEALD COLLEGE - HONOLULU	Proprietary	200
00781900	Art Institute of Portland (The)	Proprietary	200
02152100	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY - MIAMI-JACOBS CAREER COLLEGE	Proprietary	200
03072701	WESTWOOD COLLEGE - LOS ANGELES - RIVER OAKS	Proprietary	200
00842500	DAYMAR COLLEGE	Proprietary	190
01014805	COLORADO TECHNICAL UNIVERSITY - ON LINE	Proprietary	190
02179948	Argosy University - The Art Institute of California - Inland Empire	Proprietary	190
03427400	CAREER COLLEGES OF AMERICA	Proprietary	190
00887800	Miami International University of Art & Design	Proprietary	180
02117100	Art Institute of Houston (The)	Proprietary	180
03072702	WESTWOOD COLLEGE - CHICAGO LOOP	Proprietary	180
02151900	KEISER UNIVERSITY	Private, Nonprofit	170
02559316	(UNITED EDUCATION INSTITUTE) - UEI JACKSONVILLE	Proprietary	170
00927003	Art Institute of Atlanta (The) - Art Institute of Tennessee-Nashville	Proprietary	160
00982800	Altierus Career Education	Private, Nonprofit	160
01258405	Illinois Institute of Art (The) - The Art Institute of Michigan	Proprietary	160
01258406	ILLINOIS INSTITUTE OF ART (THE) - THE ART INSTITUTE OF OHIO-CINCINNATI	Proprietary	160
02263100	ANTHEM COLLEGE	Proprietary	160
02591100	CAREER POINT COLLEGE	Proprietary	160
00739800	KATHARINE GIBBS SCHOOL	Proprietary	150
00915705	WyoTech - Blairsville	Proprietary	150
04131400	Arizona Summit Law School	Proprietary	150
02075700	Briarcliffe College	Proprietary	140
02104000	HARRIS SCHOOL OF BUSINESS	Proprietary	140
02559300	UNITED EDUCATION INSTITUTE	Proprietary	140
02590904	WRIGHT BUSINESS SCHOOL - WRIGHT CAREER COLLEGE	Private, Nonprofit	140
03771300	AMERICAN CAREER INSTITUTE	Proprietary	140
04051304	Art Institute of Phoenix (The) - Art Institute of Indianapolis (The)	Proprietary	140
01115900	SAWYER SCHOOL (THE)	Proprietary	130
01206100	BRYMAN COLLEGE	Proprietary	130
02179902	Argosy University - Atlanta	Proprietary	130
00723402	HEALD COLLEGE - PORTLAND	Proprietary	120
00887806	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN - ART INST JACKSONVILLE	Proprietary	120
00979500	MISSOURI COLLEGE	Proprietary	120
01287302	WYOTECH - EVEREST COLLEGE	Proprietary	120
02179944	Argosy University - The Art Institute of California - Orange County	Proprietary	120
02313901	WESTWOOD COLLEGE - O'HARE AIRPORT - DALLAS	Proprietary	120
03480301	FORTIS COLLEGE - FORTIS INSTITUTE	Proprietary	120
03969600	UEI COLLEGE	Proprietary	120
00112300	BROOKS INSTITUTE	Proprietary	110
00493400	Hussian College - Daymar College Clarksville	Proprietary	110
00734100	INTERNATIONAL BEAUTY SCHOOL	Proprietary	110
01019800	ECPI UNIVERSITY	Proprietary	110
01162600	WESTWOOD COLLEGE - SOUTH BAY	Proprietary	110
02151100	ATI COLLEGE OF HEALTH	Proprietary	110
02237500	Las Vegas College	Proprietary	110
00149902	Everest University - Melbourne	Private, Nonprofit	100
00149905	Everest University - Brandon	Private, Nonprofit	100
00267800	BRYANT & STRATTON COLLEGE	Proprietary	100
00337100	TEMPLE UNIVERSITY	Public	100
00461900	Sullivan University	Proprietary	100
00754801	WESTWOOD COLLEGE - DENVER SOUTH	Proprietary	100
00887805	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN - ART INST. OF TAMPA	Proprietary	100

00927004	Art Institute of Atlanta (The) - The Art Institute of Charleston	Proprietary	100
00945103	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC TUCSON	Proprietary	100
00977700	KAPLAN COLLEGE	Proprietary	100
00991700	IVY TECH COMMUNITY COLLEGE OF INDIANA	Public	100
01031900	Fortis Institute - Towson	Proprietary	100
01151002	EVEREST INSTITUTE - EVEREST COLLEGE	Proprietary	100
02053000	LIBERTY UNIVERSITY	Private, Nonprofit	100
02117102	ART INSTITUTE OF HOUSTON (THE) - THE ART INSTITUTE OF AUSTIN	Proprietary	100
02171500	WESTERN INTERNATIONAL UNIVERSITY	Proprietary	100
02280800	Lincoln College of Technology - West Palm	Proprietary	100
02497300	Milan Institute	Proprietary	100
03079201	WESTWOOD COLLEGE - FORT WORTH	Proprietary	100
03395307	ICDC College	Proprietary	100
00461800	Sullivan University - Dupont Circle	Proprietary	90
00638500	CHAMBERLAIN UNIVERSITY	Proprietary	90
00675501	BROWN MACKIE COLLEGE	Proprietary	90
00739400	BERKELEY COLLEGE	Proprietary	90
00748800	KAPLAN CAREER INSTITUTE	Proprietary	90
02121800	Everest University - Everest Institute - Miami	Private, Nonprofit	90
02134500	LA' JAMES INTERNATIONAL COLLEGE	Proprietary	90
02179943	Argosy University - The Art Institute of California - San Francisco	Proprietary	90
02179945	Argosy University - The Art Institute of California - Sacramento	Proprietary	90
02263102	ANTHEM COLLEGE - ST. LOUIS PARK	Proprietary	90
02283800	BEAUTY SCHOOLS OF AMERICA	Proprietary	90
02332800	Center for Employment Training	Private, Nonprofit	90
02532100	BUSINESS CAREER TRAINING INSTITUTE	Proprietary	90
02557800	ART INSTITUTE OF YORK (THE) - PENNSYLVANIA	Proprietary	90
03099800	ILLINOIS SCHOOL OF HEALTH CAREERS	Proprietary	90
03549300	Ultimate Medical Academy	Private, Nonprofit	90
00491001	Brightwood Career Institute - Philadelphia	Proprietary	80
00675500	BROWN MACKIE COLLEGE (THE -)	Proprietary	80
00716400	BRYAN UNIVERSITY	Proprietary	80
00753100	ACADEMY OF ART UNIVERSITY	Proprietary	80
00754802	WESTWOOD COLLEGE - ANAHEIM	Proprietary	80
00754803	WESTWOOD COLLEGE - INLAND EMPIRE	Proprietary	80
00754805	WESTWOOD COLLEGE - HOUSTON SOUTH	Proprietary	80
00832200	DEVRY INSTITUTE OF TECHNOLOGY	Proprietary	80
00888700	Concorde Career College	Proprietary	80
00915706	WyoTech - West Sacramento Campus	Proprietary	80
00931302	DAYMAR COLLEGE - LOUISVILLE	Proprietary	80
02065500	BROOKS COLLEGE	Proprietary	80
02174900	INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY - COLLINS COLLEGE	Proprietary	80
02305800	FLORIDA CAREER COLLEGE	Proprietary	80
02326203	Brightwood College - Charlotte	Proprietary	80
02351901	Brightwood College - Bakersfield	Proprietary	80
02594300	CollegeAmerica Denver	Private, Nonprofit	80
02614900	SANFORD-BROWN INSTITUTE	Proprietary	80
03003200	Everest University - Everest Institute - Kendall	Private, Nonprofit	80
03006800	LE CORDON BLEU INSTITUTE OF CULINARY ARTS	Proprietary	80
03148300	AMERICAN BEAUTY ACADEMY	Proprietary	80
03339400	WESTERN GOVERNORS UNIVERSITY	Private, Nonprofit	80
03390300	LINCOLN TECHNICAL INSTITUTE	Proprietary	80
03804400	Gwinnett College	Proprietary	80
00238300	CROWN COLLEGE	Private, Nonprofit	70
00258000	Southern New Hampshire University	Private, Nonprofit	70
00467300	Baker College	Private, Nonprofit	70
00729600	Coleman University	Private, Nonprofit	70
00780400	STAR CAREER ACADEMY	Proprietary	70
00793804	LINCOLN COLLEGE OF TECHNOLOGY - GRAND PRAIRIE	Proprietary	70
02108200	ART INSTITUTES INTERNATIONAL MINNESOTA (THE) - BMC LOUISVILLE	Proprietary	70
02120700	SAN JOAQUIN VALLEY COLLEGE	Proprietary	70
02179901	Argosy University - Twin Cities	Proprietary	70
02241800	AMERICAN CAREER COLLEGE	Proprietary	70
02275100	Concorde Career Institute	Proprietary	70
02289802	KAPLAN CAREER INSTITUTE - KAPLAN COLLEGE	Proprietary	70
02306800	Miller-Motte College	Proprietary	70
02326303	FORTIS INSTITUTE - PALM SPRINGS CAMPUS	Proprietary	70
02539600	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN - ART INSTITUTE DALLAS	Proprietary	70
02559301	UNITED EDUCATION INSTITUTE - SAN BERNARDINO	Proprietary	70
02559309	United Education Institute - Chula Vista	Proprietary	70
03115802	Brightwood College - Laredo	Proprietary	70

03374300	FLORIDA COASTAL SCHOOL OF LAW	Proprietary	70
03493300	All-State Career	Proprietary	70
03545300	University of the Rockies	Proprietary	70
03819300	AMERICAN PUBLIC UNIVERSITY SYSTEM	Proprietary	70
03832300	DADE MEDICAL COLLEGE	Proprietary	70
04039300	Sullivan and Cogliano Training Centers	Proprietary	70
04051308	ART INSTITUTE OF PHOENIX (THE) - BROWN MACKIE COLLEGE - AKRON	Proprietary	70
00380700	MOUNTAIN STATE UNIVERSITY	Private, Nonprofit	60
00464604	MINNESOTA SCHOOL OF BUSINESS - ST. CLOUD	Proprietary	60
00489800	McCann School of Business & Technology	Proprietary	60
00736200	MEDTECH COLLEGE	Proprietary	60
00750700	GIBBS COLLEGE	Proprietary	60
00780401	STAR CAREER ACADEMY - STAR BRICK	Proprietary	60
00927005	ART INSTITUTE OF ATLANTA (THE) - ART INSTITUTE OF DECATUR	Proprietary	60
00946609	Brightwood College - Corpus Christi	Proprietary	60
00962100	HERZING UNIVERSITY	Private, Nonprofit	60
01085400	Thomas Jefferson School of Law	Private, Nonprofit	60
01102401	EVEREST COLLEGE - CHICAGO	Proprietary	60
01164700	SBI CAMPUS - AN AFFILIATE OF SANFORD-BROWN	Proprietary	60
02158400	Harrison College	Proprietary	60
02179919	Argosy University - Dallas	Proprietary	60
02352200	LE CORDON BLEU COLLEGE OF CULINARY ARTS IN CHICAGO	Proprietary	60
02539102	Brightwood College - Riverside	Proprietary	60
02559303	UNITED EDUCATION INSTITUTE - SAN DIEGO	Proprietary	60
02559304	UNITED EDUCATION INSTITUTE - ONTARIO	Proprietary	60
02584200	NEWBRIDGE COLLEGE	Proprietary	60
02614201	Miller - Motte Technical College	Proprietary	60
03001200	MCNALLY SMITH COLLEGE OF MUSIC	Proprietary	60
03069500	SAGE COLLEGE	Proprietary	60
03071801	ITT TECHNICAL INSTITUTE - EVERETT	Proprietary	60
03077800	ROSS COLLEGE-CANTON	Proprietary	60
03079202	WESTWOOD COLLEGE - ATLANTA MIDTOWN	Proprietary	60
03085200	HARRISON CAREER INSTITUTE	Proprietary	60
03095500	ASA COLLEGE	Proprietary	60
03096300	FORTIS INSTITUTE	Proprietary	60
03115803	Brightwood College - Beaumont	Proprietary	60
03196300	Lincoln Technical Institute - Somerville	Proprietary	60
03358300	ALLEN SCHOOL	Proprietary	60
03409500	Chester Career College	Proprietary	60
04037300	LOS ANGELES FILM SCHOOL (THE)	Proprietary	60
04051309	ART INSTITUTE OF PHOENIX (THE) - BROWN MACKIE COLLEGE - N. KENTUCKY	Proprietary	60
04051310	ART INSTITUTE OF PHOENIX (THE) - BROWN MACKIE COLLEGE - MIAMI	Proprietary	60
00158300	MORRIS BROWN COLLEGE	Private, Nonprofit	50
00266700	DOWLING COLLEGE	Private, Nonprofit	50
00319100	CONCORDIA UNIVERSITY	Private, Nonprofit	50
00450701	EVEREST COLLEGE- EVEREST COLLEGE, AURORA	Private, Nonprofit	50
00450702	EVEREST COLLEGE- EVEREST COLLEGE, ARLINGTON	Private, Nonprofit	50
00748801	KAPLAN CAREER INSTITUTE - KAPLAN CAREER INSTITUTE - BOSTON	Proprietary	50
00754700	LINCOLN COLLEGE OF TECHNOLOGY - DENVER	Proprietary	50
00793600	Lincoln College of Technology - Columbia	Proprietary	50
00926701	EVEREST COLLEGE - CHESAPEAKE	Private, Nonprofit	50
00946607	Brightwood College - McAllen	Proprietary	50
00972200	Empire Beauty School	Proprietary	50
00974800	Carrington College	Proprietary	50
00982801	EVEREST INSTITUTE- DEARBORN	Private, Nonprofit	50
01031600	LINCOLN COLLEGE OF TECHNOLOGY - MELROSE PARK	Proprietary	50
01035601	EVEREST INSTITUTE - DECATUR	Proprietary	50
01049000	REGENCY BEAUTY INSTITUTE	Proprietary	50
01185802	EVEREST COLLEGE - BURR RIDGE	Private, Nonprofit	50
01289100	ANTONELLI COLLEGE	Proprietary	50
02116011	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - NEW YORK	Proprietary	50
02117104	ART INSTITUTE OF HOUSTON (THE) - THE ART INSTITUTE OF SAN ANTONIO	Proprietary	50
02121801	EVEREST INSTITUTE - HIALEAH	Proprietary	50
02155300	CHICAGO SCHOOL OF PROFESSIONAL PSYCHOLOGY	Private, Nonprofit	50
02179903	Argosy University - Washington D.C. Area	Proprietary	50
02179909	Argosy University - Tampa	Proprietary	50
02179932	Argosy University - Inland Empire	Proprietary	50
02202300	PITTSBURGH CAREER INSTITUTE	Proprietary	50
02289801	KAPLAN CAREER INSTITUTE - KAPLAN CAREER INSTITUTE	Proprietary	50
02296605	DEVRY UNIVERSITY - ADDISON	Proprietary	50
02300104	Altierus Career College - Tacoma	Private, Nonprofit	50

02306302	Brightwood College - Fresno	Proprietary	50
02312202	Brightwood College - Friendswood	Proprietary	50
02319300	COMPUTER LEARNING CENTER	Proprietary	50
02549005	Brightwood College - Palm Springs	Proprietary	50
02559305	UNITED EDUCATION INSTITUTE - ENCINO	Proprietary	50
02590903	WRIGHT BUSINESS SCHOOL - WRIGHT CAREER COLLEGE	Private, Nonprofit	50
02591905	Brightwood College - Brownsville	Proprietary	50
02599705	Vatterott College - Sunset Hills	Proprietary	50
02605501	REMINGTON COLLEGE - MOBILE	Private, Nonprofit	50
03010802	Fortis Institute - Birmingham	Proprietary	50
03026500	Remington College	Private, Nonprofit	50
03052200	COURT REPORTING INSTITUTE,INC	Proprietary	50
03062700	PLATT COLLEGE	Proprietary	50
03069302	WESTERN CAREER COLLEGE - FREMONT	Proprietary	50
03076400	BRYMAN SCHOOL OF ARIZONA (THE)	Proprietary	50
03272303	Brightwood College - Arlington	Proprietary	50
03424400	All-State Career - Fortis College - Houston South	Proprietary	50
03427401	CAREER COLLEGES OF AMERICA - SAN BERNARDINO	Proprietary	50
03513300	LACY COSMETOLOGY SCHOOL	Proprietary	50
03618300	INSTITUTE OF TECHNICAL ARTS	Proprietary	50
03813300	Northcentral University	Proprietary	50
04051333	ART INSTITUTE OF PHOENIX (THE) - BROWN MACKIE COLLEGE - BIRMINGHAM	Proprietary	50
04131900	FASTTRAIN OF MIAMI	Proprietary	50
00108100	ARIZONA STATE UNIVERSITY	Public	40
00132800	UNIVERSITY OF SOUTHERN CALIFORNIA	Private, Nonprofit	40
00140100	POST UNIVERSITY	Proprietary	40
00150900	Nova Southeastern University-Davie	Private, Nonprofit	40
00264900	SANTA FE UNIVERSITY OF ART AND DESIGN	Proprietary	40
00464601	MINNESOTA SCHOOL OF BUSINESS - BROOKLYN CENTER	Proprietary	40
00464606	MINNESOTA SCHOOL OF BUSINESS - BLAINE	Proprietary	40
00499203	Miller-Motte Technical College	Proprietary	40
00675508	BROWN MACKIE COLLEGE (THE) - BIRMINGHAM	Proprietary	40
00743700	PITTSBURGH TECHNICAL COLLEGE	Private, Nonprofit	40
00780402	STAR CAREER ACADEMY - STAR EGG HARBOR	Proprietary	40
00822100	Universal Technical Institute	Proprietary	40
00841700	STENOTYPE INSTITUTE OF JACKSONVILLE	Proprietary	40
00907906	EVEREST COLLEGE- EVEREST INSTITUTE	Private, Nonprofit	40
00927007	ART INSTITUTE OF ATLANTA (THE) - THE ART INSTITUTE OF VIRGINIA BEACH	Proprietary	40
00959100	COMPUTER LEARNING CENTERS, INC. LOS ANGELES	Proprietary	40
00982804	Altierus Career Education - South Plainfield	Private, Nonprofit	40
01021700	INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY - NASHVILLE	Proprietary	40
01072714	DEVRY UNIVERSITY - DECATUR	Proprietary	40
01086100	WEST VIRGINIA BUSINESS COLLEGE	Proprietary	40
01116600	Broadview College	Proprietary	40
01146000	National University - La Jolla	Private, Nonprofit	40
01157400	BAUDER COLLEGE	Proprietary	40
01303913	SOUTH UNIVERSITY - THE ART INSTITUTE OF FORT WORTH	Proprietary	40
02091702	Brightwood College - Chula Vista	Proprietary	40
02179908	Argosy University - San Francisco Bay Area	Proprietary	40
02179918	Argosy University - Sarasota	Proprietary	40
02179939	ARGOSY UNIVERSITY - THE ART INSTITUTE OF CALIFORNIA - SILICON VALLEY	Proprietary	40
02201802	KAPLAN COLLEGE - HAMMOND	Proprietary	40
02217100	PIMA MEDICAL INSTITUTE	Proprietary	40
02246000	Ross University, School of Medicine	Foreign	40
02261302	EVEREST INSTITUTE - HOUSTON GREENSPOINT	Private, Nonprofit	40
02261303	Altierus Career College - Houston Hobby	Private, Nonprofit	40
02298501	EVEREST COLLEGE - FORT WORTH	Proprietary	40
02313902	WESTWOOD COLLEGE - O'HARE AIRPORT - ATLANTA NORTHLAKE	Proprietary	40
02559310	UNITED EDUCATION INSTITUTE - WEST COVINA	Proprietary	40
02576900	CHARTER COLLEGE	Proprietary	40
02599701	Vatterott College - Kansas City	Proprietary	40
02599710	Vatterott College - Vatterott Career College - Memphis	Proprietary	40
03067500	Institute of Technology	Proprietary	40
03079900	CITY COLLEGE	Proprietary	40
03115804	KAPLAN COLLEGE - LUBBOCK	Proprietary	40
03123900	SOUTHEASTERN COLLEGE	Proprietary	40
03232304	Lincoln Technical Institute - Lincoln	Proprietary	40
03380301	STAR CAREER ACADEMY - STAR PHILADELPHIA	Proprietary	40
03380303	STAR CAREER ACADEMY - STAR CLIFTON	Proprietary	40
03693300	CARNEGIE CAREER COLLEGE	Private, Nonprofit	40
03903500	SOUTHERN TECHNICAL COLLEGE	Proprietary	40

04051312	ART INSTITUTE OF PHOENIX (THE) - BROWN MACKIE COLLEGE - MICHIGAN CITY	Proprietary	40
04132000	FASTTRAIN OF FORT LAUDERDALE	Proprietary	40
00146600	BARRY UNIVERSITY	Private, Nonprofit	30
00148400	FLORIDA STATE COLLEGE AT JACKSONVILLE	Public	30
00174600	Roosevelt University - State Street	Private, Nonprofit	30
00270400	College of New Rochelle (The)	Private, Nonprofit	30
00275100	LONG ISLAND UNIVERSITY	Private, Nonprofit	30
00293700	King's College	Proprietary	30
00312100	Tiffin University	Private, Nonprofit	30
00422002	Purdue University Global - Cedar Rapids	Public	30
00446700	TUCSON COLLEGE	Proprietary	30
00450301	EVEREST COLLEGE - MCLEAN	Private, Nonprofit	30
00464605	MINNESOTA SCHOOL OF BUSINESS - ROCHESTER	Proprietary	30
00472900	MOUNT WASHINGTON COLLEGE	Proprietary	30
00739802	KATHARINE GIBBS SCHOOL (THE) - PHILADELPHIA	Proprietary	30
00750601	LINCOLN TECHNICAL INSTITUTE - UNION	Proprietary	30
00767800	SPARTAN COLLEGE OF AERONAUTICS AND TECHNOLOGY	Proprietary	30
00784400	SBI CAMPUS - AN AFFILIATE OF SANFORD-BROWN - SANFORD-BROWN INSTITUTE	Proprietary	30
00793803	LINCOLN COLLEGE OF TECHNOLOGY - NASHVILLE	Proprietary	30
00922800	DEVRY COLLEGE OF TECHNOLOGY	Proprietary	30
00946610	Brightwood College - Fort Worth	Proprietary	30
00957200	COMPUTER LEARNING CENTER OF ALEXANDRIA	Proprietary	30
00974300	BELLEVUE UNIVERSITY	Private, Nonprofit	30
01005700	AMERICAN COMMERCIAL COLLEGE	Proprietary	30
01035602	EVEREST INSTITUTE - EAGAN	Proprietary	30
01085101	BRANFORD HALL CAREER INSTITUTE - JERSEY CITY	Proprietary	30
01111200	FASHION INSTITUTE OF DESIGN & MERCHANDISING -	Proprietary	30
01162601	WESTWOOD COLLEGE - SOUTH BAY - ARLINGTON BALLSTON	Proprietary	30
01162602	WESTWOOD COLLEGE - SOUTH BAY - ANNANDALE	Proprietary	30
01185803	EVEREST COLLEGE - MELROSE PARK	Private, Nonprofit	30
01212803	LINCOLN COLLEGE OF TECHNOLOGY - VINE	Proprietary	30
01212804	LINCOLN COLLEGE OF TECHNOLOGY - NORTHLAND	Proprietary	30
01258407	ILLINOIS INSTITUTE OF ART (THE) - THE IL INSTITUTE OF ART-TINLEY PARK	Proprietary	30
02100401	EVEREST INSTITUTE - KALAMAZOO	Proprietary	30
02110800	California College San Diego	Private, Nonprofit	30
02113601	AMERICAN INTERCONTINENTAL UNIVERSITY - LOS ANGELES	Proprietary	30
02116001	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - TREVOSE	Proprietary	30
02116006	SANFORD-BROWN COLLEGE - FT. LAUDERDALE	Proprietary	30
02117103	ART INSTITUTE OF HOUSTON (THE) - THE ART INSTITUTE OF HOUSTON-NORTH	Proprietary	30
02149300	SCS BUSINESS AND TECHNICAL INSTITUTE	Proprietary	30
02179905	Argosy University - Hawaii	Proprietary	30
02179914	Argosy University - Nashville	Proprietary	30
02179921	Argosy University - Schaumburg	Proprietary	30
02179928	Argosy University - Los Angeles	Proprietary	30
02179930	Argosy University - Denver	Proprietary	30
02201803	KAPLAN COLLEGE - MILWAUKEE	Proprietary	30
02201806	Brightwood College - Indianapolis	Proprietary	30
02218700	NUC University - Florida Technical College - Orlando	Proprietary	30
02218800	BROOKLINE COLLEGE	Proprietary	30
02219500	Mildred Elley	Proprietary	30
02266200	HELMS CAREER INSTITUTE	Private, Nonprofit	30
02274100	LA' JAMES INTERNATIONAL COLLEGE - DES MOINES	Proprietary	30
02288500	PHILLIPS JUNIOR COLLEGE	Proprietary	30
02300103	EVEREST COLLEGE - EVERETT	Private, Nonprofit	30
02300105	EVEREST COLLEGE - EARTH CITY	Private, Nonprofit	30
02308900	MASTERS OF COSMETOLOGY COLLEGE	Proprietary	30
02326306	FORTIS INSTITUTE - MIAMI CAMPUS	Proprietary	30
02332900	DEVRY INSTITUTE OF TECHNOLOGY-POMONA	Proprietary	30
02342700	Fortis College - Norfolk	Proprietary	30
02559312	United Education Institute - Garden Grove	Proprietary	30
02599702	Vatterott College - Springfield	Proprietary	30
03030600	CORTIVA INSTITUTE	Proprietary	30
03031402	SANFORD-BROWN COLLEGE - ORLANDO	Proprietary	30
03031409	SANFORD-BROWN COLLEGE - INTERNATIONAL ACADEMY OF DESIGN AND TECHNOLOGY	Proprietary	30
03035800	HERITAGE INSTITUTE	Proprietary	30
03069300	WESTERN CAREER COLLEGE	Proprietary	30
03071803	ITT TECHNICAL INSTITUTE - MORRISVILLE	Proprietary	30
03115100	HERITAGE COLLEGE	Proprietary	30
03272301	KAPLAN COLLEGE - MIDLAND	Proprietary	30
03304300	Centura College	Proprietary	30
03380302	STAR CAREER ACADEMY - STAR NEWARK	Proprietary	30

03399300	BRYAN COLLEGE	Proprietary	30
03426400	ANTHEM INSTITUTE	Proprietary	30
03441400	NEWBRIDGE COLLEGE - SAN DIEGO EAST	Proprietary	30
03480304	FORTIS COLLEGE - GRAND PRAIRIE CAMPUS	Proprietary	30
03534300	JONES INTERNATIONAL UNIVERSITY	Proprietary	30
03564300	INTERNATIONAL SCHOOL OF HEALTH, BEAUTY & TECHNOLOGY	Proprietary	30
03740400	ATI COLLEGE	Proprietary	30
03763300	MEDICAL PROFESSIONAL INSTITUTE	Proprietary	30
03969601	UEI COLLEGE-RIVERSIDE	Proprietary	30
04121500	COLUMBIA SOUTHERN UNIVERSITY	Proprietary	30
04123200	INSTITUTE OF ALLIED MEDICAL PROFESSIONS	Private, Nonprofit	30
04132100	FASTTRAIN OF TAMPA	Proprietary	30
04132200	FASTTRAIN OF JACKSONVILLE	Proprietary	30
04227900	Northland College	Private, Nonprofit	30
00104700	Troy University	Public	20
00115300	CALIFORNIA STATE UNIVERSITY, NORTHRIDGE	Public	20
00121000	HEALD INSTITUTE OF TECHNOLOGY	Private, Nonprofit	20
00146700	BETHUNE COOKMAN UNIVERSITY	Private, Nonprofit	20
00148000	FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY	Public	20
00152600	SAINT LEO UNIVERSITY	Private, Nonprofit	20
00153700	University of South Florida	Public	20
00157400	GEORGIA STATE UNIVERSITY	Public	20
00166500	Columbia College Chicago	Private, Nonprofit	20
00167100	DEPAUL UNIVERSITY	Private, Nonprofit	20
00170300	National Louis University - Kendall College at National Louis Universi	Private, Nonprofit	20
00219300	MOUNT IDA COLLEGE	Private, Nonprofit	20
00229000	MICHIGAN STATE UNIVERSITY	Public	20
00232900	Wayne State University	Public	20
00252100	WEBSTER UNIVERSITY	Private, Nonprofit	20
00262900	Rutgers, the State University of New Jersey	Public	20
00273200	HOFSTRA UNIVERSITY	Private, Nonprofit	20
00278500	New York University	Private, Nonprofit	20
00283400	EXCELSIOR COLLEGE	Private, Nonprofit	20
00332900	Pennsylvania State University (The)	Public	20
00340400	JOHNSON & WALES UNIVERSITY	Private, Nonprofit	20
00364200	Texas Southern University	Public	20
00367403	Stevens Henager College-Salt Lake City	Private, Nonprofit	20
00395400	UNIVERSITY OF CENTRAL FLORIDA-MAIN CAMPUS	Public	20
00450302	EVEREST COLLEGE - SANTA ANA	Private, Nonprofit	20
00450303	Altierus Career College - Fort Worth South	Private, Nonprofit	20
00458601	Kaplan University	Public	20
00458608	Purdue University Global - Omaha	Public	20
00458612	Purdue University Global - Hagerstown	Public	20
00464201	GLOBE UNIVERSITY - EAU CLAIRE	Proprietary	20
00464602	MINNESOTA SCHOOL OF BUSINESS - PLYMOUTH	Proprietary	20
00464603	MINNESOTA SCHOOL OF BUSINESS - SHAKOPEE	Proprietary	20
00466604	Salter School (The) - Fall River Campus	Proprietary	20
00479900	Monroe College	Proprietary	20
00489805	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY - SCRANTON	Proprietary	20
00491005	KAPLAN CAREER INSTITUTE - KAPLAN COLLEGE, JACKSONVILLE	Proprietary	20
00520307	REMINGTON COLLEGE - LAFAYETTE	Private, Nonprofit	20
00675506	BROWN MACKIE COLLEGE (THE) - OKLAHOMA CITY	Proprietary	20
00723407	HEALD COLLEGE - MODESTO	Proprietary	20
00736202	MEDTECH COLLEGE - GREENWOOD	Proprietary	20
00747001	ART INSTITUTE OF PITTSBURGH (THE) - SANTA MONICA	Proprietary	20
00750703	GIBBS COLLEGE - KATHARINE GIBBS SCHOOL CENTENNIAL	Proprietary	20
00751800	Apex Technical School	Proprietary	20
00758600	REMINGTON COLLEGE - TAMPA	Private, Nonprofit	20
00777700	REMINGTON COLLEGE - CLEVELAND	Private, Nonprofit	20
00778102	KAPLAN CAREER INSTITUTE - CAREER CENTERS OF TEXAS - FORT WORTH	Proprietary	20
00822103	Universal Technical Institute - California	Proprietary	20
00850101	Rasmussen College	Proprietary	20
00869410	RASMUSSEN COLLEGE - OCALA	Proprietary	20
00888900	LEHIGH VALLEY COLLEGE	Proprietary	20
00927006	ART INSTITUTE OF ATLANTA (THE) - ART INSTITUTE OF WASHINGTON-DULLES	Proprietary	20
00931305	Daymar College - Bellevue	Proprietary	20
00931307	DAYMAR COLLEGE - PADUCAH	Proprietary	20
00963500	FLORIDA INTERNATIONAL UNIVERSITY	Public	20
00982803	EVEREST INSTITUTE - DETROIT	Private, Nonprofit	20
00998200	VICTORY UNIVERSITY	Proprietary	20
01031906	FORTIS INSTITUTE - FORTIS COLLEGE	Proprietary	20

01040500	PINNACLE CAREER INSTITUTE	Proprietary	20
01063300	Houston Community College	Public	20
01072704	DEVRY UNIVERSITY - NEWARK	Proprietary	20
01072706	DeVry University - Ontario	Proprietary	20
01072711	DEVRY UNIVERSITY - ORLANDO	Proprietary	20
01072719	DEVRY COLLEGE OF NEW YORK	Proprietary	20
01072720	DEVRY UNIVERSITY - COLUMBUS	Proprietary	20
01072724	DEVRY UNIVERSITY - IRVING	Proprietary	20
01072754	DEVRY UNIVERSITY - HOUSTON	Proprietary	20
01077900	PORTER AND CHESTER INSTITUTE	Proprietary	20
01083100	NEW COLLEGE OF CALIFORNIA	Private, Nonprofit	20
01091300	Madison Media Institute	Proprietary	20
01114500	LONE STAR COLLEGE SYSTEM	Public	20
01164400	University of Maryland Global Campus	Public	20
01212801	LINCOLN COLLEGE OF TECHNOLOGY - FLORENCE	Proprietary	20
01258408	ILLINOIS INSTITUTE OF ART (THE) - THE ART INSTITUTE OF MICHIGAN - TROY	Proprietary	20
01262700	THOMAS M. COOLEY LAW SCHOOL	Private, Nonprofit	20
01284600	LAWTON SCHOOL FOR MEDICAL AND DENTAL ASSISTANTS	Proprietary	20
01303907	SOUTH UNIVERSITY - COLUMBIA	Proprietary	20
02052002	KAPLAN COLLEGE - FLORIDA EDUCATION CENTER - LAUDERHILL	Proprietary	20
02055200	Harrington College of Design	Proprietary	20
02065501	BROOKS COLLEGE - SUNNYVALE	Proprietary	20
02074800	LIFE UNIVERSITY	Private, Nonprofit	20
02078905	ART INSTITUTE OF COLORADO (THE) - PHOENIX BRANCH	Proprietary	20
02079800	HEALD COLLEGE, SCHOOL OF BUSINESS	Private, Nonprofit	20
02103200	BROWN MACKIE COLLEGE-MERRILLVILLE	Proprietary	20
02116005	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - LANDOVER	Proprietary	20
02116008	SANFORD-BROWN COLLEGE - ATLANTA	Proprietary	20
02116009	SANFORD-BROWN COLLEGE - MIDDLEBURG HEIGHTS	Proprietary	20
02119200	COURT REPORTING INSTITUTE OF ST LOUIS	Proprietary	20
02127900	SOJOURNER-DOUGLASS COLLEGE	Private, Nonprofit	20
02128000	SUPERIOR TRAINING SERVICES	Proprietary	20
02131500	NORTHWESTERN COLLEGE	Private, Nonprofit	20
02141500	SAVANNAH COLLEGE OF ART AND DESIGN	Private, Nonprofit	20
02152102	ACADEMY OF COURT REPORTING AND TECHNOLOGY - MIAMI-JACOBS CAREER COLLEG	Proprietary	20
02174600	MARINELLO SCHOOL OF BEAUTY - BELL	Proprietary	20
02179913	Argosy University - Seattle	Proprietary	20
02179926	ARGOSY UNIVERSITY - ORANGE COUNTY	Proprietary	20
02179929	Argosy University - San Diego	Proprietary	20
02180100	ROSS MEDICAL EDUCATION CENTER	Proprietary	20
02202301	SANFORD-BROWN INSTITUTE - SANFORD-BROWN INSTITUTE	Proprietary	20
02205203	SANFORD-BROWN COLLEGE - ST. PETERS	Proprietary	20
02241801	AMERICAN CAREER COLLEGE - ANAHEIM	Proprietary	20
02245504	FORTIS COLLEGE - LARGO CAMPUS	Proprietary	20
02248200	Milan Institute of Cosmetology	Proprietary	20
02255600	MARINELLO SCHOOL OF BEAUTY - PARAMOUNT	Proprietary	20
02263104	ANTHEM COLLEGE - ANTHEM CAREER COLLEGE - NASHVILLE	Proprietary	20
02293202	ATI CAREER TRAINING CENTER - ATI COLLEGE OF HEALTH MIAMI	Proprietary	20
02295002	EVEREST COLLEGE PHOENIX - MESA CAMPUS	Proprietary	20
02296500	MASTERS INSTITUTE	Proprietary	20
02312201	TEXAS SCHOOL OF BUSINESS - SOUTHWEST CAMPUS	Proprietary	20
02312203	TEXAS SCHOOL OF BUSINESS - EAST CAMPUS	Proprietary	20
02314800	BALTIMORE INTERNATIONAL COLLEGE	Private, Nonprofit	20
02322000	COMPUTER LEARNING CENTERS, INC. SAN FRANCISCO	Proprietary	20
02326300	Fortis College - Fortis Institute - Cookeville	Proprietary	20
02330100	Pioneer Pacific College	Proprietary	20
02337800	COLLEGE OF OFFICE TECHNOLOGY	Proprietary	20
02491100	Beckfield College	Proprietary	20
02491500	Southwest University of Visual Arts	Private, Nonprofit	20
02495500	All-State Career School	Proprietary	20
02502702	UEI (UNITED EDUCATION INSTITUTE) - JACKSONVILLE	Proprietary	20
02521500	LAMSON COLLEGE	Proprietary	20
02539900	STAR TECHNICAL INSTITUTE	Proprietary	20
02559400	INTERCOAST COLLEGES	Proprietary	20
02586800	HARRISON CAREER INSTITUTE-	Proprietary	20
02588904	MEDTECH INSTITUTE- MEDTECH COLLEGE	Proprietary	20
02596503	ATI- CAREER TRAINING CENTER - HOUSTON (#038)	Proprietary	20
02599703	Vatterott College - Joplin	Proprietary	20
02599712	VATTEROTT COLLEGE - ST. CHARLES	Proprietary	20
02599718	Vatterott College - L'Ecole Culinaire	Proprietary	20
02606800	Miller-Motte College - McCann - Monroe	Proprietary	20

02611004	HERITAGE COLLEGE-KANSAS CITY	Proprietary	20
02615001	SANFORD-BROWN COLLEGE - DALLAS	Proprietary	20
02616401	SANFORD-BROWN INSTITUTE - TAMPA	Proprietary	20
02616402	SANFORD-BROWN COLLEGE - SANFORD-BROWN INSTITUTE - ISELIN	Proprietary	20
02616703	LE CORDON BLEU COLLEGE OF CULINARY ARTS - LAS VEGAS	Proprietary	20
02617503	EVEREST COLLEGE - VANCOUVER	Private, Nonprofit	20
02617506	Altierus Career College - Tigard	Private, Nonprofit	20
03003201	EVEREST INSTITUTE - FT. LAUDERDALE	Proprietary	20
03006801	PENNSYLVANIA CULINARY INSTITUTE - LE CORDON BLEU COLLEGE OF CUL ARTS	Proprietary	20
03010603	Virginia College - Jackson	Proprietary	20
03010803	Fortis Institute - Birmingham, Alabama	Proprietary	20
03022601	LE CORDON BLEU COLLEGE OF CULIANRY ARTS - ATLANTA	Proprietary	20
03031403	SANFORD-BROWN COLLEGE - LE CORDON BLEU COLLEGE OF CULINARY ARTS	Proprietary	20
03062300	WESTECH COLLEGE	Proprietary	20
03064200	COMPUTER LEARNING CENTER OF ANAHEIM	Proprietary	20
03067501	Institute of Technology - Modesto	Proprietary	20
03071802	ITT TECHNICAL INSTITUTE - WICHITA	Proprietary	20
03076402	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM COLLEGE - ORLANDO	Proprietary	20
03120300	CollegeAmerica - Flagstaff	Private, Nonprofit	20
03126800	PACIFICA GRADUATE INSTITUTE	Proprietary	20
03348400	MATTIA COLLEGE	Proprietary	20
03426300	COLLEGE OF HEALTH CARE PROFESSIONS (THE)	Proprietary	20
03427402	CAREER COLLEGES OF AMERICA - LOS ANGELES	Proprietary	20
03448300	BUSINESS INDUSTRIAL RESOURCES	Proprietary	20
03866300	GALIANO CAREER ACADEMY	Proprietary	20
03973300	SAE EXPRESSION COLLEGE	Proprietary	20
04116000	VIDEO SYMPHONY ENTERTRAINING	Proprietary	20
04122300	Grantham University	Proprietary	20
04132300	INSTITUTE OF MEDICAL EDUCATION	Proprietary	20
04184800	VANTAGE COLLEGE	Proprietary	20
00100200	ALABAMA AGRICULTURAL & MECHANICAL UNIVERSITY	Public	10
00100500	ALABAMA STATE UNIVERSITY	Public	10
00105700	UNIVERSITY OF SOUTH ALABAMA	Public	10
00108300	University of Arizona (The)	Public	10
00134201	WHITTIER COLLEGE - COLLEGE OF LAW	Private, Nonprofit	10
00141600	UNIVERSITY OF BRIDGEPORT	Private, Nonprofit	10
00144800	HOWARD UNIVERSITY	Private, Nonprofit	10
00147900	EMBRY-RIDDLE AERONAUTICAL UNIVERSITY	Private, Nonprofit	10
00148100	Florida Atlantic University	Public	10
00148900	FLORIDA STATE UNIVERSITY	Public	10
00149700	JONES COLLEGE	Private, Nonprofit	10
00149906	Altierus Career College - Orange Park	Private, Nonprofit	10
00152800	ST. PETERSBURG COLLEGE	Public	10
00153300	TALLAHASSEE COMMUNITY COLLEGE	Public	10
00153600	University of Miami	Private, Nonprofit	10
00154400	Albany State University	Public	10
00156200	GEORGIA STATE UNIVERSITY - PC-DECATUR	Public	10
00159000	SAVANNAH STATE UNIVERSITY	Public	10
00169400	CHICAGO STATE UNIVERSITY	Public	10
00180500	INDIANA INSTITUTE OF TECHNOLOGY	Private, Nonprofit	10
00181300	Indiana University - Purdue University Indianapolis	Public	10
00182200	INDIANA WESLEYAN UNIVERSITY	Private, Nonprofit	10
00208300	Morgan State University	Public	10
00212300	BECKER COLLEGE	Private, Nonprofit	10
00224900	Davenport University	Private, Nonprofit	10
00227800	Lansing Community College	Public	10
00245600	Columbia College	Private, Nonprofit	10
00251800	UNIVERSITY OF MISSOURI - KANSAS CITY	Public	10
00251900	UNIVERSITY OF MISSOURI - SAINT LOUIS	Public	10
00256900	UNIVERSITY OF NEVADA - LAS VEGAS	Public	10
00261700	MONTCLAIR STATE UNIVERSITY	Public	10
00265700	NEW MEXICO STATE UNIVERSITY	Public	10
00277200	MERCY COLLEGE	Private, Nonprofit	10
00278200	NEW YORK INSTITUTE OF TECHNOLOGY	Private, Nonprofit	10
00279100	PACE UNIVERSITY	Private, Nonprofit	10
00287200	MONROE COMMUNITY COLLEGE	Public	10
00292300	East Carolina University	Public	10
00295000	North Carolina Central University	Public	10
00305100	KENT STATE UNIVERSITY	Public	10
00325600	DREXEL UNIVERSITY	Private, Nonprofit	10
00338801	VILLANOVA UNIVERSITY - SCHOOL OF LAW	Private, Nonprofit	10

00342000	BENEDICT COLLEGE	Private, Nonprofit	10
00350900	UNIVERSITY OF MEMPHIS (THE)	Public	10
00351000	MIDDLE TENNESSEE STATE UNIVERSITY	Public	10
00352200	TENNESSEE STATE UNIVERSITY	Public	10
00359400	UNIVERSITY OF NORTH TEXAS	Public	10
00363000	Prairie View Agricultural & Mechanical University	Public	10
00365200	UNIVERSITY OF HOUSTON	Public	10
00367401	Stevens Henager College - Orem Campus	Private, Nonprofit	10
00367406	Stevens Henager College - Boise, ID	Private, Nonprofit	10
00367409	Stevens Henager College - Independence University	Private, Nonprofit	10
00371200	TIDEWATER COMMUNITY COLLEGE	Public	10
00373500	VIRGINIA COMMONWEALTH UNIVERSITY	Public	10
00373900	SAINT PAUL'S COLLEGE	Private, Nonprofit	10
00376500	NORFOLK STATE UNIVERSITY	Public	10
00399100	GREENVILLE TECHNICAL COLLEGE	Public	10
00456800	Midstate College	Proprietary	10
00458607	Purdue University Global - Cedar Falls	Public	10
00458609	Purdue University Global - Lincoln	Public	10
00458615	Kaplan University - Portland	Public	10
00461700	National College	Proprietary	10
00464205	GLOBE UNIVERSITY - LA CROSSE	Proprietary	10
00469210	Dorsey School of Business - Dearborn	Proprietary	10
00473000	MCINTOSH COLLEGE	Proprietary	10
00473100	DANIEL WEBSTER COLLEGE	Proprietary	10
00493200	DRAUGHONS COLLEGE	Proprietary	10
00493800	South College	Proprietary	10
00675000	VALENCIA COLLEGE	Public	10
00686700	COLUMBUS STATE COMMUNITY COLLEGE- MAIN CAMPUS	Public	10
00736204	MEDTECH COLLEGE - FORT WAYNE	Proprietary	10
00740100	Mandl School	Proprietary	10
00740500	WOOD TOBE - COBURN SCHOOL	Proprietary	10
00750701	GIBBS COLLEGE - KATHARINE GIBBS SCHOOL	Proprietary	10
00757200	AMERICAN MUSICAL & DRAMATIC ACADEMY	Private, Nonprofit	10
00779100	WILFRED ACADEMY OF HAIR & BEAUTY CULTURE	Proprietary	10
00793809	LINCOLN TECHNICAL INSTITUTE - WHITESTONE	Proprietary	10
00793810	LINCOLN TECHNICAL INSTITUTE - MAHWAH	Proprietary	10
00863500	IBMC COLLEGE	Proprietary	10
00887809	Miami International University of Art & Design - Art Inst Raleigh	Proprietary	10
00897600	CLAYTON STATE UNIVERSITY	Public	10
00914500	Governors State University	Public	10
00931309	DAYMAR COLLEGE - LOUISVILLE EAST	Proprietary	10
00943200	ESS COLLEGE OF BUSINESS	Proprietary	10
00972100	Bradford School	Proprietary	10
00974801	CARRINGTON COLLEGE - SAN LEANDRO CAMPUS	Proprietary	10
00982808	Altierus Career College - Atlanta	Private, Nonprofit	10
01014814	COLORADO TECHNICAL UNIVERSITY - NORTH KANSAS CITY	Proprietary	10
01035100	PSI INSTITUTE	Proprietary	10
01072702	DEVRY UNIVERSITY - PHOENIX	Proprietary	10
01072712	DEVRY UNIVERSITY - MIRAMAR	Proprietary	10
01072717	DEVRY UNIVERSITY - KANSAS CITY	Proprietary	10
01072718	DeVry University - Iselin	Proprietary	10
01072722	DEVRY UNIVERSITY - FORT WASHINGTON	Proprietary	10
01085102	Branford Hall Career Institute - North Brunswick	Proprietary	10
01088100	STARK STATE COLLEGE	Public	10
01171900	Universidad Ana G. MÃ©ndez - Gurabo Campus	Private, Nonprofit	10
01212802	LINCOLN COLLEGE OF TECHNOLOGY - FRANKLIN	Proprietary	10
01246102	Lincoln Technical Institute - Moorestown	Proprietary	10
01246103	Lincoln Technical Institute - Paramus	Proprietary	10
01248209	ATI CAREER TRAINING CENTER - GARLAND	Proprietary	10
01287200	NORTH-WEST COLLEGE	Proprietary	10
01291100	MARINELLO SCHOOL OF BEAUTY - HUNTINGTON BEACH	Proprietary	10
01303914	SOUTH UNIVERSITY - NOVI	Proprietary	10
01303922	SOUTH UNIVERSITY - CLEVELAND	Proprietary	10
02075702	Briarcliffe College - Bohemia	Proprietary	10
02100502	UNIVERSAL TECHNICAL INSTITUTE- MOTORCYCLE MECHANICS INSTITUTE DIVISION	Proprietary	10
02100505	UNIVERSAL TECHNICAL INSTITUTE -UNIVERSAL TECHNICAL INST OF N. CA, INC.	Proprietary	10
02106600	AMERICAN INSTITUTE	Proprietary	10
02113604	AMERICAN INTERCONTINENTAL UNIVERSITY - DUNWOODY	Proprietary	10
02119202	COURT REPORTING INSTITUTE OF DALLAS - COURT REPORTING INST OF HOUSTON	Proprietary	10
02131600	PENNCO TECH	Proprietary	10
02152105	ACADEMY OF COURT REPORTING AND TECHNOLOGY - ACADEMY OF COURT REPORTING	Proprietary	10

02158410	Harrison College - East	Proprietary	10
02179935	Argosy University - Salt Lake City	Proprietary	10
02179937	Argosy University - Western State University College of Law	Proprietary	10
02205207	SANFORD-BROWN COLLEGE - MILWAUKEE	Proprietary	10
02218500	SOUTH TEXAS VOCATIONAL TECHNICAL INSTITUTE	Proprietary	10
02244900	Goodwin University	Private, Nonprofit	10
02253900	Miller-Motte College - Berks Technical Institute	Proprietary	10
02261301	NATIONAL INSTITUTE OF TECHNOLOGY - HOUSTON GALLERIA	Private, Nonprofit	10
02263101	ANTHEM COLLEGE - SACRAMENTO	Proprietary	10
02294900	INSTITUTE OF AUDIO RESEARCH	Proprietary	10
02301300	PRISM CAREER INSTITUTE	Proprietary	10
02303600	Fortis College - Ravenna	Proprietary	10
02311200	AMERICAN SCHOOL OF TECHNOLOGY	Proprietary	10
02319000	COMPUTER LEARNING CENTERS,INC. CHICAGO	Proprietary	10
02341002	FORTIS COLLEGE - MONTGOMERY	Proprietary	10
02341005	FORTIS COLLEGE - MONTGOMERY NURSING CAMPUS	Proprietary	10
02504201	WALDEN UNIVERSITY - FLORIDA	Proprietary	10
02540800	GLOBE INSTITUTE OF TECHNOLOGY	Proprietary	10
02541200	Stratford University	Proprietary	10
02549400	Miller-Motte College - STVT - McAllen	Proprietary	10
02569306	LE CORDON BLEU COLLEGE OF CULINARY ARTS - SANFORD-BROWN COLLEGE	Proprietary	10
02572800	VISTA COLLEGE	Proprietary	10
02576200	MID-CONTINENT UNIVERSITY	Private, Nonprofit	10
02577900	SANTA BARBARA BUSINESS COLLEGE	Proprietary	10
02584201	NEWBRIDGE COLLEGE -	Proprietary	10
02588902	MEDTECH INSTITUTE - SILVER SPRING	Proprietary	10
02590901	WRIGHT BUSINESS SCHOOL	Private, Nonprofit	10
02596502	ATI- CAREER TRAINING CENTER - OKLAHOMA CITY (#037)	Proprietary	10
02596601	ATI CAREER TRAINING CENTER - RICHARDSON	Proprietary	10
02599706	Vatterott College - Tulsa	Proprietary	10
02609202	VATTEROTT COLLEGE - ST. JOSEPH	Proprietary	10
02611005	HERITAGE COLLEGE - WICHITA	Proprietary	10
02614205	Miller - Motte Technical College - Miller - Motte College - Greenville	Proprietary	10
02616403	SANFORD-BROWN INSTITUTE - SANFORD-BROWN COLLEGE - WEST ALLIS	Proprietary	10
02617507	EVEREST COLLEGE - EVEREST INSTITUTE - BENSALEM	Private, Nonprofit	10
02617508	EVEREST COLLEGE - WOODBRIDGE	Private, Nonprofit	10
03006802	PENNSYLVANIA CULINARY INSTITUTE - LE CORDON BLEU COLLEGE BOSTON	Proprietary	10
03010602	Virginia College - Huntsville	Proprietary	10
03010604	Virginia College - Austin	Proprietary	10
03022602	LE CORDON BLEU COLLEGE OF CULINARY ARTS - MINNEAPOLIS/ST. PAUL	Proprietary	10
03062701	PLATT COLLEGE - ONTARIO	Proprietary	10
03072500	WORLD MEDICINE INSTITUTE	Private, Nonprofit	10
03076403	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM COLLEGE - IRVING	Proprietary	10
03076404	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM INSTITUTE - LAS VEGAS	Proprietary	10
03076405	BRYMAN SCHOOL OF ARIZONA (THE) - ANTHEM CAREER COLLEGE - MEMPHIS	Proprietary	10
03091100	ACT COLLEGE	Proprietary	10
03128700	MT. SIERRA COLLEGE	Proprietary	10
03162300	FOUR-D COLLEGE	Proprietary	10
03294300	BLUE CLIFF COLLEGE	Proprietary	10
03308300	BRISTOL UNIVERSITY	Proprietary	10
03368300	MIDWEST TECHNICAL INSTITUTE	Proprietary	10
03450302	MARINELLO SCHOOL OF BEAUTY - OVERLAND PARK	Proprietary	10
03523300	Aviation Institute Of Maintenance	Proprietary	10
03625300	PERFORMANCE TRAINING INSTITUTE	Proprietary	10
03789300	UNITECH TRAINING ACADEMY	Proprietary	10
04119400	Aveda Institute - South Florida	Proprietary	10
04131901	FASTTRAIN OF MIAMI - KENDALL	Proprietary	10
04134100	JERSEY COLLEGE	Proprietary	10
	No School Listed		10
	All Other Schools with Less than 10 Pending Applications		8,730
TOTAL			128,380

**Please note the total number of pending applications includes those in the Awaiting Adjudication and Pending Notification categories.*

Question. A list of all group discharge applications the Department has received from State attorneys general including the date submitted, by whom, the school/programs, and the number of covered borrowers and the status of each application.

Answer. Information regarding the group discharge requests from attorneys general is provided in the enclosed file.

Group Submissions by Attorneys General Seeking Relief for Constituents as of April 12, 2021

SCHOOL/SCHOOL GROUP	DIPLOMA PROGRAM(S) IF APPLICABLE	ATTORNEY GENERAL	STATE	SUBMISSION DATE
American Career Institute		Maura Healy	Massachusetts	• 7/20/2016 • 7/26/2016 • 8/3/2016 • 8/12/2016 • 11/16/2016 • 11/23/2016 • 1/3/2017
Anthem University		Lori Swanson	Minnesota	• 5/3/2016 • 7/22/2016 • 10/19/2016 • 2/13/2017 • 3/9/2017 • 4/4/2017
Corinthian Colleges, Inc.		Maura Healy	Massachusetts	• 11/30/2015
Corinthian Colleges, Inc.		Brad Schimel	Wisconsin	• 2/4/2016
Corinthian Colleges, Inc.	• Dental Assistant • Electrician • Massage Therapy • Medical Administrative Assistant • Medical Assistant • Medical Insurance Billing and Coding • Pharmacy Technician	Lisa Madigan Kwame Raoul	Illinois	• 12/16/2016 • 6/3/2019
Corinthian Colleges, Inc.		Bob Ferguson	Washington	• 12/20/2016
Corinthian Colleges, Inc.	Submission for discharge for students enrolled at programs covered by the Department's job placement rate misrepresentation findings.	Lisa Madigan Bob Ferguson Maura Healy Xavier Becerra George Jepsen Matthew Dean Douglas Chin Tom Miller Andy Beshear Brian E. Frosh Janet T. Mills Lori Swanson Jim Hodd Hector Balderas Eric T. Schneiderman Ellen F. Rosenblum Josh Shapiro Mark R. Herring Karl A. Racine	Illinois Washington Massachusetts California Connecticut Delaware Hawaii Iowa Kentucky Maryland Maine Minnesota Mississippi New Mexico New York Oregon Pennsylvania Virginia District of Columbia	• 6/5/2017
Court Reporting Institute	Submission for discharge for students enrolled at CRI's Seattle and Tacoma campuses.	Bob Ferguson	Washington	• 11/21/16
Globe University & Minnesota School of Business		Lori Swanson	Minnesota	• 6/7/2016
Illinois Institute of Art and Art Institute of Colorado	Submission requests students have any federal student loan used to pay for schooling at the affected campuses from January 1, 2018 onward discharged and any amounts paid on those loans refunded.	Kwame Raoul Phil Weiser	Illinois Colorado	• 6/3/2019
ITT Technical Institute	Submission for discharge for all borrowers who enrolled at ITT between 2007 and 2010 (or who assumed federal loan debt for another person who enrolled at ITT between 2007 and 2010). During this time, ITT misled students about the value of an ITT degree using its Value Proposition Document.	Phillip J. Weiser Ellen F. Rosenblum Keith Ellison Karl A. Racine Bob Ferguson Gurbir S. Grewal Thomas J. Donovan, Jr. Stephen H. Levins (Executive Director, State of Hawaii Office of Consumer Affairs) Brian E. Frosh Lawrence G. Wasden Kwame Raoul Josh Shapiro Tom Miller Mark Herring	Colorado Oregon Minnesota District of Columbia Washington New Jersey Vermont Hawaii Maryland Idaho Illinois Pennsylvania Iowa	• 4/1/2021

		Aaron M. Frey Derek Schmidt Hector Balderas Josh Stein Letitia James Maura Healey Douglas Peterson Joshua L. Kaul William Tong Aaron D. Ford Herbert Slatery, III	Virginia Maine Kansas New Mexico North Carolina New York Massachusetts Nebraska Wisconsin Connecticut Nevada Tennessee	
Kaplan University	• Medical Assistant • Medical Billing and Coding	Maura Healy	Massachusetts	• 5/6/2016 • 5/31/2016
Lincoln Technical Institute	• Criminal Justice	Maura Healy	Massachusetts	• 1/14/2016
Premier Education Group	N/A	Maura Healey	MA	October 3, 2019; November 22, 2019
Westwood College	• Criminal Justice	Lisa Madigan Kwame Raoul	Illinois	• 12/13/2016 • 6/3/2019
Westwood College	N/A	Phil Weiser	Colorado	August 27, 2020

The table provides a list of all attorneys general submissions related to groups of borrowers for which the attorneys general seek a borrower defense discharge as of April 12, 2021. The table includes the submission date, the attorneys general, the school, and the diploma program, if applicable. If a diploma program is not provided for a submission, the submission was not limited to a specific program.

Please note that under the Department's regulations, it is within the Secretary's discretion to create a group discharge process and define the parameters of the group. The Department cannot provide the number of borrowers that will be included in a certain group unless and until a group is established and defined by the Secretary. However, individual applications submitted by attorneys general have been, and will continue to be, considered under the individual application review process.

Question. How many of the applications referenced in (d) are pending? How many have been granted? How many have been denied? Please provide a list of each.

Answer. All of the AG submissions referenced in (d) are currently under review.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, and 2021 how many borrowers covered by a group discharge application are in default on their Federal student loans?

Answer. At this time, the Department cannot narrow its reporting to individual applications submitted by attorneys general. Most of the attorney general submissions did not specifically identify the borrowers covered by their group requests, and the Department is currently working to identify the borrowers at issue.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, and 2021 how many loans of the borrowers covered by a group discharge application have been certified by the Department of Education for Treasury offset?

Answer. Please see answer to question 10(f), above.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, and 2021 how many borrowers covered by a group discharge application have been subject to an administrative wage garnishment order put in place by the Department?

Answer. Please see answer to question 10(f), above.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, and 2021 what are the total dollar amounts of Federal student loans (interest and principal) covered by each group discharge application from a State attorney general?

Answer. Please see answer to question 10(f), above.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021 what are the total dollar amounts collected through the Treasury Offset Program on defaulted student loans covered by each group discharge application from a State attorney general?

Answer. Please see answer to question 10(f), above.

Question. In January 2017, State attorneys general—led by Illinois—provided the Department with program-level enrollment data for borrowers in their states that were covered by the Department's Corinthian job placement misrepresentation findings. How many of these borrowers have still not received relief despite being eligible?

Answer. Due to data limitations, FSA is unable to respond to this question at this time. While the Illinois Attorney General did provide a borrower list in December 2016, the list did not contain the unique identifiers (Social Security Number and/or date of birth) necessary to confidently match to borrowers in FSA's systems. The Department is now working to identify any borrowers submitted by the Illinois Attorney General and any other attorneys general who may be covered by the job placement rate findings, as that work was not done previously.

Question. 34 CFR 685.300 governs Program Participation Agreements—the contracts between schools and the Department of Education. CFR 685.300(e) prohibited schools from making or enforcing class action bans and mandatory pre-dispute arbitration agreements.

Answer. As a preliminary observation, the Program Participation Agreement (PPA) is primarily governed by 34 C.F.R. § 668.14. 34 C.F.R. § 685.300 provides additional participation requirements when a school participates in the Direct Loan program. The provisions of 34 C.F.R. § 685.300 are inapplicable if an institution elects not to participate in the Direct Loan program. The provisions were removed effective July 1, 2020. Therefore, the response to question a. extends only to June 30, 2020.

Question. In how many schools' Program Participation Agreements did the Department include this prohibition?

Answer. From July 21, 2019 and through June 30, 2020, the Department created and executed Program Participation Agreements (PPAs) that have included specific language referencing class action bans and pre-dispute arbitration agreements for 1,155 schools. As of July 29, 2021, 1,070 of these schools were approved to participate in the Direct Loan program, and 85 schools were not approved to participate in the Direct Loan program. PPAs created before July 21, 2019, contained overarching language indicating that schools were required to comply with all Title IV, Higher Education Act and Direct Loan program participation requirements, which would extend to the restrictions relating to class action suits and pre-dispute arbitration agreements.

Question. In how many instances did the Department seek to enforce this prohibition? What actions did it take?

Answer. The Department does not comment on deliberative, preliminary, or ongoing investigative work, including the enforcement of the Title IV regulations. Generally speaking, through our program review authority, we will monitor compliance with the requirements that schools end enforcement of any existing mandatory pre-dispute arbitration clauses and class action restrictions in enrollment agreements.

Question. Are you aware of any class actions that schools participating in Title IV forced into arbitration while the prohibition was in effect?

Answer. The Department is aware of two competing cases that relate to the prior regulation, which is no longer in effect. The regulation itself was subject to multiple implementation delays and litigation. In Kourembanas v. InterCoast Colleges, a class action in the District of Maine, 17-cv-00331, the court granted a motion to compel arbitration. And in Young v. Grand Canyon University, the appellate court reversed the Northern District of Georgia's initial decision to compel arbitration in Carr et al. v. Grand Canyon University, 19-cv-01707.

Question. Please provide a list of all institutions for which the Department currently holds a letter of credit or other surety and the amount of such letter of credit or other surety.

Answer. Enclosed is an Excel file containing data on the Letters of Credit (LOC) and other surety that the Department held as of July 14, 2021. As of July 14, 2021, the Department held 403 LOCs and other surety from institutions, totaling more than $607.3 million in financial protection. The first tab of the Excel file contains institutional and other data regarding the LOCs held by the Department as of July 14, 2021. The second tab provides the field definitions and descriptions of the reasons why a LOC was requested from a listed institution. Please note that this report differs from reports posted to FSA's Data Center identifying LOCs requested by the Department during an Award Year period. It is a "snapshot" of LOCs held by the Department as of July 14, 2021 and it provides the most recent information recorded in FSA's data sources regarding these LOCs. The report does not provide historical context for the LOCs held as of July 14, 2021 in cases where FSA may have required an institution to renew or amend a previously provided LOC. In a limited number of cases, the report also identifies and includes funds held on deposit by the Department in lieu of a LOC.

Currently Held Letters of Credit as of 7/14/2021

Data Sources: ed-Audit and PEPS

Sorted by Alphabetical Order by State and then by Institution Name

OPE ID	Institution Name	State	Institution Type	Institution Fiscal Year End Date	LOC Request Date	Reason LOC Requested	LOC Received Date	LOC Amount	LOC Percent Requested
04118500	Alaska Christian College	AK	Non-Profit	05/31/2020	05/27/2021	Failed Past Performance Requirements	06/25/2021	$69,945.00	10
00105200	Talladega University	AL	Non-Profit	06/30/2019	09/29/2020	Untimely Refunds	11/17/2020	$6,126.00	25
00110500	Crowley's Ridge College	AR	Non-Profit	06/30/2019	07/06/2020	Failed Numeric Test	08/05/2020	$138,032.00	10
00105000	Lyon College	AR	Non-Profit	06/30/2020	05/21/2021	Failed Numeric Test	06/18/2021	$610,629.00	10
04239100	Arizona School of Integrative Studies	AZ	Proprietary	04/30/2019			09/14/2020	$278,992.00	25
03120300	Collegedimensions - Flagstaff	AZ	Non-Profit	12/31/2019	03/10/2020	Failed Past Performance Requirements	06/10/2020	$511,151.00	10
04175200	Pinnacle Academy	AZ	Proprietary		01/13/2021	New Owner Missing 2 Yrs. of Audited Financial Statements	02/02/2021	$112,073.00	25
04244500	Sonoran Desert Institute	AZ	Proprietary	12/31/2019	08/10/2020	Failed Numeric Test	12/15/2020	$2,036,951.00	50
03431300	Southwest University of Visual Arts	AZ	Proprietary	12/31/2017	12/11/2017	Failed Past Performance Requirements	05/31/2018	$298,358.00	5
02341400	Academy of Radio & TV Broadcasting	CA	Proprietary	12/31/2017	03/22/2018	Failed Past Performance Requirements	12/04/2018	$175,965.00	51
03736300	Advance Beauty College	CA	Proprietary	12/31/2019	07/07/2020	Untimely Refunds	07/20/2020	$11,429.00	25
04226100	Advance Beauty Tech Academy	CA	Proprietary	12/31/2020	06/29/2021	Going Concern	12/01/2021	$167,396.00	10
04206000	Advance Beauty Techs Academy	CA	Proprietary	12/31/2020	06/29/2021	Failed Past Performance Requirements	12/07/2021	$46,145.00	4
04127100	America Evangelical University	CA	Proprietary	06/30/2019	01/05/2021	Untimely Refunds	03/09/2021	$6,162.00	25
04139700	American Medical Sciences Center	CA	Proprietary	12/31/2019	01/07/2021	Failed Numeric Test	04/27/2021	$30,962.00	10
03740400	ART College	CA	Proprietary	12/31/2019	03/15/2021	Failed Past Performance Requirements	06/11/2021	$52,365.00	10
03740400	ART College	CA	Proprietary	12/31/2019	07/06/2020	New Owner Missing 1 Yr. of Audited Financial Statements	06/05/2020	$14,612.00	8
04229700	Bay Area Medical Academy	CA	Proprietary	12/31/2019	01/31/2021	Failed Numeric Test	01/05/2021	$172,089.00	15
04177300	California College of Barbering and Cosmetology	CA	Proprietary	12/31/2019	11/25/2020	Untimely Refunds	12/29/2020	$18,827.00	25
02110500	California College San Diego	CA	Non-Profit	12/31/2019	03/16/2020	Failed Past Performance Requirements	06/16/2020	$1,103,287.00	10
02332600	Center for Employment Training	CA	Non-Profit	06/30/2019	05/14/2020	Failed Numeric Test	09/10/2020	$1,233,609.00	5
03007700	Central California School of Continuing Education	CA	Proprietary	12/31/2019	10/30/2020	Untimely Refunds	12/17/2020	$19,302.00	25
00116500	Church Divinity School of the Pacific	CA	Non-Profit	06/30/2019		Failed Numeric Test	07/19/2020	$254,169.00	50
00126900	Claremont School of Theology	CA	Non-Profit	06/30/2019	08/13/2020	Failed Numeric Test	09/30/2020	$1,429,160.00	50
02110200	Columbia College Hollywood	CA	Non-Profit	09/01/2018	11/08/2019	Untimely Refunds	12/09/2019	$40,443.00	25
03673400	Community Christian College	CA	Non-Profit	06/30/2019	11/09/2020	Failed Numeric Test	02/02/2021	$274,114.00	30
00120200	Fuller Theological Seminary	CA	Non-Profit	06/30/2019	09/09/2019	Untimely Refunds	11/08/2019	$19,574.00	25
04161600	Integrity College of Health	CA	Proprietary	12/31/2019	09/11/2020	Failed Numeric Test	07/17/2020	$32,794.00	7
04161600	Integrity College of Health	CA	Proprietary	12/31/2019	09/11/2020	Failed Numeric Test	07/17/2020	$32,794.00	7
04161600	Integrity College of Health	CA	Proprietary	12/31/2019	09/11/2020	Failed Numeric Test	07/17/2020	$32,794.00	7
04217500	J D Academy of Salon and Spa	CA	Proprietary	12/31/2020	10/09/2020	New Owner Missing 1 Yr. of Audited Financial Statements	12/28/2020	$192,982.00	25
03664400	Los Angeles College of Music	CA	Proprietary	09/30/2019			09/29/2020	$101,500.00	25
02161600	Musicians Institute	CA	Proprietary	09/30/2019	07/17/2020	Failed Numeric Test	09/30/2020	$1,187,454.00	10
04049200	New School of Architecture and Design	CA	Proprietary		01/06/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	03/09/2020	$1,714,050.00	25
04718700	North Ashton's College of Beauty	CA	Proprietary	02/28/2020	12/31/2020	Failed Numeric Test	02/02/2021	$178,023.00	10
03027200	Pacific College of Arts and Sciences	CA	Proprietary	12/31/2017	11/13/2018	Failed Numeric Test	02/04/2019	$3,142,945.00	10
00135000	Pacific Union College	CA	Non-Profit	06/30/2019	09/14/2020	Failed Numeric Test	12/03/2020	$4,965,347.00	30
00130200	Saint Mary's College of California	CA	Non-Profit	06/30/2020	09/17/2020	Untimely Refunds	10/19/2020	$8,179.00	25
01205100	San Diego Christian College	CA	Non-Profit	06/30/2019	09/16/2020	Failed Numeric Test	10/06/2020	$634,424.00	10
02276500	Sofia University	CA	Proprietary	06/30/2020	03/02/2021	Failed Numeric Test	04/20/2021	$698,560.00	24
02276500	Sofia University	CA	Proprietary	06/30/2020	03/02/2021	Failed Numeric Test	04/20/2021	$437,455.00	17
02276500	Sofia University	CA	Proprietary	06/30/2020	09/02/2020	Failed Numeric Test	04/20/2021	$248,757.00	9
02036400	Spartan College of Aeronautics & Technology	CA	Proprietary	12/31/2019	12/16/2020	Failed Numeric Test	03/03/2021	$1,467,320.00	15
04009300	United States University	CA	Proprietary	04/30/2020	01/20/2021	Untimely Refunds	03/03/2021	$9,027.00	25
04169700	Unitek College	CA	Proprietary				09/11/2020	$3,699,499.00	25
04195400	Unitek College	CA	Proprietary				09/11/2020	$1,439,065.00	25
00115200	University of San Francisco	CA	Non-Profit	05/31/2020	09/12/2019	Untimely Refunds	09/12/2019	$24,369.00	25
03171300	University of St. Augustine for Health Sciences	CA	Proprietary	12/31/2019	09/21/2020	Failed Numeric Test	12/03/2020	$14,178,203.00	10
04118500	Valley College of Medical Careers	CO	Proprietary	12/31/2019	01/24/2020	Other	03/10/2020	$102,444.00	10
04068300	West Med College	CA	Non-Profit	06/30/2017	06/30/2018	Failed Numeric Test	04/14/2019	$124,394.00	10
04249600	Westcliff University	CA	Proprietary	12/31/2018	04/27/2020	Other	09/29/2020	$698,744.00	10
04249600	Westcliff University	CA	Proprietary	12/31/2019	09/29/2020	Untimely Refunds	07/13/2021	$24,499.00	25
02176900	Westminster Theological Seminary in California	CA	Non-Profit	06/30/2019	06/19/2020	Failed Numeric Test	09/10/2020	$302,540.00	50
04093100	Academy of Natural Therapy	CO	Proprietary	12/31/2019	01/29/2021	Failed Numeric Test	03/17/2021	$40,477.00	10
02094300	Collegeamerica Denver	CO	Non-Profit	12/31/2018	03/16/2020	Failed Past Performance Requirements	06/16/2020	$1,027,426.00	10
04105200	Colorado Academy of Veterinary Technology	CO	Proprietary	12/31/2019	04/15/2021	Failed Numeric Test	07/13/2021	$106,744.00	12
04185200	Colorado Academy of Veterinary Technology	CO	Proprietary	12/31/2019	04/15/2021	Failed Numeric Test	09/12/2021	$34,369.00	4
03137200	Colorado School of Trades	CO	Proprietary			New Owner Missing 2 Yrs. of Audited Financial Statements	06/09/2021	$242,602.00	25
04185300	Elevate Salon Institute	CO	Proprietary	12/31/2019	10/16/2020	Failed Numeric Test	01/29/2021	$133,914.00	25
01300700	Nazarene Bible College	CO	Non-Profit	06/30/2019	04/09/2020	Untimely Refunds	09/09/2020	$6,415.00	25
04218500	Rocky Vista University	CO	Proprietary	06/30/2020	05/17/2021	Failed Numeric Test	06/10/2021	$93,739,009.00	14
04218500	Rocky Vista University	CO	Proprietary	06/30/2020	09/17/2021	Failed Numeric Test	06/10/2021	$13,433,418.00	4
00729700	Spartan College of Aeronautics and Technology	CO	Proprietary	12/31/2019	12/16/2020	Failed Numeric Test	03/03/2021	$698,984.00	15
04105700	United College of Health and Beauty	CO	Proprietary	12/31/2019	10/16/2020	Failed Numeric Test	12/03/2020	$56,477.00	50
04275000	American Institute of Healthcare & Technology	CT	Proprietary		06/11/2021	New Owner Missing 2 Yrs. of Audited Financial Statements	06/15/2021	$117,096.00	25
00743300	Paier College of Art	CT	Proprietary	06/30/2019	07/06/2020	New Owner Missing 1 Yr. of Audited Financial Statements	07/23/2020	$65,491.00	25
04014500	Post University	CT	Proprietary	06/30/2020	09/06/2021	Untimely Refunds	07/09/2021	$1,579,880.00	25
04439600	Bennett Career Institute	DC	Proprietary	12/31/2017	06/05/2019	Untimely Refunds	07/09/2019	$22,797.00	25
04142700	Mansfield John Paul II Institute for Studies on Marriage and Family	DC	Non-Profit	12/31/2019	03/31/2020	Failed Numeric Test	10/01/2020	$96,605.00	50
04139500	Delaware College of Art and Design	DE	Non-Profit	06/30/2019	06/24/2020	Going Concern	07/29/2020	$1,160,000.00	50
03732300	Delaware Learning Institute of Cosmetology	DE	Proprietary	12/31/2020	05/06/2021	Failed Numeric Test	06/15/2021	$56,627.00	10
00144500	Wesley College	DE	Non-Profit	06/30/2019	03/12/2021	Going Concern	04/07/2021	$2,744,850.00	25
00734600	Wilmington University	DE	Non-Profit	06/30/2019	06/25/2019	Untimely Refunds	07/25/2019	$145,871.00	25

OPE ID	Institution Name	State	Institution Type	Institution Fiscal Year End Date	LOC Request Date	Reason LOC Requested	LOC Received Date	LOC Amount	LOC Percent Requested
03616300	Artistic Nails & Beauty Academy	FL	Proprietary	12/31/2017	01/03/2018	Untimely Refunds	03/12/2018	$46,389.00	25
04249400	Center for Neuromimetic Studies	FL	Proprietary	12/31/2019	06/30/2021	Untimely Refunds	06/09/2021	$7,977.00	25
03036600	Corbeta Institute	FL	Proprietary	12/31/2019	11/02/2020	Failed Numeric Test	01/15/2021	$6,222,134.00	20
03674300	Florida Coastal School of Law	FL	Proprietary	07/31/2019	09/25/2020	Failed Numeric Test	10/19/2020	$3,573,289.00	22
03674300	Florida Coastal School of Law	FL	Proprietary	07/31/2019	03/03/2020	Failed Numeric Test	10/19/2020	$1,626,316.00	10
03674300	Florida Coastal School of Law	FL	Proprietary	07/31/2019	09/25/2020	Failed Numeric Test	09/14/2020	$404,000.00	3
04098700	Florida School of Traditional Midwifery	FL	Proprietary	06/30/2019	03/02/2020	Going Concern	12/19/2020	$76,387.00	20
04168000	HCI College	FL	Proprietary	12/31/2018	03/04/2019	Untimely Refunds	10/15/2019	$138,279.00	25
02180300	Hobe Sound Bible College	FL	Non-Profit	06/30/2019			12/08/2020	$74,760.00	10
04174200	Institute Infotech	FL	Proprietary	12/31/2019	09/29/2020	Failed Numeric Test	12/15/2020	$53,853.00	50
04213200	Keiser Beauty Academy	FL	Proprietary	12/31/2019	06/30/2020	Failed Past Performance Requirements	09/25/2020	$96,344.00	17
04137100	K J Commercial Training Solutions Airline Academy	FL	Proprietary				03/17/2021	$730,000.00	10
04186300	Palm Beach Academy of Health & Beauty	FL	Proprietary	12/31/2018	09/27/2019	New Owner Missing 2 Yrs. of Audited Financial Statements	09/17/2019	$190,369.00	25
04186300	Palm Beach Academy of Health & Beauty	FL	Proprietary	12/31/2019	09/29/2020	Untimely Refunds	12/29/2020	$86,470.00	25
02435900	Palm Playground Grooming School	FL	Proprietary	12/31/2019	01/14/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	02/10/2020	$10,000.00	25
04167300	Salon Professional Academy (The)	FL	Proprietary	12/31/2019	09/15/2020	New Owner Missing 1 Yr. of Audited Financial Statements	11/17/2020	$60,319.00	10
02314100	Schiller International University	FL	Proprietary		01/14/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	03/03/2020	$393,340.00	20
00135200	Southeastern University	FL	Non-Profit	08/31/2019	06/09/2020	Failed Numeric Test	08/20/2020	$5,995,912.00	10
03010500	Southern Technical College	FL	Proprietary	12/31/2019	01/03/2020	Failed Numeric Test	12/08/2020	$5,836,341.00	15
03554900	Ultimate Medical Academy	FL	Proprietary	12/31/2019	07/30/2020	Failed Numeric Test	09/10/2020	$2,134,369.00	11
00198400	Warner University	FL	Non-Profit	06/30/2019	12/17/2019	Failed Numeric Test	02/18/2020	$1,396,050.00	11
04173300	Atlanta's John Marshall Law School	GA	Proprietary	12/31/2019	04/07/2020	Failed Past Performance Requirements	07/07/2020	$1,430,457.00	10
04011300	Augusta School of Massage	GA	Proprietary	12/31/2019	01/09/2020	Failed Numeric Test	04/13/2020	$94,753.00	50
03635300	Career Step College	GA	Non-Profit	06/30/2019	06/07/2017	Failed Past Performance Requirements	11/14/2017	$5,000.00	10
04195500	Divine Healing Institute(The)	GA	Proprietary	12/31/2019	09/15/2020	Untimely Refunds	10/13/2020	$18,199.00	25
04260000	Institute of Medical Ultrasound	GA	Proprietary	12/31/2018	03/30/2019	Failed Past Performance Requirements	12/11/2019	$19,389.00	10
04221100	New Horizons Medical Institute	GA	Proprietary	12/31/2019	04/29/2020	Going Concern	07/29/2020	$40,440.00	3
00136700	Paine College	GA	Non-Profit	06/30/2019	03/02/2020	Other	11/17/2020	$1,871,691.00	10
04147000	Paul Mitchell the School Atlanta	GA	Proprietary	12/31/2019	05/18/2020	New Owner Missing 1 Yr. of Audited Financial Statements	09/22/2020	$345,802.00	15
03436300	Pacific Islands University	GU	Non-Profit	06/30/2019	07/10/2020	Failed Numeric Test	12/09/2020	$95,991.00	25
04182200	Kreon Medical College	HI	Proprietary	12/31/2019	03/14/2020	Untimely Refunds	09/30/2020	$59,484.00	25
00144600	Briar Cliff University	IA	Non-Profit	05/31/2019	10/07/2020	Untimely Refunds	11/17/2020	$10,000.00	25
00107100	Iowa Wesleyan University	IA	Non-Profit	05/31/2019	05/17/2019	Failed Numeric Test	07/07/2020	$498,664.00	10
00169300	Upper Iowa University	IA	Non-Profit	06/30/2019	09/30/2020	Untimely Refunds	11/17/2020	$59,459.00	25
01162500	Brigham Young University - Idaho	ID	Non-Profit	12/31/2020	06/15/2021	Untimely Refunds	07/09/2021	$286,617.00	25
04166000	College of Massage Therapy	ID	Proprietary	12/31/2019			02/17/2021	$15,000.00	25
04150600	Urban Life School of Cosmetology	ID	Proprietary		06/17/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	09/15/2020	$49,762.00	25
00116200	American Academy of Art College	IL	Proprietary	12/31/2019	03/09/2021	Failed Numeric Test	11/10/2021	$478,525.00	15
00159300	Cannella School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 Yr. of Audited Financial Statements	05/12/2021	$49,341.00	25
02499200	Cannella School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 Yr. of Audited Financial Statements	05/12/2021	$16,584.00	10
02202600	Cannella School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 Yr. of Audited Financial Statements	05/12/2021	$14,063.00	10
04152000	Curves Metric School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 Yr. of Audited Financial Statements	05/12/2021	$20,083.00	10
00107700	Elmhurst University	IL	Non-Profit	06/30/2019	10/14/2020	Failed Past Performance Requirements	10/27/2020	$61,435,000.00	10
02061100	ETI School of Skilled Trades	IL	Proprietary	12/31/2019	11/27/2019	Failed Past Performance Requirements	03/06/2020	$246,858.00	10
02061000	John Amos School of Hair Design 2	IL	Proprietary	12/31/2019	03/04/2019	Failed Past Performance Requirements	09/05/2019	$13,402.00	10
00170000	Judson University	IL	Non-Profit	05/31/2019	09/25/2020	Untimely Refunds	01/12/2021	$96,094.00	25
00170000	Judson University	IL	Non-Profit	05/31/2019	05/25/2018	Failed Numeric Test	01/12/2021	$1,194,709.00	10
00171200	Lutheran School of Theology at Chicago	IL	Non-Profit	06/30/2019	09/15/2020	Failed Numeric Test	07/14/2020	$228,421.00	50
01120500	National Latino Education Institute	IL	Non-Profit	06/30/2019	07/09/2019	Failed Past Performance Requirements	09/27/2019	$15,509.00	10
01236200	Northwestern College	IL	Proprietary	07/31/2020	05/14/2021	Failed Numeric Test	09/14/2021	$1,162,389.00	10
02297500	Oakfield School of Cosmetology	IL	Proprietary	12/31/2019	01/14/2020	Failed Numeric Test	02/19/2021	$61,000.00	15
04165200	Salon Professional Academy (The)	IL	Proprietary	12/31/2019	09/30/2021	Going Concern	06/10/2021	$119,170.00	20
04165200	Salon Professional Academy (The)	IL	Proprietary	12/31/2019	01/03/2020	Failed Past Performance Requirements	11/03/2020	$46,980.00	10
04165200	Salon Professional Academy (The)	IL	Proprietary	12/31/2019	01/03/2020	Failed Past Performance Requirements	11/03/2020	$16,574.00	2
04165200	Salon Professional Academy (The)	IL	Proprietary	12/31/2019	01/03/2020	Failed Past Performance Requirements	11/03/2020	$15,613.00	2
04139600	State Career School	IL	Proprietary	12/31/2019	07/07/2020	Failed Numeric Test	09/09/2020	$69,646.00	10
01161000	Taylor Business Institute	IL	Proprietary	12/31/2019	10/15/2020	Failed Numeric Test	11/17/2020	$74,545.00	15
00170500	University of St. Mary of the Lake/Mundelein Seminary	IL	Non-Profit	06/30/2019	09/12/2020	Failed Numeric Test	09/16/2020	$16,213.00	50
01139300	Wisconsin College of Mortuary Science	IL	Proprietary	12/31/2019	09/10/2020	Failed Numeric Test	10/27/2020	$500,000.00	50
03936300	Alexandria School of Scientific Therapeutics	IN	Proprietary	12/31/2019	10/30/2019	Failed Past Performance Requirements	04/13/2020	$26,500.00	10
04256200	Christina and Company Education Center	IN	Proprietary	12/31/2019	03/09/2019	Failed Past Performance Requirements	12/10/2019	$1,293.00	10
04256100	Indiana College of Sports & Medical Massage	IN	Proprietary	12/31/2019	03/14/2022	Failed Numeric Test	06/14/2022	$65,432.00	15
03799200	Lincoln College of Technology	IN	Proprietary	12/31/2019	02/04/2022	Failed Numeric Test	12/16/2020	$106,367.00	25
00130500	Saint Mary of the Woods College	IN	Non-Profit	06/30/2019	03/03/2020	Failed Numeric Test	04/28/2020	$4,618,490.00	50
00913000	Taylor Institute of Cosmetology	IN	Proprietary			New Owner Missing 2 Yrs. of Audited Financial Statements	11/17/2020	$37,724.00	50
04246600	Textures Institute of Cosmetology	IN	Proprietary	12/31/2017	03/07/2019	Failed Numeric Test	04/09/2019	$26,400.00	10
00130400	Bethany College	KS	Non-Profit	06/30/2019	09/17/2020	Failed Numeric Test	09/14/2020	$793,350.00	10
00130800	Central Christian College of Kansas	KS	Non-Profit	06/30/2019	03/02/2020	Failed Numeric Test	09/23/2020	$734,212.00	10
02059100	Crane Beauty Academy	KS	Proprietary	12/31/2019	10/15/2020	Untimely Refunds	11/17/2020	$7,542.00	25
02160700	Kansas Christian College	KS	Non-Profit	06/30/2019	03/02/2020	Failed Numeric Test	11/01/2020	$127,799.00	10
00134000	Southeastern College	KS	Non-Profit	06/30/2019	09/14/2020	Failed Numeric Test	06/30/2020	$1,076,389.00	10
01050300	Wichita Technical Institute	KS	Proprietary	12/31/2019	03/26/2020	Untimely Refunds	09/18/2020	$28,960.00	25
01049500	American National University	KY	Proprietary	12/30/2019	01/24/2020	Other	06/10/2020	$430,263.00	10
04060300	ATA College	KY	Proprietary			New Owner Missing 2 Yrs. of Audited Financial Statements	01/05/2021	$165,463.00	25
04060300	ATA College	KY	Proprietary	05/07/2020	07/24/2020	Failed Numeric Test	06/09/2021	$95,125.00	10
03093700	Galen-Health Institutes	KY	Proprietary		03/03/2021	Other	03/19/2021	$43,498,916.00	40

OPE ID	Institution Name	State	Institution Type	Institution Fiscal Year End Date	LOC Request Date	Reason LOC Requested	LOC Received Date	LOC Amount	LOC Percent Requested
[illegible]	Galen Health Institutes	KY	Proprietary		[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Lexington Healing Arts Academy	KY	Proprietary	12/31/2019	[illegible]	Untimely Refunds	[illegible]	[illegible]	[illegible]
[illegible]	Medical Career and Technical College	KY	Proprietary	06/30/2016	[illegible]	Failed Past Performance Requirements	[illegible]	[illegible]	[illegible]
[illegible]	Paul Mitchell the School - Louisville	KY	Proprietary	12/31/2020	[illegible]	Untimely Refunds	[illegible]	[illegible]	[illegible]
[illegible]	Blue Cliff College	LA	Proprietary	12/31/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Opelousas School of Cosmetology	LA	Proprietary		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Setting the Standard Barbering and Natural Hair Academy	LA	Proprietary	12/31/2018	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Benjamin Franklin Institute of Technology	MA	Non-Profit	06/30/2019	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Conway School of Landscape Design	MA	Non-Profit	06/30/2018			[illegible]	[illegible]	[illegible]
[illegible]	Hellenic College & Holy Cross Greek Orthodox School of Theology	MA	Non-Profit	06/30/2017	[illegible]	Failed Past Performance Requirements	[illegible]	[illegible]	[illegible]
[illegible]	Lowell Academy Hair Styling Institute	MA	Proprietary	12/31/2018	[illegible]	Untimely Refunds	[illegible]	[illegible]	[illegible]
[illegible]	Pope St. John XXIII National Seminary	MA	Non-Profit	06/30/2020	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Signature Healthcare Brockton Hospital School of Nursing	MA	Non-Profit	09/30/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Urban College of Boston	MA	Non-Profit	08/31/2017	[illegible]	Failed Past Performance Requirements	[illegible]	[illegible]	[illegible]
[illegible]	Fortis Institute - Towson	MD	Proprietary	06/30/2020	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Maple Springs Baptist Bible College & Seminary	MD	Non-Profit	06/30/2019	[illegible]	Failed Past Performance Requirements	[illegible]	[illegible]	[illegible]
[illegible]	Maryland University of Integrative Health	MD	Non-Profit	07/31/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Adrian College	MI	Non-Profit	06/30/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Creative Hair School of Cosmetology	MI	Proprietary	12/31/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]
[illegible]	Detroit Business Institute - Downriver	MI	Proprietary		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Douglas J Aveda Institute	MI	Proprietary	12/31/2019	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Finlandia University	MI	Non-Profit	06/30/2019	[illegible]	Failed Numeric Test	[illegible]	[illegible]	[illegible]

OPE ID	Institution Name	State	Institution Type	Institution Fiscal Year End Date	LOC Request Date	Reason LOC Requested	LOC Received Date	LOC Amount	LOC Percent Requested

OPE ID	Institution Name	State	Institution Type	Institution Fiscal Year End Date	LOC Request Date	Reason LOC Requested	LOC Received Date	LOC Amount	LOC Percent Requested
00049300	[illegible] Career Institute	PR	Proprietary	12/31/2016	12/06/2016	Failed Past Performance Requirements	02/22/2017	$30,776.00	10
04239000	B-Unique Beauty and Barber Academy	SC	Proprietary	12/31/2018	09/26/2019	Failed Past Performance Requirements	06/04/2019	$22,596.00	8
04239000	B-Unique Beauty and Barber Academy	SC	Proprietary	12/31/2018	09/26/2019	Failed Past Performance Requirements	12/12/2018	$8,000.00	3
04244100	Construction Training Center	SC	Proprietary	06/23/2019	03/11/2021	Untimely Refunds	08/08/2019	$7,612.00	25
00405720	National American University	SD	Proprietary	05/31/2020	06/17/2021	Failed Numeric Test	06/29/2021	$4,739,426.00	10
00405600	North American Baptist Seminary	SD	Non Profit	06/30/2019	05/26/2020	Failed Numeric Test	06/19/2020	$10,950.00	10
02257400	Arnold's Beauty School	TN	Proprietary	12/31/2017	02/04/2019	Failed Past Performance Requirements	04/05/2019	$45,902.00	10
03006300	Brillare Beauty Institute	TN	Non Profit	12/31/2020	09/20/2021	Untimely Refunds	03/02/2021	$6,462.00	25
00346100	Carson - Newman University	TN	Non Profit	07/31/2019	07/29/2020	Failed Numeric Test	09/29/2020	$2,206,541.00	10
00346200	Christian Brothers University	TN	Non Profit	05/31/2019	05/27/2020	Untimely Refunds	06/25/2020	$12,660.00	25
04236600	Gould's Academy	TN	Proprietary	12/31/2019	04/08/2021	Failed Numeric Test	05/18/2021	$1,636,616.00	50
03216100	Loraines Academy & Spa	TN	Proprietary		06/22/2017	New Owner Missing 1 Yr. of Audited Financial Statements	09/29/2020	$79,577.00	10
04165000	Meridian Institute of Surgical Assisting	TN	Proprietary	12/31/2019	11/27/2019	Failed Past Performance Requirements	11/26/2019	$55,761.00	25
02275000	Paul Mitchell the School Knoxville	TN	Proprietary	12/31/2018	09/05/2019	Untimely Refunds	10/31/2019	$17,145.00	25
02539400	Queen City College	TN	Proprietary	06/30/2020	10/30/2020	New Owner Missing 1 Yr. of Audited Financial Statements	11/17/2020	$74,529.00	10
03600000	SAE Institute of Technology	TN	Proprietary	06/30/2020	01/19/2021	Failed Numeric Test	02/02/2021	$4,667,290.00	15
03600000	SAE Institute of Technology	TN	Proprietary	06/30/2020	01/19/2021	New Owner Missing 2 Yrs. of Audited Financial Statements	02/02/2021	$7,336,882.00	25
00352500	Tennessee Wesleyan University	TN	Non Profit	06/30/2019	08/26/2020	Failed Numeric Test	10/20/2020	$776,071.00	10
00513500	Williamson Christian College	TN	Non Profit	06/30/2019	05/27/2020	Failed Numeric Test	07/20/2020	$108,241.00	50
04166000	ABC Beauty Academy	TX	Proprietary	12/31/2019	09/01/2020	Failed Numeric Test	09/30/2020	$75,274.00	50
04267200	Allgood Beauty Institute	TX	Proprietary	12/31/2018	01/17/2020	Untimely Refunds	12/15/2020	$8,851.00	25
03660600	Baptist Health System School of Health Professions	TX	Proprietary	12/31/2019	09/17/2020	Failed Numeric Test	11/17/2020	$3,630,756.00	50
02056600	BK Cosmo College of Cosmetology	TX	Proprietary	12/31/2019	06/01/2021	New Owner Missing 2 Yrs. of Audited Financial Statements	07/09/2021	$77,424.00	25
04177900	Buckner Barber School	TX	Proprietary	12/31/2019	10/22/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	12/02/2020	$22,796.00	25
04169100	Diamonds Cosmetology College	TX	Proprietary	06/30/2020	03/05/2021	New Owner Missing 1 Yr. of Audited Financial Statements	03/30/2021	$44,293.00	10
00390600	Episcopal Theological Seminary of the Southwest (The)	TX	Non Profit	05/31/2016	07/16/2016	Failed Past Performance Requirements	09/13/2016	$26,610.00	10
02320200	Houston Graduate School of Theology	TX	Non Profit	06/30/2019	07/14/2020	Failed Numeric Test	09/30/2020	$130,730.00	10
02527500	Houston Training Schools	TX	Proprietary	12/31/2018	12/05/2019	Untimely Refunds	07/28/2020	$47,476.00	25
00357700	Huston - Tillotson University	TX	Non Profit	06/30/2016	06/30/2017	Failed Past Performance Requirements	02/23/2018	$1,939,569.00	10
02316200	KD Conservatory College of Film and Dramatic Arts	TX	Proprietary	12/31/2019	09/04/2020	Failed Numeric Test	12/31/2020	$166,013.00	10
04129600	MediaTech Institute	TX	Proprietary	12/31/2018	09/30/2020	Untimely Refunds	10/20/2020	$16,912.00	25
04226400	MT Training Center	TX	Proprietary	12/31/2017	10/04/2018	Failed Past Performance Requirements	12/20/2018	$146,262.00	10
04166700	Pelston College	TX	Proprietary	12/31/2019	11/10/2020	Failed Past Performance Requirements	12/15/2020	$445,447.00	10
04166700	Pelston College	TX	Proprietary	12/31/2019	12/15/2020	Untimely Refunds	01/14/2021	$40,754.00	25
02176100	Pipo Academy of Hair Design	TX	Proprietary	12/31/2018	05/30/2019	Failed Past Performance Requirements	07/20/2019	$6,907.00	10
03026500	Remington College	TX	Non Profit	06/30/2019	05/07/2020	Failed Numeric Test	05/22/2020	$6,710,709.00	10
04165600	Salon Professional Academy (The)	TX	Proprietary	12/31/2019	12/09/2020	Failed Numeric Test	12/29/2020	$107,296.00	10
03032300	School of Automotive Machinists & Technology	TX	Proprietary	12/31/2019	04/07/2021	Failed Numeric Test	06/01/2021	$149,177.00	10
04213300	Southern Texas Careers Academy	TX	Proprietary	12/31/2019	10/13/2020	Failed Numeric Test	12/15/2020	$130,175.00	10
03174300	Trend Barber College	TX	Proprietary	12/31/2019	05/18/2021	Failed Numeric Test	07/01/2021	$159,193.00	10
04272600	Vogue International Academy	TX	Proprietary	12/31/2019	03/12/2020	Failed Past Performance Requirements	03/30/2020	$6,457.00	10
00366900	Wiley College	TX	Non Profit	06/30/2019	03/08/2021	Going Concern	11/18/2019	$1,351,151.00	10
00367400	Independence University	UT	Non Profit	12/31/2019	03/16/2020	Failed Past Performance Requirements	06/16/2020	$16,236,215.00	10
03082100	Myotherapy College of Utah	UT	Proprietary	06/30/2019	07/13/2020	Failed Numeric Test	10/06/2020	$230,394.00	50
02590600	Paul Mitchell the School Salt Lake City	UT	Proprietary	12/31/2019	01/14/2021	Untimely Refunds	03/09/2021	$96,209.00	25
03110400	Paul Mitchell The School St. George	UT	Proprietary	12/31/2018	09/05/2019	Failed Past Performance Requirements	11/18/2019	$11,215.00	10
02360000	Provo College	UT	Proprietary		03/02/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	09/29/2020	$1,642,182.00	25
00368100	Westminster College	UT	Non Profit	06/30/2019	10/26/2020	Untimely Refunds	11/17/2020	$21,950.00	25
00372600	American National University	VA	Proprietary	11/30/2018	02/24/2020	Other	06/10/2020	$1,430,994.00	10
04180600	Appalachian College of Pharmacy	VA	Non Profit			Other	04/29/2021	$1,525,364.00	15
00370300	Bluefield College	VA	Non Profit		02/24/2021	Other	04/07/2021	$2,246,836.00	15
04269400	Bristol School of Hair Design	VA	Proprietary		12/08/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	03/02/2021	$43,172.00	25
04219000	Global University	VA	Proprietary		05/27/2021	Failed Numeric Test	06/14/2021	$5,736.00	10
01274400	Southside College of Health Sciences	VA	Proprietary	12/31/2019	02/12/2021	Failed Numeric Test	03/29/2021	$349,176.00	35
02541200	Stratford University	VA	Proprietary	12/31/2019			09/30/2020	$37,360.00	10
00668600	O'Briens Aveda Institute	VT	Proprietary	04/26/2020	01/14/2021	Failed Numeric Test	03/04/2021	$290,936.00	50
04284400	Altura College	WA	Proprietary	12/31/2018			12/12/2020	$36,650.00	50
03689400	Faith International University	WA	Non Profit	06/30/2019			06/01/2021	$607,495.00	94
04149400	Gary Manuel Aveda Institute	WA	Proprietary	12/31/2019	03/23/2021	Failed Numeric Test	12/17/2019	$95,421.00	10
04194000	Gather 4 Him Christian College	WA	Non Profit	12/31/2019	06/09/2021	Failed Numeric Test	06/29/2021	$36,283.00	50
02109300	Gene Juarez Beauty Schools	WA	Proprietary	12/26/2019	02/22/2021	New Owner Missing 1 Yr. of Audited Financial Statements	04/13/2021	$210,434.00	10
00973900	Glen Dow Academy of Hair Design & Salons	WA	Proprietary	12/31/2019	11/02/2020	Untimely Refunds	12/08/2020	$14,445.00	25
03125100	College of Menominee Nation	WI	Non Profit	06/30/2019	07/07/2020	Failed Past Performance Requirements	09/27/2019	$60,250.00	10
04182100	First Class Cosmetology School	WI	Proprietary	12/31/2018	01/08/2020	Untimely Refunds	02/04/2020	$6,127.00	25
00397400	Nashotah House	WI	Non Profit	06/30/2019	03/02/2020	Failed Numeric Test	12/12/2018	$22,808.00	10
00397500	Northland College	WI	Non Profit	06/30/2019	05/06/2020	Going Concern	06/18/2020	$1,290,107.00	50
00392600	Alderson Broaddus University	WV	Non Profit	06/30/2019	07/15/2020	Failed Numeric Test	11/24/2020	$2,211,850.00	15
00794400	Appalachian Bible College	WV	Non Profit	05/31/2019	06/05/2020	Failed Numeric Test	07/10/2020	$88,000.00	10
00380600	Bethany College	WV	Non Profit	06/30/2018	11/25/2019	Failed Past Performance Requirements	07/20/2019	$706,000.00	10
04028300	Mountain State School of Massage	WV	Proprietary	12/31/2019	05/27/2021	Failed Numeric Test	07/13/2021	$146,800.00	50
00381900	Ohio Valley University	WV	Non Profit	06/30/2019	09/30/2020	Failed Numeric Test	09/29/2020	$452,505.00	10
04021400	American College, Dublin Limited (The)		Foreign Private	04/30/2019	03/10/2020	Failed Numeric Test	04/30/2020	$36,844.00	10
04295000	Buckinghamshire New University		Foreign Private	07/31/2020	05/07/2021	Failed Numeric Test	05/25/2021	$180,026.00	50
03377300	Cardiff Metropolitan University		Foreign Public	07/31/2020	11/25/2020	Failed Numeric Test	12/28/2020	$45,729.00	50
00136500	Concordia University		Foreign Public	04/30/2020	05/10/2021	Failed Numeric Test	05/18/2021	$605,100.00	50
01168300	Franklin University Switzerland		Foreign Private	06/30/2020	04/15/2021	Failed Numeric Test	05/20/2021	$81,703.00	10
04279500	Hartpury University		Foreign Public	07/31/2019	07/23/2020	Failed Numeric Test	09/17/2020	$46,751.00	50
02235300	London Metropolitan University		Foreign Public	07/31/2019	09/18/2020	Failed Numeric Test	10/27/2020	$377,096.00	50
03300300	Medical University of the Americas		Foreign For-Profit	04/30/2020	12/10/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	02/04/2021	$1,361,452.00	10
02180500	Middlesex University		Foreign Public	07/31/2019	06/25/2020	Failed Past Performance Requirements	09/17/2020	$80,995.00	10
01276600	National University of Ireland, Galway		Foreign Public	09/30/2019	08/20/2020	Failed Past Performance Requirements	09/16/2020	$179,609.00	10
02087900	Oxford Brookes University		Foreign Private	07/31/2020	03/17/2021	Failed Numeric Test	06/07/2021	$490,387.00	50
04075300	Quest University Canada		Foreign Private	04/30/2020	04/15/2021	Failed Numeric Test	05/20/2021	$276,035.00	50
01009400	Richmond, The American International University in London		Foreign Private	07/31/2019	07/23/2020	Failed Past Performance Requirements	01/11/2021	$376,291.00	10
03524300	Royal Veterinary College (The), University of London		Foreign Public	07/31/2020	03/12/2021	Failed Past Performance Requirements	04/27/2021	$1,595,221.00	10
03780300	Saba University School of Medicine		Foreign For-Profit	04/30/2020	12/10/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	02/04/2021	$1,659,419.00	10
00669400	School of Oriental and African Studies University of London		Foreign Public	07/31/2019	08/10/2020	Failed Past Performance Requirements	06/07/2021	$472,092.00	10
03764300	St. Matthew's University School of Medicine		Foreign For-Profit	04/30/2020	12/10/2020	New Owner Missing 2 Yrs. of Audited Financial Statements	02/04/2021	$654,655.00	10
04275700	Staffordshire University		Foreign Private	04/30/2020	03/01/2021	Failed Numeric Test	04/20/2021	$240,794.00	50
00086000	Swansea University		Foreign Public	07/31/2019	07/24/2020	Failed Past Performance Requirements	09/28/2020	$110,772.00	10
00670400	University College Cork		Foreign Public	09/30/2019	02/27/2020	Failed Past Performance Requirements	06/07/2020	$199,960.00	10
01018900	University College Dublin, National University of Ireland, Dublin		Foreign Public	09/30/2019	09/06/2020	Failed Past Performance Requirements	10/05/2020	$1,300,026.00	10
03726300	University of Derby		Foreign Public	07/31/2018	02/01/2019	Failed Past Performance Requirements	03/27/2019	$36,262.00	10
00084200	University of Dublin Trinity College		Foreign Public	09/30/2019	07/07/2020	Failed Past Performance Requirements	09/06/2020	$700,152.00	10
01066400	University of Dundee		Foreign Public	07/31/2019	06/15/2020	Failed Numeric Test	11/13/2020	$444,364.00	50
03045000	University of East London		Foreign Public	07/31/2019	01/14/2021	Failed Past Performance Requirements	03/05/2021	$375,189.00	10
00660700	University of Essex		Foreign Public	07/31/2019	07/15/2020	Failed Past Performance Requirements	09/25/2020	$312,901.00	10
01045600	University of Haifa		Foreign Public	09/30/2018	03/01/2018	Failed Past Performance Requirements	05/21/2018	$28,382.00	10
02229100	University of Leicester		Foreign Private	07/31/2020	05/15/2021	Failed Numeric Test	07/05/2021	$326,350.00	50
03084300	University of Limerick		Foreign Private	09/30/2018	03/06/2020	Failed Past Performance Requirements	03/03/2020	$167,476.00	10
04230700	University of the Highlands and Islands		Foreign Public	07/31/2020	03/22/2021	Failed Numeric Test	04/20/2021	$175,766.00	50
03945300	University of West London (The)		Foreign Public	07/31/2020	05/15/2021	Failed Numeric Test	06/01/2021	$316,797.00	50

Notes regarding the report:

* The report identifies Letters of Credit held as of July 14, 2021.
* A Letter of Credit covering multiple institutions may be reported for one OPEID rather than all OPEIDs in the school group.
* An institution may have posted multiple Letters of Credit to satisfy the Department's financial surety requirement.
* Cash deposits held as an alternative to a Letter of Credit are reported.
* LOC Percent Requested data are recorded in whole numbers.

Definitions of Letter of Credit Terms

Term	Definition
OPE ID	An OPE ID is a unique eight digit code utilized by the Department to identify an institution in its systems.
Institution Name	The institution name is the legal name of the institution.
State/Country	State or country where the main institution is physically located.
Institution Type	Describes the institution as an nonprofit, public, or proprietary institution
Institution Fiscal Year End Date	For the purposes of the LOC disclosure, this refers to the fiscal year end date of the institution. The compliance or financial statement audits, which served as the basis for most LOC requests, are due to the Department no later than six months (proprietary) or nine months (non-profits) after the end of the institution's fiscal year. **NOTE: If this field is left blank, it is because the LOC was not predicated on the receipt of an annual financial statement.**
LOC Request Date	This serves as the date the Department formally requested a LOC from the institution.
Reason LOC Requested	Describes the reason the Department requested the LOC. See detailed descriptions for reasons below.
LOC Received Date	This serves as the date the Department formally received the irrevocable LOC from the financial institution posting on behalf of the requisite institution. In most cases, the LOC must be received by the Department within 75 days of the date of the Department's correspondence requesting remittance of a LOC. **NOTE: In some instances, the LOC Received Date precedes the LOC Request Date because an existing LOC on file was renewed or extended. In those cases, the subsequent Award Year LOC Received Date is noted.**
LOC Amount	This serves as the total LOC dollar amount the Department received and accepted from the institution. The vast majority of designated amounts are based on a percentage applied against Title IV funds received by the institution during its most recently completed fiscal year or refunds not returned during that year.
LOC Percent Requested	This represents the percentage applied against the Title IV funds received or unreturned by the institution and serves as the basis for the LOC requested amount. The regulations in 34 CFR Part 668 Subpart L set minimum and/or designated percentages for LOCs due to non-compliance of the financial responsibility standards.
Reason LOC Requested	**Description**
Disclaimer	An institution is not considered financially responsible if, in the institution's audited financial statements, the opinion expressed by the auditor was an adverse, qualified or disclaimed opinion, unless the Secretary determines that a qualified or disclaimed opinion does not have a significant bearing on the institution's financial condition.
Failed Numeric Test	The most common reason why an institution is required to remit a letter of credit (LOC) to the Department is because they have a failing financial responsibility composite score (generally a score of 1.4 or less on a scale of -1.0 to +3.0) and are not deemed financially responsible. In accordance with 34 CFR 668.175, an institution with a composite score of 1.4 or less may continue to participate in the Title IV programs under the Provisional certification alternative. Institutions participating under provisional certification are subject to heightened cash monitoring, and may be required to submit an irrevocable LOC of not less than 10 percent of the Title IV aid the institution received during its most recently completed fiscal year. *Institutions that passed the score in the previous year may score from 1.0 to 1.4 for up to three consecutive years without providing a LOC, provided other reporting conditions are met. Institutions that score below a 1.0 are required to submit a LOC of not less than 10 percent of the Title IV aid the institution received during its most recently completed fiscal year.*
Failed Past Performance Requirements	Institutions are required to submit acceptable annual compliance and financial statement audits no later than six months (proprietary) or nine months (non-profits) after the end of the institution's fiscal year. Institutions cited for such past performance violations under 34 CFR 668.174 are provisionally certified and must submit a LOC for a period of five years in an amount equal to no less than 10 percent of the Title IV aid the institution received during its most recently completed fiscal year.
Going Concern	A LOC is generally requested when an auditor expresses a "going concern" in an audited financial statement which could result in risk to the Department and taxpayers.
New Owner Missing 1 Yr. of Audited Financial Statements	Prospective new owners of a participating institution are required to provide two years of audited financial statements to determine financial solvency. If a new owner can only provide one year of financial statements, they are required to remit a LOC of at least 10% of the amount of Title IV aid the Department determines the institution would receive in its first year of operations.
New Owner Missing 2 Yrs. of Audited Financial Statements	Prospective new owners of a participating institution are required to provide two years of audited financial statements to determine financial solvency. If a new owner can not provide the required financial statements, they are required to remit a LOC of at least 25% of the amount of Title IV aid the Department determines the institution would receive in its first year of operations.
Other or "Blank"	A LOC may be requested for less common reasons such as institutional ownership having a monetary liability owed to the Department or an institution's failure to meet debt obligations or not being in compliance with a financial lender's loan covenants. The insitution may have submitted the LOC without it being requested by the Department to resolve a financial responsibility issue.
Untimely Refunds	Institutions are required to maintain sufficient cash reserves to return Title IV funds to the Department for students that withdrew from the institution in a timely fashion. As noted in 34 CFR 668.173, an institution found in violation of the reserve standard is required to submit a LOC equal to 25% of the total amount of unearned Title IV funds the institution was required to return or should have returned for its most recently completed fiscal year.

Question. Regarding institutional compliance with the incentive compensation rules to date, please provide:

The number of program reviews, investigations, audits, or other reviews that have examined institutional compliance with the requirements of incentive compensation;

Answer. The Department has issued determinations for 60 program reviews that were initiated during fiscal years 2017—20 and fiscal year 2021 through June 30, 2021 that examined institutional compliance with incentive compensation requirements.

The Department received and finalized its review and audit resolution process for more than 15,900 compliance audit reports whose audit period included any portion of fiscal years 2017, 2018, 2019, 2020, or 2021 through July 28, 2021. The compliance audit reports were prepared either in accordance with the OIG's Guide for Audits of Proprietary Institutions and For Compliance Attestation Engagements of Third Party Servicers Administering Title IV Programs, or in accordance with the OMB Compliance Supplements (2 CFR Part 200, Appendix XI—Compliance Supplement) for audits reports prepared under the Single Audit Act. The scope of these audits included audit objectives for an independent auditor to determine whether the auditees did or did not comply with the incentive compensation prohibitions.

Additionally, the Department conducted close to 300 "New School Visits" during fiscal years 2017—20 and fiscal year 2021 through July 28, 2021 that reviewed incentive compensation requirements. A New School Visit is a process focused on the start-up issues and needs of schools that are new Title IV participants or that might not have recent Title IV experience. A New School Visit is not a program review, but rather a tool used to identify and eliminate any weaknesses that, if left unaddressed, could result in improper use of Federal funds and possible liabilities for the school. A standard component of a New School Visit includes a discussion of incentive compensation requirements, which may lead to the identification of a compliance deficiency.

Question. how many program reviews, investigations, audits, or other reviews found;

Answer. The Department has identified 10 instances of incentive compensation noncompliance in the population of finalized program reviews, investigations, and other reviews conducted in fiscal years 2017—20 and fiscal year 2021 through July 28, 2020, and finalized compliance audit resolutions whose audit period included any part of fiscal years 2017–20 and fiscal year 2021 through July 28, 2021.

Question. Noncompliance with the requirements of incentive compensation; and the actions the Department has taken to ensure that institutions correct deficiencies in compliance with the requirements of incentive compensation

Answer. The Department has issued fine actions totaling $3,411,002 for four institutions in fiscal years 2017—20 and fiscal year 2021 through July 28, 2021.

Question. In recent years, several for-profit colleges have attempted to convert to not-for-profit status in an effort to avoid the stigma associated with the predatory for-profit college industry and to avoid regulations meant to protect students and taxpayers. Dream Center Education Holdings, which collapsed leaving thousands of students stranded and whose conversion received preliminary Department approval, is just one example. Please provide a list of all for-profit conversions in the last 10 years including those pending (with current status), previously approved, and denied or withdrawn.

Answer. An Excel file providing the requested information is enclosed. Within the last 10 years, the Department has received 78 applications for a for-profit to nonprofit conversion. Of those 78 applications, the Department has made final decisions on 40 conversion requests as of August 1, 2021. Of those 40 decisions, 37 were approved.* The Department denied Argosy University's request for nonprofit recognition. The Department also denied Grand Canyon University's and the American Academy of Art College's requests for nonprofit recognition when it approved their respective Change in Ownership applications. Additionally, 18 applications, including pre-acquisition review applications, were closed due to a voluntary withdrawal

*In August 2016, the four main locations operated by the Center for Excellence in Higher Education (CEHE) were originally denied their conversion request. Following the receipt of additional information and an updated valuation in October 2018, the Department determined that it would be appropriate to grant those institutions conditional approval to convert to nonprofit institutions and issued Provisional Program Participation Agreements in December 2018. The Department's December 2018 determination of CEHE's nonprofit status—based on the new information CEHE provided—also provided a basis to dismiss a longstanding lawsuit filed against the Department, because that was the relief sought in the lawsuit. Just recently, under pressure from further reviews of its conduct by FSA, CEHE made the decision to close its remaining campuses effective Aug. 1, 2021. Additionally, one approved Change in Ownership transaction involving Kaplan University and Purdue University resulted in Kaplan University's conversion to public institution status (rather than to nonprofit institution status).

or school closure. There are 19 outstanding conversion requests, and one pending pre-acquisition application where the Change in Ownership date is imminent.

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021

PART 1

(Please Note: This table includes part 1 and part 2)

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit
00162800	American Academy of Art	North Central Association of Colleges and Schools (Higher Learning Commission).	American Academy of Art, Inc.—Richard Otto—100% owner.	363778690	Council on Postsecondary Education, Inc. (changed name to American Academy of Art)
02266200	Helms Career Institute	Council on Occupational Education (COE).	American Professional Institute	582641179	Goodwill Industries of Middle Georgia, Inc.
03416500	Dallas Nursing Institute	Accrediting Bureau of Health Education Schools (ABHES).	ATI, Inc.	752060087	TCS Education—Texas, Inc.
03612300	Birthwise Midwifery School	Midwifery Education Accreditation Council.	Birthwise Midwifery School	200551503	Birthwise Midwifery School (corporation converted to Maine nonprofit and received 501(c)(3) designation)
00342100	Bob Jones University	Transnational Association of Christian Colleges and Schools (TRACCS).	Bob Jones University, Inc.	570360095	BJU, Inc.
00751800	Apex Technical School	Accrediting Commission of Career Schools and Colleges (ACCSC).	Breton International Inc.	131949995	Fedcap Group, Inc.
00188100	Ashford University	WASC Senior College and University Commission (WASC).	Bridgepoint Education, Inc	593551629	University of Arizona Foundation
00188100	Ashford University	WASC Senior College and University Commission (WASC).	Bridgepoint Education, Inc	593551629	AU NFP
00267800	Bryant & Stratton College	Middle States Commission on Higher Education.	Bryant & Stratton College, Inc.	160364420	Prentice Family Foundation, Inc.
02110800	California College San Diego	Accrediting Commission of Career Schools and Colleges (ACCSC).	California College San Diego, Inc.	562364005	Center for Excellence in Higher Education
00489000	Central Penn College	Middle States Commission on Higher Education.	Central Pennsylvania Business School, Inc. / Central Penn, Inc. Employee Stock Ownership Plan Trust.	231857027232527882	Central Penn 1801
00489000	Central Penn College	Middle States Commission on Higher Education.	Central Pennsylvania Business School, Inc. / Central Penn, Inc. Employee Stock Ownership Plan Trust.	231857027232527882	Central Pennsylvania Educational Institution
03120300	CollegeAmerica Arizona	Accrediting Commission of Career Schools and Colleges (ACCSC).	CollegeAmerica Arizona, Inc.	841611427	Center for Excellence in Higher Education
02594300	CollegeAmerica Denver	Accrediting Commission of Career Schools and Colleges (ACCSC).	CollegeAmerica Denver, Inc.	841225827	Center for Excellence in Higher Education

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021

PART 1—Continued

(Please Note: This table includes part 1 and part 2)

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit
01274400	Southside College of Health Sciences	Accrediting Bureau of Health Education Schools (ABHES).	Community Health Systems, Inc	133883191	Bon Secours Mercy Health, Inc.
00149900	Everest University—Orlando, FL	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00450700	Everest College—Thornton, CO	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02237500	Everest College—Henderson, NV	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00915700	WyoTech—Laramie, WY	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00450300	Everest College—Colorado Springs, CO	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00709100	Everest Institute—Pittsburgh, PA	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00907900	Everest College—Portland, OR	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00926700	Everest College—Newport News, VA	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
00982800	Everest Institute—Southfield, MI	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
01185800	Everest College—Skokie, IL	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02250600	Everest College—Springfield, MO	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02261300	Everest Institute—San Antonio, TX	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02300100	Everest College—Bremerton, WA	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02346200	WyoTech—Ormand Beach, FL	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02606200	Everest College—Renton, WA	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
02617500	Everest College—Seattle, WA	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc.	330717312	Zenith Education Group, Inc.
03967400	Community Care College	Accrediting Commission of Career Schools and Colleges (ACCSC).	Dental Directions, Inc.—Teresa Knox—100% owner.	731480285	Community HigherEd Institute
00758600	Remington College—Tampa, FL	Accrediting Commission of Career Schools and Colleges (ACCSC).	Education America, Inc.	710641858	Remington College
00777700	Remington College—Cleveland, OH	Accrediting Commission of Career Schools and Colleges (ACCSC).	Education America, Inc.	710641858	Remington College
02605500	Remington College—Mobile, AL	Accrediting Commission of Career Schools and Colleges (ACCSC).	Education America, Inc.	710641858	Remington College
03026500	Remington College—Houston, TX	Accrediting Commission of Career Schools and Colleges (ACCSC).	Education America, Inc.	710641858	Remington College
03012100	Remington College—Colorado Springs, CO.	Accrediting Council for Independent Colleges and Schools (ACICS).	Education America, Inc.	710641858	Remington College
02179900	Argosy University	WASC Senior College and University Commission (WASC).	Education Management Corporation	251119571	The Dream Center Foundation
04051300	The Art Institute of Las Vegas (closed 12/13/19).	Accrediting Council for Independent Colleges and Schools (ACICS).	Education Management Corporation	251119571	The Dream Center Foundation
01019500	The Art Institute of Fort Lauderdale (closed 12/14/18).	Accrediting Council for Independent Colleges and Schools (ACICS).	Education Management Corporation	251119571	The Dream Center Foundation
02078900	The Art Institute of Colorado (closed 12/14/18).	Higher Learning Commission (HLC)	Education Management Corporation	251119571	The Dream Center Foundation
00747000	The Art Institute of Pittsburgh	Middle States Commission on Higher Education.	Education Management Corporation	251119571	The Dream Center Foundation
00781900	The Art Institute of Portland (closed 12/14/18).	Northwest Commission on Colleges and Universities.	Education Management Corporation	251119571	The Dream Center Foundation
00835000	The Art Institute of Philadelphia (closed 12/14/18).	Middle States Commission on Higher Education.	Education Management Corporation	251119571	The Dream Center Foundation
02291300	The Art Institute of Seattle	Northwest Commission on Colleges and Universities.	Education Management Corporation	251119571	The Dream Center Foundation
01258400	The Illinois Institute of Art (closed 12/14/18).	Higher Learning Commission (HLC)	Education Management Corporation	251119571	The Dream Center Foundation
00887800	Miami International University of Art & Design.	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation	251119571	Educational Principles Foundation
01303900	South University	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation	251119571	Educational Principles Foundation
00927000	The Art Institute of Atlanta	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation	251119571	Educational Principles Foundation
02117100	The Art Institute of Houston	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation	251119571	Educational Principles Foundation

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021

PART 1—Continued

(Please Note: This table includes part 1 and part 2)

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit
02547600	Florida National University	Southern Association of Colleges and Schools Commission (SACS).	Florida National University, Inc.	650021295	
04150100	Golden State College of Court Reporting & Captioning.	Accrediting Council for Independent Colleges and Schools (ACICS).	Golden State College of Court Reporting & Captioning.	593770508	Goodwill Industries of the Greater East Bay, Inc.
00458600	Kaplan University	North Central Association of Colleges and Schools (Higher Learning Commission).	Graham Holdings Company	530182885	Purdue University
00107400	Grand Canyon University	Higher Learning Commission (HLC)	Grand Canyon Education, Inc.	203356009	Gazelle University (changed name to Grand Canyon University)
01050900	Hallmark University	Accrediting Commission of Career Schools and Colleges (ACCSC).	Hallmark Aero-Tech, LP	741684588	Hallmark University, Inc.
00962100	Herzing University	North Central Association of Colleges and Schools (Higher Learning Commission).	Herzing Inc.	391040865	Herzing Educational Foundation
03374300	Florida Coastal School of Law	American Bar Association (ABA)	Infilaw Holding, LLC	113790327	PhoenixLaw Foundation
03173300	Atlanta's John Marshall Law School	American Bar Association	John Marshall Law School, LLC	200209197	John Marshall Law School, Inc.
03001200	McNally Smith College of Music	National Association of Schools of Music.	McNally Smith, Inc.	411540201	MSP College of Music
03813300	Northcentral University	WASC Senior College and University Commission (WASC).	NCU Holdings, LLC/Innova Management Group, Inc./Northcentral University, Inc.	860930587	WestMed (changed name to Northcentral University)(affiliated with National University System)
00743700	Pittsburgh Technical Institute	Middle States Commission on Higher Education.	Pittsburgh Technical Institute Employee Stock Ownership Plan.	270093054	Center for Excellence in Education, Inc.
02533600	Ross Medical Education Center	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC	202222476	Ross Education Holdings, LLC
02099700	Ross Medical Education Center	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC	202222476	Ross Education Holdings, LLC
02246300	Ross Medical Education Center	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC	202222476	Ross Education Holdings, LLC
02339700	Ross Medical Education Center	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC	202222476	Ross Education Holdings, LLC
02180100	Ross Medical Education Center	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC	202222476	Ross Education Holdings, LLC
00746800	School of Visual Arts	Middle States Commission on Higher Education.	School of Visual Arts, Inc.	135568364	SVA Alumni Association, Inc.
00746800	School of Visual Arts	Middle States Commission on Higher Education.	School of Visual Arts, Inc.	135568364	SVA Alumni Society, Inc. [501(c)(3)]
03280300	Seattle Institute of East Asian Medicine	Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).	Seattle Inst. of Oriental Medicine	911637769	Center for Integrated Care
04195600	Tribeca Flashpoint College	Accrediting Council for Independent Colleges and Schools (ACICS).	Sterling Partners—Small Market Growth 2009, L.P..	263922906	Columbia College Hollywood
00367400	Stevens Henager College	Accrediting Commission of Career Schools and Colleges (ACCSC).	Stevens Henager College, Inc.	87050023	Center for Excellence in Higher Education
02326900	Sunstate Academy—Ft. Myers	Accrediting Commission of Career Schools and Colleges (ACCSC).	Sunstate College, Inc.	592390702	Compass Rose Foundation, Inc.
02524000	Sunstate Academy—Clearwater	Accrediting Commission of Career Schools and Colleges (ACCSC).	Sunstate College, Inc.	592390702	Compass Rose Foundation, Inc.
02491500	Southwest University of Visual Arts	Higher Learning Commission (HLC)	The Art Center (a Subchapter S Corporation).	860567728	The Art Center
02151900	Keiser University	Southern Association of Colleges and Schools Commission (SACS).	The Keiser School, Inc.	591829662	Everglades College
03549300	Ultimate Medical Academy	Accrediting Council for Independent Colleges and Schools (ACICS).	Ultimate Medical Academy, LLC	202000570	UMA Education, Inc.
00170300	Kendall College	North Central Association of Colleges and Schools (Higher Learning Commission).	Wengen Alberta, Limited Partnership (Laureate Education).	208658661	National Louis University
03874300	Cambridge Junior College	Accrediting Council for Independent Colleges and Schools (ACICS).	Workforce Training Solutions, Inc.	680466305	ASPIRA Inc. of Pennsylvania

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021
PART 2
(Please Note: Column 1 repeated from Part 1)

OPE ID	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
00162800	463291995	Change in Ownership occured and PPPA issued on 1/5/2021 which allows the school to participate in Title IV, HEA programs under its new ownership. However, the institution's request for recognition as a nonprofit institution was denied on 1/5/2021. The IHE subsequently submitted a request for reconsideration for the Department's review on 3/26/2021. The Department is evaluating the submission and request for reconsideration on nonprofit status..	12/9/2014		1/7/2021	CIO approved—conversion to non-profit denied.	
02266200	581249683	Change in Ownership and conversion—Approved PPPA issued 2/3/14; Institution closed 12/31/15.	8/9/2013		2/3/2014	Approved—Inst Closed	12/31/2015
03416500	364769956	Change in Ownership and conversion—Approved PPPA issued 12/29/14.	10/18/2013		12/29/2014	Approved	
03612300	200551503	Application submitted 3/4/2021; TPPPA issued 4/21/2021; application under review.	3/4/2021	4/21/2021		Pending	
00342100	571088101	Change in Ownership has occurred—Change in Ownership and conversion pending final review and determination by the Department.	3/10/2017	8/31/2020		Pending	
00751800	830765672	Application submitted 1/23/2020; abbreviated pre-acquisition review letter issued 9/3/2020; transaction closed 9/18/2020; TPPPA issued 9/28/2020; application under review.	1/23/2020	9/28/2020		Pending	
00188100	866050388	Application submitted 10/2/2020; application under review	10/2/2020	1/11/2021		Pending	
00188100	830529332	Change of ownership and conversion application originally submitted 11/1/2018; revised transaction information submitted on 2/12/2020. In July 2019, ED issued preacquistion review letter identifying a $103 million LOC requirement for the 2018 proprosed transaction. The institution submitted an update to the proposed transaction which resulted in ED omitting the LOC requirement in July 2020. However, the institution proceeded with a third type of transaction, involving U. of Arizona Foundation, discussed in the preceding row..	11/1/2018			Withdrawn	
00267800	202557712	Application submitted 2/26/2020; application under review	2/26/2020	12/10/2020		Pending	

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021
PART 2—Continued
(Please Note: Column 1 repeated from Part 1)

OPE ID	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
02110800	208091013	Change in Ownership Approved and **PPPA** issued on 8/31/16 Conversion application denied on 8/11/16. Institution submitted additional information and filed lawsuit which was eventually settled. Conversion approved on the basis of updated information regarding the transaction, and **PPPA**s issued 12/19/18..	11/7/2012		12/19/2018	Approved—Inst Closed	8/1/2021
00489000	852896768	Abbreviated pre-acquisition review determination letter issued 6/11/2021; transaction closing scheduled for 8/22/2021.	3/26/2021			Pending—Pre-acq	
00489000	821929393	Application submitted 12/14/2018; Institution requested application be purged 9/6/19.	12/14/2018			Withdrawn	
03120300	208091013	Change in Ownership Approved and **PPPA** issued on 8/31/16 Conversion application denied on 8/11/16. Institution submitted additional information and filed lawsuit which was eventually settled. Conversion approved on the basis of updated information regarding the transaction, and **PPPA**s issued 12/19/18..	11/7/2012		12/19/2018	Approved—Inst Closed	8/1/2021
02594300	208091013	Change in Ownership Approved and **PPPA** issued on 8/31/16 Conversion application denied on 8/11/16. Institution submitted additional information and filed lawsuit which was eventually settled. Conversion approved on the basis of updated information regarding the transaction, and **PPPA**s issued 12/19/18..	11/7/2012		12/19/2018	Approved—Inst Closed	8/1/2021
01274400	521301088	Application submitted 1/14/2020; transaction closed 1/1/2020; **TPPPA** issued 3/26/2020; application under review.	1/14/2020	3/26/2020		Pending	
00149900	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15	4/10/2014		7/24/2015	Approved	
00450700	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 6/30/19.	4/10/2014		7/24/2015	Approved—Inst Closed	6/30/2019
02237500	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15. Sold by Zenith to for-profit owner, Nevada Career Education, Inc. on 11/9/18.	4/10/2014		7/24/2015	Approved	
00915700	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Sold by Zenith to for-profit owner, **DEUDM** Enterprises **LLC** on 7/1/18.	4/10/2014		7/24/2015	Approved	
00450300	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
00709100	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 2/17/16.	4/10/2014		7/24/2015	Approved—Inst Closed	2/17/2016
00907900	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 8/22/16.	4/10/2014		7/24/2015	Approved—Inst Closed	8/22/2016
00926700	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
00982800	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
01185800	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 8/25/15.	4/10/2014		7/24/2015	Approved—Inst Closed	8/25/2015
02250600	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 6/20/17.	4/10/2014		7/24/2015	Approved—Inst Closed	6/20/2017
02261300	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
02300100	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
02346200	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 6/28/18.	4/10/2014		7/24/2015	Approved—Inst Closed	6/28/2018
02606200	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 7/25/16.	4/10/2014		7/24/2015	Approved—Inst Closed	7/25/2016
02617500	472237488	Change in Ownership and conversion—Approved **PPPA** issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
03367400	472654761	Change in Ownership has occurred on 6/30/2015—Change in Ownership and conversion pending final review and determination by the Department.	4/30/2015	7/28/2015		Pending	
00758600	273339369	Change in Ownership and conversion—Approved **PPPA** issued 12/15/11. Merged into Remington Houston, TX campus on 7/3/13, now an additional location, no longer separately eligible..	11/16/2010		12/15/2011	Approved	
00777700	273339369	Change in Ownership and conversion—Approved **PPPA** issued 12/15/11. Merged into Remington Houston, TX campus on 7/3/13, now an additional location, no longer separately eligible..	11/16/2010		12/15/2011	Approved	
02605500	273339369	Change in Ownership and conversion—Approved **PPPA** issued 12/15/11. Merged into Remington Houston, TX campus on 7/3/13, now an additional location, no longer separately eligible..	11/16/2010		12/15/2011	Approved	
03026500	273339369	Change in Ownership and conversion—Approved **PPPA** issued 12/15/11.	11/16/2010		12/15/2011	Approved	
03012100	273339369	Change in Ownership and conversion—Approved **PPPA** issued 12/15/11. Withdrew from Title IV 5/20/14.	11/16/2010		12/15/2011	Approved—Inst Closed	5/20/2014

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021

PART 2—Continued

(Please Note: Column 1 repeated from Part 1)

OPE ID	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
02179900	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. The institution was included in the DCEH receivership filed in January 2019. The Department denied Argosy's request for change of ownership and conversion to nonprofit status on February 27, 2019, thereby terminating its eligibility. In March 2019 the receiver closed all Argosy campuses, other than its law school (Western State College of Law). The law school is in the process of becoming an additional location of Westcliff University. No further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	5/11/2016	11/30/2017		Denied—(see current status)	3/8/2019
04051300	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. The institution was included in the DCEH receivership filed in January 2019. The institution closed due to loss of accreditation on 12/13/19. No further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	5/11/2016	11/30/2017		Institution Closed	12/13/2019
01019500	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. DCEH closed the institution on 12/14/18 as part of a planned closure. Subsequently, DCEH and its subsidiaries were subject to a receivership order entered by a federal court in January 2019. As a result of the receivership and closure of the school, no further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/30/2016	11/30/2017		Institution Closed	12/14/2018
02078900	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. DCEH closed the institution on 12/14/18 as part of a planned closure. Subsequently, DCEH and its subsidiaries were subject to a receivership order entered by a federal court in January 2019. As a result of the receivership and closure of the school, no further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/30/2016	2/20/2018		Institution Closed	12/14/2018
00747000	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. DCEH closed the institution on 12/14/18 as part of a planned closure. Subsequently, DCEH and its subsidiaries were subject to a receivership order entered by a federal court in January 2019. As a result of the receivership and closure of the school, no further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/30/2016	2/20/2018		Institution Closed	3/8/2019
00781900	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. DCEH closed the institution on 12/14/18 as part of a planned closure. Subsequently, DCEH and its subsidiaries were subject to a receivership order entered by a federal court in January 2019. As a result of the receivership and closure of the school, no further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/31/2016	11/30/2017		Institution Closed	12/14/2018
00835000	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. DCEH closed the institution on 12/14/18 as part of a planned closure. Subsequently, DCEH and its subsidiaries were subject to a receivership order entered by a federal court in January 2019. As a result of the receivership and closure of the school, no further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/31/2016	2/20/2018		Institution Closed	12/14/2018

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021

PART 2—Continued

(Please Note: Column 1 repeated from Part 1)

OPE ID	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
02291300	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. The institution was included in the DCEH receivership filed in January 2019. The receiver closed the institution on 3/8/19. No further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	8/31/2016	10/17/2017		Institution Closed	
01258400	412269686	Preacquisition review completed in September 2017, and the institution was thereafter acquired by the Dream Center Educational Holdings school group. The institution was included in the DCEH receivership filed in January 2019. The receiver closed the institution on 3/8/19. No further action will be taken on the change of ownership or requested conversion to nonprofit status under Dream Center ownership..	9/1/2016	2/20/2018		Institution Closed	12/14/2018
00887800	464265864	Prior to the institution's acquisition by EPF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EPF and conversion to nonprofit status is currently under review..	9/25/2017	2/28/2019		Pending	
01303900	464265864	Prior to the institution's acquisition by EPF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EPF and conversion to nonprofit status is currently under review..	1/18/2019	2/28/2019		Pending	
00927000	464265864	Prior to the institution's acquisition by EPF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EPF and conversion to nonprofit status is currently under review..	1/18/2019	2/28/2019		Pending	
02117100	464265864	Prior to the institution's acquisition by EPF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EPF and conversion to nonprofit status is currently under review..	1/18/2019	2/28/2019		Pending	
02547600		Application Purged 12/20/2018	10/17/2018			Withdrawn	
04150100		Institution closed on March 9, 2018				Withdrawn	
00458600	356002041	Change in ownership to become affiliate of a public institution approved. PPPA issued on 8/24/18Purdue University Global is new name of institution.	6/19/2017		8/24/2018	Approved	
00107400	472507725	Grand Canyon announced the closing of its sale to a nonprofit entity in July 2018 without the Department's completion of the requested pre-acquisition review. On 11/6/2019 the Department approved GCU's change of ownership and denied its request for nonprofit status. GCU subsequently submitted additional information for the Department's review and requested reconsideration on 1/8/2020 with additional submissions on 5/6/2020 and 5/12/2020. The Department conducted a supplemental review after additional requested information was submitted. Reconsideration decision letter denied nonprofit conversion request on 1/12/2021. Grand Canyon files lawsuit against ED due to denial of nonprofit conversion on 2/2/2021 in US District Court in Arizona..	1/18/2018		11/14/2019	CIO approved—conversion to non-profit denied.	
01050900	45462000	Change in Ownership and conversion—Approved PPPA issued 6/12/14	11/15/2012		6/12/2014	Approved	
00962100	271503981	Change in Ownership and conversion—Approved PPPA issued on 2/13/18.	6/27/2014		2/13/2018	Approved	
03374300		The school intended to contribute all of its assets and liabilities to a non-profit foundation, the PhoenixLaw Foundation, an Arizona nonprofit; abbreviated preacquisition offer issued—school withdrew this application because ABA would not approve the transaction—proposed transaction with Campbellsville University (KY) has been described but not formally applied.	5/24/2019			Withdrawn	
03173300	811827820	Application submitted 2/13/2020; comprehensive pre-acquisition review letter issued 11/16/2020; transaction closed 12/31/2020; TPPPA issued 3/31/2021; application under review.	2/13/2020	3/31/2021		Pending	
03001200		The Preacquisition review was completed, but the institution closed on December 15, 2017.	12/19/2016			Institution Closed	12/15/2017
03813300	900171867	Change in Ownership has occurred—Change in Ownership and conversion pending final review and determination by the Department.	9/6/2018	10/17/2019		Pending	
00743700	810903939	Change in Ownership and conversion—Approved PPPA issued on 9/27/17.	5/26/2016		9/27/2017	Approved	
02533600	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	
02099700	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	

Proprietary to Non-Profit Conversions—Status of Applications During 10 Year Period through August 1, 2021
PART 2—Continued
(Please Note: Column 1 repeated from Part 1)

OPE ID	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
02246300	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; **TPPPA** issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	
02339700	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; **TPPPA** issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	
02180100	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; **TPPPA** issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	
00746800		Application submitted 9/12/2019; application withdrawn 8/21/2020—plan to finalize the transaction later for a 9/1/2021 close.	5/31/2016			Withdrawn	
00746800	237193748	Preacquisition Review completed. Application purged on 6/22/18	9/12/2019			Withdrawn	
03280300	271791496	Application submitted 4/15/2019; transaction closed 9/1/2019; **TPPPA** issued 3/2/2021; application under review.	4/15/2019	3/2/2021		Pending	
04195600	952077629	Acquisition of Tribeca as an additional location of Columbia closed on 3/20/18. Merger approved, full **PPA**s reflecting merger issued 6/11/18. **No** longer separately eligible.	1/3/2017		6/11/2018	Approved	
00367400	208091013	Change in **Ownership** Approved and **PPPA** issued on 8/31/16 Conversion application denied on 8/11/16. Institution submitted additional information and filed lawsuit which was eventually settled. Conversion approved on the basis of updated information regarding the transaction, and **PPPA**s issued 12/19/18..	11/7/2012		12/19/2018	Approved—Inst Closed	8/1/2021
02326900	590972013	Change in **Ownership** and conversion—Approved**P PPA**s issued on 10/18/17.	9/11/2015		10/18/2017	Approved	
02524000	590972013	Change in **Ownership** and conversion—Approved **PPPA**s issued on 10/18/17.	9/11/2015		10/18/2017	Approved	
02491500	860567728	**SUNA** has changed its tax status under an Arizona law that allows an existing corporation to transition to nonprofit. That transaction has occurred and a **TPPPA** has been issued.. While the conversion to nonprofit status was under review by the Department, the institution entered bankruptcy and closed 11/30/2020..	1/3/2019	4/1/2019		Institution Closed	11/30/2020
02151900	650216638	Change in **Ownership** and conversion—Approved **PPPA** issued 8/10/11	11/11/2010		8/10/2011	Approved	
03549300	472578950	Change in **Ownership** and conversion—Approved **PPPA** issued 7/9/15	4/1/2015		7/9/2015	Approved	
00170300	362167804	Acquisition of **Kendall** as an additional location of **National** Louis. Merger approved, full **PPA**s reflecting merger issued 9/20/18. **No** longer separately eligible.	1/17/2018		9/20/2018	Approved	
03874300		Application voluntarily withdrawn by ownership (purged 10/11/2016) ..	6/5/2015			Withdrawn	

Question. Please provide, disaggregated for Corinthian Colleges, Inc., ITT Educational Services, Inc., Charlotte School of Law, Education Corporation of America, Vatterott Colleges, and Dream Center Education Holdings, respectively:

The number of borrowers and the total loan amount of such borrowers for whom the Department estimates are eligible for the applicable closed school discharge window (either 120 days or as extended due to "exceptional circumstances");

The number of borrowers and the total loan amount of borrowers who applied for a non-automatic, traditional closed school discharge;

The number of borrowers and the total loan amount that has been discharged through non-automatic, traditional closed school discharge;

The number of borrowers and the total loan amount that has been discharged through automatic closed school discharge; and

The number of borrowers and the total loan amount of such borrowers in some form of debt collection (Treasury offset, wage garnishment, assigned to PCAs).

Answer. Please find an Excel file with the requested data enclosed.

	Durbin 16.a- Estimated Eligible Borrowers for Closed School Discharge		Durbin 16.b- Borrowers Who Applied for a Non-Automatic, Traditional Closed School Discharge		Durbin 16.c- Borrowers Who Received Closed School Discharge		Durbin 16.d- Borrowers Who Received Automatic Closed School Discharge		Durbin 16.e- the number of borrowers and the total loan amount of such borrowers in some form of debt collection (Treasury offset, wage garnishment, assigned to PCAs).	
	Borrowers	Dollars (in millions)	Borrowers	Dollars (in millions)	Borrowers	Dollars (in millions)	Borrowers	Dollars (in millions)	Borrowers*	Value of Loans (in millions)*
Charlotte School of Law	100	$ 6	200	$ 20	100	$ 5	<10	Privacy Restricted	100	15
Dream Center Education Holdings	7,900	$ 178	9,600	$ 301	4,300	$ 103	Not Yet Eligible		80,500	1,325
Education Corporation of America	11900	$ 81	11,700	$ 120	6,500	$ 39	Not Yet Eligible		101,900	1,084
ITT Educational Service	25,800	$ 349	30,700	$ 569	18,600	$ 250	8000	$ 99	72,800	1,037
Vatterott Acquisition Co.	1,500	$ 20	1,300	$ 20	900	$ 11	Not Yet Eligible		15,200	279
Corinthian Colleges	17,500	$ 200	10,500	$ 128	9,500	$ 104	8300	$ 96	42,000	456

NOTES
- Estimated eligibility for closed school discharge was calculated as of July 22, 2021 and excludes Title IV borrowers who graduated, transferred, or whose loans were subsequently cancelled. Non-Title IV aid recipients are not eligible for closed school discharge.
- For 16.b, application data was reported directly by the current federal servicers, including DMCS and ECSI (which weren't reported in the past). Applications submitted to former federal servicers are not included in the counts (i.e. Cornerstone). Dollar amounts are based on outstanding balance at the time of application.
- Durbin 16.c and 16.d were run as of 7/22/2021.
- Borrower counts are rounded to the nearest 100. Dollar counts are rounded to the nearest million.
- Borrowers may be counted more than once in the discharge numbers if the same borrower attended more than one location of the school.
- Schools that have not been closed for at least three years are not eligible for automatic closed school discharge.
- Data for Durbin 16.e only includes non-consolidation loans. Please note that the data reported in 16.c only includes those currently assigned to PCAs since pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act, all collection activities on federal student loans are suspended as of March 13, 2020. The "Value of Loans" column is the total dollar value of positive balance loans as of July 23, 2021. Borrowers could be counted multiple times if they owe loans for more than one school that is part of the same school group.

Question. Your predecessor allowed borrower defense claims to balloon at the Department without processing any claim for more than a year. At one time, the backlog had grown to several hundred thousand claims. As pressure mounted to clear the backlog—of her own creation—Secretary DeVos issued blanket and cursory denials of tens of thousands of claims. Many of these are potentially meritorious claims that were simply cast aside by the previous administration that always looked at borrower defense as more of a problem to ignore than a mechanism for justice and

fairness. What steps will you take to review the DeVos Department's borrower defense denials?

Answer. The Department agrees that all borrowers who have filed borrower defense to repayment applications deserve a thorough and fair review that is done as expediently as possible. While the Department continues to approve new categories of borrower defense claims, I have asked Federal Student Aid to conduct extensive outreach to state attorneys general, other government agencies, and any other parties that might be in possession of evidence showing institutional misconduct. I have also asked FSA to reopen any borrower defense denials when new evidence, or any other evidence in FSA's possession, indicates misconduct or other concerns that were not considered during the initial adjudication. In addition, FSA is conducting a review of our policies related to borrower defense and will reopen any denied claims based upon any of those policy changes.

The Department is working diligently to process borrower defense claims in a timely manner. We are aware of the significant number of borrowers with a denied claim and are reviewing potential options for these borrowers.

Question. You recently announced an ambitious higher education regulatory agenda which will include topics like gainful employment, for-profit conversions, borrower defense, financial responsibility, administrative capability. While I'm pleased the Department is undertaking this process, it is lengthy and the Department's rules subject to litigation. As it goes through the negotiated rulemaking process, how will the Department—under your leadership—use its extensive existing authorities to engage in aggressive oversight and enforcement activities related to predatory for-profit colleges?

Answer. The Department of Education is working to ensure stronger oversight of predatory institutions through multiple venues. I expect that the rulemaking process will help the Department to design far stronger protections against predatory practices by institutions. Additionally, the Office of Federal Student Aid is working to ensure careful oversight of institutions, investigating reports of problematic practices and increasing monitoring of institutions that receive Federal aid under Title IV of the Higher Education Act. The new Chief Operating Officer of FSA, Richard Cordray, is committed to ensuring consumer protection is embedded in how FSA serves students and borrowers.

Question. During the Obama Administration, then-Secretary Arne Duncan created a Federal interagency taskforce to coordinate oversight and enforcement efforts related to for-profit colleges. The task force was based on a bill that the late Rep. Elijah Cummings and I wrote called the Proprietary Education Oversight Coordination Improvement Act. The task force was successful in coordinating Federal action in response to misconduct by several for-profit colleges—including a $100 million DeVry settlement with the Federal Trade Commission. Would you be open to recreating this task force that was disbanded by Secretary DeVos?

Answer. The Department is deeply interested in strengthening oversight of misconduct across higher education. The interagency task-force created by the Obama Administration provided a critical opportunity for collaboration to identify potential illegal practices and misrepresentations. The Department is already working to reestablish those relationships with other Federal agencies through MOUs and data-sharing agreements, as well as opening the lines of communication with state Attorneys General, to improve accountability in higher education.

Question. As part of the American Rescue Plan (Public Law 117–2), Congress closed the 90/10 loophole which incentivized for-profit colleges to prey on student veterans and servicemembers. I understand that the bill prohibited the Department from promulgating regulations to implement the statutory change before October 2021. In the meantime, will the Department release Federal 90/10 data which counts accurately as Federal revenue all revenue received by for-profit colleges from Federal taxpayer-funded educational assistance programs? This would include Department of Veterans Affairs GI Bill and Department of Defense Tuition Assistance funding. While this data could not be used for enforcement purposes yet, it would be very helpful to the public's understanding of the problem. In fact, the Department released this data, upon my request, in December 2016. On December 10, 2018, Chairman Takano, Senator Carper, Representative Cohen, Ranking Member Murray, Chairwoman DeLauro, Ranking Member Reed, Chairman Adam Smith, Senator Blumenthal, Representative Susan Davis, and I wrote to then-Secretary DeVos asking her to continue this data release. She refused during her tenure.

Answer. As referenced in your question, section 2013 the American Rescue Plan Act modifies section 487(a)(24) of the Higher Education Act of 1965 (HEA) to require a proprietary institution to derive not less than 10 percent of such institution's revenues from sources other than "Federal funds that are disbursed or delivered to or on behalf of a student to be used to attend such institution." The Department unfor-

tunately does not have an updated report covering Federal 90/10 data that counts accurately as Federal revenue all revenue received by for-profit colleges from Federal taxpayer-funded educational assistance programs report to release to you. Additionally, the Department does not maintain the requisite VA, DoD, and other Federal education benefits program funding data to prepare an updated 90/10 impact analysis.

The Department wishes to clarify that although it released a 90/10 data report in 2016 covering VA and DoD funds, the Department did not prepare that report. The Department's 2016 press release indicates DoD and VA prepared that 90/10 estimate. The Department's December 21, 2016, transmittal letter identifies significant data limitations and includes a cautionary note against using the data to draw inferences about individual institutions or trends. The Department's subsequent March 28, 2019, response to your December 2018 letter reiterated these themes.

Due to the complexity and individualized nature of the 90/10 evaluation including, but not limited to, a requirement for an institution to use the cash basis of accounting under section 487(d)(1)(A) of the HEA, an institution's 90/10 compliance is disclosed in an institution's audited financial statement notes. To perform an accurate analysis of the impact of the statutory change, an evaluation must be conducted at the individual student account receivable level for every recipient of any type of Federal taxpayer-funded educational assistance program who attended every proprietary school. This type of analysis is necessary in view of the requirements. The Department has no confidence that any other analytical approach would yield the accurate assessment requested.

The Department appreciates your longstanding concern with institutions receiving Federal education benefits from multiple funding sources. However, the knowing release of a report that uses questionable data and depends on unsound assumptions could have harmful effects in advance of the upcoming rulemaking, including possibly misinforming and misleading members of the public who may seek to forecast the anticipated impact of new rules, which may undermine public trust. The Department is also concerned that the release of an inaccurate report would violate the Government Accountability Office's (GAO's) Standards for Internal Control in the Federal Government (GAO–14–704G), especially Principle 13, "Use Quality Data."

Question. Over the last four fiscal years, this Subcommittee—with the support of Chairman Blunt and Ranking Member Murray—has provided $24 million to an Open Textbooks Pilot to expand the use of open textbooks on college campuses to achieve savings for students. While this program may be small, it has energized students and faculty across the country who see open textbooks—free, high-quality alternatives to costly traditional textbooks—as key to reducing student debt and improving learning outcomes. Many students don't purchase required course materials because they are too costly. It puts them at an academic disadvantage and hits low-income, first-generation, and students of color hardest. So, on a bipartisan basis, Congress created this program. In early June, the Department made nine new awards with its fiscal year 2021 appropriation—funding down the slate of fiscal year 2020 applications. I am pleased that the Department took Congressional directive and made a great number of awards. In order to do so though, the Department only funded 1 year of the applicants' projects. It was my understanding that if the Department took that step, it would fully fund those nine projects pending the appropriation of additional funds in fiscal year 2022.

Please confirm that remains the Department's intention.

How is that intention being relayed, with the appropriate caveats, to the 9 grantees?

Answer. The Department worked extensively with Congress to identify and implement a funding strategy that would maximize the number of new awards in fiscal year 2021 that could be awarded with the $7 million in available funding, ultimately making nine new awards from the fiscal year 2020 slate. This strategy required a shift from the previous strategy of frontloading OTP grantees, an approach that fully paid all multi-year project costs with a single year's appropriation, but which consequently required making a much smaller number of awards. The larger number of awards enabled by the shift to incremental funding allowed roughly twice as many highly rated applicants to launch their projects in fiscal year 2021 as would have been possible with frontloading. The Department used approximately $5.9 million to pay first-year costs and approximately $1.1 million to partially pay down the second-year costs for the 2021 OTP cohort. We plan to use an estimated $8.3 million in fiscal year 2022 funds to pay remaining second- and third-year costs for this cohort, as shown in the fiscal year 2022 Congressional budget justification for this program.

While the project period for these grantees does not begin until September 1, 2021, program staff have held post-award calls with the nine grantees to explain the impact of the change in funding strategies for the 2021 OTP cohort.

Question. When you came before us, I asked you about the high percentage of denials under the Public Service Loan Forgiveness (PSLF) program. You voiced your support for PSLF and your determination that borrowers receive the forgiveness that they expected and to which they are entitled. PSLF reform is part of the higher education regulatory agenda that you have announced. What steps will you take administratively, outside of formal rulemaking, to help fix the problems with PSLF?

Answer. As we continue investigating the challenges of PSLF, the Department is committed to undertaking a serious review of the PSLF program and to making improvements that will result in better access to relief for eligible borrowers. In addition to including PSLF on the regulatory agenda, we recently issued a Request for Information (RFI), inviting feedback on borrower experiences and possible policy solutions with the PSLF program, to identify broader areas for improvement. The Department has already begun to make improvements, including by launching and updating the PSLF Help Tool, by allowing lump sum and prepayments to count as qualifying payments, and by creating a single application for PSLF, Temporary Expanded PSLF (TEPSLF), and Employment Certification Forms (ECFs). We look forward to making additional administrative and operational improvements that help eligible borrowers access the benefits they have earned.

Further, on October 6, 2021, the Department of Education announced an overhaul of the PSLF Program that it will implement over the next year to make the program live up to its promise. This policy will result in 22,000 borrowers who have consolidated loans—including previously ineligible loans—being immediately eligible for $1.74 billion in forgiveness without the need for further action on their part. Another 27,000 borrowers could potentially qualify for an additional $2.82 billion in forgiveness if they certify additional periods of employment. All told, the Department estimates that over 550,000 borrowers who have previously consolidated will see an increase in qualifying payments with the average borrower receiving another 2 years of progress toward forgiveness. Many more will also see progress as borrowers consolidate into the Direct Loan program and apply for PSLF, and as the Department rolls out other changes in the weeks and months ahead.

The first major change will result in a limited PSLF waiver that allows all payments by student borrowers to count toward PSLF, regardless of loan program or payment plan. This waiver will allow student borrowers to count all payments made on loans from the Federal Family Education Loan (FFEL) Program or Perkins Loan Program. It will also waive restrictions on the type of repayment plan and the requirement that payments be made in the full amount and on-time for all borrowers.

Given this new policy, borrowers who currently have FFEL, Perkins, or other non-Direct Loans, will receive the benefit of this limited waiver if they apply to consolidate into the Direct Loan program and submit a PSLF form by October 31, 2022. The waiver applies to loans taken out by students.

Also, these changes will allow active duty service members to count deferments and forbearances toward PSLF. This solves a problem for service members who have paused payments while on active duty but were not getting credit toward PSLF.

The Department is automatically providing credit toward PSLF for military service members and Federal employees using Federal data matches. The Department will implement data matches next year to give these borrowers credit toward PSLF without an application.

Finally, the Department is reviewing denied PSLF applications for errors and giving borrowers the ability to have their PSLF determinations reconsidered. These actions will help identify and address servicing errors or other issues that have prevented borrowers from getting the PSLF credit they deserve.

Question. Students' Federal financial aid for higher education is dependent on their expected family contribution. For many students from low-income families, their expected family contribution qualifies them for Federal assistance in the form of a Pell Grant. To confirm accurate family contributions, some financial aid applications are flagged for additional verification. Past data from the Department shows that over half of Pell-eligible applicants were selected for verification in 2015–2016. It is estimated that more than 1 in 5 low-income students selected for verification never complete the process, thus never end up receiving Federal financial aid. Students who receive Pell grants have much higher college retention rates than their peers who are Pell eligible but do not receive the aid. This data implies it is possible that the verification process is disproportionately harming the educational success of low-income students, which is the opposite intention of the Pell Grant program. The 2017/2018 Award Year ushered in a new verification model. The Quality Assurance Program ended, which had given institutions of higher education discretion on

application verification, leaving the Department to select which students needed to be verified. The risk-model developed by the Department to identify which FASFA applications needed verification led to a drastically higher percentage of applications flagged. In fact, some schools reported that nearly 50 percent of Pell eligible students were selected for verification multiple times over their course of study even though their financial information hadn't changed.

Please provide the metrics by which the Department selects which applications are to be verified.

Answer. Prior to 2018, FSA relied solely on a Classification and Regression Tree (CART) model to choose FAFSA filers for financial verification. The CART model used combinations of Targeted Selection Criteria (TSC) to choose FAFSA filers for verification. In September 2017, FSA funded the creation of an advanced Python-coded machine learning model (MLM) to improve FSA's verification selection model by better identifying applicants for whom an error on the FAFSA was more likely to impact their Expected Family Contribution and, ultimately, their Federal aid award. FSA has used this model since October 1, 2018. The MLM updates the criteria used for selection of FAFSA filers for verification to a gradient boosting classification and regression model. The metrics the model employs to choose FAFSA filers for verification include data from the FAFSA, as well as demographic data, in several complex algorithms. In certain cases, TSC are used to supplement MLM selection, and a small percentage of applicants are randomly selected to provide necessary data for model building and evaluation. As part of this single, overall selection process, a separate TSC model is used to select applicants for identity/fraud verification.

Finally, for your awareness, in July we announced some modifications to our verification approach to the 2021–2022 FAFSA processing cycle in response to the challenges and barriers resulting from the ongoing national emergency by focusing solely on identity and fraud. We continue to evaluate potential approaches for upcoming cycles to ensure that they are balanced and equitable.

Question. What percentage of students chosen for verification, did not complete, and failed their verification during the last award year under model?

Answer. FSA uses the receipt of either a Pell Grant or Subsidized Direct Loan as a measure of whether an applicant successfully completes verification once selected. Of those selected for verification during the 2020–21 FAFSA cycle, 64.5 percent received either a Pell Grant or a Subsidized Direct Loan. Some students that submit a FAFSA do not enroll in an institution of higher education for a variety of reasons, so we would not expect this percentage to equal 100. Therefore, to understand the impact of the verification process on student enrollment, the Department compares this rate to the population not chosen for any type of verification. The rate for those not selected for verification receiving either a Pell Grant or a Subsidized Direct Loan is 56.8 percent. Please note this data is as of July 28, 2021 and may change slightly as Award Year 2021 aid is finalized.

Question. We have a student debt crisis that isn't going to resolve itself. Currently 45 million Americans hold more than $1.7 trillion in student loan debt. Student debt is larger than credit card debt in our nation. It is second only to mortgages when it comes to consumer debt. The average debt per student borrower is more than $37,000. Most of this is in Federal student loans. The student debt crisis is limiting young people's life and career choices. Americans are putting off starting a family and buying a home because of student debt. And it's not just young people. More than 8 million Americans over age 50 have student loan debt. For years, I have introduced legislation to fix the absurd way that the bankruptcy code treats student debt. If a person overextends himself on his credit card or goes into debt buying a car or a boat or a luxury watch, he can address those debts in bankruptcy. But the bankruptcy code provides no meaningful relief for student loan debt. In 1998, Congress put Federal student loans in the category of nondischargeable debts, along with alimony, child support, overdue taxes, and criminal fines. Right now, the only way a student borrower can get bankruptcy relief for student loans is if she can demonstrate "undue hardship." This standard is not defined in law, and courts have interpreted it to make it nearly impossible to meet. But, Secretary Cardona, you have the ability to help this situation. The Department of Education can set internal standards for when it views an undue hardship as being met, and can direct its contractors and servicers not to challenge those undue hardship claims in bankruptcy court. For years, I have urged previous Secretaries of Education to use this authority and to issue undue hardship guidance for its guaranty agencies and contractors. There are categories of debtors where undue hardship can be presumed—for example, debtors who suffer from certain disabilities, or who have had a low income for a number of consecutive years. If the Department would use this authority, it would create an option of last resort for student debtors who truly have nowhere else to

turn. Will you commit to issue guidance on the Department's views of when an undue hardship claim can be met?

Answer. The Administration is committed to ensuring that student loan borrowers have options to make the burden of student loans more manageable . The consequences of delinquency and default on Federal student loans can be substantial, particularly for borrowers who are suffering from other economic hardships, including many who ultimately file for bankruptcy relief on their debts. We have already taken initial actions to support borrowers; but we recognize that more work remains to be done.

To that end, the Department is committed to reviewing its 2015 guidance on undue hardship student loan discharges in bankruptcy proceedings, as well as other policies related to such proceedings to assess the types of changes that might better protect borrowers. We hope to have more to share on this soon.

Question. A recent report by the National Student Loan Defense Network, entitled "The Missing Billion," highlights the aggressive tactics the Department uses to collect from struggling borrowers—including challenging claims of undue hardship in bankruptcy. At the same time, the report finds that the Department has failed to collect on more than $1 billion owed to taxpayers by for-profit institutions and executives. Please comment on the findings of this new report.

Answer. The National Student Loan Defense Network's (NSLDN's) report, "The Missing Billion," compares the differences in the Department's collection of liabilities owed by institutions and its collection of student loans owed by individual borrowers in default. This difference primarily comes from statutory provisions that make it difficult to hold individual owners liable for the corporate debts of the institutions, in contrast to provisions that substantially limit any bankruptcy relief under an "undue hardship" standard. See 11 U.S.C. §523(a)(8). The "undue hardship" standard applies to educational debts when individuals seek bankruptcy protection. In seeking to enforce that standard uniformly, the Department considers as a factor the availability of several student loan repayment plans that can take a borrower's circumstances into account to reduce a borrower's scheduled loan installments to a more affordable monthly payment.

The Department uses oversight measures as provided in the Department's regulations to identify institutions that are financially weak and institutions with impaired administrative capability. These measures include monitoring the numeric composite score of financial responsibility, requiring institutions with failing financial scores to provide letters of credit (LOCs), using Heightened Cash Monitoring (HCM) methods of payment, and provisional certification to monitor schools' compliance with the Department's requirements to mitigate risk.

Frequently, LOC amounts, HCM requirements, and provisional certification are linked to an institution's performance under the Department's financial responsibility requirements and an institution's numeric composite score determined by financial analysis of the institution's annual financial statements in accordance with the Department's regulations. Consistent with the Department's regulations, LOC amounts are indexed to an institution's annual Title IV, HEA funding. The proceeds of LOC collections can be applied towards an institution's unpaid debts after any related appeals are fully resolved. When the Department perceives increased financial or administrative risk, the Department may require institutions to comply with more stringent requirements, such as raising the amount of financial protection an institution must provide and increasing the level of scrutiny applied to payment requests through the HCM2 method of payment. The Department also considers risks associated with increased compliance requirements. One outcome of stringent enforcement and oversight can be that an IHE may close if it is unable to fully comply with more rigorous requirements, such as a posting a larger LOC.

The Department's Office of Finance and Operations collects debts owed to the Department and follows applicable Federal debt collections laws, including the Debt Collection Improvement Act of 1996, when collecting debts and when referring delinquent debts for collections. If an institution files for bankruptcy, it immediately loses eligibility to participate in the Title IV, HEA programs. The Department is bound to follow applicable bankruptcy law and pursues debt recovery from the institution's estate through the bankruptcy court. Institutions that close often do so with a lot of debt and limited assets to be distributed among the creditors. Collection of liabilities against an institution is generally limited to the direct owner corporate entity unless there is litigation to "pierce the corporate veil," which often proves difficult. Litigation to recover liabilities against individuals can only be brought by the U.S. Department of Justice and requires piercing the corporate veil in order to hold individuals personally accountable. The Department has taken steps to prevent individuals with unpaid school debts or bad track records running schools from operating other schools. The Department's past performance regulations can bar school

owners who owe unpaid debts from owning or exercising substantial control over other schools until their outstanding debts are paid.

We are reviewing the report to determine if there are any outstanding actions that need to be resolved for currently participating schools. While the report is critical of the Department's administration of debts owed by institutions, an initial reading also indicates the report contains unfounded conclusions and inaccurate claims because it fails to take into account the requirements to establish liabilities against institutions. The report also appears to misinterpret the data provided to NSLDN via the Freedom of Information Act (FOIA).

As an example, the report is critical of the Department's administration of debts owed by institutions owned by Zovio, Inc, and claims the Department failed to collect a $883,613 liability amount assessed against the University of the Rockies (owned by Zovio, Inc.). In actuality, the Department's efforts to collect this liability (arising from a final close-out audit determination) have been suspended in accordance with 34 C.F.R. Part 668, Subpart H—Appeal Procedures for Audit Determinations and Program Review Determinations because an appeal is currently pending resolution with the Department's Office of Hearings and Appeals. The suspension of collections is required under the Department's regulations at 34 C.F.R. §§668.23(f)(1); (g)(1)(i)-(ii); and 668.123. These regulations provide that an institution must repay an audit liability within 45 days of the date of the Department's notification, unless the institution files a timely appeal or unless a longer repayment period is permitted. A liability may be established but not paid in full because an institution is repaying the liability owed under a repayment agreement. The Department monitors institutional compliance with repayment requirements. Failure to comply with these repayment requirements is a violation of the Department's financial responsibility standards, as described above.

The report suggests that Department improperly issued a Program Participation Agreement to Ashford University (also owned by Zovio, Inc.) while Ashford owed a $32,965 liability. The Department's Federal Student Aid office received confirmation on Oct. 5, 2016, that Ashford University had fully repaid the $32,965 liability to the Department on Sept. 9, 2016. The Department would not dispute that the $32,965 receivable erroneously included in the records provided to NSDLN through the FOIA request was the result of a recordkeeping error. However, before the Department provided a Program Participation Agreement to Ashford University on Oct. 20, 2017, the Department had determined that Ashford had fully paid the liability.

As another example, the report states "The Department has asserted a $283,782,751 claim in the bankruptcy proceeding against ITT Technical Institute, plus an additional $1,544,738 against the school due to its ownership and operation of Daniel Webster College. Yet the Department's list of unpaid debt only includes approximately $343,000 from ITT and nothing with respect to Daniel Webster College." In this instance, the Department did not issue final determinations associated with the debts identified in the proof of claim to avoid violating the automatic stay provisions of the Bankruptcy Code.

The NSLDN report unfortunately misinforms its readers that "[t]he Department's inaction has irrevocably cost at least $218 million because the statute of limitations on collections has expired" by misconstruing 28 U.S.C. §2462. The NSLDN report cites as support 28 U.S.C. §2462 and the Lincoln University case (Docket 13–68–SF), April 25, 2016, in Footnote 35. A reading of 28 U.S.C. §2462 undermines the notion that there is a statute of limitations on collections. Rather, 28 U.S.C. §2462 establishes a statute of limitations for commencing actions to assess civil fines, etc. which must be commenced within 5 years from the date when the claim first accrued. In Lincoln University, the Department asserted on Oct. 25, 2013, fines for Clery Act violations which occurred on Oct. 1, 2006, and were repeated annually on that date until 2009 under the Department's regulations at 34 C.F.R. Part 668, Subpart G—Fine, Limitation, Suspension and Termination Proceedings (Subpart G). The question was whether the §2462 statute of limitations for these violations had elapsed based on the date the violation occurred. After close review of §2462, the Subpart G hearing official held in the initial decision dated March 16, 2015 that the statute of limitations barred the Department's fines for the 2006, 2007, and 2008 Clery Act violations, but that the fines for the 2009 violations were not barred. There is however no discussion in the Lincoln University decisions to support the assertion that a fine is uncollectable under §2642 simply because the debt is asserted or continues to exist more than 5 years after the claim first accrued. Indeed, the initial and remand decisions ordering payment of fines in Lincoln University were dated more than 5 years after the violation. To assert otherwise implies that those who are subject to a civil penalty or fine action can evade and self-discharge their payment obligation after 5 years of making no payments. Additionally, 28 U.S.C. §2462 only applies to civil fines, penalties and forfeitures; it does not apply

to repayment liabilities. Funds owed back to the Title IV program are not subject to any statute of limitations.

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 having multiple of these emotional scars can reduce life expectancy by up to 20 years make you two times less likely to graduate high school and make you 10 times more likely to attempt suicide. Prior to COVID–19, we already had an epidemic of gun violence, suicides, and overdoses—all of which exacerbate and stem from the root issue of trauma. But the pandemic has magnified this problem, with a recent CDC study finding a 50 percent increase in suicide attempts by teenage girls. Senator Capito of West Virginia and I teamed up in 2018 to pass legislation to increase funding and coordination across the Departments of Education and HHS to promote this understanding of trauma in more Federal grant programs. Specifically, we authorized 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 Act—would support schools in adopting trauma-informed practices, training more staff, engaging families, and forging partnerships with clinical mental health professionals. I know the Biden Administration is proposing $1 billion to support more counselors in schools—sign me up for that. Would you also support appropriations for this already authorized program to address the breadth of trauma needs in schools—setting up comprehensive plans, trainings, and partnerships, beyond just adding school psychologists or counselors?

Answer. COVID–19 has had a devastating impact on many families, contributing to significant trauma resulting from isolation, economic stress, housing insecurity, and the loss of loved ones, among other traumatic events. Prior to COVID–19, many of these kinds of traumas and others already existed and were only further exacerbated by the pandemic. A significant number of students, predominantly students from low-income backgrounds, rely on their schools for access to mental health services and other services that are intended to meet their physical, social, emotional, and mental health needs. The need for all students, especially those most underserved, to have access to these critical services is why the Department requested $1 billion to double the number of school counselors, nurses, social workers, and school psychologists over the next decade. It is also why we requested $250 million for IDEA, Part D Personnel Preparation to support the pipeline into the profession , including mental health service providers, and their preparation, development, and support. The Department is also requesting $443 million to support Full Service Community Schools—schools which have in place the kinds of comprehensive plans and partnerships you describe to support students and families. We also call for increased investments in the Promise Neighborhoods, School Safety National Activities, and Student Support and Academic Enrichment Grants programs, all in effort to provide a comprehensive set of investments intended to mitigate the impact of traumatic experiences and help our students heal from the trauma, develop, and thrive. We look forward to working with you to make these kinds of critical investments in existing programs and identify additional opportunities for targeted and increased investments.

Question. Multiple Congressionally mandated Department of Education studies of the D.C. Opportunity Scholarship program—the only federally-funded voucher program—have found that the program does not improve the academic achievement of students in the program. In fact, two recent Department of Education studies of the program found that students using vouchers have performed worse academically than their peers not in the voucher program. And, previous studies have indicated that many of the students in the voucher program are less likely to have access to key services such as ESL programs, learning supports, special education supports and services, and counselors than students who are not part of the program. Moreover, a study from the Urban Institute found that receiving a voucher does not increase D.C. students' college enrollment rates. Given these troubling findings, do you support continuing Federal support for the program?

Answer. The Administration seeks to phase out the D.C. Opportunity Scholarship Program while providing scholarships to students currently participating in the program through 12th grade. Accordingly, the Administration has requested level funding for fiscal year 2022 to continue funding scholarships for continuing students in school year 2022–2023.

QUESTIONS SUBMITTED BY SENATOR JACK REED

Question. PSLF and Military Service Members—Earlier this year, the Government Accountability Office (GAO) issued a report finding that 94 percent of the Public Service Loan Forgiveness (PSLF) applicants in military service or Department of Defense (DoD) civilian jobs were denied. Additionally, the GAO recommended that the Department of Education could take additional steps to improve information sharing about PSLF with DoD about military service members and DoD civilian personnel seeking to participate as well with potential beneficiaries. According to the GAO, as of February 17, 2021, 178,215 active-duty service members had direct loans eligible for PSLF, and another 16,195 active-duty service members had Federal loans that could be consolidated into new qualifying direct loans. These statistics offer just a small snapshot of the full scope of eligible military borrowers who should be benefiting from the protections of PSLF since borrowers first became able to secure forgiveness through the program in 2017.

Using the Department of Defense's DMDC website, please provide the total number of active duty service members (and veterans) with Federal student loans who have served since PSLF launched on October 1, 2007 and who continue to be in repayment on Director Loans and/or FFELP loans.

Answer. FSA is working to produce such an analysis, in collaboration with the Department's Office of the General Counsel and the Department of Defense.

Question. Please provide information on the Department's efforts to implement the GAO recommendations. Also please include information about the Department's plans to use any other authority, such as authorities under the HEROES Act of 2003, to ease the process and expand access to PSLF for military service members.

Answer. The Government Accountability Office (GAO) made two recommendations for the Secretary of Education in its recent report, "Public Service Loan Forgiveness: DoD and Its Personnel Could Benefit from Additional Program Information (GAO–21–65)." The other three recommendations in the report were addressed to the Department of Defense (DoD).

First, the GAO recommended that Federal Student Aid (FSA) collaborate with officials in DoD's Office of the Under Secretary of Defense for Personnel and Readiness to share information about the Public Service Loan Forgiveness (PSLF) Program, including current information on program participation and eligibility, as well as program requirements. The Department concurred with the recommendation and has already begun this collaboration with DoD. For example, FSA had already begun discussions with DoD about enhancements to our digital toolsets and is actively working with DoD on providing more and improved information to employees interested in PSLF.

Second, the GAO recommended that FSA update the student loan guide for service members to provide information on applying for PSLF and TEPSLF, as well as the steps borrowers can take to count their annual payment from DoD's student loan repayment program as multiple qualifying payments for the PSLF program. The Department again concurred with the recommendation and intends to update the next version of the student loan guide for service members to reflect the new combined PSLF form, which no longer requires borrowers to separately apply for TEPSLF. In addition, FSA currently makes information available on lump sum payments made by DoD for service members through StudentAid.gov. We agree this information should be included in the next version of the student loan guide for service members. FSA will work with DoD to ensure there are clear instructions for borrowers participating in DoD's student loan repayment program to earn qualifying payments for the PSLF Program.

On October 6, 2021, the Department of Education announced a set of actions that, over the coming months, will restore the promise of PSLF. We will offer a time-limited waiver so that student borrowers can count payments from all Federal loan programs or repayment plans toward forgiveness. This includes loan types and payment plans that were not previously eligible. We will pursue opportunities to automate PSLF eligibility, give borrowers a way to get errors corrected, and make it easier for members of the military to get credit toward forgiveness while they serve. We will pair these changes with an expanded communications campaign to make sure affected borrowers learn about these opportunities and encourage them to apply.

The Department is working hard to eliminate barriers for military service members to receive PSLF. The Department will allow months spent on active duty to count toward PSLF, even if the service member's loans were on a deferment or forbearance rather than in active repayment. This change addresses one major challenge service members face in accessing PSLF. Service members on active duty can qualify for student loan deferments and forbearances that help them through peri-

ods in which service inhibits their ability to make payments. But too often, members of the military find out that those same deferments or forbearances granted while they served our country did not count toward PSLF. This change ensures that members of the military will not need to focus on their student loans while serving our country. Federal Student Aid will develop and implement a process to address periods of student loan deferments and forbearance for active-duty service members and will update affected borrowers to let them know what they need to do to take advantage of this change.

Finally, the Department is working to automatically help service members and other Federal employees access PSLF. Military service members and other Federal employees devote themselves to serving the United States, and we should make it as easy as possible for them to receive PSLF. Next year, the Department will begin automatically giving Federal employees credit for PSLF by matching Department of Education data with information held by other Federal agencies about service members and the Federal workforce. To date, approximately 110,000 Federal employees and 17,000 service members have certified some employment toward PSLF. These matches will help the Department identify others who may also be eligible but cannot benefit automatically, like those with FFEL loans.

Question. Restarting Student Loan Repayment—Payments on Federal student loans have been paused for over a year due to the pandemic, with borrowers currently expected to begin repaying their student loans on October 1 of this year. There are indications that the restart will trigger unprecedented outreach to servicers, with survey data showing that servicers could field inquiries from more than 9 million borrowers. There have been indications that it will take approximately 2–4 months for servicers to rehire, train, and obtain background checks for their workforce.

As the U.S. Department of Education and its student loan servicers prepare for the repayment restart, what are the essential steps that the Department is considering to ensure a seamless return to repayment? What is the timeframe for implementing these steps so that the Office of Federal Student Aid and servicers have sufficient time to implement this plan so that both borrowers and servicers can prepare? What is the Department's monitoring plan for servicers on their implementation of the restart of repayment?

Answer. The Department's goal is to achieve a smooth transition that minimizes borrower harm due to confusion, lack of awareness, and insufficient servicing capacity. To this end, the Department has produced a comprehensive plan that combines elements of borrower outreach, servicer hiring, training and preparation, and vendor and process oversight to ensure borrowers have the resources they need to effectively manage the process of returning to repayment.

From an outreach perspective, in March 2020, FSA launched an ongoing communications and engagement campaign to provide borrowers clear, concise messaging related to available CARES Act benefits and the eventual transition to repayment. Since then, FSA has engaged in continuous communication efforts to encourage student loan borrowers to take actions to put them on the best repayment plan for their economic situation before payments resume. From July 2020 until the end of February 2021, FSA sent over 220 million emails to borrowers, supplemented by multiple paid media campaigns.

FSA has also posted information on StudentAid.gov to assist borrowers in preparing for payments to resume, specifically recommending that borrowers update their contact information with their loan servicer and in their StudentAid.gov profile, use Loan Simulator to find a repayment plan that meets their needs and goals, and consider applying for an income-driven repayment plan. As we approach the end of the forbearance period, outreach to borrowers will increase and include broad campaigns aimed at increasing general awareness of payment resumption and options to address ability to repay, as well as targeted outreach to at-risk borrowers.

To ensure our servicers are prepared for the restart of repayment, FSA engaged in ongoing conversations with loan servicers about their preparations and staffing levels since the CARES Act was passed in March 2020. During the payment pause, FSA has clearly communicated expectations for how loan servicers should engage with borrowers. FSA is continually analyzing historical, current, and projected future loan servicer staffing levels against several customer service metrics to ensure servicers are ready for payments to resume. As we prepare for borrowers to enter repayment, FSA will provide detailed communications "playbooks" for loan servicers to follow. To ensure loan servicers are held accountable for customer service performance during the return to repayment effort, FSA plans to add explicit return-to-repayment performance expectations, called service level agreements (SLAs), to the servicers' existing contracts. Proposed SLAs would focus on call center performance, such as abandon rates and Average Speed to Answer, to ensure borrowers

have prompt, easy access to information. As borrowers exit the payment suspension period, FSA will expand our monitoring to include all aspects of return to repayment. Vendors who fail to adhere to any statutory, regulatory, or contractual standards will be held accountable through appropriate corrective actions, which may include financial penalties.

On Aug. 6, 2021, the Department announced a final extension of the payment pause until Jan. 31, 2022. The Department is already working diligently to ensure a smooth transition back to repayment for all borrowers

The pause on student loan repayment will end on January 31, 2022, and we are planning around that date. The Department's priority is to ensure students and borrowers get the service they deserve. We are committed to ensuring that student loan borrowers are able to transition smoothly into repayment. The Department has established timelines with key deadlines related to returning student loans to repayment. Those plans include substantial communications and outreach to make borrowers aware of the resumption of loan payment obligations. FSA also continues to communicate with servicers about return to repayment as information becomes available. Additionally, the Department plans to collaborate with Federal and state regulators to ensure our oversight of Federal student loan servicers is as effective as possible, and are working to ensure the tools available to the Office of Federal Student Aid are used to the fullest extent possible.

Question. FFEL and Repayment Relief—In April, Senator Murkowski and I sent you a letter asking you to address the over 5 million FFEL and the roughly 1.7 million Perkins loans borrowers who have been left out of the CARES Act relief and the subsequent extensions of the pause on student loan repayment.

What steps is the Department taking to ensure that all Federal student loan borrowers have equal access to any current or proposed new relief and benefits?

Answer. We have taken steps to assist those FFEL borrowers that have defaulted during the national emergency. In March 2021, the Department announced that the payment pause on interest and collections would be extended to all defaulted FFEL loans, protecting more than 800,000 borrowers from debt collection activity such as wage garnishment and seizure of tax refunds. FFEL loans on which borrowers defaulted since March 13, 2020, the start of the national emergency, are being restored to good standing, and the record of default removed from their credit reports. The Department continues to explore additional opportunities to aid all Federal student loan borrowers, whether they hold FFEL, Perkins, or Direct Loans, and to ensure that their payments remain affordable, particularly during a period that has been challenging for so many borrowers.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. I want to once again thank you for working with myself and Senator Murkowski on getting out the first tranche of the American Rescue Plan funding for homeless children and youth in an expedited manner, so we could ensure that homeless children and youth are identified and are able to access summer programming and wrap-around supports they need in light of the COVID–19 Pandemic. In the Department's initial announcement surrounding this funding, you indicated that the second tranche of this funding could be available as soon as June, to help states and school districts prepare for the fall. This is critical as we expect to see even greater numbers of homelessness and higher level of service needs, as communities return to in person learning.

Can you tell me if those plans for the release of the second tranche of homelessness funding are on schedule, and will be out this month?

Answer. The awards for the second tranche of American Rescue Plan funding for homeless students were made on July 27, 2021.

Question. In the final fiscal year 2021 spending package, I was able to secure language urging the Department to ensure that local educational agencies (LEA's) set aside adequate amounts of Title I Part A funds for students experiencing homelessness and use those resources effectively.

Can you tell me what the Department has done to date to implement this request and does this budget proposal do anything to implement that language further?

Answer. In July 2018, the Department sent a letter to State educational agencies (available at: https://oese.ed.gov/files/2020/02/letterforessatitleialeahomelesssetaside-1.pdf) that highlights the requirement that an LEA reserve sufficient funds under Title I, Part A to provide services for students experiencing homelessness. This clarification was included in an update in August 2018 to the non-regulatory guidance for the Education for Homeless Children and Youth (EHCY) program and it is also part of the monitoring protocol for the EHCY program. The Department asks the

States that it is monitoring to provide a list of all Title I, Part A set-asides by LEA. These are compared with the latest available homeless student enrollment counts, which usually lag by 1 year. The SEA is asked to explain if any LEAs had homeless students enrolled but did not set aside a reservation from Title I, Part A to serve them. We also correlate a per-pupil amount to look for statewide patterns of insufficiency. The EHCY State Coordinator Handbook developed by the National Center for Homeless Education (NCHE) has a Summary of EHCY Performance Management Pilot Monitoring, fiscal year 2015–18 that summarizes which States had findings or recommendations in this area (Indicator 3.3). For fiscal year 2022, due to the American Rescue Plan funds for homeless children and youth, the Department will expand its monitoring of States for homeless education programs, including the Title I, Part A LEA set-aside.

In addition, NCHE also provides technical assistance concerning Title I, Part A requirements for serving students experiencing homelessness (see https://nche.ed.gov/legislation/title-1-part-a/).

The key proposal in the fiscal year 2022 request that would support stronger implementation of Title I requirements related to meeting the needs of homeless students is the additional $20 billion for Title I, which would more than double funding for Title I districts and schools, direct more funds to LEAs with the greatest concentrations of poverty, and help close equity gaps for all students, including homeless students.

Question. Student loan disclosure forms are essential in helping students and families understand the costs and terms of their student loans, but as currently written they are filled with unhelpful legal jargon, are complicated. lengthy, and don't show the true cost associated with taking out the loans leading to excess borrowing, further contributing to the nation's student debt crisis.

What is the Department doing to address this issue and simplify student loan disclosure forms? Is there anything in this budget proposal to help with this?

Answer. We are regularly looking at ways to help students, families, and borrowers better understand and support their efforts to meet their student loan obligations. For instance, we continue to promote use of the College Financing Plan, which provides a standardized financial aid offer letter so students can understand and compare their options for paying for college. If there are additional improvements you have in mind, my staff would be grateful to have them for consideration.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

STUDENT LOAN SERVICING

Question. Mr. Secretary, your budget requests $2.1 billion, which is an increase of $200 million from the fiscal year 2021 level, to administer the student aid programs. Yet the budget provides very few details about how those funds would be used on student loan servicing activities aside from mentioning a "long-term servicing solution." Can you provide the Subcommittee additional details on your plans for the long-term servicing solution?

Answer. The Department is currently working on its long-term servicing plans and looks forward to sharing more information in the future.

Question. For the last several years the Labor/HHS bill has included appropriations language requiring the allocation of Federal student loans to servicers based on the quality of their performance to encourage the Department to leverage competition among student loan servicers. The budget request proposes to strike this language because the requirement will be included in FSA's "long-term servicing solution" despite the fact that no information is included in the request on what the long-term solution will look like. How will you continue to hold the Federal student loan servicers to performance-based allocations as required by years of appropriations laws regardless of what a future long-term servicing solution may look like?

Answer. The Department currently allocates loan volume based on servicer performance. We will continue this practice going forward under the two-year extensions of servicer contracts (as outlined in the appropriations language), as well as in the future under the final servicing solution.

Question. The Department has struggled to complete the contracting process to fully implement its Next Generation Financial Services Environment. In light of that prolonged struggle, what are your plans for using the current five Business Process Operations contractors, which were awarded in June 2020, in the servicing of student loans moving forward?

Answer. As you are aware, the Consolidated Appropriations Act, 2021 included several provisions related to the future state of loan servicing, including provisions

directly applicable to the Interim Servicing Solution (ISS) solicitation and Business Process Operations (BPO) contracts. Specifically, the language prohibited the use of ISS as a transitional servicing solution and called for an accelerated BPO implementation that would make it possible for BPO providers to perform the full suite of loan servicing activities upon migrating accounts to the ISS platform. After reviewing the change in the solicitation's requirements as a result of the appropriations provisions, Federal Student Aid (FSA) decided to cancel the ISS solicitation.

FSA is using this opportunity to work with our new leadership in the Biden-Harris Administration to refine our long-term strategy for loan servicing, with the first priority being to ensure student loan borrowers have a stable, reliable, and accountable solution that meets their needs. In developing this long-term solution, FSA will continue to build on the newly modernized systems, tools, and resources for customers. In particular, FSA expects to leverage the new StudentAid.gov, the myStudentAid mobile app, and enhanced systems that allow FSA to improve how we collect and analyze data, offer more self-service options, provide better customer service, and communicate directly with students, parents, and borrowers.

In addition, FSA will continue its work to bring BPO vendors online in preparation for a fall 2021 migration of all non-servicing contact center work. This work includes taking on FSA's legacy contact center functions, including the Federal Student Aid Information Center, Student Loan Support Center, Feedback Center, FSA Ombudsman, borrower defense hotline, and Office of Inspector General fraud referral. The BPO vendors will handle much of FSA's direct communication with customers and partners, including inbound and outbound calls, email, chat, social media inquiries, and physical correspondence. BPO vendors will receive training from FSA to ensure they are providing customers with correct and consistent information and are treating customers and partners equitably.

The five-month transition to fully onboard the BPOs is expected to begin in November 2021 and be finalized by April 2022.

CAREER PATHWAYS

Question. Programs that provide academic and career counseling and exposure to postsecondary opportunities to students, as early as 8th grade and continuing through secondary and postsecondary education, have been shown to significantly increase rates of postsecondary enrollment and completion among rural students. To that end, the fiscal year 2021 Labor/HHS bill included $10 million for the Department of Education to improve rates of postsecondary enrollment and completion among rural students through development of career pathways aligned to high-skill, high-wage, or in-demand industry sectors and occupations in the region. What is the timeline for publishing a Notice Inviting Applications for these funds? What can you tell me about how the Department plans to prioritize and spend this funding this year?

Answer. While the Department is still developing a notice inviting applications (NIA), we plan to make up to 7 awards to institutions of higher education and other public and private non-profit organizations and agencies for 3-year projects that would implement innovative approaches to improve rates of postsecondary enrollment and completion among rural students through development of career pathways aligned to high-skill, high-wage or in-demand industry sectors and occupations in a specific region.

Question. The budget request proposes a new $1 billion program to expand career pathways for middle and high school students, particularly in underserved communities. This Subcommittee will only be considering the discretionary request, but providing students in high school or middle school with access to quality work-based learning opportunities and exposure to their full range of postsecondary college and career opportunities should be happening in every school. How will additional funding for CTE help meet that goal?

Answer. Additional funding under both the Career and Technical Education (CTE) State Grants formula program and CTE National Programs would support opportunities to provide high school or middle school students with access to quality work-based learning opportunities and exposure to postsecondary college and career opportunities, albeit in different in ways. The reauthorization of the Perkins Act in 2018 added provisions and requirements pertaining to work-based learning and including students in middle school in certain CTE activities. However, States and local grantees have been expected to implement these and other new requirements with relatively small increases in funding. After more than a decade of relatively flat funding, the increase in funding for the program since fiscal year 2019 (the implementation date for the reauthorized Perkins program) has been approximately

5.7 percent. Increases for this program would provide additional resources to State and local grantees to implement these provisions.

Increases in funding under CTE National Programs would provide opportunities to quality work-based learning opportunities and exposure to support and evaluate targeted activities to provide high school or middle school students with access to postsecondary college and career opportunities. Under that program the Department could fund focused, high quality proposals for such activities and set priorities for funding, such as funding to high-poverty LEAs and LEAs serving a high percentage of students of color or a high percentage of students from low-income backgrounds.

K–12 COVID–19 FUNDING/SCHOOL REOPENING

Question. Mr. Secretary, you and I both agree it is crucial that we get kids back in the classroom to prevent further learning loss. While I'm encouraged to see that more and more schools are reopening for in-person learning, the latest data from the Department shows that only 51 percent of 4th graders and 41 percent of 8th graders are enrolled in fully in-person learning and these numbers are even worse for low-income and minority students. Given the significant amount of COVID–19 emergency funding that has gone to K–12 schools, I would expect these numbers to be closer to 100 percent. What actions have you taken to help states and school districts use their ESSER funds to reopen schools and get kids back in the classroom? Do you expect that all schools will be fully open for in-person learning this fall?

Answer. We are doing everything possible to support students, families, teachers, staff, school leaders, and communities to in returning to full-time, in-person learning this fall, and the Administration is confident that we, as a nation, will achieve this goal to the greatest extent possible.

Most recently, on August 2, 2021, the Department released the "Return to School Roadmap," an online resource available at https://sites.ed.gov/roadmap/to support students, schools, educators, and communities as they prepare to return to safe, healthy in-person learning this fall and emerge from the pandemic stronger than before.

The Roadmap includes three "Landmark" priorities that schools, districts, and communities are encouraged to focus on to ensure all students are set up for success in the 2021–2022 school year: (1) prioritizing the health and safety of students, staff, and educators, (2) building school communities and supporting students' social, emotional, and mental health, and (3) accelerating academic achievement. The Roadmap also includes planned releases of additional resources for practitioners and parents on each of these priorities and will highlight schools and districts that are using innovative practices to address these priorities. These resources also will explain how American Rescue Plan funds, including ESSER funds, can be used to address these priorities in schools and communities across the country.

The Roadmap is part of the Department's broader efforts to support schools and districts in the safe and sustained return to in-person learning since the beginning of the Biden Administration. In addition to releasing the Roadmap, the Department has issued three volumes of the COVID–19 Handbook to support K–12 schools and institutions of higher education in their reopening efforts, prioritized the vaccination of educators, school staff and child care workers, published a Safer Schools and Best Practices Clearinghouse, which includes over 200 examples of schools and communities safely returning to in-person learning, held a National Safe School Reopening Summit, provided $122 billion in support through the American Rescue Plan Elementary and Secondary School Emergency Relief Fund for K–12 schools, provided over $3 billion in IDEA funds within the American Rescue Plan to support children and families with disabilities impacted by the pandemic, awarded $800 million within the American Rescue Plan to support students experiencing homelessness who have been disproportionately impacted by the pandemic, released a report on the disparate impacts of COVID–19 on underserved students, and launched an Equity Summit Series focused on addressing school and district inequities that were made worse by the pandemic.

STUDENT LOAN PAUSE

Question. Mr. Secretary, I am concerned that the Administration has not outlined a plan to transition borrowers back into repayment when the student loan pause ends this fall. Now that the pandemic is winding down, it is time for this pause to end. Furthermore, the extension of the pause beyond what was originally authorized in the CARES Act cost taxpayers an additional $36 billion. I understand that some borrowers may still be struggling, but they have access to income-driven repayment

plans where they can pay as little as $0 per month. Will you commit to end the pause as scheduled at the end of this fiscal year?

Answer. On Aug. 6, 2021, the Department announced a final extension of the payment pause until Jan. 31, 2022. We believe this additional time and definitive end date will allow borrowers to plan for the resumption of payments and reduce the risk of delinquency and defaults after restart. The Department is already working diligently to ensure a smooth transition back to repayment for all borrowers

Question. Federal student loan borrowers have gone over a year without making a payment on their loans. It is absolutely imperative that the Department begins communicating with borrowers early and often to ensure that all borrowers understand their responsibilities and their repayment options when their loans come due on October 1, 2021.

What are your plans to help ensure that borrowers are prepared to begin repaying their loans when the pause ends?

Answer. In March 2020, FSA launched an ongoing communications and engagement campaign to provide borrowers clear, concise messaging related to available CARES Act benefits and the eventual transition to repayment. Since then, FSA has engaged in continuous communication efforts to encourage student loan borrowers to take actions to put them on the best repayment plan for their economic situation before payments resume. From July 2020 until the end of February 2021, FSA sent over 220 million emails to borrowers, supplemented by multiple paid media campaigns.

FSA has also posted information on StudentAid.gov to assist borrowers in preparing for payments to resume, specifically recommending that borrowers update their contact information with their loan servicer and in their StudentAid.gov profile, use Loan Simulator to find a repayment plan that meets their needs and goals, and consider applying for an income-driven repayment plan. As we approach the end of the forbearance period, outreach to borrowers will increase and include broad campaigns aimed at increasing general awareness of payment resumption and options to address ability to repay, as well as targeted outreach to at-risk borrowers.

Question. How will the Department engage the Federal student loan servicers and provide the necessary instructions so that the return to repayment process goes smoothly?

Answer. FSA has engaged in ongoing conversations with loan servicers about their preparations and staffing levels since the CARES Act was passed in March 2020. During the payment pause, FSA has clearly communicated expectations for how loan servicers should engage with borrowers. FSA is continually analyzing historical, current, and projected future loan servicer staffing levels against several customer service metrics to ensure servicers are ready for payments to resume. As we prepare for borrowers to enter repayment, FSA will provide detailed communications "playbooks" for loan servicers to follow.

To ensure loan servicers are held accountable for customer service performance during the return to repayment effort, FSA plans to add explicit return-to-repayment performance expectations, called service level agreements (SLAs), to the servicers' existing contracts. Proposed SLAs would focus on call center performance, such as abandon rates and Average Speed to Answer, to ensure borrowers have prompt, easy access to information. As borrowers exit the payment suspension period, FSA will expand our monitoring to include all aspects of return to repayment. Vendors who fail to adhere to any statutory, regulatory, or contractual standards will be held accountable through appropriate corrective actions, which may include financial penalties.

Question. Both the CARES Act and the December COVID–19 supplemental, as well as the American Rescue Plan, provided a total of $161 million to FSA to prevent, prepare for, and respond to the COVID–19 pandemic. How much of this funding has been used and what has it been used for?

Answer. As of July 30, 2021, approximately $25 million has been committed and obligated for the following activities: system changes due to COVID–19; targeted communication campaigns to notify borrowers of administrative forbearance; increased server capacity and support for telework; and personnel and compensation for approximately 38 on-board staff at FSA to support CARES Act related activities.

Question. Does the Department intend to use the remaining funds to improve communications and outreach with borrowers about the upcoming end of the repayment pause?

Answer. Yes, the remaining funds will be used to improve communications and outreach to borrowers, as well as any additional actions needed to support borrowers regarding the end of the payment pause.

CHARTER SCHOOLS

Question. During the last school year, several states saw significant enrollment shifts into charter schools. For example, charter schools in California saw an increase of around 2.5 percent while districts saw a decrease of 3 percent, Colorado saw a 4 percent increase while districts saw the same decline. New York City charter schools had an influx of 10,000 students—a 7 percent increase. And yet the President's budget does not request new funding for the Charter Schools program. Given the demand we are seeing at the state level, why isn't the administration requesting more funds for the Charter School Program?

Answer. The Administration's fiscal year 2022 request would provide over $210 million for new awards under the various grant components of the Charter Schools Program. We believe these resources will be sufficient to meet demand for funding.

Question. The budget proposes prohibiting Charter School Program funds from being provided to schools that are substantially operated or managed through a contract with a for-profit entity. However, most public schools are utilizing the services of for-profit entities in some way, including for spending their COVID–19 relief funds.

What does "substantially operated or managed" mean? Does it include contracting for services such as payroll and benefits, staffing, curriculum, professional development, or individual student services?

Answer. We recognize that public schools, including charter schools, may contract with for-profit vendors for specific services that do not constitute management or control of operations and do not intend to prevent schools engaged in such procurements from accessing funds under the CSP or other programs.

Question. Why are you proposing this restriction only for charter schools? Are you considering this requirement for other programs?

Answer. The Administration believes that Charter Schools Program (CSP) funds should not support charter schools that are operated or managed by for-profit entities, and we urge Congress to adopt language that would prohibit CSP funds from supporting schools that are operated or managed by such entities through contractual relationships. We believe this is consistent with intent of the program statute, under which charter school developers or management organizations seeking CSP funds must be nonprofit.

TITLE I EQUITY GRANTS

Question. The budget request includes $20 billion for a new Title I Equity grant that proposes to create a new formula not authorized in statute to force State and local behavior changes related to school funding systems, teacher compensation, access to advanced curricula, and access to preschool. There have been a lot of questions and concerns about this proposal, specifically how funding would be allocated. Do you have any further details on the impact of this formula and where the money would be allocated?

Answer. The Administration remains committed to addressing longstanding concerns around equity in education funding at the Federal, State, and local levels. However, we also recognize that further consultation with a wide range of stakeholders, including Congress, will be necessary to develop a comprehensive set of proposals aimed at improving education funding equity that can generate broad support. Consequently, the Administration supports allocating the proposed $20 billion increase for Title I through the authorized funding formulas.

Question. Why is the Department proposing to create a new grant program that interferes with decisionmaking that is best left to State and local school districts rather than putting additional funding into programs we know work to increase student achievement, such as the Charter Schools Program, or further increasing this existing Title I programs or IDEA, which has long been underfunded?

Answer. The nearly $30 billion, or 41 percent, increase for the Department of Education proposed by President Biden for fiscal year 2022 provides strong support for Federal education programs across the board, including a $3 billion or 21 percent increase for IDEA State formula grant programs. However, because nearly all Federal education programs provide supplemental funding, the impact and effectiveness of that funding depends in large part on a level playing field in terms of the overall education resources made available at the State and local levels. For this reason, the Administration strongly believes that a key goal of any major new Federal investment in education should be to leverage significant improvement in equity for all students, but especially for students from low-income families and students of color. In this context, the Administration is working closely with Congress and stakeholders to leverage additional investments in Title I to improve education funding equity, support high-quality preschool, address teacher compensation, and

enhance rigorous coursework in Title I schools. In that context, the Department believes the proposed $20 billion increase for Title I would provide a meaningful incentive for systemic changes in the equity of our decentralized education system.

NAEP FUNDING

Question. NAEP provides crucial information about what our nation's students know and can do in various subject areas. Ensuring we continue to have this information is more important than ever given the widespread learning loss that is expected as a result of the pandemic. Your budget requests an additional $15 million for NAEP in fiscal year 2022. Will this increase ensure that the planned assessment schedule can remain on track?

Answer. The $15 million proposed for fiscal year 2022, if sustained in future years, would support operational funding needs, including planned assessments, through 2024.

MENTAL HEALTH

Question. Mr. Secretary, one of my priorities in the Senate has been mental health—and ensuring that a person's mental health is treated the same as their physical health. The Department's budget requests $1 billion for a new program to increase the number of health professionals in our public schools, including school counselors, nurses, school psychologists, and social workers. I share your concern about the well-being and mental health of our nation's students, particularly given the widespread disruption to school that students have experienced over the past year due to the COVID–19 pandemic. However, states and school districts have yet to spend the vast majority of COVID–19 funding provided to them, and one of the ways they can spend this money is to provide mental health services to students. What has the Department done to help states and school districts use their COVID–19 funding to support the mental health of their students?

Answer. The Administration has recognized from the beginning of its response to the pandemic that students need a strong social and emotional foundation to excel academically. It is clear that many students, and especially students from low-income backgrounds and students of color, have suffered much over the past 18 months and require additional support to help them heal and recover from all the trauma and hardship the pandemic has brought. And we know for many students, schools are the only place where they can access mental health professionals, school counselors, nurses, and support structures they need—including their friends—to help them through the adversity of the last year. This is why we have emphasized meeting students' mental health needs as part of our overall effort to reopen schools for fully in-person learning, including through the hiring of school-based health professionals as well as other efforts to address social and emotional development needs.

For example, the Department published Volume 2 of the ED COVID–19 Handbook: Roadmap to Reopening Safely and Meeting All Students' Needs (see https://www2.ed.gov/documents/coronavirus/reopening-2.pdf), in April, 2021, which includes a section on Supporting Student Mental Health Needs that highlights examples and best practices that States and school districts can implement using funds provided by the American Rescue Plan. Additional guidance is provided in our ESSER Fund Frequently Asked Questions document (see Question C–14 at https://oese.ed.gov/files/2021/05/ESSER.GEER—.FAQs__5.26.21__745AM__FINALb0cd6833f6f46e03ba2d97d30aff953260028045f9ef3b18ea602db4b32b1d99.pdf).

We have seen the results of these efforts in the plans that States have developed for using ARP ESSER funds. For example, Nevada is reserving ARP funds to hire 100 school-based mental health professionals and Alaska is using ARP funds to help social workers provide virtual lessons in self?care and methods to reduce student stress, depression, and anxiety. The New York City Department of Education is using ARP funding to hire over 600 mental health professionals to provide care as students returned back this fall. This means that every school will have at least one full-time social worker or school-based mental health clinic.

In addition, we plan to issue guidance on using ARP funs to address student mental health needs in fall 2021.

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. The Institute of Education Sciences (IES) funds education research, data collection and analysis, and a national assessment of student progress. The fiscal year 2016 Omnibus included a $44 million (8 percent) increase for IES. The

budget request includes a further $76 million (12 percent) increase. The Investing in Innovation (i3) grant program required that at least 20 percent of recipients be located in rural areas. The i3 competition has been replaced with a new grant program, the Education Innovation and Research program, in fiscal year 2017. Geographic diversity in all research grant programs is important. From 2013 to 2015 the Department made almost 1,900 grants to institutions of higher education and other research organizations. However, those grants went to colleges, universities, and research organizations in only 35 states. Not one went to a school or organization in Mississippi and generally the same schools and organizations tend to get the bulk of research grants year after year.

In my state, 92 percent of school districts and more 50 percent of students are rural, yet most research is conducted in urban and suburban communities. The Every Student Succeeds Act requires that schools implement evidence-based strategies to improve student outcomes yet most education research is conducted in urban and suburban settings.

How will you ensure that education research addresses the unique needs of rural districts?

Answer. Supporting education research to help understand and address the unique needs of rural districts is a priority for IES. We support education research, including on rural education, primarily through two funding mechanisms: (1) field-initiated research grants, and (2) research conducted by the Regional Educational Laboratories. We discuss the role of each below.

Research Grants. As a scientific agency, funding decisions are based on peer reviewer's independent assessments of the scientific merit of applications, including the significance of the proposed research project, the scientific quality of the research plan, the skills of the personnel, and the resources available to support the proposed project. We hold competitions on various topics to ensure that the education research that we fund meets the needs of the diverse populations and geographic settings of our nation.

For example, in 2021, IES launched a new research competition inviting State agencies to apply for funds to expand use of their State Longitudinal Data Systems (SLDS) for generating evidence in support of education policy decisions. Using SLDS as a data source ensures that all districts within a State can be included in their research activities. Of the 7 awards made, 5 are made to States with substantial rural populations, including Tennessee, Montana, Virginia, Pennsylvania, and Oregon. Mississippi received $6.6 million in 2016 for an NCES SLDS grant that ended 9/30/20 to enhance its SLDS system, so we encourage the State education agency to apply for funding under this program for projects using data from its SLDS for research on rural populations, and to reach out to IES program officers for input as they prepare their application.

In addition, IES invested $20 million in two five-year research and development centers focused on the needs of rural education in 2019: The National Center for Rural Education Research Networks (NCRERN) and The National Center for Rural School Mental Health (NCRSMH): Enhancing the Capacity of Rural Schools to Identify, Prevent, and Intervene in Youth Mental Health Concerns. Rural districts participating in the work of these two centers are located in: New York, Ohio, Iowa, New Mexico, Wyoming, Missouri, Virginia, and Montana. Both rural centers are actively engaged with communities in these States and beyond and are developing and sharing resources for the rural education community. For example, NCRSMH has developed an Early Identification System (EIS) Intervention Hub (https://www.ruralsmh.com/intervention-hub/) designed to connect rural educators to resources focused on preventing and remediating student mental health challenges.

In addition, 27 of our new fiscal year 2021 research awards and 16 of our fiscal year 2020 research awards are being carried out in rural settings. These studies are addressing teacher retention in rural schools, fostering positive family-school involvement for students from economically disadvantaged households in rural communities, interventions to help special educators with behavior management, and web-based professional development to help teachers improve students, reading comprehension in rural districts.

The Regional Educational Laboratories (RELs). For more than 50 years, the REL program has worked in partnership with State, district, and college and university leaders to develop and use research that improves academic outcomes for students and their communities. REL Southeast serves has successfully completed a number of projects focused on the needs of rural communities in Mississippi, including:

—The Improving Schools in Mississippi Research Alliance, a professional learning community that supports research and practice on rural school improvement. Partners include district leadership from the Vicksburg/Warren Public Schools, Durant Public Schools, Yazoo City Public Schools, Holmes County Public

Schools, and Humphreys County Public Schools, as well as Alcorn State University and Mississippi Valley State University.

—The Southeast School Readiness Research Alliance, which seeks to build the capacity of preschool teachers and administrators across Mississippi and the other five States in the Southeast region to use evidence-based emergent literacy instruction to support three-to five-year old children's language and literacy learning and to help policymakers understand the factors that influence access to high-quality childcare and preschool programs.

—Examining School-level Reading and Math Proficiency Trends and Changes in Achievement Gaps for Grades 3–8 in Florida, Mississippi, and North Carolina, which detailed student achievement trajectories for Mississippi students overall and within student group, supporting stakeholders decisionmaking about how to prioritize school improvement efforts.

—Educator Outcomes Associated with Implementation of Mississippi's K–3 Early Literacy Professional Development Initiative, which examined changes in teacher knowledge of early literacy skills and ratings of quality of early literacy skills instruction, student engagement during early literacy skills instruction, and teaching competencies.

—Beating the Odds in Mississippi: Identifying Schools Exceeding Achievement Expectations, which identified K–12 schools that were performing better than would have been predicted and was used to inform decisionmaking on statewide school improvement efforts.

—Math Course Sequences in Grades 6–11 and Math Achievement in Mississippi, which examined the relationship between students' course-taking patterns in middle- and high-school and their subsequent performance on college admission tests, supporting local and State college readiness efforts.

Question. In awarding research grants, how will you ensure that the Department considers the geographic distribution of research projects and geographic disparities in education research funding? How will you ensure funding is going to colleges, universities, and research institutions in under-researched and underserved areas?

Answer. IES is required by law, under the Education Sciences Reform Act, to base our funding decisions on the independently assessed scientific merit of applications. In all of our grant competitions, we explicitly seek to broaden participation in our research studies and to expand the populations and geographic settings within which our studies are taking place. We are currently supporting a research project at the University of Southern Mississippi (grant award R305A200185) and two projects that are collaborations between Arizona State University and Mississippi State University (grant awards R305A180261 and R305A180144). IES also periodically holds competitions with a specific focus on addressing the unique needs of rural America, such as the two R&D Centers on rural education awarded in 2019. It is important to stress that these are competitive grant programs which are funded based on the scientific merit of the applications submitted. We do not include the State or geographic region in which the applicant institution is located in the selection criteria for our education or special education research grant programs.

We also actively seek to broaden participation in our applicant pool through our research training programs. For example, our Pathways to the Education Science Research Training program was established to develop a pipeline of talented education researchers who bring fresh ideas, approaches, and perspectives to addressing the issues and challenges faced by the nation's diverse students and schools. These grants are awarded to minority-serving institutions (MSIs) and their partners. In the initial two rounds of competitions, IES made awards to 7 institutions and their partners. IES is currently accepting applications for a new program: Early Career Mentoring Program for Faculty at Minority Serving Institutions that seeks to prepare faculty at MSIs to conduct high-quality education research that advances knowledge within the field of education sciences and addresses issues important to education policymakers and practitioners.

Question. President Biden's campaign included a Plan for Rural America. That plan opened with the statement "Rural America is home to roughly 20 percent of Americans, but we are all connected to rural communities in many ways. Rural Americans fuel us and feed us. Rural lands provide us with places to spend time outdoors with friends and family and relax." This statement suggests an attitude that rural people and places exist to provide for and serve more populated urban and suburban areas. The current version of the plan, available here https://joebiden.com/rural-plan/contains some of the same language but has been revised. It will be important that the administration move beyond metro-centric policy making to ensure rural schools are treated equitably.

How will you ensure that policies and practices in the Department recognize and value the strengths and unique contexts of rural schools and communities?

Answer. The Department is committed to educational opportunity and academic achievement for all students throughout the nation, including those in rural areas. Our Rural Education Achievement Program, for example, recognizes the need of many rural school districts for additional funding, as well as flexibility around the use of Federal education funds, to address their unique circumstances. Similarly, many of our discretionary (competitive) grant programs include rural set-asides to ensure that rural applicants receive an equitable share of grant funds, and we also use grant priorities for rural and new applicants that help level the playing field and ensure that rural applicants can compete successfully for Federal funds.

Question. In 2018, the Department released the Section 5005 Report on Rural Education in response to a provision in the Every Student Succeeds Act that called on the Department to critically examine its policies and procedures in related to rural education. The 2018 report touted some things the Department is doing to ensure the needs of rural schools and students are met, and also listed steps the Department intended to implement to address the needs of rural schools. To date, not all of those seven steps have been accomplished, most notably, NCES has not updated its 2007 report on the status of rural education. In 2019 this analysis by Devon Brenner (of MSU) of the Section 5005 report summarized the reports findings and plans or implementation and critiqued the report, saying "it falls short of the 5005 mandate to self-assess and determine actions to be taken. The Department engaged in listening sessions and sought feedback from rural stakeholders, but does not seem to have incorporated feedback from key stakeholder organizations (e.g., AASA and Rural School and Community Trust, The University Council for Educational Administration (UCEA), the National Indian Education Association (NIEA), and the National Association of federally Impacted Schools). The Department commits to increasing listening sessions and improving communication but is not clear that rural input is or will be "baked into" the system to ensure that rural communities are considered in every facet of the Department's work, particularly rulemaking." See https://journals.library.msstate.edu/index.php/ruraled/article/view/535/501.

How will you ensure that the Department completes these commitments to improve policies and procedures for rural schools and considers the needs of rural schools in the development of regulations and the implementation of programs?

Answer. The Department is committed to ensuring educational opportunity for all students, including those in rural areas, and recognizes the need to account for all education settings when developing policies and procedures.

To that end, in recent years, the Department's Rural Interagency Working Group has helped offices responsible for our programs, including the Rural Education Achievement Program (REAP), collaborate on issues such as access to broadband services which disproportionately impacts rural schools and communities. Department staff are examining how we can build upon these internal collaborations. Drawing on the experience of other Federal agencies, the Department also plans to collaborate more closely with the Departments of Agriculture, Interior, and Health and Human Services to better support and serve students in rural communities.

The Department interacts regularly with REAP grantees and organizations advancing the interests of rural schools. The Department appreciates input from rural stakeholders and is working toward being responsive to that feedback. For example, in order to reduce burden on rural local educational agencies (LEAs), the Department has simplified the application process for the Small, Rural School Achievement (SRSA) grant, under which OESE awards over 4,000 LEA grants annually. OESE plans to increase its outreach to REAP grantees and its participation in events organized by rural advocacy organizations such as the National Rural Education Association (NREA). Additionally, the Department has recently been in contact with the Organizations Concerned about Rural Education (OCRE) regarding issues affecting rural schools and communities and emphasizing collaborative efforts to support rural schools.

The Department will continue to rely on local leaders and rural stakeholders for their expertise and knowledge of rural schools, with those conversations informing plans to support student achievement in all settings.

Question. Across the nation, equitable access to effective teachers remains an issue. Rural schools, especially, often struggle to recruit and retain talented teachers and school leaders. Previous programs such as the Transition-to-Teaching grant program provided for scholarships for teacher preparation programs to meet the needs of schools with demonstrated teacher shortages. In Mississippi, Transition-to-Teaching grants awarded in the last decade led to the successful licensure of hundreds of new teachers in the past 5 years, addressing the needs of rural schools.

Please discuss how you envision the that the Department can explicitly addresses inequitable distribution of effective teachers, particularly in rural areas.

Answer. The Administration's fiscal year 2022 request provides both flexible ESEA formula grant funding and competitive opportunities that can help States and school districts carry out strategies aimed at putting effective teachers in front of every classroom:

—The $20 billion increase proposed for the Title I program would more than double the formula grant funding available to help address under-resourced school districts while helping to ensure that teachers in Title I schools, including thousands of rural Title I schools, are paid competitively.

—The $2.1 billion requested for Title II will support ongoing State and local efforts to improve teacher and principal effectiveness and help ensure that all students have equitable access to well-prepared, qualified, and effective teachers and principals. In particular, States may use Title II–A funds for programs that provide alternative routes for State certification of teachers in areas where the State experiences a shortage of educators, similar to the previously authorized Transition to Teaching program.

—The $250 million request for IDEA Personnel Preparation, an increase of nearly $160 million, would help ensure that there are adequate numbers of personnel in underserved rural schools with the skills and knowledge necessary to help children with disabilities succeed educationally, including enhanced support for beginning special educators.

—The $80 million requested for Supporting Effective Educator Development (SEED) would support evidence-based educator preparation and development efforts that can serve as models for similar efforts across the country; new projects could have a stronger focus on building and enhancing the instructional skills of a more diverse educator workforce.

—The $200 million requested for Teacher and School Leader (TSL) Incentive grants would support reforms to human capital management systems and performance-based compensation systems; the statue requires that priority be given to applicants that support teacher and leaders in high-need schools; in addition, consideration is given to ensuring an equitable geographic distribution of grants, including equitable distribution between urban and rural areas.

—The $30 million requested for first-time funding (since reauthorization) of the School Leader Recruitment and Support program would support grants for high-quality professional development for principals, other school leaders, and aspiring principals and school leaders. Under the first competition for the program since the reauthorization of the ESEA, projects would focus on ensuring that the nation's most underserved schools have resources to improve school leadership.

—The $132.1 million request for the Teacher Quality Partnership program, an increase of $80 million, supports projects that improve the preparation of teachers, including through teacher residencies and "grow your own" programs that can be especially valuable in rural communities.

—The $20 million request for first-time funding of the Hawkins Centers of Excellence program would support diversifying the educator workforce, including in rural areas, by increasing the number of high-quality teacher preparation programs at Minority Serving Institutions.

Question. Rurally located and rural serving public colleges and universities have an important role to play in the economic and social recovery from the COVID–19 pandemic. Public institutions of higher learning are important economic anchors in their communities and provide important access to educational opportunities that drives rural economies. However, rural colleges and universities are often underfunded compared to more urban and suburban institutions of higher learning, and students face particular challenges including geographic access and access to broadband Internet and technology. This report on the role that rural serving institutions play and Federal policy solutions to strengthen rural anchor institutions https://www.regionalcolleges.org/project/ruralanchor.

How will you work to enact policies and practices that strengthen rural serving and rurally located public colleges and universities, including HBCUs and other minority serving institutions, and the communities they serve?

Answer. The Department, in general, provides funding to institutions of higher education (IHEs) through two primary vehicles: (1) formula-based institutional capacity-building grants, and (2) discretionary competitive grants. For the Department's formula-based institutional capacity-building grants, such as HBCUs, HBGI, PBIs, and HBCU Masters, the Department has little flexibility given statutory requirements to provide additional funding to rural IHEs. For discretionary competitive grants, unless specifically prohibited by statute, the Department generally can give priority to particular types of institutions.

More broadly, rural-serving postsecondary institutions, include HBCUs, would benefit significantly from key mandatory programs proposed as part of the American Families Plan and now included in the Building Back Better Act. These include Free Community College, which would provide $108.5 billion over 10 years to create a new partnership with States, territories, and Tribes to make 2 years of community college free for first-time students and workers wanting to reskill, potentially allowing up to 5.5 million students to pay zero in tuition and fees for 2 years of community college; the Advancing Affordability for Students program, which would award $39 billion over 10 years for eligible 4-year HBCUs, TCUs, or MSIs to provide 2 years of subsidized tuition for students from families earning less than $125,000; and Completion Grants, which would provide $62 billion over 10 years for grants to States and Tribes to support completion and retention activities designed to ensure postsecondary success for low-income and underserved students in high-need institutions.

QUESTIONS SUBMITTED BY SENATOR PATRICK J. LEAHY

Question. Even before the COVID–19 pandemic, Vermont was facing a mental health crisis in its schools. Many students have been irrevocably impacted by the opioid epidemic, losing parents and caregivers. This trauma has had a negative impact on their mental and behavioral health, leaving many teachers and school staff struggling to deal with the consequences. This is why I am so pleased to see the new $1 billion fund proposed by the administration to help schools hire more counselors, nurses, and mental health professionals. Unfortunately, Vermont is plagued with a severe shortage not only of teachers but of mental health professionals. As of May 2021, there were 780 staffing vacancies among our mental health agencies in the state. The number of kids seeking inpatient mental healthcare in Vermont tripled between 2010 and 2019, as a dearth of community-based resources has led many families no choice but to turn to the Emergency Room as a last resort.

How does the administration propose to help schools, particularly schools in rural areas, utilize this fund to hire school based health staff in areas where there are community, or even statewide, shortages of mental health professionals?

Answer. The School-Based Health Professionals proposal recognizes the challenges to hiring such professionals in areas facing shortages, and would allow State educational agencies to reserve up to 15 percent of their allocations to address shortages of health professionals by establishing partnerships with institutions of higher education to recruit, prepare, and place graduate students in school-based health fields in high-need LEAs and to complete required field work, credit hours, internships, or related training as applicable for the degree, license, or credential program of each health-based candidate. SEAs also may use a portion of these funds for review and revision of State licensure standards to promote mobility of health professionals into school settings.We look forward to working with both chambers to ensure this proposal provides adequate support for both hiring these key-staff and developing the pipeline.

Question. I strongly support the administration's goal to increase equity in public education funding. The COVID–19 pandemic has particularly laid bare the systemic inequalities that exist in our nation's schools. Vermont has many small and rural schools that have historically struggled to close both the equity gap and the digital divide due to a lack of resources. The proposed $20 billion for a new Title I equity grant program would represent the most significant Federal investment the program has ever seen. It is vital that this grant program is an option for all schools that need it around the country.

How will you ensure that these equity grants are distributed among geographically diverse areas, particularly rural areas?

Answer. State educational agencies would allocate funds to school districts based on existing Title I formulas, ensuring that virtually all school districts—urban, suburban, and rural—receive significantly more Title I funding to help close equity gaps in teacher compensation, access to rigorous coursework, and access to preschool.

Question. TRIO and GEAR UP are vital student assistance programs that helps first generation, disabled and low income college students in Vermont succeed in all aspects of college life. These programs have proven effective in increasing postsecondary enrollment and graduation rates, as well as helping to address workforce shortages in the state. Unfortunately, both the COVID–19 pandemic and a historical lack of Federal funding for the programs has meant that many of the grant application cycles have become highly competitive. For example, the fiscal year 2020 TRIO Student Support Services (SSS) competition faced a significant increase in appli-

cants. Separated by mere percentage points, 80 longstanding SSS programs were defunded, among more than 600 un-funded applicants. This left nearly 15,000 high-need students without access to services provided by the program.

How does the administration propose to allocate the increase in fiscal year 2022 funding for TRIO and GEAR UP? Will any of the funding become eligible to programs that were defunded in the fiscal year 2020 SSS cycle?

Answer. The Administration recognizes that limited resources under the TRIO and GEAR UP programs have historically resulted in an inability to fund all high-scoring applicants. This is why the increased funding proposed for TRIO in fiscal year 2022 would be allocated, in part, based on historical trends in the programs scheduled for competition in fiscal year 2022. Specifically, the Administration reviewed peer review scores on all applications submitted for fiscal year 2017 competitions under Upward Bound, Upward Bound Math and Science, Veterans Upward Bound, and McNair Postbaccalaureate programs (the last year in which competitions were held under these programs also scheduled for competition in fiscal year 2022), and proposed to allocate additional funds to each program based on the number of high-scoring unfunded applicants from that year to ensure that funding more appropriately met demand. In addition, the Administration has proposed to provide all grantees under the Student Support Services program a 10 percent supplemental award to support the critical services they provide our students. However, at this time there are no plans to make additional Student Support Services awards to applicants that were unsuccessful in the fiscal year 2020 competition.

Question. The Public Service Loan Forgiveness (PSLF) Program forgives Federal student loan debt of borrowers who work for at least 10 years in qualifying public service employment. The program has been plagued by complicated eligibility criteria and ongoing administrative problems that have resulted in a dismal approval rate. I was pleased to see the administration recently announce a regulatory review of PSLF and other Federal student loan relief programs to understand how they can better serve the needs of our nation's borrowers. However, the President's Budget proposes a decrease in funding for PSLF.

Could you explain the justification for a 50 percent budget decrease for PSLF? What progress has the agency made in addressing the issues that have resulted in such a low approval rate for loan forgiveness?

Answer. The Department recognizes that there are PSLF areas for improvement and we are committed to addressing them as quickly as possible so that our public servants receive the benefits they have worked hard to earn. We have already made some improvements to make it easier for eligible borrowers to access relief through administrative actions and others are in store. For instance, the Department has launched and updated the PSLF Help Tool, is now allowing lump sum and prepayments to count as qualifying payments, and created a single application for PSLF, Temporary Expanded PSLF (TEPSLF), and Employment Certification Forms (ECFs). However, we recognize more needs to be done. To that end, we recently announced that PSLF is among the topics we intend to revisit through an upcoming rulemaking process. We also recently issued a Request for Information, inviting feedback on borrower experiences and possibly policy solutions with the PSLF program, to identify broader areas for improvement.

At the same time, Congress has provided funds annually toward TEPSLF so borrowers who may have made payments in a repayment plan not previously eligible for PSLF could still qualify for relief. Though these funds have remained largely unspent to-date, the Department still requested additional funds for fiscal year 2022 in recognition of the importance of this program to public servants. The additional $25 million the Administration requested will ensure even more borrowers can access the program and receive relief under the TEPSLF program. In addition to those funds, we are also working to improve administration of the TEPSLF program and streamline access to its benefits; we believe those improvements will lead to these funds being more easily awarded to borrowers in the future.

SUBCOMMITTEE RECESS

Senator MURRAY. With that, this hearing is adjourned.

[Whereupon, at 11:31 a.m., Wednesday, June 16, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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

WEDNESDAY, JULY 14, 2021

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

The subcommittee met at 10 a.m. in room SD–138, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.

Present: Senators Murray, Reed, Shaheen, Merkley, Baldwin, Blunt, Kennedy, and Braun.

DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

STATEMENT OF HON. MARTIN J. WALSH, SECRETARY OF LABOR

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 Labor. Senator Blunt and I will each have an opening statement. Then I will introduce our witness, Secretary Walsh.

After his testimony, Senators will each have 5 minutes for a round of questions. While we are unable to have this hearing fully open to the public, or media for in-person attendance, live video is available on our committee website. And if you need accommodations, including closed captioning, you can reach out to the Committee of the Office of Congressional Accessibility Services.

VISION OF THE FISCAL YEAR 2022 PRESIDENT'S BUDGET

You know, a budget is a reflection of values and through our hearings on President Biden's budget for the Department of Health and Human Services, and the Department of Education, we have seen a welcome change in values from the previous administration, and the budget proposal for the Department of Labor is no exception.

This budget is a message to workers across the country; President Biden is fighting for you. Workers are the backbone of our

economy. When we invest in workers, in keeping them safe, strengthening their rights, providing pathways for their development, ensuring their financial security, and more, we are investing in a stronger economy and a country for everyone.

And that is exactly what this budget, which proposes increasing funding for the Department of Labor by 14 percent, does. When it comes to workers' safety, this past year has been a painful lesson on how important it is for every person to have a safe workplace. But even before the pandemic, our Nation saw 5,000 workplace deaths a year, one every 99 minutes. And on-the-job deaths have disproportionately spiked for Black and Latino workers since 2016, increasing 8 percent and 25 percent respectively, compared to just 3 percent overall. And while we know the economic cost of these deaths, a substantial $250 billion a year, the loss to families is immeasurable.

PROTECTING WORKERS AND THEIR WAGES

That is why the Occupational Safety and Health Administration was founded 50 years ago, with the mission to protect worker health and safety. President Biden's budget would help us recommit to that mission by increasing OSHA's (Occupational Safety and Health Administration) funding level by 73 million from last year, and that will help the agency hire more staff, provide more assistance to workers and businesses, hold employers accountable to providing safe, healthy workplaces, and ultimately save lives.

In addition to protecting workers' lives, this budget also includes funding to protect their wages. It would provide $276.5 million to the Wage and Hour Division, an increase of $30 million. This agency investigates employer wage theft and illegal compensation practices used to cheat people out of their hard-earned wages, something which most commonly happens to women, workers of color, and foreign-born workers. The Wage and Hour Division recovers, on average, $1,120 per affected employee. And they do it with a staff of barely 1,300 people covering 148 million workers at over 10 million workplaces.

The funding in this budget would help them expand their capacity, and put even more money back in the pockets of even more workers who have been cheated by their employer. And President Biden's budget not only invests in accountability for employers in our country, but also in accountability for our trading partners. So workers in Washington State, or Missouri, or across the country, don't pay the price for unfair labor practices across the world.

This budget increases funding for the International Labor Affairs Bureau (ILAB) by over a quarter, including $19.16 million for ILAB to expand monitoring and enforcement of worker rights under our trade agreements and preference programs, and critical new investments to fight forced labor and child labor.

This budget also provides support to help workers struggling in light of the economic crisis caused by COVID–19, including the millions who have lost jobs, and especially women, workers of color, and others who have been most set back by it.

TRAINING AMERICA'S WORKFORCE

President Biden's budget would increase funding for registered apprenticeships by $100 million, an increase well over half of what its budget was last year.

These are proven apprenticeship models and lead to good-paying jobs in high-demand fields. Funding for them will help address long-standing inequities in apprenticeships, and change the fact that women and workers of color are historically underrepresented in these apprenticeship programs, and in the careers that they lead to.

The budget would also increase funding throughout the workforce training system, including with the $203 million increase for workforce development State grants, which help States make investments in career pathways for youth, and support adults and dislocated workers, including those most affected by the pandemic, and a new National Youth Employment Program, and Veterans Clean Energy Training Initiative.

Secretary Walsh, I look forward to hearing more about your plans here.

MODERNIZING UNEMPLOYMENT INSURANCE SYSTEMS

And finally, this budget includes funding to administer and improve State unemployment insurance systems. This COVID–19 pandemic made really clear what a lifeline that support can be, and how outdated and inadequate some of our systems are. This budget would help modernize our unemployment insurance system, and address vulnerabilities, inefficiencies, and other issues with processing these critical benefits, so families can get the support they need faster.

Of course, the need for better unemployment insurance systems, workforce training programs, and workplace safety are just a few of the many issues we have to tackle in the wake of this pandemic.

EMPOWERING AMERICA'S WORKERS

If we want a stronger economy, if we want a stronger country it all starts with stronger rights for workers. We also need to make sure workers are safe from pandemics, sexual assault, and harassment, and more. We need to make sure workers have paid family, sick, and medical leave, quality, affordable childcare, a livable minimum wage of $15 an hour, without exceptions, and a secured retirement.

We need to make sure workers are not disadvantaged by pay inequality. We need to address the inequities in our economy that makes things so much harder for women, workers of color, workers with disabilities, and others.

And we need to defend and strengthen the right to form and join a union, a right, which allows workers to secure better pay and benefits, and safer working conditions. This budget is a bold step in the right direction. And my colleagues and I have proposed other steps as well.

Secretary Walsh, I look forward to working with you and President Biden in the months ahead to support workers in our country.

With that, I will turn it over to Senator Blunt for his opening statement.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Thank you, Senator Murray.

Good morning, Secretary Walsh. Welcome to the committee. I look forward to your testimony today, and the chance to talk about the Department's budget request for the coming year.

You know, the past 18 months have been challenging for our country. The COVID–19 pandemic put unprecedented strain on the economy, on its workforce, and on families who suddenly were dealing with issues they hadn't expected to deal with, and that families hadn't dealt with in the same way before.

Prior to the COVID–19 Public Health Emergency Declaration, the unemployment rate was 3.5 percent. That was the lowest since the late 1960s. I think you have to assume from that, that some of the things that we are doing that were different, were making a difference. But at the height of the pandemic, in April of 2020, our unemployment rate exceeded 14 percent. While we have made great strides in bringing our unemployment rate back down since that point, I am concerned we won't reach the 3.5 percent pre-pandemic number due to, frankly, some misguided Federal policies, specifically the additional $300 in Federal supplemental unemployment payments that have unintentionally incentivized unemployed individuals to remain exactly that, unemployed.

In May of this year, the weekly—the average weekly unemployment check in the country was $318. That is a bigger check than a lot of people had taken home before, and you didn't have the expenses of going to work. And so frankly, a lot of people did not go to work. While businesses in America have been searching for workers, this benefit has really misaligned the workforce needs across the Nation.

And in Missouri recently, I continue, to see "Help Wanted" signs all across the State, and in my hometown of Springfield, these help wanted signs often included hiring bonuses, and pay well above the $10.30 minimum wage in our State. Missouri, like many States across the country, has decided to end the Federal supplemental payment to increase the level of participation in the economy.

I believe that it is beginning to work, but I also believe it is now time for Congress to recognize the importance of balancing, providing a safety net when you need it, and ensuring that our labor needs are met. We need to create an environment for Americans to thrive, where people want to go back to work, where they are encouraged to go back to work, and where people who can't go back to work have a basic unemployment benefit.

However, I am concerned that some of the components of the Department's budget request, and particularly some of the increases, don't consider this, or the very real needs of local communities, and the needs for a workforce to be more actively engaged. Really, too much of this budget is driven by the politics of the administration. Now every administration should, and has every reason to make some changes. I think this budget makes way too many changes, in way too short a time.

For example, instead of focusing funding on flexible workforce training, determined by States to meet their own unique employment needs, the administration is tying training funds in many, many cases to green jobs. I am not opposed to green jobs. I am just opposed to the Federal Government deciding how States approach the needs they have right now.

According to the analysis of the U.S. Energy and Employment Report, and the Department of Labor's Bureau of Labor Statistics, when compared to jobs in fossil fuels, jobs in solar, and wind power, employ a larger share of individuals in their construction, rather than more permanent roles, as plant managers, and other jobs. These jobs don't pay enough, and are unionized at lower rates.

Mr. Secretary, I agree with you, and we have talked about this, that we really need to target funding to the workforce of the future. However, I think it is unlikely that the Federal Government alone will be able to figure out what that workforce of the future should look like. And we need to have more involvement from States, communities, and local economies.

Now, we are going to disagree on some things in this budget, but I am encouraged to see things we are going to agree on. For instance, the increase of the apprenticeship program, I think this has been, and needs to continue to be a successful tool to allow workers to get paid while they train. And frankly, to find out as early as possible, if what they think they want to do is not meeting their expectations. So they don't get way too far down a line before they realize, this is not what I want to do.

This budget supports programs that are targeted to the hardest hit parts of the country. For instance, the Appalachian and the Lower Mississippi Delta regions have challenges there. And I think your budget does what it needs to, to begin to allow us to look at those challenges; there is support here for veterans transitioning to civilian workforce, one of the key priorities of this committee, and I think of this Congress.

Mr. Secretary, we are in a challenging environment. It is going to be a difficult year. I believe we can work toward consensus with the Department's budget, but frankly, as I have said at our other budget hearings this year, I think this can only be achieved by more parity between the defense and nondefense funding. The President's budget request did not achieve that goal. However, I remain confident that the final appropriations bill will.

And Mr. Secretary, I am glad that you plan to be in St. Louis tomorrow. I know we were told yesterday a couple of the things you would be talking about: one, promoting vaccines, and the other, the Job Corps. On the vaccine front, I was talking about this at our leadership stakeout yesterday. I have talked about it I think in every event I have been in in Missouri since we started the Warp Speed effort to try to get vaccines available more quickly.

Vaccines are a necessary, an absolutely necessary part of us creating an environment where this virus can't continue to replicate itself and change in new ways, and the variants are going to be the future enemy. Vaccine is the answer to those variants.

On Job Corps, Senator Murray, and I, and the committee have worked together the last 6 years to increase that funding. I know those programs continue to be programs that we can do more with

and, can look for reforms in. And I look forward to your leadership in that area.

So again, thank you for your time here today. I look forward to working together, as we try to be sure that Americans, working families, have the opportunities they need, and that our economy continues to grow. Thank you, Senator.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Thank you, Chair Murray. Good morning and welcome, Secretary Walsh. I look forward to your testimony on the Department of Labor's fiscal year 2022 budget request.

The past 18 months have been challenging for our nation. The COVID–19 pandemic put unprecedented strain on our economy and its workforce. Prior to the COVID–19 public health emergency declaration, the unemployment rate was at 3.5%, the lowest since the late 1960s. At the height of the pandemic, in April 2020, our unemployment rate exceeded more than 14%. While we have made great strides in bringing our unemployment rate back down since that point, I'm concerned that we won't reach that 3.5% pre-pandemic number due to misguided federal policies.

Specifically, the additional $300 in federal supplemental unemployment payments have unintentionally incentivized unemployed individuals to remain exactly that: unemployed. While so many businesses in America are searching for workers, this excessive benefit seems misaligned with the workforce needs across the nation.

When I was in Missouri recently, I saw "help wanted" signs across the state. In my home town of Springfield, these "help wanted" signs included hiring bonuses and pay well above the $10.30 minimum wage in the state. Missouri, like many states across the country, has decided to end the federal supplemental payment to increase the level of participation in our state's economy. And I believe it is now time for Congress to recognize the importance of balancing providing a safety net, when needed, with ensuring that our labor needs are met.

We need to create an environment for Americans to thrive—where people want to go back to work, where they are encouraged to go back to work, and where people who can't go back to work have a basic unemployment benefit. However, I am concerned that some components of the Department of Labor's budget request, and particularly some of the increases don't consider this or the very real needs of the local communities. Instead, too much of the budget is engrossed in the politics of this Administration.

For example, instead of focusing funding on flexible workforce training determined by states to meet their own unique employment needs, the Administration is tying training funds to "green jobs." Yet, according to an analysis from the U.S. Energy and Employment Report and the Department of Labor's Bureau of Labor Statistics, when compared to jobs in fossil fuels, jobs in solar and wind power employ a larger share of individuals in their construction rather than in more permanent roles as plant operators; these jobs also don't pay as much, and are unionized at lower rates.

Mr. Secretary, I agree with you that we should target funding to the workforce of the future. However, I think it's wrong for the federal government to dictate what that workforce should look like, and for bureaucrats in Washington, DC to determine the speed at which we get there. That should be left up to states, to communities, and to local economies.

While we may disagree on this point, there are many components of the budget request on which we do agree. I'm encouraged to see an increase for the Apprenticeship Program—which has been a successful tool to allow workers to get paid as they train—support for programs targeted to the hardest hit parts of our country—in the Appalachian and Lower Mississippi Delta regions—and support for our veterans transitioning to the civilian workforce.

Mr. Secretary, we are in a challenging environment and this is going to be a difficult year. I believe we can work toward consensus with the Department's budget, but as I have said at other FY2022 budget hearings this year, this can only be achieved when there is parity between defense and non-defense funding. The President's budget request did not achieve this goal. However, I remain confident that final appropriations bills will.

Thank you for your time here today. I look forward to working with you to strengthen our nation's workforce and create a more prosperous economy for all Americans. Thank you.

Senator MURRAY. Thank you, Senator. Thank you.

And with that, we will turn to Secretary Walsh. Welcome to our committee. And you may begin your testimony.

SUMMARY STATEMENT OF HON. MARTIN J. WALSH

Secretary WALSH. Thank you very much, Chairwoman Murray, I appreciate it; and Ranking Member Blunt, and the members of the subcommittee, thank you for having me today.

I look forward to aligning the Biden-Harris administration's version of the Department of Labor's fiscal year 2022 budget and beyond. And I am excited to be here in person. This is my second in-person hearing. My first was my confirmation. So if I make some mistakes, bear with me until I get used to this process. So I truly appreciate it.

I want to just start by saying how humbled and honored I am to be here, as the son of Irish immigrants, and a member—my father was a member of the Labors Union in Boston, to lead the Department of Labor. Just to think about their journey to America, and having their son sitting in front of Congress—in front of the Senate today.

I also believe, as the President says, we are at an inflection point in our Nation's history right now. We are coming out, as was mentioned a couple of times, of a pandemic that has taken over 600,000 American lives. And it has pushed working people to the breaking point in so many different ways, in so many different corners of our country.

The President and Congress worked together to pass the American Rescue Plan. It changed the course of the pandemic. It delivered relief to the American people, and it certainly set us on a pathway to recovery. At the Department of Labor, the team over there is working hard to implement this plan, from strengthening our unemployment systems to fully subsidizing the corporate premiums, to protecting workers' health and safety.

But there is certainly much more work to be done. We need to build back better. That means putting workers at the center of a more resilient, more inclusive, and ultimately more competitive economy as a country. That is what the President's economic vision is all about.

The Bipartisan Infrastructure Framework negotiated with members of the Senate would rebuild our communities and create millions of good jobs all across this country. And the Build Back Better agenda would make historic investments in working people through job training, and education, which I think we can all agree on, the CARES economy, and paid family leave, and medical leave, and workers' rights and protections.

BUDGET INVESTMENTS

Building on that vision, the Department of Labor's fiscal year 2022 budget request proposes an investment of $14.2 billion. That is, as the Chairwoman mentioned, a 14 percent increase over 2021 enacted levels. That includes $3.7 billion in Workforce Innovation and Opportunity Acts, and the Wagner Peyser state formula grants. It is an increase of 6 percent. That is about creating more pathways to good-paying jobs for workers who need them the most.

And we have seen it with people unemployed now, and underemployed, the opportunity to make those investments.

This budget also would invest $285 million in registered apprenticeship programs. That is an increase of $100 million that would allow us to expand and diversify a model of economic mobility that has proven to produce results for both workers and employers all across this country.

For unemployment insurance, we would fully fund and update the formula for what States receive to administer UI (Unemployment Insurance), it is the first update, quite honestly, in decades. We also request $100 million for technology solutions to prevent fraud and ensure access to UI benefits for all people that need them.

For our worker protection agencies, this budget requests $2.1 billion, a 17 percent increase. We need to rebuild and strengthen our capacity to protect workers, wages, benefits, and rights, and safety on the job sites.

This budget also requests $100 million for the multiagency POWER Plus Initiative that is aimed at empowering displaced workers in coal communities with new—with new skills and new job opportunities. And it requests $20 million for a new program to help veterans. The ranking member mentioned this. It is transitioning services for members and military spouses to get good careers in clean energy.

It was developed with the Department of Labor—with the Department of Labor's Department of Veterans Affairs. Across the Department of Labor's work, this budget invests in those who have been shut out of economic opportunities in the past, from women, and people of color, to rural Americans, and veterans, to at-risk youth, justice-involved adults, and people with disabilities.

The pandemic proved that the systems failing some workers end up failing all workers, and failing our country, ultimately. But we have an opportunity to do better now, coming out of the pandemic. We can empower all American working people. It is a moment in history when we need to move forward together, we need to come together.

Madam Chairwoman, Ranking Member, thank you for the opportunity; I know that we will have many more conversations, and we will work together to support the economic recovery that works for all American workers.

I look forward to discussing the budget proposals and requests with you and the committee today. And I am happy to respond to any questions that you have. And if I do not have an answer to your question, I guarantee you our team will get back to you in the next couple of days with questions—answers that I don't have today. So thank you.

[The statement follows:]

PREPARED STATEMENT OF MARTIN J. WALSH

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, thank you for the invitation to testify today. I am pleased to appear before this Subcommittee for the first time and to outline the Biden Administration's vision for the Department of Labor in Fiscal Year (FY) 2022 and beyond. I am honored and humbled to lead the Department in its critical work.

The Department's mission is to foster, promote, and develop the welfare of the wage earners, job seekers, and retirees of the United States; improve working conditions; advance opportunities for profitable employment; and assure work-related benefits and rights. This mission is personal to me and my family's story. My father's participation in the Laborers Union, Local 223 in Boston, was the pathway to a fair wage, so my family was not worried about housing insecurity. My parents had a safe workplace, so I never knew the fear of them not returning from work. The job came with a pension, so my parents could retire with dignity. And the job included health insurance, so that when my parents experienced the worst nightmare of having a child diagnosed with cancer, they had health insurance so that I could be treated and recover.

Years later, I followed my father into construction and joined the same union, and experienced those same benefits of having a safe workplace, health insurance, a fair wage, and a pension. These are not abstract policies—these are life-changing rights. I have spent my career fighting for the rights of working people as a State Representative, as General Agent for the Metro Boston Building Trades Council, and as Mayor of Boston. I feel privileged to continue this work as the Secretary of Labor.

AMERICAN RESCUE PLAN

As a former Mayor, I know that our communities—and our families—have been hit hard by the COVID–19 pandemic. That's why it was so important that Congress worked with President Biden to pass the American Rescue Plan (ARP) to change the course of the pandemic and deliver immediate relief for American workers. In terms of jobs, not only did the ARP extend unemployment insurance benefits for our friends and neighbors who lost their jobs during this pandemic, but it also laid the groundwork for shoring up and modernizing our unemployment insurance system to help workers get the benefits they deserve when they need them. The ARP also helps workers who lost their jobs or had their hours reduced pay for health insurance by fully subsidizing COBRA premiums for eligible individuals from April 1 through September 30 of this year. And it provides additional funding for the Department to help keep vulnerable workers healthy and safe. Finally, ARP also distributes more than $360 billion in emergency funding for state, local, territorial, and Tribal governments to ensure that they are in a position to keep front line public workers on the job and paid, while also effectively distributing the vaccine, scaling testing, reopening schools, and maintaining other vital services. We appreciate this landmark law, and we are working hard to ensure that this law is implemented in the way that Congress and the President intended to reopen our economy.

AMERICAN JOBS PLAN

As a former construction worker, I know a good job can change your life. One of the most important things we do at the Labor Department to improve the economy and strengthen the workforce is help people pursue training that leads to good jobs and helps close racial and gender equity gaps throughout the economy. The President's American Jobs Plan is a historic investment in the working people of America. It will create millions of good paying, family sustaining jobs that rebuild the middle class by empowering our workers to build America's future.

The President's plan provides funding for sector-based training programs focused on growing, high-demand sectors, such as clean energy, manufacturing, and caregiving, helping workers of all kinds to find good-quality jobs in an ever-changing economy. In addition, the plan provides for a new Dislocated Workers Program that provides comprehensive supports for workers who have lost jobs through no fault of their own, to ensure they are able to successfully participate in training that can prepare them for in-demand jobs. The plan will prioritize workforce development opportunities for underserved communities and ensure job opportunities are open to, and support, women, people of color, people with disabilities, and people impacted by the criminal justice system, among other disadvantaged groups. Further, subsidized jobs programs will support unemployed and underemployed workers who have faced significant barriers to employment to gain a key foothold in the labor market. Additional investments to establish more pathways to good jobs include creating up to two million new registered apprenticeship slots, while strengthening access for women, people of color, and individuals with disabilities; creating career pathway programs in middle and high schools, including those that increase access for underrepresented students to computer science and other STEM sectors; and supporting community college partnerships that build capacity to deliver job training programs that lead to good jobs. The plan also makes key investments in expanded career services and adult literacy programs to equip job seekers with the

tools, information, and foundational skills they need to be successful in the labor market.

The plan provides critical funding to strengthen the capacity of our labor enforcement agencies to prevent discrimination, protect wages and benefits, enforce health and safety rules, and strengthen health care and pension plans. In addition to these investments, the President is calling for increased penalties when employers violate workplace safety and health rules, which have proven inadequate to address serious violations.

FY 2022 BUDGET: SUPPORTING AMERICA'S WORKERS THROUGH THE PANDEMIC TO RECOVERY

Building on the American Rescue Plan and the American Jobs Plan, the Department's FY 2022 budget proposes investments in workers and in our country's future: a future of opportunity and shared prosperity, a future of robust job growth and a thriving middle class, a future where workers nationwide get the skills and training that leads to jobs that pay a fair wage without risking their health or safety. The Department's budget requests an investment of $14.2 billion in discretionary resources, which is a 14 percent increase above the FY 2021 enacted level.

The budget includes resources to expand training opportunities, supporting workers and building a better future. There is no single path to a good-paying job, and the country's future growth and prosperity depend, in part, on ensuring workers have multiple pathways to high-quality, good-paying jobs. To that end, the budget requests $3.7 billion, a six-percent increase, for the Workforce Innovation and Opportunity Act and Wagner Peyser state formula grants to make employment services and training available to more dislocated workers, low-income adults, and disadvantaged youth hurt by the economic fallout from the COVID–19 pandemic.

The budget also invests additional resources in programs that serve marginalized groups, such as justice-involved individuals, at-risk youth, and vulnerable veterans. While higher-income earners have recovered many of the jobs lost, workers in low-wage industries have experienced persistent net loss. As seen in the June 2021 Employment Situation, disparities among workers continue, and over 5.7 million jobs that existed last February are yet to return. While the overall unemployment rate was 5.9 percent, the African American unemployment rate was 9.2 percent and the Hispanic rate was 7.4 percent, compared with 5.2 percent for Whites. For individuals with disabilities, the unemployment rate was 10.9 percent. Due in large part to the impact of the pandemic, there are roughly 3.4 million fewer women working now than there were in February 2020—and many women have had to reduce their hours, often in response to caregiving demands. Women, particularly women of color, continue to face barriers to good jobs with equal pay. The budget prioritizes investments in these communities of color, with a goal of increasing success for all groups, because systems that are failing these populations are failing us all.

The Department will continue to invest in proven approaches, such as expanding the Registered Apprenticeship model by investing $285 million, an increase of $100 million, which will allow the Department to create a more balanced apprenticeship portfolio, support states' efforts to implement a reauthorized National Apprenticeship Act, and further the development of youth apprenticeship and pre-apprenticeship opportunities, all while increasing equity for under-represented populations. Registered Apprenticeships provide a pathway to good-paying jobs, and as Secretary of Labor, I am committed to expanding these opportunities across the United States, in order to help rebuild the middle class and create millions of new opportunities for workers to enter into relevant, high quality training that both protects workers' rights and propels workers into career paths that provide a sufficient and fair wage. Registered Apprenticeships produce strong results for both employers and workers. The Department's investments in Registered Apprenticeship will work to address the systemic disparities that have impacted women, people of color, and other under-served and under-represented populations.

This last year has again demonstrated that Unemployment Insurance (UI) is an essential social insurance program and economic stabilizer, and it has been a lifeline to millions of workers and to the economy throughout the pandemic. Yet the pandemic uncovered longstanding problems in the UI system, including the challenges facing states' administration of their UI systems. These systems, in part as a result of persistent underfunding and inadequate technology, have been plagued by delays and obstacles that disproportionately affect workers of color. When benefits are slow to reach workers who have lost their jobs, it delays both their recovery and negatively impacts the country. To address these challenges, the budget provides resources to ensure States can better handle higher volumes of claims and be better prepared for future crises or high unemployment levels. The budget request fully

funds and updates the formula for determining the amount states receive to administer UI—the first comprehensive update in decades. In addition, the budget requests $100 million to support the development of information technology solutions that can be deployed in states to ensure timely and equitable access to benefits. The $100 million increase will further support and complement the resources the Department was appropriated under the American Rescue Plan to prevent fraud, promote equitable access, and ensure timely payment of benefits.

The Biden-Harris Administration has taken stock of the challenges the unemployment system faces and developed a set of high-level principles that should guide future efforts to reform the UI system. Those principles include ensuring adequate benefit levels and duration for unemployed workers; ensuring the UI system can ramp up quickly and automatically in response to recessions; addressing the lack of access to UI for workers misclassified as independent contractors, low-income and part-time workers, and workers with non-traditional work histories; shoring up UI trust funds; and improving UI program access and integrity.

The budget request includes $2.1 billion—a 17 percent increase in funding—for our worker protection agencies, enabling the Department to conduct the enforcement and regulatory work needed to ensure workers' wages, benefits, and rights are protected, address the misclassification of workers as independent contractors, and improve workplace safety and health. These are the staff who recover back wages owed, help prevent fatalities and life-altering injuries or illnesses, respond to whistleblower complaints, reduce exposure to cancer-causing agents, help ensure retirees get their benefits, and address pay inequities.

Over the past four years, the Department's worker protection agencies have lost 14 percent of their staff. A lack of enforcement makes workers more vulnerable to workplace violations. The President's budget reverses this trend by proposing $304 million in additional funding for the Department's worker protection agencies, including $73 million for the Occupational Safety and Health Administration, $67 million for the Mine Safety and Health Administration, $35 million for the Office of Federal Contract Compliance Programs, $31 million for the Wage and Hour Division, and $37 million for the Employee Benefits Security Administration.

The budget continues the President's commitment to tackling the climate crisis. For the Department, the request includes an additional $100 million investment in an initiative as part of the new Interagency Working Group on Coal and Power Plant Communities and Economic Revitalization, aimed at reskilling and reemploying displaced workers in legacy energy communities. The request also includes $20 million for a new discretionary program, developed in collaboration with the Department of Veterans Affairs, which is focused on helping transitioning service members, veterans, and military spouses to pursue careers in clean energy, which will help combat climate change, while preparing this population for good-paying jobs.

I know we will have a lot of conversations, as we collaborate on the American Jobs Plan and the FY 2022 Budget. I look forward to those collaborations and partnering with you all to invest in the nation's economic recovery. The Department plays an important role in expanding opportunity.

Madam Chairwoman, Ranking Member, thank you for the opportunity to testify. I look forward to discussing our budget request with the committee, and I am happy to respond to any questions you may have.

Senator MURRAY. Thank you very much, Mr. Secretary. We will now begin a round of 5-minute questions of our witness. I ask our colleagues to please keep track of your clock and stay within your allotted time.

OSHA INCREASES IN THE AMERICAN RESCUE PLAN

I appreciate that the budget addresses the need to rebuild and strengthen the capacity of the occupational safety and health administration. Under the previous administration, OSHA didn't do more than issue non-binding guidance on how employers could protect workers from COVID–19. And that left a lot of workers exposed, as we witnessed thousands of deaths and illnesses of workers in healthcare, and meat packing, and other essential industries.

Now, the Biden administration recently issued an Emergency Temporary Standard, but it does not yet cover all frontline work-

ers. And as you know, OSHA received $100 million in the American Rescue Plan, which it plans to use to support more than 80 compliance and safety health officers, among some other priorities. But as the economy continues to reopen, and more contagious COVID variants emerge, workers need OSHA to be fully engaged in its job of making sure employers provide a safe workplace for their employees, and their workers.

So I wanted you to describe for the committee this morning, your plans to use those ARP (American Rescue Plan) funds to hire the staff OSHA needs to do its job, and how quickly do you expect to get these staff on the job.

Secretary WALSH. Thank you very much, Madam Chair. OSHA is one of the areas that, when I was sworn in, work had already begun there, due to the help of the American Rescue Plan, and investments in staffing up. They were severely understaffed to be able to make sure that we keep our workplaces safe in America. Certainly, we have a difficult time keeping up with the average volume of business, but if you throw COVID–19 and the atrocities of some of the workplaces in our country with COVID–19, it made it very complicated.

We are currently in the process of hiring up and staffing up in OSHA so that we can have more inspectors to go out to job sites. Quite honestly, I would love OSHA, at some point—we are asking for an increase in this budget—I would love OSHA at some point to get to a point where we are not responding to accidents on the job site, that we are actually being proactive working with businesses, in how do we create better, safer work conditions, and work sites.

We are not at that point right now, so we are at the point where we are still looking to staff up, and hire up. And also just—and I have spent many, many hours on Zooms with the OSHA employees across the country, just thanking them for their work, because throughout the pandemic OSHA employees went to work every day. They didn't have the luxury of sitting home on a Zoom and doing their job. They had to be on a job site. They had to be touring facilities, and they had to see some of the toughest situations out there. So I look forward to working with this committee and continuing the staffing up of OSHA.

OSHA INCREASES IN FISCAL YEAR 2022 BUDGET

Senator MURRAY. Well, the budget requests an increase of $73 million for OSHA in fiscal year 2022. Can you describe why those funds are needed in addition to the ARP funds that were provided?

Secretary WALSH. Yes, because—thank you. With the ARP funds as it just—it restores us back to where we were pre-5-years-ago. What the new funds allow us the opportunity to do is expand the office and to get into some of the other work that we want to do. People should not be, businesses should not look at OSHA as a burden. People should be looking at OSHA as a partner, and being able to create opportunities to help create safe work environments.

When I was a young person working on construction sites, and OSHA came on the job, they would come on the job to investigate, but they were not investigating after an accident happened, they were not investigating after a tragedy happened, they were making

sure that there were proper procedures in place there to make sure that workplaces are safe.

We need to do work around this country to make sure that our workplaces are safe, that workers are safe. And that we collectively work with businesses as well as we move forward here. So that additional revenue will go into continuing to hire up in OSHA, and to create better opportunities to training, and to have the best prepared—OSHA inspectors we have in the country.

Senator MURRAY. You didn't mention whistleblower complaints, but I understand that last year the inspector general reported a significant increase in complaints, and insufficient staff to investigate those complaints. What are you going to do to address that issue?

Secretary WALSH. Again, it is about the staffing when—I might have the numbers wrong—let me just get the numbers here for you. We are going to double the number of inspectors by the end of the administration, the first administration, Biden-Harris administration, the first term, we are about—we were at about 360 inspectors in the country, inspecting about 170 million workers in our country. That certainly is not going to do the job.

So what we are doing here is making sure that we have enough inspectors out there that when an employee calls the office with a complaint, we are able to respond to that, and not have it sit in a pile, or sitting in an inbox somewhere. And again, it is about when you think about whether it is OSHA, Wage and Hour, the Department of Labor was down about 3,000 employees to where it was 4 years ago.

And when you are down employees in the Department of Labor, the Department of Labor is an agency, as you know, that is out there protecting workers. If we don't have the staff and don't have the employees to protect the workers, then we can't be on the job sites, we can't be checking Wage and Hour, we can't be making sure that people are working in safe conditions.

So our intention, with this investment that we are asking for today, and with the intention of the American Rescue Plan, to staff back up, to build back pre-4-years-ago level, but also enhance that.

Senator MURRAY. Okay. I have a number of other questions, and I am going to ask them at the end, so our other committee members can have their time.

I will turn to Senator Blunt.

CREATING A WELL-PREPARED WORKFORCE

Senator BLUNT. Thank you, Chair. Let me start with a question that is really going to be more of a question I will follow up with later, but I want to be sure we cover this. You and I have talked about this before, Mr. Secretary, the idea that people don't get the information they need early enough to decide what kind of job is out there, what their personal sense of job satisfaction would be, and what those jobs pay.

A few years ago I went with the Secretary of Labor to the Carpenter Training facility in St. Louis, and as we visited individually, the people, at the end of that visit, they were all in their late-20s; they all had a similar story, and it was sort of that lost decade of

not knowing what they wanted to do, or not having information about the importance of benefits, the importance of job satisfaction.

And we have looked at that as sort of a lost decade that we would like to avoid. It is hard to recover, frankly, from that lost decade. You ask for $10 million to continue to pursue that in your budget. The Secretary of Education didn't ask for the $10 million education had last year. We put $10 million in both budgets.

At some point when you have had time to think about this more, I am going to ask you, I will be asking the Secretary of Education what the two of you are doing to try to close that gap between getting the information you need. If you want to talk about the importance of knowing what jobs are out there sooner rather than later. Just let me let you do that for a moment.

Secretary WALSH. No. Thank you, ranking member. And to be quite honest with you, I want to ask—add another component to that: the Secretary of Commerce. So the Secretary of Commerce, Gina Raimondo; the Secretary of Education, Secretary Cardona, and myself, have had conversations. And when you think about the jobs of the future, the three of us, the three of our departments catch people—catch employers in educational opportunities to prepare people for the future.

So what we are doing is, we are working collectively together to make the investments. Gina Raimondo is working with the business community as well as I am, to find out where the gaps are, where they need employers—employees now, and in the future, working with education on how do we create those programs in our primary schools, in our high schools? How do we create those opportunities in community college moving forward?

And the Department of Labor is offering—obviously has the workforce development grants, and the workforce grants to be able to fund those jobs. So it really has to be real intentional work that we are doing here to make sure that this money that we are asking for today, and the money through the rescue plan, and potentially, through the CARES Economy Plan, that this investment is preparing workers of the future.

ADAPTING TRAINING PROGRAMS TO MEET INDUSTRY NEEDS

You just said it yourself. I mean, when you think back and look at the history of this country, and you look at the investments that were made in the '50, and '60s and '70s, lots of schools around America had training—had Vo-Tech schools, and they were doing Vo-Tech training, and young people that were going to those programs were going into the trades. That would become an electrician, plumber, carpenter, laborer, and mechanic, what have you.

Many of those programs are very different today. And I think we are at a moment in time, coming out of a pandemic, or getting through a pandemic, I should say—we are not out of it yet—that we have an opportunity right now to retrain and reskill workers, young people, as well as some older workers as well, into those careers. But it has to be a coordinated effort, it has to be the secretaries of commerce, labor, and education, and it has to be Democrats and Republicans, quite honestly.

Senator BLUNT. All right. I am going to run out of time here. I agree with that, but the component I want to be sure we continue to add is like those Vo-Tech programs.

I was at a great new facility in Buffalo, Missouri, the other day that they are building, and being focused again, people need to know, sooner rather than later, what jobs are out there, what those jobs pay. A lot of jobs that have that kind of training actually produced greater satisfaction and more income than jobs that you have a college degree for. And sharing all that information early is important.

One way to create an early sense of what you want to do are apprenticeships. Missouri, where you will be tomorrow, is ranked second in the United States in apprenticeships. We are working toward a goal in our State of having 20,000 active apprenticeships by 2025. The one thing left out of that, it appears to be the nontraditional industries and what we can do to develop apprenticeships outside of the well-run trade union programs, and other programs. For instance, like healthcare, cybersecurity, even finance. What can we be doing to think about how we expand that apprenticeship opportunity to new fields?

Secretary WALSH. Well, what I have been doing, and what we are going to continue to do is talk to companies, the tech companies as well. We have opportunities in tech, and biotech, and high-tech, and even pharmaceuticals. So having conversations with those industries on how we create pathways into those industries would be important. Those are good-paying jobs, and they are looking for people.

And quite honestly, we have a huge opportunity right now in this country to really think about those apprenticeships, and how do we create more apprenticeships; and the beauty is—I know my time is over—the beauty is, is the apprenticeships you are paying while you are learning. And that is the difference between workforce development and job training. You are actually getting paid in the apprenticeship while you are learning on the job.

Senator BLUNT. Right.

Secretary WALSH. And that allows a person that might be unemployed or underemployed right now, to get on-job experience, real-life experience moving forward.

Senator BLUNT. Thank you, Secretary. I will have some more questions also later, Chairwoman. And thank you for the time.

Senator MURRAY. Thank you.

Senator Reed.

SHORT-TERM COMPENSATION PROGRAM

Senator REED. Thank you very much, Madam Chairwoman.

And congratulations, Secretary Walsh, I am glad you are there in the Department. Let me raise the first question about the Short-Term Compensation Program, or otherwise known as "work sharing". After the last recession in 2010/2009, it is estimated that we saved 570,000 jobs. And I know Congress and the Biden administration stepped up and they are providing fiscal support for this program, and it is saving tens of thousands of jobs.

And as you know, what it does is it basically provides 1 or 2 days on unemployment compensation while the individual works at the

facility. Can you explain how, and if you will continue to support this program, and try to extend it to every State in the union?

Secretary WALSH. Thank you very much, Senator. And thank you for raising this issue. Work sharing certainly is an important and innovative tool. I agree with you, and I wished that we had seen it across the States, and we want to see it across the States. I think it is going to be very important for the future of our workforce. It is important that we continue to explore that. I am going to, as Secretary of Labor; our Department is. The Department is certainly committed to promoting State adaptation of this program.

And we are going to continue to find ways to increase awareness and participation in the program. We have seen—you have seen the benefit of it, and I think that—and workers are seeing the benefit of it. And I think that those are opportunities for us throughout the United States of America for other States, and other workers, more honestly, to see the benefit as well.

So I know that, Rhode Island, they have been a leader on this, and I want you to know that I want to continue to work with you, and maybe some of the other members of the Senate, in governance, quite honestly, around the country to expand the program.

DEMAND-DRIVEN TRAINING PROGRAMS

Senator REED. Thank you, Mr. Secretary. Switching gears a bit, I secured about $28 million in the Defense Appropriations Bills for a submarine, industrial-based support of workers, and of training, and education initiatives. And I think you have seen one of these when you visited Westerly, Rhode Island, and saw our training program, where our Department of Labor, together with Electric Boat collaborates. And I think this is another example of what Senator Blunt was getting at. This demand-driven model for training, it is not the old-fashioned: We turn out X, we have always done that. It is: What does business need?

And up in our place where Electric Boat, over the next several years, is going to have to hire 17,000 people, many of them machinist, welders, et cetera. So how are you going to continue to work with the Department of Defense to support programs like this, and with other agencies to support demand-driven programs?

Secretary WALSH. Well, first of all, thank you for your work on this. Ranking Member Blunt talked about this as well. I think first I want to say is that, the jobs that you work with your hands are now computer jobs, meaning that you have to have not just the skill to be able to be the craft person working with your hands, but you need to be able to learn and read off a computer because the work has gone so technical.

The Department of Labor has just awarded the State of Rhode Island a $3 million—$3.9 million grant to expand registered apprenticeship opportunities. I think that this is one of the areas that we have such a great opportunity. Electric Boat is a great example. I was in Connecticut; we went through Rhode Island to get to Connecticut. I know there is facility in Rhode Island, as well, and the expansion that was going on there, and the opportunity for employees.

I guess the best way I can sum it up is what I am going to do about it is make sure that these investments are there, and that

we work with companies like Electric Boat, but the human side of it. When I was at Electric Boat, I was talking to a couple of apprentices that were standing there next to me, and I got to talking with them.

And I am like: What are you doing? You know, did you go to college? One kid went to college a little while, dropped out. It wasn't for him. I told them my story. I dropped out of college after a-year-and-a-half.

He is now on a pathway to a career. He is on a pathway to working on submarines for the United States of America. He is on a pathway to doing some amazing work. He is proud of his work. He is happy with what he does. He told me he is earning good money. He is making a living. He is able to raise a family.

That is the type of stories that we need to continue to happen. So I think it is incumbent upon us. If I do anything as Secretary of Labor, it is making sure that the money in the workforce development grants, in the apprenticeship program, money that we get, we get out in the street because that, that is going to be the fundamental, biggest game changer in the United States of America, to get workers retrained, or workers trained, and the ability to raise and get into the middle-class. That is what we can do. That is the one thing. If I accomplish anything and I do that, I will be happy.

COMBATING LITERACY ISSUES

Senator REED. Well, thank you very much, Mr. Secretary. Just a final point, not a question; as I was sitting down with adult educators in Rhode Island a few weeks ago, they pointed out that one of the problems is literacy; that they have a significant number of adults who walk in and they want jobs, they want to work, but they have very poor literacy, and very poor numeracy and, digital skills too.

And I will just, not a question, but I assume, and I know you will follow up with the Department of Education to try to collaborate, to see how we can integrate our literacy programs, as well as our training programs. And I will then—I won't follow up with additional question. I will just, thank you. Thank you, ma'am.

Senator MURRAY. Thank you.

Senator Kennedy.

Senator KENNEDY. Thank you, Madam Chair.

BUDGET INCREASES

Mr. Secretary, welcome. I agree with you, by the way, for what it is worth, about getting the money out on the streets, literally. So I am looking at your budget here. Your current budget is $12.5 billion. You are asking for $14.2 billion. Does that sound about right?

Secretary WALSH. Yes.

Senator KENNEDY. That is a 14 percent increase. You want an extra $1.7 billion?

Secretary WALSH. Yes.

Senator KENNEDY. Okay. Explain to me why the American people would be better off giving you $1.7 billion, than taking that $1.7 billion and spending it on infrastructure? I did a little math and for $1.7 billion, we can resurface a four-lane highway from

Washington to Denver. So why are the American people better off giving you more money than putting it on infrastructure?

Secretary WALSH. Well, thank you very much, Senator. And thank you for the question. It is a great question. And I think the way I would think about it is the $1.7 billion increase to my—to the budget, my budget is an investment in infrastructure as well. It is an——

Senator KENNEDY. It is what? I am sorry?

Secretary WALSH. Infrastructure investment as well. It is an infrastructure investment in the American worker in this country. It is an opportunity for us to look at, as I think about the Department of Labor——

Senator KENNEDY. Would you believe every—excuse me for interrupting—I am sorry, Mr. Secretary.

Secretary WALSH. No problem.

Senator KENNEDY. We don't have much time. Do you believe that every expenditure by the Federal Government is an investment?

Secretary WALSH. This——

Senator KENNEDY. What is the difference between an investment and an expenditure?

Secretary WALSH. An investment is an investment in the future of workers, and expenditure is an expenditure in building a bridge.

Senator KENNEDY. Okay. Well, you have a union background, which I respect and admire. If we took $1.7 billion that you say you need, you need more to run your Department, and we spent that on infrastructure. That is going to create a lot of union jobs. Isn't it?

Secretary WALSH. It is going to create a lot of jobs, but we are also not going to be able to educate the workforce that needs those new jobs that are going to be created off of that infrastructure investment of new bridges.

Senator KENNEDY. But they are already educated. The people building the roads are already educated. They are good at what they do.

Secretary WALSH. Well, Senator Reed just mentioned of—an issue around literacy in this country. So again, it is an investment in helping people to be able to be retrained and trained in the jobs of the future. I come out of construction. I worked construction as well. The construction industry that I worked on in the early-'90s and late-'90s is different than the construction industry of today.

TAX INCREASES FOR INFRASTRUCTURE BILL

Senator KENNEDY. Yes, sir. Let me stop you for a second. I don't want to get too far afield here into a history of the construction industry. I used to work construction too.

Let me be sure I understand what you are saying. When my constituents call me and they say, look, you are being asked to raise taxes to pay for infrastructure. Why, instead of putting $1.7 billion in extra taxes on us, why did you give $1.7 billion to the Department of Labor? Why didn't you use that for infrastructure? Am I just supposed to say, because the Department of Labor says they are going to make an investment?

What metrics are you going to use this time next year to be able to prove to this Congress that your investment paid off better than $1.7 billion in infrastructure?

Secretary WALSH. Before I answer that, let me just quickly go back to the tax question. I think the beauty for your constituents is that the infrastructure bill that is being negotiated right now does not raise taxes on the average American who earns under $400,000. So the average American is not paying for that.

Senator KENNEDY. That is not true.

Secretary WALSH. Okay. Well, that is not why I am here today.

Senator KENNEDY. We just have to agree to disagree.

Secretary WALSH. It really——

DEPARTMENT OF LABOR SURVEYS

Senator KENNEDY. Let me move on, because I have got one minute left, and I like to stay within my time. Does your agency conduct surveys?

Secretary WALSH. As far as employee surveys?

Senator KENNEDY. Any surveys.

Secretary WALSH. We do, yes.

Senator KENNEDY. Okay. Do you pay people?

Secretary WALSH. Pay the people who do the surveys?

Senator KENNEDY. No, to take the survey.

Secretary WALSH. I actually don't know the answer to that.

Senator KENNEDY. Well, here is why I am asking. And I am not trying to——

Secretary WALSH. I will get back. I don't know. I don't know the answer to that.

Senator KENNEDY. I need your help finding something. One of my constituents got this in the mail. It is a letter—I know it is not under your jurisdiction—from the Bureau—Census Bureau. And they asked him to fill out a form on children's health, and he opened it up, and look what fell out, a five-dollar bill. And there is no reference in the letter to the $5 in cash he got from the Federal Government. What is this all about?

Secretary WALSH. I have no idea. I will look into——

Senator KENNEDY. Can you help me find out?

Secretary WALSH. I will help you find out.

Senator KENNEDY. I took the——

Secretary WALSH. I didn't get one of those letters.

Senator KENNEDY. Well, I filled out my census, my survey. I want five bucks.

Secretary WALSH. I do, too.

Senator KENNEDY. And I understand that under the Biden administration is also sending people $40 gift cards.

Secretary WALSH. I doubt that is from the Biden administration. But I will look into it.

Senator KENNEDY. I looked it up, it is on the Internet. It must be true.

Secretary WALSH. I will look into it with you, my friend.

Senator KENNEDY. Would you?

Secretary WALSH. I promise.

Senator KENNEDY. Thank you, Mr. Secretary.

Secretary WALSH. All right, sir.

Senator MURRAY. Senator Shaheen.

IMPORTANCE OF THE JOB CORPS PROGRAM

Senator SHAHEEN. Well, thank you, Madam Chair.

And congratulations, Mr. Secretary, we are delighted to have you in your current role, and it is nice to have a New Englander who I can understand.

You were talking earlier about the need to have more nontraditional apprenticeships, and the potential for doing that for organizations to make that possible. One of those organizations in New Hampshire is the Job Corps where they have a number of training programs that train people for healthcare roles, for dental assistants, for some of the things that have been nontraditional.

Can you speak to the importance of the Job Corps and why it is a great opportunity for young people who may not have another alternative?

Secretary WALSH. Absolutely, Senator. Thank you for that. You know, prior to my being here, I did not have, per se, a Job Corps Center in the City of Boston, but we had lots of workforce development programs. My first Job Corps visit was in Memphis, Tennessee, where I got a chance to tour the Job Corps facility there. And I saw first-hand the unbelievable potential of creating pathways for so many young people in America.

And then I started to look into it, and realize the amount of young people that go through Job Corps. Job Corps, there is no question in my mind, that everybody today who brought up the question with me so far, Job Corps should be a main stay in Opportunity For Economic Development and Job Growth.

I think that we need to continue—I am going to continue to partner with Job Corps. I am going to do everything I can. I have asked for a budget increase for Job Corps. I am also going to do everything I can to make sure that Job Corps all across this country is successful.

I know your Job Corps in New Hampshire. I know it is successful, and we want to take those models and make it successful. So I am spending, you know—again not to kind of get off the beaten path here—but I know when I became Secretary of Labor, you know, people talk about OSHA, unemployment insurance, and all of the—kind of the bigger ticket items, Job Corps is as important as any of these, if we do it right and continue to create pathways.

Senator SHAHEEN. Well, thank you. I worked for 20 years, first as governor, to get that Job Corps, with a lot of other people who supported it. So it is really nice to see it be successful. And I appreciate the support from—your support for Job Corps.

H–2B VISAS

Something that has not been so positive this year has been the challenges with finding workers in New Hampshire, as everyone has spoken to already. And one of those issues in New Hampshire has been the access for H–2B visa workers. You and I talked about this last spring. But we have a lot of seasonal businesses that rely on H–2B visa workers to fill those temporary jobs. When we don't have workers in New Hampshire who are willing to take those

jobs, and we have an unemployment rate that is now back to under 3 percent.

Congress charged the Secretary of Homeland Security and you, as Secretary of Labor, with the responsibility of collaborating to determine the appropriate number of additional H–2B visas to release for this fiscal year. I was disappointed to see the administration's ultimate decision to release just 22,000 additional visas. And just 16,000 of those were set aside for returning workers. They were fully applied for less than 2 weeks after being made available.

So can you tell us how the administration determined that 22,000 number, and why only 16,000 of those should be available for returning workers?

Secretary WALSH. Yes. I can. First and foremost, it was, as somebody who was literally on the job about 3 weeks at that particular moment, I sat with Secretary Mayorkas, and we were looking at different numbers. He had a very high number—a much higher number than that. And we were looking at the consistency of what the past practice has been, and what the average number of additional visas have been; 22,000—well, let me, 16,000 of the traditional ones is about the average of the last 3 years, not including last year, what the average was.

The 6,000 that were added was for the Northern Triangle of Central America and Southern America. So we have made—my office and Homeland Security's office is coming up with a better formula for how we operate and move forward next year. And I think that, certainly, your office, I spoke to you directly, and Senator Hassan called me, and many Senators from around the country called me as well, from all over the country, really concerned about this.

We got the number out late. And so what we want to do now is prepare for next year as we move forward so this same thing doesn't happen. I know that in New Hampshire, Maine, and other places, the tourism industry is in desperate need of these workers, and other parts of the country, the fishing industry is desperately in need of these workers.

And then we are also looking at the H–1B program as well for the farmers. So I don't have a great answer for you, how we came up with that number, other than we sat down and had a compromise, a conversation. But I can tell you this: you have my commitment that next year we will not be dealing with this at the last minute. We will have this conversation beforehand, and may be even an opportunity for me to visit with you and talk to some of the workers that are in your State, to talk about the importance of that program.

Senator SHAHEEN. Well, thank you very much. I appreciate that.

ADDRESSING THE WORKFORCE SHORTAGE

And I know I am out of time, Madam Chair. But I would just remind us all that we are dealing with an aging workforce in this country. And if we expect to fill the jobs that we are creating, we need to get more older workers into the workplace, and we need to get more immigrants into the workplace. And I understand that is a charged political issue, but it is one we need to face if we are going to address our workforce shortage. Thank you.

Senator MURRAY. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Chair Murray.

PARTNERS ACT APPRENTICESHIP LEGISLATION

Secretary Walsh, I am going to join the chorus here as a big supporter of apprenticeship programs. And I plan to shortly re-introduce my apprenticeships legislation, known as the PARTNERS Act, in the near future. That is focused particularly on collaboration between smaller work places, and technical colleges, and workforce Boards to sometimes create novel apprenticeships, but to assist, especially, smaller businesses, in standing up apprenticeship programs.

DIVERSITY IN APPRENTICESHIP PROGRAMS

Anyways, I was pleased to see that your budget requested a $100 million increase for apprenticeship programs, along with a commitment to increase access to apprenticeships for, historically underrepresented groups. I wanted to call your attention to my home State of Wisconsin, where in Milwaukee we learned that the number of Black apprentices decreased by nearly 22 percent over the last year. That is a deeply disturbing statistic.

And so I am interested in learning how the Department will use the appropriated funds to attract more racially-diverse apprentices. And what strategies you have to prevent the sort of numbers that we have seen in Wisconsin, and Milwaukee in particular?

Secretary WALSH. No. Thank you. I was in Milwaukee about 3 weeks ago, or with the Mayor, and we were on a job site, replacing lead pipes, they were replacing lead pipes in one of the neighborhoods in Milwaukee. And prior to that I was at a roundtable with the Building Trades, I think that there are two things we have to do.

Number one is, I think the people that we have to—that want to get access to these apprenticeship programs, that there are people of color, African-American, Latino. People want to get in. It is about, you have to be real intentional about reaching out to the community and creating open-door opportunities for these programs. I have done it in the city as a head of the Building Trades. I have done it as the Mayor of the City of Boston.

And I think that we have a unique opportunity right now in the—you know, at the Department of Labor equity is kind of at the core of everything that we are doing, and we need to make sure, if we want to really come back and build back better, it has to be built back better for all people, it cannot just be build back better for some communities.

And so I think we—number one, to answer your question, at the Department of Labor, when we start to think about putting RFPs (Request for Proposals) out, we start to expand these apprentice programs, we also have to put in some recommendations on how, and explain to people, how do you get people that don't have access to these programs, access.

So you just got to be intentional about it, bottom line. I mean, in Boston, it has worked. I mean, are the numbers great? No. Are the numbers better? Yes. So we have to be better than we were.

IT SOLUTIONS FOR AGING UI SYSTEMS

Senator BALDWIN. During the pandemic Wisconsin's Department of Workforce Development really struggled to make timely unemployment insurance payments because of outdated computer systems.

Secretary WALSH. Yes.

Senator BALDWIN. And they were a product of years of neglect, and frankly, partisan attacks on the unemployment insurance program to begin with. I am encouraged to see that your budget will provide, again, $100 million specifically for IT solutions that can be deployed in the State. And this money, I think will be well spent in Wisconsin. But I was also interested in learning more about the first comprehensive update in decades to the formula that determines the funding States received to administer unemployment.

Can you provide more information on the proposed changes to the formula? And is this something that the Department expects to undertake administratively? Or do you think you are going to need changes to authorizing language?

Secretary WALSH. Well, first of all, thank you for bringing this up. Because as I was prepping for this hearing, most of my prep was about—around unemployment insurance, so I thank you for bringing it up. I think that a lot of what we can do, Department of Labor, is working, going to be working with States and territories to be able to look at what investments are needed in those different areas.

We are using the funds that—through the American Rescue Plan to tackle the most acute problems that the systems have been facing for a long time. There are kind of four key priorities, which I will touch upon: one is sending teams to States to provide intensive technical assistance that is first and foremost, really finding out, because every State system is a little different on how they operate, and their computer systems are completely different. We are going to provide States with direct assistance and experts, to learn about the challenges, and to begin to help immediately on what we need to do. So that is one space.

Second is a focus on ID verification, and looking in that area. A third is modernizing technology, probably one of the biggest things that we have an issue with is technology, and States are running on incredibly antiquated systems that they have had for 30, 40, 50 years; and then a direct grant to States to help them solve the challenges that they have in the system.

I mean, reforming the united system will do a lot. Number one, as you mentioned at the very beginning, at the beginning of the pandemic people had problems accessing the benefit. They couldn't get in. They were waiting, and they were waiting on Zoom, they were waiting in the line, they were waiting and they couldn't get through.

So creating a platform, a system, when somebody needs unemployment, they can either sign up online, or get a phone call. They can get in; number one.

Number two; it is also the fraud piece of it. Lots of—there was lots of organized crime and fraud with the UI system where mil-

lions and billions of dollars were taken that should have gone to people. Again, that will address the fraud.

So we are going to have a comprehensive approach moving forward. We are being very, very, focused on how we administer this program, and how we move forward.

Senator BALDWIN. Okay. And if you can follow up with some more information about the formula changes that are being undertaken, that would be great.

Secretary WALSH. Yes. I will get back to you. Thank you.

Senator MURRAY. Thank you very much.

BUDGET INCREASES FOR WORKFORCE DEVELOPMENT PROGRAMS

Mr. Secretary, the budget request includes significant increases in funding across the workforce development program, and like COVID itself, the economic impacts of the pandemic issue now have fallen disproportionally on the most vulnerable, including women, workers with low incomes, workers of color; so the investments in this budget would help our economic recovery, but also address changing workforce needs that were apparent actually long before COVID; such as the transition to clean energy, and the development of other in-demand industries and sectors.

Can you talk to us about why the increases in workforce development programs are so important right now, and specifically what this budget does to address inequities in our workforce programs?

Secretary WALSH. Yes. Let me try and do a better job than the first time I was asked the question. Most people here today that have asked me a question have discussed either, the underemployment of people, or the lack of ability to get into a better paying job. What the pandemic—we have known this before the pandemic—but what the pandemic has really shown is that we are in a crossroad in our country, and we have an opportunity to create a platform for people to get into the middle-class.

President Biden's "Build Back Better" plan, not the plan, but build back better, the words "build back better" when he talked about in the very beginning before there were any plans associated with that, was about creating opportunities and pathways into the middle-class, that people wouldn't have to live in poverty, people wouldn't have to worry about unemployment, people wouldn't have to worry about not having healthcare, and child's care, daycare, education, all of that.

And what our workforce investments are—what we are asking for in this budget, and what we want to do with our workforce investments in the Department of Labor, in this budget, is to continue to advance what the President's agenda is, what we all want to do moving forward. And so for every dollar that we spend, with all due respect to one of the Senators today, for every dollar that we spent in workforce development, it is an investment in the future of America's workforce. And it is an opportunity.

Ranking Member Blunt mentioned new emerging tech—new emerging industries, those industries right now, a lot of them, are just for college graduates. They are going into cities like Boston, and they are grabbing up college graduates, but they have more opportunities than they have people to work in those jobs. And when I—when you talk to those CEOs, and the people that create those

companies, what they say is that we can train the workforces to work in those industries. We don't need to have a college degree, or a Ph.D, or a law degree.

So we have a unique opportunity right now. So the investments that I am asking this committee to support, and I am going to be asking the Full Senate and Congress to support, are investments we are making in the future of American workers.

We don't want the same-old, same-old Department of Labor, where we are going to be giving grants to States and States will be taking the money and maybe doing something with it. What we want to do is make sure that these investments are going in the right places so we can continue the opportunity to get our—your constituencies, my constituents into good-paying jobs.

That is the opportunity in front of us at this particular moment in time. And I think that nobody wants to go back to the old way. I think it is important for us, we continue to make investments in American people for those jobs.

COMBATING WAGE THEFT

Senator MURRAY. Okay. There are workers around the country right now, as you well know, trying to support their families, make ends meet, but they are being denied the unacceptable—or the unacceptably low Federal minimum wage, overtime pay, or both. And it is clear more needs to be done to ensure workers received the wages that they actually earn. And it is the Wage and Hour Division's job, as you know, to investigate these cases and recover back wages and damages on their behalf. Can you talk to us about how your Department would use the $30 million increase that you have requested for Wage and Hour, to address wage theft or increased back pay recovery, particularly for our vulnerable workers?

Secretary WALSH. Yes. First and foremost I want to—again, I wanted to just thank you for the American Rescue Plan because we have made some investments there as well in Wage and Hour, and we are building back up where we were a previous—to previous levels. The investments that we want to invest there, again it goes back to thinking about the Department of Labor in a different way, as far as, the way I view the Department of Labor is we represent workers in the morning, in the afternoon, and at night.

And we represent workers in all different levels, whether it is security on the job site, safe retirement, and safe working conditions. So what we want to do in Wage and Hour is make sure that we truly make an opportunity for people that are being shortchanged or not getting their wages that they earn and deserve, that we have the proper opportunity for investigation to go in and investigate any cases out there, so we are able to follow up, and get people's back wages.

If you look at the Department of Labor's website, every day we have another case where we are able to recoup benefits of people that lost their money.

Senator MURRAY. Thank you.

Senator Blunt.

Senator BLUNT. Thank you. Thank you, Chair.

ALLEVIATING LICENSING RESTRICTIONS FOR MILITARY WORKERS AND THEIR SPOUSES

The President on Friday released an executive order that encourages the FTC (Federal Trade Commission) to ban unnecessary occupational licensing restrictions. I have been particularly involved in that as it related to returning veterans who bring skills back with them, or veteran spouses or military spouses who are going from one State to the next. What are you doing? And what do you think we can do to encourage more cross-State collaboration in licensing, and to eliminate needless barriers for licensing, particularly for those people who in some way have either been in the military, or have spouses in the military?

Secretary WALSH. Yes. I don't have a direct answer for you to that question, but my past understanding of being in the legislature, or in the City of Boston as the mayor, it is a concern because people would come to our city and they would want to work in a certain industry, and the license was not recognized in the City of Boston.

And there was an ability at the State level to get a waiver, but it is something that I don't have enough information on, and I will look into it. But I definitely think that, particularly military families, as military families they are not in—I have a cousin that is in the Coast Guard. In the last 10 years he has spent time in San Diego, up in Portland, Maine, he has been all over the country because he gets shifted from base to base every 3 years.

Senator BLUNT. Right.

Secretary WALSH. So again, you know, if he had a career that, a side career that had a license, he needed to get that. So let me—I will work on that with you. I don't have the direct answer for you on that.

Senator BLUNT. Let us work on that. I think the executive order clearly heads in the right direction, but let us work on what we can do now. That is largely a State and a local determination. Up until this point many of the States, including Missouri, are moving in the direction of making it much easier. We just, I think our first military spouse that got an immediate license when she came to this State, was a lawyer, who, within a few days of moving to Missouri with her husband who was at Fort Leonard Wood was practicing law. And the more of that sort of thing, whether it is a lawyer, or a beautician, or an electrician, or——

Secretary WALSH. A teacher.

INCREASE IN H–2B VISAS

Senator BLUNT [continuing]. A commercial truck driver, whatever those licenses are, I want to work with you on that.

In another area, I was pleased to see the Department, in conjunction with the Department of Homeland Security, announce the availability of an additional 22,000 H–2B visas, provided for in the 2021 Omnibus Bill. You know, these H–2B visas are, a lot of them in hospitality, and landscaping, in timber.

In our State, I see those generally as jobs that actually protect the other jobs that are there, coming in, filling a part-time gap that allows the full-time Missouri resident employees to have a job that

they wouldn't have, if the hotel couldn't be open, or that they wouldn't have if all of the landscaping work that needs to be done at a given time, couldn't be done.

I don't want a detailed answer from you here today, but I would like you to commit to working with this subcommittee to guarantee that the program has sufficient returning workers to meet the seasonal needs of our small businesses, and our local industries. And fishing would be one of those industries in coastal areas. Senator Mikulski and I used to work closely on this particular issue.

Would you be willing to continue to work with us on this, Secretary?

Secretary WALSH. Yes. There is no question about that. And not only that, I think that this program also benefits the people that are coming here, working and taking back home, the revenue back home to their families. And I think that that also is a kind of a win-win for all sides. So I certainly will continue to work with you on that.

FUNDING FOR THE APPALACHIAN AND DELTA COMMISSIONS

Senator BLUNT. Another area I mentioned in my opening comments was that your budget request included a $35 million set aside to serve workers in the Appalachian and Lower Mississippi Delta regions, that we began funding in 2018. I was the Chairman of the committee at the time, and Senator Murray was the ranking member, and that funding has created, and will create employment opportunities by providing reemployment and training assistance in areas where they are needed.

Can you speak to the success of the grants in this area, these regional commissions, like the Appalachian Regional Commission, and the Delta Regional Commission?

Secretary WALSH. Certainly. I mean, there is no question that these grants are beneficial to those areas of the country and, you know, I hear, the feedback I get from the Department of Labor, from the workforce development side of it, is that a lot of these different areas want increased grants, and opportunity to access to grants. So it is beneficial. And that is why the additional revenue that I am looking for in some of this workforce development and grant money will allow us the opportunity to make more investments in those areas.

Senator BLUNT. Thank you, Secretary.

Chair, I think that I will have some more questions for the record. But I believe those are, at this point, at least all the questions I have for the hearing today.

Senator MURRAY. Very good.

Senator Braun.

OSHA ENFORCEMENT BUDGET INCREASE

Senator BRAUN. Thank you, Madam Chair.

And good to see you, Mr. Secretary, enjoyed our conversations in the past. And, you know, I come from the business world, and especially small business, and I have been able to see our business grow over the years, and interface with all the things you have to do with government. And I have always felt an inherent responsi-

bility to do things right, keep your employees safe, that that is part and parcel of growing an enterprise.

I noticed where there is a request for $350 million increase in enforcement funding, and would be curious, I tried to get the information what that is on top of already, and is it related to. I know maybe during the Trump administration, which I welcomed, a lot of easing up on certain stuff that maybe was in overdrive, still acknowledging that many things need to be in place to keep a safe environment, to keep a safe workplace.

Has there been an uptick in OSHA-related cases that would warrant that kind of increase that would be targeted towards enforcement?

Secretary WALSH. That is a great question. The problem we have with OSHA is that we have seen an increase in cases, and we have also seen a decrease in OSHA inspectors. So I guess the answer is: that we are seeing increased potential problems, and we have fewer people to go out and investigate those problems. So we have a lot of our cases that are going kind of, I guess, unchecked, if you will.

Again, as I said earlier, before you came in Senator, this, I would like to get OSHA to a point where it is not just going out and seen as a "gotcha" organization. I mentioned, when I was a younger person, I worked on construction, and OSHA would come out to the job site, and not because they are out there because of an accident, they are out there to make sure that there was proper safety procedures in place in construction, which is dangerous, as you know.

I would like to get OSHA back where we are doing a lot more collaboration of working with businesses to make sure we create work—safe work sites across America, rather than having to respond to a tragedy. And we are not there yet. So the increase that we are looking for is to build back the OSHA Department, and build back the Department of Labor to pre—you know, the last 5 years we are down, the lowest amount of inspectors, I believe, in the history since the beginning of the Department of Labor, we are at the lowest number right now.

Senator BRAUN. So what I would like, and you can get that to our office, would be: what the number of enforcement issues have been from 5 years ago to the present, what the funding levels were each year, to make sure it might get related to that in some fashion.

OSHA ENFORCEMENT IN LARGE BUSINESS VS. SMALL BUSINESS

And then also I would want to bring up the distinction between large business and small business. And NFIB (National Federation of Independent Business Inc.) has been out there with so many stats that have shown that small businesses have been decimated, challenged with COVID, some of the things they had to do there that was on top of what they have to normally do to move forward and prosper. And I have also been an observer there. The smaller your business is, normally, the more intimate that relationship is with your employees.

So again, I would like to know whether the Department currently differentiates between how it looks at enforcement among big businesses versus small businesses. And to see if there is a distinction in how you carry out those functions.

Secretary WALSH. Yes. Let me get back to you on that one. I don't have the answer for you.

Senator BRAUN. Yes.

Secretary WALSH. But I understand here what you are saying. And when you talk about small businesses, you are not necessarily talking about the three-person mom-and-pop store, you are talking about the 200-person store and——

Senator BRAUN. I would give it 500 and fewer.

Secretary WALSH. Yes.

Senator BRAUN. And it is that——

Secretary WALSH. So let me get back to you on that.

Senator BRAUN. Yes.

Secretary WALSH. Because I understand, I recognize the fact that there is a big difference between a small business and a corporation.

Senator BRAUN. Especially 50 and under.

Secretary WALSH. Yes.

Senator BRAUN. But let us take the common definition, and whatever is being done in the future, I would want to make sure it is based upon the need to do it, number one, especially in the context of scarce resources. So much of what we are doing today and not just after the Biden administration took over, because we do it on borrowed money on anything that we do enhance in a budget. And I think that will come into question in the long run as well.

So if you could get back to my office on those two particular pieces of information, I would appreciate it.

Secretary WALSH. I definitely will.

And I was at the Indy 500 the other day, I went around the track, it was pretty amazing.

Senator BRAUN. Yes. And that is a kind of, I guess, a big version of a small business.

Secretary WALSH. Yes. It certainly is.

Senator BRAUN. Right in my home State.

Secretary WALSH. It certainly is. It was interesting. It was fun.

Senator BRAUN. Yes. Okay. Thank you.

Secretary WALSH. Thank you, Senator.

Senator MURRAY. Thank you very much.

That will end our hearing today, Mr. Secretary; and our hearings on President Biden's Budget Proposal for fiscal year 2022.

I want to thank all of our fellow committee members for their participation.

Secretary Walsh, thank you for your very thoughtful answers. I look forward to continuing to work together with you to fight for workers, and build a stronger, fair economy for everyone.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due Friday, July 23 at 5 p.m. The hearing record will also remain open until then for members who wish to submit additional materials 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 HON. MARTIN J. WALSH

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

WHISTLEBLOWER COMPLAINTS AND STAFFING

Question. I'd like to follow-up on my question about OSHA's whistleblower program. Last year's Inspector General report described the significant increase in complaints and insufficient staff to investigate those complaints during the pandemic.

Please describe the impact of complaints not being timely and effectively investigated and the steps planned and being taken to address this issue.

Answer. Over the past several years, OSHA has experienced a significant increase in new whistleblower complaints being filed, while the level of staffing has remained steady. This, coupled with new whistleblower statutes added to the agency's growing portfolio, including statutes unrelated to worker safety and health, has resulted in a significant increase in the inventory of outstanding investigations, with many going on for extended periods of time (overage/backlog cases). These factors have created a lag time in completing investigations and making agency determinations based on the merits of the complainants' allegations. With the onset of the coronavirus pandemic (with more than 5,500 COVID–19-related whistleblower complaints filed so far), the additional increase in new filings and subsequent backlog inventory have limited the agency's ability to complete investigations in a timely manner. If OSHA does not have sufficient resources to meet quality and efficiency standards for its whistleblower investigations, and is unable to review all complaints alleging workplace retaliation, the agency cannot properly protect employees' rights to engage in protected activity and prevent retaliation.

OSHA has taken many steps to address the challenge of achieving a reasonable balance between an investigation's timeliness and quality in order to handle its whistleblower inventory more efficiently and effectively. First, the agency instituted a pilot program whereby the agency conducted two rounds of assignments of complaints across regional boundaries, allowing for regions with a lesser workload to assist regions with a higher workload, focusing on establishing a more reasonable workload balance nationwide. OSHA is actively exploring other avenues to address backlogged inventory, both nationally and regionally. Second, the agency is overhauling the Whistleblower Investigations Manual (WIM) to streamline procedures without compromising case quality. OSHA instituted a new Pilots Directive that allows for innovative ideas and suggestions to be 'tested' to see if added efficiency is gained and successful pilots are incorporated into the WIM and made national policy. Third, OSHA developed an investigative checklist to ensure that key investigative steps are followed, establishing clear and effective case monitoring during the final stages of an investigation, and thus ensuring that the quality of the investigation is maintained. Finally, OSHA is actively hiring additional whistleblower staff to assist not only in addressing the inventory of backlogged cases but also the total inventory of cases, by promptly processing and investigating new complaints so they don't become overaged. The agency's fiscal year 2022 budget request also includes a requested increase 63 FTE and $5.3 million to provide additional whistleblower staff to meet the workload demands.

OSHA will also continue to engage its stakeholders with meetings throughout the year. These meetings provide a forum for the public to offer suggestions and comments on ways the agency can improve the whistleblower program. This will allow OSHA an opportunity to go beyond the protection of individual whistleblowers by increasing outreach efforts through the Whistleblower Outreach Plan in an effort to educate employers about their responsibilities and employees on their rights afforded under the statutes OSHA enforces. The agency will focus its outreach efforts on industries with the highest, as well as the fewest number of complaints filed, whistleblower protection provisions of the newest statutes enacted, and vulnerable populations least aware of worker protections while also continuing to promote the "Recommended Practices for Anti-Retaliation Programs" guidance for employers. This document outlines the steps recommended for employers to establish a workplace where employees feel comfortable raising concerns, without fear of retaliation. In turn, the employer benefits from improved employee morale and productivity, as well as the likelihood of fewer whistleblower complaints being filed by its workers.

Question. How would the American Rescue Plan Act funds, additional funds requested in the fiscal year 2022 budget and policy changes address a recommendations made by the Office of Inspector General to more equitably distribute whistleblower complaints amongst investigators, and provide consistent enforcement of whistleblower rights among the regions.

Answer. OSHA will use the funding received under the American Rescue Plan Act to address COVID–19 related whistleblower complaints. OSHA published the COVID–19 National Emphasis Program, which prioritizes investigating employers that retaliate against workers for complaints about unsafe or unhealthy conditions, or for exercising other rights protected by Federal law. OSHA plans to spend $13,079,000 to support 32 FTE in the Whistleblower budget activity, including 25 investigators over the course of the three-year supplemental. Funding would also support seven national and regional whistleblower staff to address evolving policy issues, and provide required high level review of the growing number COVID–19 retaliation claims received by the agency, with more than 5,500 COVID–19-related whistleblower complaints filed so far.

In fiscal year 2022, OSHA is requesting $24,999,000 and 185 FTE, which includes a program increase $4,100,000 and 50 FTE for whistleblower investigators to effectively enforce 25 whistleblower statutes, including the recently added Criminal Antitrust Anti-Retaliation Act and the Anti-Money Laundering Act. In addition to investigators, OSHA is requesting a program increase of $1,243,000 and 13 FTE to support the Alternative Dispute Resolution (ADR) Program, policy development and review, and appropriate management support for the Whistleblower Protection Program (WPP). As part of the effort to build a stronger whistleblower program and have the necessary level of resources to support the significant number of whistleblower statutes the agency has been mandated to enforce, OSHA will make sure that every worker, especially those in vulnerable and underserved communities, knows about their rights and what to do if they believe their safety and health is not being protected. The agency is committed to ensuring that every worker is protected and feels empowered to raise concerns when they feel their workplaces are unsafe.

The additional investigators requested in fiscal year 2022 will be distributed throughout the agency's regional offices with a focus on preventing an increase in the backlog of complaint investigations while also reducing the overall inventory of pending investigations. The requested resources will help OSHA keep up with the high demand, and ensure that workers' concerns are properly and thoroughly processed and responded to as expeditiously as possible.

OSHA has taken many steps to address this challenge of achieving a reasonable balance between an investigation's timeliness and quality in order to handle its whistleblower inventory more efficiently and effectively. First, the agency instituted a pilot program whereby the agency conducted two rounds of assignments of complaints across regional boundaries, allowing for regions with a lesser workload to assist regions with a higher workload, again, focusing on establishing a more reasonable workload balance nationwide. OSHA is actively exploring other avenues to address backlogged inventory, both nationally and individually by Region. Second, the agency is overhauling the Whistleblower Investigations Manual (WIM) to streamline procedures without compromising case quality. OSHA has instituted a new Pilots Directive that allows for innovative ideas and suggestions to be 'tested' to see if added efficiency is gained—those successful pilots are incorporated into the WIM and made national policy. Third, OSHA developed an investigative checklist to ensure that key investigative steps are followed, establishing clear and effective case monitoring during the final stages of an investigation, and thus ensuring that the quality of the investigation is maintained. Lastly, the agency is actively hiring additional staff to assist not only in addressing the inventory of backlogged cases but also the total inventory of cases, by promptly processing and investigating new complaints so they don't become overaged.

In addition, with new fully trained staff in place, along with new staff requested in the fiscal year 2022 Budget Request, OSHA will continue to streamline its processes by developing alternative procedures through piloted programs and strategies that are evaluated, found to be effective, and implemented nationwide. Specific focus will continue to be placed on backlog reduction strategies to reduce the inventory of overaged cases. Additionally, OSHA will continue its efforts to expand the use of the Alternative Dispute Resolution (ADR) Program, which has proven to be an effective strategy to efficiently process complaints/cases in a timely manner and with positive results. With the delegation of two additional whistleblower laws in fiscal year 2021, the Anti-Money Laundering Act (AMLA) and the Criminal Antitrust Anti-Retaliation Act (CAARA), OSHA plans to conduct training on the investigative processes concerning these new laws for its staff in fiscal year 2022, as done with the Taxpayer First Act (TFA) in fiscal year 2020. OSHA also plans to develop an Intranet-based Whistleblower Investigator (WBI) Resource Page for whistleblower personnel that will include technical assistance and answer a myriad of questions presented by the field, including those related to COVID–19, which is constantly evolving. This will be accessible to all Regions, ensuring nationwide consistency. All

of the initiatives will be developed and implemented to assist the agency in addressing the recommendations made by the Office of the Inspector General.

DAVIS BACON ENFORCEMENT

Question. Mr. Secretary, construction workers across this nation rely on the Department's Wage and Hour Division to enforce their right to prevailing wages on federally assisted construction projects. As a former construction worker, you know as well as anyone that construction is hard, dangerous work. These protections ensure the Federal Government is creating good jobs with fair pay and bringing countless economic benefits to local communities. The workers and communities who build our bridges, highways, and other critical infrastructure deserve the protections and the benefits prevailing wage provides.

Mr. Secretary—how would your Department use the funds requested for the Wage and Hour Division to better enforce the Davis-Bacon Act, particularly with respect to working with other Federal agencies to ensure compliance?

Answer. The Davis Bacon Act protects construction workers' rights to receive the local prevailing wage and leverages the purchasing power of the Federal Government to support local contractors, local workers, and local economies. The Department is currently engaged in a comprehensive review of its Davis Bacon program including outreach, education, compliance assistance in partnerships with contracting agencies and enforcement. Additional enforcement resources will allow the Wage and Hour Division to put more investigators into the field and onto construction sites to make sure workers are getting the wages they have earned on Davis Bacon projects.

ILAB MONITORING AND ENFORCEMENT

Question. Mr. Secretary, my home state of Washington is one of the most trade dependent economies in the United States. That's one of the reasons I support trade deals with strong labor and environmental protections. So, I was pleased to see the budget proposes $124 million, an increase of more than $27 million, for the International Labor Affairs Bureau. This includes significant new investments for ILAB to expand trade-related monitoring and enforcement of labor provisions in our trade programs and new resources to investigate the use of forced and child labor in global supply chains.

I know you have dedicated resources for work on our trade agreement with Mexico and Canada. However, with 150 international trading partners under existing free trade agreements or trade preferences, your budget request won't stretch far enough to conduct monitoring and enforcement with all of our trading partners.

How will you prioritize countries for monitoring and enforcement activities?

Answer. DOL is committed to monitoring and enforcing the labor provisions in all of our trade agreements and preference programs. Over the last year, in addition to creating a new division dedicated to enforcing the labor provisions of the U.S.-Mexico-Canada Free Trade Agreement, our Office of Trade and Labor Affairs (OTLA) within the Bureau of International Labor Affairs has increased the staffing level and resources devoted to enforcing labor provisions in the other trade agreements and trade programs as well. This has enabled us to intensify our engagement with countries with the greatest need. For example, so far in 2021, the Department has dramatically increased its work allocated to our trade agreement with Central America (CAFTA–DR), enabling us to integrate labor enforcement into the important work being led by the White House on Central America. Likewise, with the preference programs, we are continuing to monitor all countries benefiting from the Generalized System of Preferences (GSP) and the African Growth and Opportunity Act (AGOA) through the GSP triennial assessment and the annual AGOA review. Based on these processes, our team prioritizes and engages with key countries in an ongoing manner. Both the GSP and AGOA processes consider information from a broad array of sources, including U.S. government reporting, international and national labor rights organizations, and public comment mechanisms included in the preference programs. Our team shares the results of its fact-finding, along with recommendations for priority countries, with the Trade Policy Staff Committee (TPSC). Subsequent discussions with interagency partners further shape OTLA's identification of priority countries and inform ongoing strategies for engagement to promote progress towards meeting the worker rights eligibility criteria.

Question. And, how will you partner with the State Department and Office of the Trade Representative to ensure the most robust enforcement possible of labor provisions in our trade programs?

Answer. DOL works closely with the Department of State and the Office of the U.S. Trade Representative (USTR) in our goal for strong enforcement of labor provi-

sions in our trade agreements and trade preference programs. DOL engages with key countries through bilateral work and is in constant communication with our interagency partners, trade partner country stakeholders, and the International Labor Organization to maximize our effectiveness in labor enforcement. In addition, DOL works with State and USTR in a variety of formal mechanisms, such as the Trade Policy Staff Committee (TPSC), labor and trade-related working groups such as the CAFTA–DR working groups, and Trade and Investment Framework Agreements (TIFAs). For example, DOL's Office of Trade and Labor Affairs (OTLA) collaborates with USTR's labor office to develop and deliver talking points on labor priorities in connection with TIFAs between the U.S. and parties to the TIFA. OTLA also convenes regular calls with USTR and State to discuss and share updates on priority labor issues, and ensures USTR and State's participation on relevant labor-related country briefings.

CHILD LABOR

Question. According to the latest report on child labor produced by the International Labour Organization and UNICEF, the number of children in child labor around the world dropped from 246 million in 2000 to 152 million in 2016. Unfortunately, this 16-year downward trend has been reversed over the past 4 years, increasing to 160 million children worldwide in 2020 with nearly half of these children engaged in hazardous work.

Please describe how funds currently available to the International Labor Affairs Bureau will be used to contribute to a reversal of this increase in child labor.

Answer. Reversing the upward trend in child labor, as reported in the latest ILO and UNICEF global estimates, will require a multi-faceted approach. A range of factors have contributed to the significant increase in child labor noted in some parts of the world, particularly Sub-Saharan Africa. ILAB is increasing its focus on a number of key areas where there is a great need and where we can have a significant impact. This includes increased focus on global supply chains; promoting greater access to social protection, training, and education opportunities for vulnerable children and families; confronting gender and racial inequity; and strengthening worker voice and workers' rights.

ILAB's Office of Child Labor, Forced Labor and Human Trafficking is currently overseeing 46 projects with activities in over 40 countries. These projects are addressing root causes of child labor and forced labor through research, awareness raising, education, improved livelihoods, strengthening labor laws and enforcement, and by increasing the capacity of governments and other stakeholders to scale up and sustain effective practices for preventing and reducing these abusive labor practices. ILAB has also worked with these existing grantees to address urgent needs resulting from the global pandemic. ILAB has allocated project resources to increase vulnerable groups' access to information about the virus, address food insecurity, support remote education and training, and provide masks and hygiene resources to reduce exposure of vulnerable children and workers. ILAB is also deeply engaged in addressing child labor and forced labor in Sub-Saharan Africa, with over $40 million in active programming in the region, including more than $18 million in new programming awarded in 2020 addressing child labor in key supply chains such as cobalt, cocoa, and mica. These projects include a focus on issues of gender equity and the need for enhanced monitoring and remediation. With fiscal year 2021 funds, ILAB is also currently in the process of funding new projects that will address some of the key gaps identified in the ILO–UNICEF report. For example:

—In Malaysia, ILAB is funding a $5 million project to combat forced labor and child labor by increasing advocacy by workers and civil society in the production of palm oil and garments, worker voice in the implementation of a social compliance systems, and workers access to remedies in these sectors.

—In El Salvador, Guatemala, and Honduras, a $7 million ILAB-funded project will build civil society and workers organization capacity to address child and forced labor and other unacceptable conditions of work, promote greater gender and racial equity, and address the needs of some of the most vulnerable populations in these countries, including persons of African descent and indigenous communities.

Moreover, as part of our efforts to achieve a larger and more sustainable reduction in child labor and forced labor, ILAB will actively engage with governments, the private sector, worker organizations, civil society actors, other donor governments, and international organizations to promote the replication of effective practices. ILAB will call on governments to mainstream child and forced labor elimination strategies into broader social initiatives as a way to take to scale strategies that can help to reduce the vulnerability of children, families, and workers to abu-

sive labor practices. ILAB will also continue to use its flagship reports on child labor and forced labor to urge governments to take specific action to reduce these abusive labor practices.

Question. How would resources requested in the fiscal year 2022 budget build on and learn from prior investments?

Answer. From more than 25 years of experience funding international child labor projects and contributing to significant strides in the fight against child labor, we have learned that our most successful and impactful initiatives are those that adopt a holistic approach, based on a broader rights-based ecosystem that places workers and vulnerable communities at the center. We have also learned that it is critical to create the right incentives for governments and businesses to take actions to address child labor and forced labor, particularly in global supply chains.

In fiscal year 2022, ILAB will focus its programming on addressing the persistence of abusive labor practices in supply chains, including through the funding of research to trace goods through supply chains and targeted action to increase workers' voice in the monitoring of labor rights abuses. Rigorous research and reporting can help us hold both governments and corporations accountable for goods produced by forced labor and child labor throughout the supply chain. We will also support projects that help address decent work gaps, as child labor tends to persist where adult workers cannot exercise their rights at the workplace, especially the rights of freedom of association and collective bargaining. Another critical element of ILAB's approach will be to promote good practices and the expansion of social protection schemes that build social safety nets for vulnerable communities where labor abuses are most prevalent (e.g., in rural areas, in agricultural sectors). ILAB will also increase support for workers in informal sectors, where vulnerability to labor exploitation is more pronounced, as noted in the new ILO–UNICEF global child labor estimates, including through support for informal worker organizations. ILAB's increased focus in these areas will be particularly important in addressing the significant increase in child labor in Sub-Saharan Africa, as well as the persistence of child labor in other parts of the world. Finally, ILAB will partner with other donors and organizations to leverage our resources and experience and support our goal for the replication and scaling up of good practices to achieve the broader impact needed.

ILAB will continue to use evidence to inform action, drawing upon our own research and reporting on forced and child labor as well as lessons learned from past and current projects. ILAB's research serves as an essential knowledge base for ILAB's technical cooperation projects, helping ILAB focus its technical assistance in areas where it is most needed and where it can have the greatest impact. ILAB also relies on external evaluations of our projects, which systematically assess the relative effectiveness of different approaches or combination of approaches. ILAB uses good practices, identified through project experience and project evaluations, as a way to leverage learning to promote greater impact in the countries where we work. The following are just a few examples of the impact of ILAB's strategic approach:

—In Uzbekistan, our strategy of consistent, multi-year diplomatic engagement coupled with programming on a broad labor rights/decent work agenda helped achieve a radical reduction in the country's use of forced labor in the cotton sector;

—In Honduras, we have used a multidisciplinary approach—research on labor issues, monitoring, and technical assistance and cooperation—to holistically and sustainably advance labor rights, including child labor, freedom of association, collective bargaining, minimum wages, hours of work, and occupational safety and health (OSH). With support from an ILAB's project, three Honduran cooperatives that export coffee to the United States implemented a sustainable social compliance system to reduce the prevalence of child labor in their supply chain.

—In Mexico, we have focused research and technical assistance efforts in the agriculture sector and on goods where there is high risk of child labor, forced labor, and other labor violations. ILAB has used strategic engagement to empower workers and civil society organizations to advocate for increased access to education and social protection services for children at risk of child labor, their families, and migrant workers.

Question. What are the specific plans to address the worst forms of child labor in the cocoa supply chain in West Africa and build on prior investments made toward this objective?

Answer. The recent release of the ILAB-funded, NORC (formerly the National Opinion Research Center at the University of Chicago) report on child labor in cocoa-growing areas of Côte d'Ivoire and Ghana underscores the significant challenges remaining in the sector. ILAB recognizes that moving toward large-scale re-

duction of child labor in the cocoa supply chain will require securing a commitment to broader action by the two West African governments and the International Chocolate and Cocoa Industry, including to improve labor monitoring, better regulate the sector, and expand remediation efforts. Current ILAB programming is supporting efforts to build the capacity of cocoa cooperatives to enhance child labor monitoring in the cocoa supply chain and facilitate enforcement of child labor laws. ILAB is also funding programming to help law enforcement, private sector due diligence monitors, social service and civil society organizations, and workers themselves to prevent, detect, and eliminate forced labor and labor trafficking in supply chains.

During the most recent meeting of the Child Labor Cocoa Coordinating Group (CLCCG)—a group established in 2010 under the Declaration and Framework— in May 2021, the Governments of Côte d'Ivoire and Ghana, the International Chocolate and Cocoa Industry and ILAB agreed on the need to continue to coordinate on joint efforts to reduce child labor in the cocoa sector. ILAB is currently engaged in dialogue with the two governments and industry on ways to (1) expand this partnership to include other donor governments (e.g., the E.U.) and organizations; (2) promote more active engagement with worker organizations and civil society actors; (3) expand the scope of efforts to include a greater focus on forced labor and human trafficking and the advancement of decent work; (4) take good practices to scale and increase support to children and families in more remote areas where NORC research found the most significant increase in child labor; and (5) increase transparency and develop and report more regularly on indicators of progress.

ILAB will also continue to report on child labor and forced labor in Cote d'Ivoire and Ghana in its three flagship reports—the Findings on the Worst Forms of Child Labor, the List of Goods Produced by Child Labor or Forced Labor, and the List of Products Produced by Forced or Indentured Child Labor. In addition, ILAB continues to engage in active dialogue with other U.S. government agencies, such as the State Department, USAID, USDA, MCC, and DHS/CBP on efforts to combat child and forced labor in the cocoa sector and potential opportunities for enhancing interagency coordination and collaboration.

OFCCP ENFORCEMENT

Question. Mr. Secretary, the Department of Labor plays a unique and vital role in Federal contracting policy through the Office of Federal Contract Compliance Programs to protect workers' rights on jobs created by Federal contracting. These critical protections ensure the Federal Government is creating a fair and safe workplace when it does business with the private-sector. And I'm pleased to see that the Biden Administration has placed such a substantial emphasis on these protections, including a guarantee of a $15 an hour minimum wage.

Mr. Secretary—how would your Department use the funds requested for OFCCP to vigorously enforce anti-discrimination, safety, pay, and other important protections for workers on Federal contracts?

Answer. OFCCP would use the $140,732,000 in funds requested for fiscal year 2022 to rebuild its workforce, strengthen its enforcement to remove systemic barriers to equal opportunity, advance workplace equity, increase contractor accountability, and invest in its technological infrastructure. An investment of critically needed resources will enable OFCCP to play a powerful role in advancing President Biden's commitment to equity by addressing employment inequities that have denied opportunities to vulnerable workers.

Rebuilding Workforce

The fiscal year 2022 OFCCP funding request is $140,732,000 and 639 FTE. This includes a program increase in the amount of $34,756,000 and 188 FTE to rebuild OFCCP's workforce. Over the past 4 years, OFCCP's staffing levels have dropped significantly. In fiscal year 2020, OFCCP operated with a staffing level of 452 full-time equivalents (FTE) compared to 755 in fiscal year 2011.

Strengthening Enforcement

Specifically, the agency will focus on identifying ways to strategically allocate our limited resources on comprehensive compliance evaluations that identify and remedy systemic issues including in hiring and pay, especially as our economy begins to rebuild. Our approach has often been data driven to identify disparities, but OFCCP is interested in developing strategic approaches to identify issues that do not lend themselves to the same kinds of statistical analysis, such as discrimination against workers with disabilities and LGBTQ+ workers.

OFCCP will also focus on reinvigorating its compliance program for Federal construction contractors and subcontractors and federally assisted construction contractors and subcontractors. This effort will be instrumental for the Department to en-

sure equal employment opportunity for good jobs in the construction industry. OFCCP plans to launch an outreach and education campaign to advance equity in construction contractor workplaces and to educate workers of their rights under the mandates enforced by OFCCP.

On its regulatory agenda, OFCCP listed its intention to modernize its supply and service regulations. OFCCP is interested in updating its requirements to align them with the realities of today's workforce and how employers operate. The agency is considering how it can streamline its processes and reduce unnecessary burdens on contractors while ensuring OFCCP can comprehensively address indicators of discrimination across all its authorities.

Workplace Equity Initiative

The funding request would support OFCCP developing a comprehensive initiative to advance all forms of equity at work. President Biden has made a historic commitment to advancing equity, prioritizing it as a key pillar of his Administration. OFCCP has a critical opportunity to work with a broad coalition of stakeholders in the pursuit of a common goal—to eliminate discrimination in the workplace and proactively advance equality of opportunity for all workers, including women, people of color, LGBTQ people, people with disabilities, veterans, and people belonging to multiple protected classes.

The purpose of this initiative is to identify promising practices, evidenced-based research, and innovative initiatives that can lead to more diverse, equitable, and inclusive workplaces that increase equity in employment opportunities. In particular, the initiative will focus on examining employment practices that have been effective in closing pay gaps, increasing the recruitment and hiring of underrepresented workers, and facilitating the promotion of underrepresented workers into senior-level and executive positions.

Technology Modernization

In fiscal year 2022, OFCCP will continue to prioritize expediting the modernization of its technology to promote greater employer compliance while maximizing the efficiency of agency staff. This includes completing OFCCP's Compliance Management System (CMS) development and deploying the Notification Construction Award Portal (NCAP), which allows Federal procurement officers, States, and construction contractors and subcontractors to electronically notify OFCCP of constructions awards valued at $10,000 or more. This IT modernization effort centralizes the notification process in the national office, increasing field efficiencies by relieving staff from having to manage contract award notifications

Question. Please describe your hiring plans for the proposed investments in OFCCP included in your budget request.

Answer. This funding request specifically supports the hiring, retention, and training of a highly qualified and diverse workforce to support OFCCP in advancing its mission through enforcement, outreach and education, stakeholder engagement, and compliance assistance while emphasizing efficiency, productivity, and accountability throughout the organization. The support for additional staff will enable OFCCP to strengthen its capacity to conduct compliance evaluations, and identify and resolve instances of systemic discrimination in hiring and pay.

OFCCP is actively hiring to fill critical vacancies the agency lost over the course of several years, especially compliance officers. OFCCP is strengthening its internal capacity to support the hiring surge by filling the vacant HR Branch Chief position and hiring additional management analysts to support the agency's hiring and employee engagement needs. To expedite the hiring process, OFCCP is utilizing standardized position descriptions, single vacancy announcements for multiple positions at various locations, and an array of hiring authorities, including the Recent Graduate authority for entry level positions. In addition, OFCCP encourages its employees to share announcements through their professional and social networks. OFCCP is also working with OHR to reach a diverse talent pool for its vacancy announcements.

OFCCP is developing several new training courses and resources for its compliance officers. With the recent OMB approval of the construction scheduling letter and the upcoming release of the construction scheduling list, OFCCP will ensure that its compliance officers are fully trained to handle construction compliance evaluations in the most efficient and effective manner. This training is scheduled to commence prior to the release of the scheduling list.

OFCCP is also developing training for new compliance officers. The training will cover the foundational topics a new compliance officer must know in order to successfully start performing their job, such as relevant legal authorities, policies, enforcement authorities, compliance evaluations, complaint processing, and compliance

assistance. This training will be ongoing for all cohorts of new compliance officers as the agency continues to hire.

The training OFCCP provides to its compliance officers allows them to communicate agency standards and processes through compliance assistance and apply those standards and processes during compliance evaluations and complaint investigations. A uniform training program ensures consistency in training across the regional offices, which is critical in following OFCCP's regulations, processes, and procedures and carrying out the agency's mission. OFCCP will continue to prioritize investing in compliance officer training as the agency rebuilds and hires.

OSHA FARMWORKER SAFETY

Question. Under a longstanding appropriations rider of more than 40 years, farms with fewer than 10 employees at all times during the prior year and no temporary labor camp within the previous 12 months are exempt from enforcement of all rules and requirements of the Occupational Safety and Health Act. Yet, according to the National Institute of Occupational Safety and Health, agriculture ranks as one of the most dangerous industries, with farmers at a very high risk for fatal or nonfatal injuries. Any worksite fatality is unacceptable and every step must be taken to avoid such tragic loss of life.

How would the Occupational Safety and Health Administration (OSHA) use Federal funds to improve farmworker safety if Congress removed this rider in the fiscal year 2022 appropriations bill for the Department of Labor? Please describe compliance assistance it would undertake, as well as how farms would be factored into planned enforcement activities, including any emphasis programs or directives.

Answer. The existing appropriations rider has precluded OSHA from conducting enforcement activities at a farming operation if it: (1) employs 10 or fewer non-family member employees currently and all times during the preceding twelve months and (2) has not had an active temporary labor camp during the preceding twelve months. If Congress removes the rider, OSHA can respond to imminent danger situations at currently exempt farming operations and remove employees from those dangers. The agency would also be able to respond to employee complaints regarding workplace safety and health hazards, and investigate fatalities (such as from grain engulfment) and severe injuries. Lastly, OSHA would include small farming operations in programmed or planned inspections, such as national, regional, and local emphasis programs, that are aimed at specific high-hazard industries.

While the appropriations rider has significant implications for OSHA's enforcement activity, it should first be noted that it has not prevented the agency from developing and distributing workplace safety and health resources for agricultural settings, including those where OSHA is unable to conduct enforcement. For example, OSHA maintains an Agricultural Operations Safety and Health Topics Page with information about hazards related to grain bins and silos, hazard communication of chemicals, noise, musculoskeletal injuries, heat, and others. OSHA also has a plethora of publications in both English and Spanish that are relevant to agricultural operations that may be printed from the agency's website directly or ordered free of charge from our Publications Office.

The agency also conducts significant outreach to the agricultural industry as a whole, and engages with agricultural industry stakeholders whose target audiences include small agricultural workplaces and family-operated farms. For example, following a significant increase in fatal grain engulfments between fiscal year 2015 and fiscal year 2016, OSHA's Regions 5, 6, 7, and 8 launched a "Stand-Up for Grain Engulfment Prevention" event in fiscal year 2017. That same year, OSHA signed an Alliance with the National Grain and Feed Association, which helped to expand the Grain Stand-Up. Two additional organizations, the Grain Elevator and Processing Society (GEAPS) and Grain Handling Safety Coalition (GHSC), have since joined the Alliance and lent their resources to expanding this initiative. GHSC, in particular, has played a key role in ensuring the Grain Stand-Up reaches smaller growers/producers over which OSHA does not have jurisdiction.

If the rider were removed, and funds became available, OSHA could greatly expand its outreach to smaller agricultural employers and workers. Staff could pursue new relationships with Federal and state farm associations, and proactively establish alliances for the express purpose of conducting outreach, developing educational materials, and providing workplace safety and health training opportunities to smaller farm owners, operators, and employees. Removal of the rider would also enable OSHA to expand its On-Site Consultation Program to provide no-cost workplace safety and health services to smaller agricultural operations who were previously not eligible for these services. Information collected during OSHA's inspections (e.g., regarding types and location of fatalities in smaller farm operations)

could also be used to strengthen, and more effectively target, outreach and compliance assistance.

Question. How would OSHA use Federal funds to improve farmworker safety if Congress were instead to modify the rider by allowing the fiscal year 2022 appropriation to be used only to investigate fatalities on such small farms and provide associated compliance assistance necessary to decrease the likelihood of a similar injury or fatality?

Answer. Farming operations experience workplace fatalities from a variety of hazards, including from grain engulfment, falls from structures, entanglement in grain moving machinery, and electrocution. Researchers with the Agricultural Safety and Health Program of Purdue University publish a report yearly, showing trends in the number of grain entrapments and associated fatalities. Because small farming operations are exempt from OSHA enforcement activities, OSHA cannot investigate such incidents and determine the root causes to prevent recurrence of such incidents. If Congress modifies the rider, OSHA can inspect and thoroughly investigate the fatalities, and provide necessary abatement methods and hazard recognition training to employers engaged in small farming operations.

We assume that the provision of the direct compliance assistance would be limited to the employers involved in the fatalities investigated, and focused on decreasing the likelihood of a similar injury or fatality at that facility. In this case, the agency would continue the outreach it already engages in (noted above) but could not meaningfully expand proactive outreach and compliance assistance to smaller farm operations. In many instances, when OSHA responds to a fatality in an agricultural operation and determines that it has no enforcement jurisdiction (e.g., where an incident is voluntarily reported), the responding staff will nevertheless advise them that there is important safety and health information on the OSHA website that could help them to decrease the likelihood of a similar injury or fatality. However, the agency could enhance this effort by using the findings gathered through any resulting investigations to augment existing compliance assistance materials and share them broadly through its outreach efforts. The agency may also be able to engage with the individual employers through the On-site Consultation program; this would need to be evaluated at the time the rider is issued.

MULTILINGUAL WORKER PROTECTION STAFF

Question. The missions of worker protection agencies of the Department of Labor include coverage of and assistance to all workers, including those who speak languages other than English.

Please provide current counts of the number of multilingual staff for the Wage and Hour Division (WHD) and Occupational Safety and Health Administration (OSHA) in total and by region.

Answer. OSHA has a total of 111 staff who are multilingual. The breakout by region is shown in the table below.

OSHA Multilingual Staff 2021	
Region	Staff
1	4
2	4
3	8
4	14
5	38
6	14
7	16
8	0
9	7
10	4
National Office	2

OSHA Multilingual Staff 2021	
Region	Staff
Total	111

These data were provided by the Office of the Assistant Secretary for Administration and Management and includes positions that may require a foreign language capability.

In total, WHD has 573 employees who are multilingual and speak 21 different languages.

By Region, the Northeast Region has 136 multilingual staff, the Midwest Region has 87 multilingual staff, the Southeast Region has 107 multilingual staff, the Southwest Region has 117 multilingual staff, and the Western Region has 126 multilingual staff.

Question. How will the Department use resources in the current fiscal year and requested for fiscal year 2022 to recruit and hire multilingual, qualified candidates for roles as investigators, inspectors and other critical positions where language barriers could prevent an agency from fulfilling its statutory mission? How will the Department assess such language gaps and plan to meet its language needs in carrying out the missions of its agencies?

Answer. OSHA plans to recruit and hire multilingual qualified candidates for investigators, inspectors and other positions by working with organizations such as Historically Black Colleges and Universities, Hispanic Serving Institutions, the Asian American Network and other organizations so that the agency's workforce has the multilingual capabilities that reflects the communities that OSHA serves. By reaching the most hazardous worksites and facilities, the agency not only helps secure safe and healthy workplaces and reduce workplace injuries, illnesses, and deaths, but also protects at-risk workers in marginalized communities, who are less likely to have the protections and training to work safely in high-hazard workplaces.

The Wage and Hour Division (WHD) utilizes targeted recruitment strategies to attract a diverse pool of highly qualified candidates for WHD positions. WHD routinely includes language requirements when hiring to ensure that investigators can successfully communicate with workers and employers about their rights and responsibilities under the law. Currently, WHD has more than 570 multilingual staff.

In fiscal year 2022 WHD will continue to assess hiring needs through a data-driven approach that will help to identify gaps in services and resource allocation to particular communities. WHD is implementing plans to increase recruitment and outreach to Minority Serving Institutions and community based organizations to continue to reach diverse applicants and ensure a pipeline of investigators who reflect the communities they serve. Finally, WHD is opening positions in remote, low-wage, underserved communities nationwide and increasing flexibility in telework to serve these areas.

Question. Please describe how the WHD and OSHA will work with stakeholders, including community-based organizations in reaching worker populations such as those with language access barriers and other factors that may contribute to a decreased likelihood of filing of a complaint for a violation of labor law protections.

Answer. OSHA remains committed to working with and engaging its whistleblower stakeholders. The agency has been conducting two stakeholder meetings per year, some targeting specific industries, seeking input and suggestions from them on a myriad of issues, such as how to provide better customer service and how to conduct better outreach to the public. The agency also listens to their concerns regarding how the coronavirus pandemic has affected their workplaces. The agency reviews each and every comment and suggestion from these meetings and has implemented a number of them.

As a result of the most recent stakeholder meeting in May 2021, OSHA is reaching out to migrant worker groups who provided comments, to more fully understand their concerns, and to work with them on enhanced ways to reach out to the people they represent. In addition, the agency's whistleblower website, www.whistleblowers.gov, contains many outreach documents that provide information to workers who may have been retaliated against for engaging in protected activity. Much of the information is available in English and Spanish.

The agency is committed to not only inform workers of their rights, but also to remind employers of their responsibilities under these laws. Moreover, OSHA is actively promoting its Recommended Practices for Anti-Retaliation Programs guidance document, which focuses on assisting employers in creating an effective anti-retaliation program in their workplaces, where workers feel comfortable reporting concerns

without fear of retaliation, and without the need to file a whistleblower complaint in the first place.

OSHA continues to prioritize outreach to vulnerable worker populations. For example, OSHA translated its educational and outreach materials into Spanish [1] and more than 30 other languages.[2] These resources are printable from OSHA's website and print copies may be shipped at no cost upon request. Several focus specifically on workplace rights [3] and OSHA created a video on filing a complaint that is available in both English [4] and Spanish,[5] which is shared along with its publications through the agency's outreach efforts.

OSHA's Labor Liaisons [6] maintain communication with organized and unorganized workers, Committees on Occupational Health and Safety, worker centers and coalitions, helping them navigate OSHA's organizational structure and complaint procedures, and assisting them in developing and updating health and safety programs.

The agency maintains regular communication with worker advocacy organizations such as the National Council for Occupational Safety and Health (National COSH), to ensure that safety concerns workers have about their jobs are heard and addressed. On June 23, 2021, Acting Assistant Secretary Jim Frederick participated in a bilingual town hall meeting where he responded directly to questions from farm, poultry plant, nursing home and other workers. Topics included the urgent need to protect workers from heat exposure and the COVID–19 Emergency Temporary Standard for healthcare. The recording is available in English here [7] and in Spanish here.[8]

OSHA has numerous regional and area office alliances with Consulates [9] of Mexico and other Latin American countries through which the agency shares information in English and Spanish about workplace safety and health hazards and workers' rights, including use of the OSHA complaint process. OSHA's Region 5 Regional Office also has an Alliance with the Consulate of the Philippines in Chicago.

OSHA Compliance Assistance Specialists participate in regional task forces and committees established to protect migrant farmworkers in both the midwest and southeastern United States. Each August, OSHA and WHD collaborate in supporting Labor Rights Week, a joint initiative between the governments of the United States and Mexico to increase awareness in the Mexican and Latino communities about the rights of workers, including immigrant workers.

WHD is currently engaged in the Essential Workers, Essential Protections initiative, which includes collaborating with stakeholders nationwide to train them in protections for the most vulnerable, at-risk worker populations as we emerge from the pandemic. Efforts to date include conducting hundreds of educational webinars, reaching more than 26,000 participants; training advocates on how to file complaints; producing and continuing to air television and radio public service announcements in English and Spanish; and producing and placing workers' rights posters in local stores to reach marginalized populations. A nationwide series of listening sessions is now underway to hear directly from stakeholders in contact with these workers how we can better reach them. These efforts are designed to strengthen relationships with community based organizations who are trusted resources for the most vulnerable workers and can refer workers, file third-party complaints, and amplify WHD's enforcement efforts.

SUBMINIMUM WAGE

Question. The budget requests $42.7 million, an increase of $3.7 for the Office of Disability Employment Policy (ODEP). The budget notes a priority for ODEP to advise Federal agencies and assist states and employers in transitioning workers away from sub-minimum wage employment currently authorized under 14(c) of the Fair Labor Standards Act to competitive, integrated employment. My home state of Washington recently enacted legislation ending a similar authority for issuing certificates to pay workers with a disability less than the state minimum wage generally as of July 31, 2023.

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[1] https://www.dol.gov/newsroom/releases/odep/odep20200429-0.
[2] https://www.osha.gov/publications/bylanguage.
[3] https://www.osha.gov/publications/bytopic/workers'-rights-outreach.
[4] https://www.youtube.com/watch?app=desktop&v=k70Ln7gRWDE.
[5] https://www.youtube.com/watch?app=desktop&v=zgv-Fuqx3K4.
[6] https://www.osha.gov/workers/liasons.
[7] https://drive.google.com/file/d/1HFikHihuIMbB69LGgdNsRsVkWCINtOXG/view.
[8] https://drive.google.com/file/d/1gbM7sdTTonaNEGaMP-PVO3Itdpf3uoH4/view.
[9] https://www.osha.gov/alliances/byemphasis#consulate-alliances.

Please identify the Federal agencies involved and describe the planned advisements that ODEP has for this and next year.

Answer. ODEP works with multiple Federal agencies to advance competitive integrated employment (CIE) in order to reduce reliance on Section 14(c) certificates. CIE is employment that pays at least the Federal minimum wage (or state minimum wage when higher) and allows an employee with a disability to interact with people without disabilities to the same extent able-bodied employees interact with one another. The main Federal agencies ODEP collaborates with include:

—AbilityOne
—Department of Labor (DOL), Office of Federal Contract Compliance Programs (OFCCP)
—DOL, Employment and Training Administration (ETA)
—DOL, Employee Benefits Security Administration (EBSA)
—DOL, Veterans' Employment and Training Services (VETS)
—DOL, Wage and Hour Division (WHD)
—Department of Education (ED), National Institute on Disability Independent Living, and Rehabilitation Research (NIDILRR)
—ED, Office of Career Technical and Adult Education (OCTAE)
—ED, Office of Special Education and Rehabilitation Services (OSERS)
—ED, Office of Special Education Programs (OSEP)
—ED, Rehabilitation Services Administration (RSA)
—Department of Health and Human Services (HHS), Administration for Community Living (ACL)
—HHS, Centers for Medicare and Medicaid Services (CMS)
—HHS, Substance Abuse and Mental Health Services Administration (SAMHSA)
—Social Security Administration (SSA)
—Department of Veterans Affairs (VA), Veterans Health Administration (VHA)
—VA, Veterans Readiness and Employment (VRE)

ODEP planned activities and advisements for this year and next year to promote CIE: In fiscal year 2021, ODEP is investing significant effort[10] to advance national and state-level policy promoting CIE to reduce reliance on Section 14(c) certificates. ODEP maintains a list of state "Employment First" policies and initiatives aimed at phasing-out Section 14(c). The list is readily available to share with Federal agencies, state partners and other stakeholders on request. ODEP maintains a learning library of webinars and resources focused specifically on advancing CIE and has worked directly in over 27 states to align state policy, funding and service strategies to incentivize integrated over segregated employment. ODEP remains a resource for Federal agencies and state/local systems on use of best practices for achieving CIE, such as supported and customized employment, and reasonable accommodations. In designing activities to advance CIE and eliminate Section 14(c) employment, ODEP organized the recommendations of the Advisory Committee on Increasing Competitive, Integrated Employment for Individuals with Disabilities (ACICIEID) into 10 critical areas. These 10 areas are needed for employment service providers and systems to transform their systems from segregated to competitive integrated business models and provide the overarching framework for ODEP's work. Based on this framework, ODEP created a Transformation Guide for states to assist in organizing the multiple aspects of transformation needed across policy, funding and practice to achieve CIE.[11] Specific ODEP activities and advisements for fiscal year 2021–2022 include:

—*National Expansion for Employment Opportunities Network (NEON):* ODEP's NEON project assists provider agencies to increase CIE outcomes and thus reduce reliance on Section 14(c) employment. In fiscal year 2020, NEON selected and worked with five national provider organizations (NPOs): ACCESS, the American Network of Community Options and Resources (ANCOR), the Association of People Supporting Employment First (APSE), the Arc US and SourceAmerica. ODEP helped the NPOs create national strategic plans for their employment provider networks to transition away from Section 14(c) strategies and increase CIE outcomes. Through NEON, ODEP also supported 19 local provider organizations (LPOs) transition to CIE in fiscal year 2020. In fiscal year 2021, NEON is assisting 48 providers in 19 states, including Washington state. ODEP is also working through NEON to create a National Plan to Increase CIE within the provider community (anticipated for release in late 2021). In addition, ODEP manages a monthly Community of Practice bringing national experts, promising practices and real-life examples of provider transformation to

[10] https://www.dol.gov/agencies/odep/program-areas/integrated-employment.
[11] http://drivedisabilityemployment.org/employment-first-resources/e1st-state-transformation-guide.

the over 2,700 participants from every state. In fiscal year 2022, NEON will support up to 75 LPOs with transition to CIE, and will provide support and technical assistance to implement the NEON National Plan to Increase CIE.[12]

—*Advancing State Policy Integration for Recovery and Employment (ASPIRE):* Established in fiscal year 2021, ODEP's ASPIRE initiative provides technical assistance to seven states to help them develop and align policies, funding and service strategies to increase CIE for people with mental health conditions. Each state is required to involve key systems that provide employment service and support including: Vocational Rehabilitation, Mental/Behavioral Health, Medicaid and Workforce Development. ASPIRE's goal is to coordinate policy, funding and service strategies to increase availability of evidence-based supported employment opportunities for people with mental health conditions in the state. A technical working group (TWG) composed of national mental health stakeholder organizations, mental health national experts and intermediary associations of state and local government agencies provide ongoing information and assistance to ASPIRE states. In addition, a supported employment learning community meets monthly to bring cutting-edge information on key issues in supported employment implementation to ASPIRE states. In fiscal year 2022, ODEP will expand the number of states included in ASPIRE, and will utilize its State Exchange on Employment and Disability (SEED) to increase state policy alignment across systems to increase CIE for people with mental health conditions.[13]

—*ODEP's work with VA and DOL VETS on CIE for Veterans with Disabilities:* In fiscal year 2021, ODEP partnered with the VA's VRE and VHA and DOL's VETS to develop and release two videos to raise awareness about customized employment as an effective strategy to help veterans with disabilities move from sheltered employment or unemployment into CIE. Released in February 2021, the videos are available at: Customized Employment Works for Veterans: A Job That I Love [14] and Customized Employment Works for Veterans: A Win-Win Strategy.[15]

—*ODEP work on Rate Rebalancing to Incentivize CIE:* In May 2021, ODEP released a comprehensive policy guide on state rate reimbursement restructuring titled "Value-Based Payment Methodologies to Advance Competitive Integrated Employment: A Mix of Inspiring Examples from Across the Country". Guidance on rate reimbursement restructuring is critical to increasing CIE for people with significant disabilities. Many existing rate structures are based on the assumption that some people with disabilities are incapable of work, rather than on an Employment First framework that assumes all people are capable of work if given the necessary supports, accommodations and work environment. ODEP developed three webinars on rate restructuring in which relevant state agencies (Medicaid, Vocational Rehabilitation, Mental/Behavioral Health) and providers discuss how adjusting service rates enabled them to incentivize CIE over segregated work models. This is important because some state systems may reimburse providers higher amounts for segregated outcomes. These systems could instead elect to include services necessary for CIE in their list of covered services and incentivize their use through higher reimbursement rates. The webinars providing examples from multiple states and multiple different systems include: (1) Value, Outcome and Performance-Based Payment Methodologies to Advance Competitive Integrated Employment in State Medicaid Long-Term Services and Supports (LTSS) Systems and Managed Care LTSS Systems; (2) Supporting Employment Service Providers to Succeed and Prosper by Partnering to Advance Competitive Integrated Employment: Applying Value, Outcome and Performance-Based Payment Methodologies; and (3) Advancing Competitive Integrated Employment: Value, Outcome and Performance-Based Payment Methodologies in State Vocational Rehabilitation and Behavioral Health Systems.

—*Financial Literacy and Benefits Planning through the Lifespan: Financial Literacy Toolkit:* ODEP also worked with DOL's EBSA to develop a toolkit for youth and adults with disabilities to assist with their finances as they consider employment, retention and advancement. It also shows them how they can build savings. This toolkit provides valuable information for all phases of employment, including consideration of the impact on benefits from working as people with disabilities move from sheltered settings to CIE. It provides infor-

[12] https://www.dol.gov/newsroom/releases/odep/odep20200429-0.
[13] https://www.dol.gov/agencies/odep/initiatives/aspire.
[14] https://www.youtube.com/watch?app=desktop&v=xIsekJpeyiw.
[15] https://www.youtube.com/watch?app=desktop&v=5CFjKwJtXqc.

mation in essential areas such as work incentives, Achieving a Better Life Experience (ABLE) accounts, and other areas of financial literacy essential for people with disabilities. For example, one important resource is the new fact sheet on the Medicaid buy-in, developed by ODEP in collaboration with ACL and CMS (see Medicaid Buy-In Q&A Medicaid "Buy-In" Q&A (dol.gov)).[16] ODEP will continue to develop new resources in this area and add them quarterly. On July 27, ODEP and EBSA hosted a webinar, Secure Your Financial Future: A Toolkit for Individuals with Disabilities,[17] to launch this new financial literacy toolkit.[18] I provided welcoming remarks for the webinar.

—*Workforce Innovation and Opportunity Act (WIOA) Workforce Development System:* ODEP efforts to expand access to CIE includes leveraging the services and connections available through the American Job Centers (AJC) system operated under WIOA. AJCs can register to become Employment Networks (ENs) under the Ticket to Work (TTW) program. ENs are reimbursed for employment services on a milestone basis for successfully assisting people with disabilities into CIE employment. Consequently, ODEP worked to expand the impact of the TTW/EN program by connecting providers of CIE employment services to ENs. The goal was to leverage additional support in achieving CIE for people with disabilities who are eligible Social Security recipients under TTW. To assist in this effort, on May 2021, DOL released a Ticket to Work: Operating a Workforce EN Planning Guide and Workbook to promote the benefits of operating as a workforce EN and to enhance awareness of available resources to help in this process, including guidance and promising practices. ODEP, ETA and SSA developed this technical guide with input from 19 workforce systems currently operating as ENs. The planning guide and workbook assist state and local area workforce leadership in the process of becoming and operating as a workforce EN. It includes a set of activities (e.g., checklists, discussion questions and exercises) to help walk through the process to make an informed decision, and serve as an operational resource for existing workforce ENs. ODEP also held a webinar on May 26, 2021, Practices in Workforce Employment Network Operation—New Technical Guidance,[19] which provided highlights from the technical guide, promoted the advantages this opportunity provides to local workforce systems and shared the experiences of three current workforce systems from the workforce EN operators.

—*Advisement to Federal State and Local Governments, Providers and Individuals with Disabilities on Current Federal Investments to Advance CIE:* In July 2021, in recognition of the 31st anniversary of the Americans with Disabilities Act, ODEP released a new fact sheet, "Recent Funding Opportunities to Expand Access to Competitive Integrated Employment (CIE) for Individuals with Disabilities", developed in collaboration with the HHS' CMS, ACL, SAMHSA; ED's RSA and OSEP; and SSA. The fact sheet highlights new funding and flexibilities which provide significant opportunities to increase access to CIE for youth and adults with disabilities. The increased funding and flexibilities are provided under the Coronavirus Aid, Relief and Economic Security Act (CARES), the American Rescue Plan Act of 2021 (ARP), the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA), the Further Consolidated Appropriations Act of 2020 (FCAA), and through the work of multiple Federal agencies providing services to individuals with disabilities. The CIE fact sheet is located on the ODEP web page at: Recent Funding Opportunities to Expand Access to Competitive Integrated Employment (CIE) for Individuals with Disabilities.[20]

—*Disability Innovation Fund:* ED's RSA and ODEP are discussing RSA's 2020 and 2021 Disability Innovation Fund, which currently has approximately $110 million in fiscal year 2020 available funding, resulting from unused Federal vocational rehabilitation funding returned by states. Congress directed RSA to consult with DOL regarding the use of fiscal year 2021 funds. For the fiscal year 2021 funds, Congress stipulated that the funds be used to award competitive grants to improve opportunities for CIE for individuals with disabilities. ODEP is working with WHD, RSA, ACL and CMS to design the next set of grants.

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[16] https://www.dol.gov/sites/dolgov/files/odep/topics/medicaidbuyinqaf.pdf.
[17] http://leadcenter.org/webinars.
[18] https://www.dol.gov/agencies/ebsa/secure-your-financial-future.
[19] https://www.workforcegps.org/events/2021/03/23/13/16/Practices-in-Workforce-Employment-Network-Operation-New-Technical-Guidance.
[20] https://www.dol.gov/sites/dolgov/files/ODEP/pdf/508__odep__cie__07152021.pdf.

Question. How does ODEP plan to assist states and employers in such transitions?

Answer. ODEP remains committed to helping states and employers transition from segregated Section 14(c) employment to CIE outcomes. ODEP's most critical activities include NEON, ASPIRE, and a new collaboration between ODEP's SEED initiative with ASPIRE and NEON.

—*National Expansion for Employment Opportunities Network (NEON):* As described above, ODEP's NEON project assists provider agencies to increase CIE outcomes and thus reduce reliance on Section 14(c) employment. In fiscal year 2022, NEON will increase the number of providers developing and implementing transformation plans and assist states in the critical task of rebalancing/aligning their service funding in support of CIE. ODEP is also developing multiple NEON tools for release. These include, but are not limited to: an Employment First statewide strategic planning manual to assist states in organizing their statewide strategic planning efforts to effectively engage stakeholders and implement Employment First systems change and a state self-assessment tool for increasing CIE to assist states in evaluating current policies, practices and infrastructures in each of the Ten Critical Areas to Increase Competitive Integrated Employment. The 10 sections of the assessment tool are based on the recommendations of the final report of the Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities. Additional focus in NEON fiscal year 2022 activities will assist providers in implementing the NEON National Plan to Increase CIE (expected release late 2021).

—*Advancing State Policy Integration for Recovery and Employment (ASPIRE):* As described above, ODEP's ASPIRE initiative is assisting states and providers with aligning policy, funding and service strategies across systems This is needed to expand access to evidence-based supported employment throughout participating states. In fiscal year 2022, ODEP will expand the number of states included in ASPIRE, and will collaborate with ODEP's SEED initiative to increase state policy alignment across systems in other states to increase CIE for people with mental health conditions.

—*State Exchange on Employment and Disability/ASPIRE/NEON partnership:* ODEP's SEED works through state intermediary organizations such as the National Conference of State Legislatures (NCSL), the National Governors Association (NGA), and the Council of State Governments (CSG) to assist state legislatures and governors in developing more inclusive workforce policies that promote disability employment. Since transitioning away from subminimum wage is a priority for DOL and an increasing priority for states, SEED and its intermediaries will actively promote legislative and administrative policy options for consideration by all of the states, as well as share examples of recently passed or enacted legislation. In fiscal year 2022, SEED and its intermediaries, including NGA, will work with ODEP's ASPIRE and NEON initiatives to establish a policy collaborative that will focus on assisting those states supporting CIE and the phase-out of Section 14(c). States with more mature CIE policy in place will participate as CIE leaders to assist states with less developed CIE policy, and subject matter experts will work directly with participating states to develop CIE transformation plans.[21]

BLS MOVE

Question. The last two Department of Labor Appropriations Acts have appropriated a total of $40 million requested for the move of the headquarters of the Bureau of Labor Statistics (BLS). The Congressional Budget Justifications for fiscal years 2020 and 2021 both identified this amount as the share of total project costs that BLS would contribute to the move, with the General Services Administration (GSA) paying for the remainder of construction and real property costs of nearly $50 million. The fiscal year 2022 BLS budget requests $28.5 million for a portion of these real property costs and indicates the remaining costs would be initially financed by the GSA and repaid by BLS over time after the move is complete.

Why has GSA backed out of paying its share of project costs?

Answer. The fiscal year 2020 Budget, released in March 2019, announced that the BLS headquarters would move to the Suitland Federal Center. At the time, based on a high-level assessment of the project, the Budget estimated a total project cost of $89 million. The personal property costs of $40 million were assigned to BLS, and GSA was assigned the real property costs at $49 million. These estimates were done

[21] https://www.dol.gov/agencies/odep/state-policy.

in advance of a detailed building assessment study which expanded the scope of the renovation project resulting in a new cost estimate and a detailed assignment of costs between BLS and GSA. The fiscal year 2022 BLS budget request for $28.5 million reflects this revised cost estimate and an updated determination that BLS would fund tenant improvement costs, the costs to be borne by the agency consistent with the publicly posted GSA pricing guide, through a combination of appropriated dollars (paid up front) and a tenant improvement allowance (repaid over time through the rent stream). GSA's fiscal year 2022 budget also reflects increased renovation costs with a request of $20 million in fiscal year 2022. GSA continues to fund all renovation costs consistent with the pricing guide while BLS is funding the tenant related costs consistent with projects in GSA owned facilities.

Question. What actions has DOL taken to secure the GSA contribution that DOL stated in prior Congressional Budget Justifications GSA would provide?

Answer. Throughout the project, DOL has worked closely with GSA to refine cost estimates and clarify funding mechanisms. This has involved numerous and regular meetings with GSA executives within the National Capital Region, in consultation with the Office of Management and Budget.

Question. Please describe how the $28.5 million requested for costs that GSA was going to cover could instead be used to strengthen BLS programs for measuring labor market activity, working conditions, productivity and other critical information for understanding the economy of the United States? What about the additional $23.8 million in costs that would need to be repaid in the future?

Answer. As mentioned above, the fiscal year 2022 BLS budget request for $28.5 million reflects the revised cost estimate to realize the move with the associated reduced footprint and the long-term rent savings for the BLS National Office. The Department strongly supports the move, as it will produce considerable savings and efficiencies that will contribute to BLS' achievement of its mission. If the BLS appropriation for fiscal year 2022 instead directed the $28.5 million in additional funding for base programs, the BLS could fund work on additional statistical program improvements that have been of interest to Congress, such as improving the Job Openings and Labor Turnover Survey (JOLTS) and Consumer Expenditure (CE) program poverty measurement. However, without this funding, the BLS Suitland move would be interrupted and the project timeline would be prolonged. Additionally, it is critical for work to proceed in a timely fashion as the $40 million appropriated to date for the move expires September 2024. Once the BLS National Office is located at Suitland, rental savings are expected, which could be used to cover the tenant improvement costs to be repaid over time and future program improvements.

The $23.8 million in estimated costs to be paid to GSA in the future are intended to take place over the course of several years in the form of a tenant improvement allowance. As such, the payments will be part of the BLS rent bill at the Suitland Federal Center (SFC) and, at that level, will reduce the expected rent savings at the SFC by approximately $2.5 million per year.

WHD AND OSHA FOIA REQUESTS

Question. With over 1,700 Freedom of Information Act requests backlogged at the Wage and Hour Division and more than 800 backlogged at the Occupational Safety and Health Administration as of the second quarter of fiscal year 2021, it's clear more needs to be done to timely process these requests.

Please identify the funding and staffing level dedicated to this work at each of these agencies in the current fiscal year and the amounts and staffing level in the fiscal year 2022 request.

Answer. OSHA's FOIA program is decentralized, with designated staff performing FOIA work largely as an additional duty in the national office and field offices across the country, and does not have a designated budget line item. The funding and staffing for OSHA's FOIA work is calculated based on a survey on the number of staff involved and amount of time spent working on the program. In fiscal year 2020, eight FTE worked full-time on FOIA. Staff working on FOIA as an additional duty accounted for the equivalent of 54 FTE, for a total of 62 FTE working on the FOIA program at a cost of $6.4 million.

In fiscal year 2021, the Wage and Hour Division had nine FTE at an approximate cost of $1.1 million performing work related to the Freedom of Information Act. In fiscal year 2022, the Wage and Hour Division expects staffing levels to be 11 FTE for approximately $1.3 million to perform this work.

Question. What steps are these agencies taking and planning to timely process FOIA requests?

Answer. OSHA acknowledges that there is room for improvement in the FOIA program and is working to address the backlog of requests and to improve the time-

liness of responses to new requests. OSHA processes approximately 9,000 FOIA requests every fiscal year. This accounts for approximately 60 percent of all FOIA requests that come into the Department of Labor. OSHA's FOIA program is decentralized and consists mainly of staff working on FOIA requests as an additional duty. OSHA's Office of Communications (OOC) coordinates the agency's FOIA program and routinely coordinates with staff working on FOIA throughout the country to address any issues, share information, and provide necessary training. OOC continuously looks for ways to improve the effectiveness and efficiency of the FOIA program. For example, OOC has conducted two pilots to evaluate potential changes to the program's structure in order to streamline and improve overall efficiency, consistency and quality of the agency's FOIA process. The agency is evaluating the results of the pilots and is considering next steps.

During fiscal year 2021, the Wage and Hour Division has reduced its FOIA back log from 530 outstanding requests at the end of fiscal year 2020 to 285 as of July 30, 2021. WHD has accomplished this by recruiting and retaining FOIA leadership and staff as well as leveraging technological tools to speed processing requested records within WHD.

EBSA CONSOLIDATED BUDGET

Question. The budget request for the Employee Benefit Administration (EBSA) requests a consolidated employee benefits security programs budget activity in place of separate budget activities for enforcement and participant assistance, policy and compliance assistance, and administration.

How would this new structure better enable EBSA to achieve its statutory mission?

Answer. EBSA seeks to aggregate and consolidate program budget activities for enforcement and participant assistance, policy and compliance assistance, and program oversight.

By restructuring these three budget activities into a single activity for Employee Benefits Security Programs, EBSA can simplify agency performance reporting and streamline agency performance and operating plan development and implementation.

Question. How would EBSA continue to provide transparency and oversight of its spending for each of the eliminated budget activities?

Answer. EBSA believes that restructuring its budget activities will facilitate the allocation and redistribution of resources from lesser performing and lower priority strategies/programs to better performing and higher priority strategies/programs. The restructured budget activities will create a responsive organization that facilitates results-based management. Additionally, the restructured budget eliminates artificial lines between activities, all of which are aimed at a single outcome—employee benefits security. While this restructuring would promote the more efficient allocation of resources, it would not have any negative impact on EBSA's ability and responsibility to report responsibly to Congress on how it expends appropriated funds or on the agency's resulting performance.

RESEARCH AND EVALUATION FUNDING

Question. The budget proposes new evaluation funding flexibility for the Chief Evaluation Officer and Bureau of Labor Statistics at the Department of Labor, as well as for certain offices within the Department of Health and Human Services.

Please describe how each of the new authorities requested would better advance research, evaluation and statistical purposes at the Department of Labor.

Answer. High-quality evaluations, research, and statistical surveys are essential to building evidence about what works, why, and for whom. They are also inherently complicated, dynamic activities, with uncertainty about the timing and amount of work required to design, implement, and complete the studies. Further, we often want to know about the outcomes for workers both in the short- and longer-term. This usually requires information collections spanning five or more years beyond the particular intervention or program under study. The proposal allows flexibility to strategically plan evaluations over time by extending the obligation period to 5 years, rather than constraining obligation within 1–2 years (as current authorities for BLS or the Chief Evaluation Office allow). In addition, the currently available procurement vehicles lack the flexibility needed to match the dynamic nature of these evidence-building projects. Some studies provide high quality information useful across DOL sub-agencies or across Federal agencies; the proposed authority to use a single Treasury account for such activities, when multiple originating appropriations are used, enables efficiencies for awarding contracts to evaluate DOL programs when portions of funding from several DOL accounts are needed to suffi-

ciently fund the project, or when cosponsoring research across Federal agencies. The proposed flexibilities enable DOL to maximize the use of evaluation resources, reduce burden to the public, and mitigate duplication of Federal efforts.

Further, evaluation and research projects often encounter unexpected circumstances due to their dynamic nature. The proposed authority would permit unexpended funds to be repurposed for another research, evaluation, or statistical project, which is often not currently possible because of the time-limited and inflexible nature of these funds. This would allow the funds to be used efficiently for their original intent. In order to streamline these procurement processes, improve efficiency, and make better use of existing evaluation resources the Budget proposes to provide the Department of Labor with expanded flexibilities to spend funds over a longer period of time through the "Evaluation Funding Flexibility" outlined in General Provision, Section 521. This request is part of a provision which includes the Departmental Program Evaluation activity in the Departmental Management appropriation and the Bureau of Labor Statistics; as well as the Department of Health and Human Services' Assistant Secretary for Planning and Evaluation and the Office for Planning, Research and Evaluation in the Administration for Children and Families. These flexibilities will allow agencies to meet the collective aim of efficient government investment in evidence-building with embedded adaptability to reflect changing circumstances on the ground.

WCF UNOBLIGATED BALANCES

*Question.*The budget proposes to increase the transfer authority from unobligated balances available to the Secretary in fiscal year 2022 to the Working Capital Fund (WCF) from $18,000,000 to $36,000,000. The budget also proposes to create a multi-year funding authority for building space optimization within the WCF.

Please identify the additional investments that could be supported by the increased transfer authority and describe the cost avoidance and risk reduction expected to be achieved through these additional projects.

Answer. The Department will use these funds to modernize a host of legacy agency applications. DOL's 27 agencies have developed and maintained distinct, customized systems and applications to meet the unique requirements of their respective missions, but many of these systems and applications are outdated and quite cumbersome by modern standards. These legacy applications are costly to maintain, inefficient for both Federal staff and the public to use, and are less secure than modernized alternatives.

The Department is well prepared to modernize these systems thanks to investments in the centralized IT platform made through the IT Modernization appropriation. By investing in and promoting DOL's centralized IT platform, the Department has established common foundational components that are being leveraged across the Department to ensure scalability, reliability, innovative development and minimum time to deployment. DOL's platform and standardized process to consolidate disparate and outdated systems, enables data sharing and component re-use—allowing DOL to be forward-focused and on the forefront of innovation with capabilities such as data analytics, case management, artificial intelligence and machine learning, and Robotic Process Automation. In addition to access to this standardized process and best practices, agencies have access to optimized infrastructure in a hyper-converged, hybrid-cloud data center environment and technologies that facilitate design of an overall improved user experience to allow employees to focus on mission work instead of technology. The cloud-based platform has helped achieve DOL-wide operational efficiencies in support of mission-driven IT applications resulting in consolidated resources, eliminated redundancies, accelerated modernization, and enhanced security.

While DOL has made significant progress in investing in the IT platform, there is still an extensive list of legacy systems requiring modernization overhauls. By applying a set of common criteria, DOL prioritized legacy systems for modernization. DOL has been working to address the top 50 systems and is making progress in this multi-year effort. Based on DOL's FITARA's score, DOL has a proven track record of making the right investment decisions to streamline technologies and garner efficiencies for its IT, but budget limitations impede progress. Consolidating, integrating, and updating DOL's legacy systems improves DOL's security posture with capabilities such as standardized PIV-based application access, multi-factor authentication, Continuous Diagnostics & Mitigation (CDM) for cyber incident detection and response, and real-time vulnerability and threat monitoring. Investing in information technology provides significant public-impacting benefits in many policy areas, including mine safety, visa processing, grants management, and retirement benefits assurance, among many others. This authority will enable DOL to mod-

ernize systems to ease public access to DOL services, improve accessibility for users with disabilities, mitigate security issues due to legacy technologies, and reduce the increasing costs of supporting incompatible and obsolete technologies. Each effort will improve reliability and accessibility for the public to the Department's programs for employment, worker safety and health, and benefits.

The investments that can benefit by the increased budget authority include (but are not limited to):

—*OLMS—Electronic Labor Organization Reporting System (e.LORS) Investment:* OCIO has identified e.LORS as one of the highest priority systems in the Department for modernization due to inherent risks associated with this outdated legacy technology which has no vendor support nor is it supportable by DOL's cloud-based enterprise platform infrastructure. Modernization is projected to provide initial annual cost savings of approximately $600,000 the year following initial deployment. After the system is fully deployed, OLMS expects to experience a 15 percent savings in annual IT cost due to a reduction in costs for maintenance of the new system versus the old.

—*OSHA—Information Management System Investment:* The data modernization and Transparency Initiative will help with the Agency's ability to store data, retrieve it in the most applicable form for operational use, and provide it in the most user-friendly format for the public. Internally, easier accessibility, paired with standardized data output from the OSHA systems, will result in more efficient searches and better ability for staff to analyze the data to lead to swifter decisionmaking. Improvements in data retrieval and analysis could also provide OSHA staff with insight into the types of violations they might find at a facility, or enable a compliance assistance specialist to provide best practices to abate hazards most likely to be found at the worksite. These efficiencies will lead to improved performance and cost savings will be realized in the higher utilization by OSHA data stakeholders of standardized reports with reliable information.

—*WHD—Wage Determination System Investment:* Modernizing the agency's technology infrastructure is critical to WHD's success and a key factor in mitigating risk across the agency. With the recent implementation of the Electronic Case File (ECF), WHD is realizing the ways in which streamlined business processes and more agile technology can revolutionize and bring value to the agency's work. In doing so, WHD improves its abilities to be good stewards of taxpayer money and to provide the best possible service and results to those the agency is here to serve. Cost savings will be achieved in the following areas: (1) a shift to the cloud will minimize the need for WHD to pay for expensive O&M resources, which will yield an estimated savings of $3 million per year; (2) elimination of paper record keeping costs associated with case files storage and administration once ECF is fully rolled out, will yield an estimated savings of $500,000 per year which equates to 1,557,000 pages transferred between offices and to record centers per year; and (3) automated ingestion of data through the new WDS customer portal will yield a reduced need for contractor support on data entry and processing of paper records and provide an estimated savings of $300,000 per year in actual contract costs. This represents total costs impacts of $4 million per year, which can be readily redirected towards mission-critical enforcement staff and activities.

—*OFCCP—Case Management System Investment:* The Affirmative Action Verification Initiative (AAVI) is modernization need that would allow OFCCP to ingest and process its administrative data in a more uniform digital format. It will also allow staff to retrieve and store data in a central repository that will improve operations and enforcement by driving efficiency and increasing the number and depth of analytical assessments performed by the scheduling, policy, and enforcement branches. Once development is completed, the ongoing costs will be operations & maintenance, and a fraction of the help desk service. The total operating cost is anticipated to be reduced by approximately 65 percent, assuming no further development efforts.

Question. How will the Department assure that unobligated balances for the WCF are only generated from unexpected balances rather than the delay of spending on the original purpose of the Congressional appropriation?

Answer. The Department has a robust program to ensure that unobligated balances are only generated from unexpected balances. The Office of the Chief Financial Officer meets regularly with agencies to review budget execution data and, in coordination with the Performance Management Center, tracks the percent of discretionary appropriations canceled after the five-year period of obligation authority has expired. The results are reported in the Congressional Budget Justification. In fiscal year 2020, the Department targeted 1.9 percent in canceled appropriations and outperformed this target with a cancellation rate of only 1.6 percent.

LEARNING AGENDAS AND EVALUATION PLAN

Question. The "Foundations for Evidence-Based Policymaking Act of 2018" includes key provisions related to developing a multi-year learning agenda, evaluation plan, improving coordination of data government at the Department, and improving accessibility of labor data. The Department has indicated it plans to release an updated learning agenda and Capacity Assessment for Research, Evaluation, Statistics, and Analysis in February 2022.

Please describe stakeholder consultations that have occurred or will occur during the development of these plans.

Answer. The Department has engaged with a wide range of stakeholders external to DOL to understand evidence production, use, and future needs. For example, given the critical role of the Department in supporting the public workforce system across the country, DOL targeted early engagement with the workforce development field. From November 2020 to April 2021, the Department sponsored unstructured group discussions and individual conversations with 104 individuals representing 53 organizations spanning the U.S. workforce development system. The objectives of the meetings were to encourage participants to discuss what research, information, or evidence would be most useful to them to improve the services they provide, and to identify future research topics related to employment programs and services and the future of work.

In addition to this broad-based engagement, the Department convened an 11-member panel of highly qualified experts in the workforce development field, including representatives from workforce boards, academics, nonprofit organizations that partner with or study the workforce system, and labor unions. The panel provided DOL with targeted input on high-priority research topics related to WIOA programs and services that could build on the current evidence base, fill key knowledge gaps, and could be potentially suitable for rigorous evaluation. A summary of the findings from these engagements will be available on the Department's Chief Evaluation Office website later this year.

DOL has also sought input on our evidence-building agenda from Congressional stakeholders. On July 29, 2021, DOL's Office of Congressional and Intergovernmental Affairs sponsored a Congressional outreach session, which included a high-level briefing on the Department's strategic and evidence-building planning approach. Further, it allowed Congressional aides from both appropriations and authorizations committees to ask questions and to provide direct comments and reactions on the Department's activities.

Looking to the future, the Department will gain insights from additional activities. For example, the responses to the equity RFI issued by OMB on May 5, 2021 will be helpful to all Federal agencies, including the Department, in evidence-building plans.[22] Further, the Department will engage in further targeted stakeholder feedback, to support ongoing evidence development and dissemination activity. As evidence building evolves to meet emerging needs, the Department anticipates refining activities based on future stakeholder inputs. DOL is especially interested in ensuring perspectives from a diverse array of stakeholders who represent the communities our programs serve.

Question. What has the Department learned from its prior evaluations and how has the information been used in decisionmaking and its programs, policies and operations? How will it inform future decisions on programs, policies and operations?

Answer. The Department has learned a great deal from its evaluations, data analytics efforts, surveys, and other rigorous research projects to help improve our work on specific programs and topics, and also to better understand how to best help specific populations, especially populations facing barriers to full participation and inclusion in the labor market. Specifically, the Department has used the results from its evaluations and rigorous research to expand and scale proven training strategies, to better target enforcement and worker protection activities, to identify underrepresented populations for tailored outreach, and even to improve internal employee engagement, among other outcomes.

As decision-makers develop policies and programs to support workers with job training and other employment supports, they have used the results of evaluations to effectively target future investments. One important example comes from evaluations of the Registered Apprenticeships (RA) program. DOL funded a large-scale impact study of RAs across 10 states, which was published in 2012. That study found that RA participants had substantially higher short- and long-run earnings than did

[22] The full text on the OMB RFI, Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government, can be found here: https://www.govinfo.gov/content/pkg/FR-2021-05-05/pdf/2021-09109.pdf.

non-participants and that the broader benefits of the RA program for apprentices, government agencies, and society greatly outweighed program costs. RA participants earned an average of $5,839 more than similar nonparticipants. Further, the completers of RA programs earn over $300,000 more in salary and benefits during their careers than similarly situated individuals who do not complete such programs. This study is regularly cited by researchers, program administrators, and policymakers as evidence for the return on investment to RAs.

In part on the basis of those findings, both Congress and the Department have pursued expansions of the RA program. In partnership with the Department's Employment and Training Administration, the Chief Evaluation Office is now actively evaluating these new investments in the RA program, including studying efforts to expand apprenticeships to underrepresented populations, as well as assessing the effectiveness of expanding apprenticeships into high-growth and high-paying industries, such as information technology.

Another important area of ongoing evidence-to-practice is related to building the capacity of the nation's community colleges' education-to-employment pipeline to meet 21st century demands. Based on the results of a national evaluation of the DOL capacity-building grant program, Trade Adjustment Assistance Community College and Career Training (TAACCCT), the Department identified a range of promising practices for future adoption including accelerated learning/career pathways, persistence and completion strategies, and learning-based connections to employment. The national evaluation generated these and a wealth of other findings based primarily on a synthesis of 71 evaluation reports completed by grantees' third-party evaluators. Evidence-based practices and insights from these studies' findings are being applied to the Strengthening Community Colleges Training Grants (SCCTG) Round 2 Funding Opportunity Announcement and future DOL investments.

The Department has also helped states and local areas in their efforts to build strong evaluation capacity, such as with the Reemployment Services and Eligibility Assessment (RESEA) program. Beyond funding and broadly disseminating findings from the largest evaluation of the RESEA predecessor program, Reemployment and Eligibility Assessment (REA) program, the Department has developed a suite of resources to support states in implementing and leveraging insights from the evidence base, as they build, pilot, and evaluate new RESEA program components. The Department has provided evaluation technical assistance resources, including webinars and other tools and templates to help states understand, build, and use evidence.[23]

Other research efforts with notable impact on Departmental operations include the Family and Medical Leave Act (FMLA) surveys of workers and businesses. Fielded in 1995, 2000, 2012, and 2018, these large-scale nationally representative surveys represent a primary source of credible information about workers' leave needs, patterns of usage, reasons for leave, awareness of leave benefits, among many other factors. In addition, the size of the survey sample permits disaggregation and analysis by geography and a variety of demographic groups. The results of these surveys have helped the Department improve and target educational campaigns on Federal leave worker protections, as well as to provide technical assistance to businesses with administration of this benefit as part of compliance and enforcement efforts. The surveys have also been very important to Federal, state, and local policymakers interested in understanding gaps in worker leave needs and designing potential leave program proposals.

Question. What are the Department's plans for increasing the investment in evaluation and evidence-building activities authorized by the annual evaluation transfer provided in the Department of Labor Appropriations Acts which significantly decreased from more than $22,000,000 in fiscal year 2016 to $2,000,000 in fiscal year 2020?

Answer. The Department is committed to supporting a robust research and evaluation portfolio, including the capacity to develop and deploy evidence across agency management activities. Doing so is consistent with this Administration's priorities, as reflected in the President's Memorandum on Restoring Trust in Government through Scientific Integrity and Evidence-Based Policymaking and through the Office of Management and Budget's guidance to Federal agencies on the implementation of the Evidence Act (OMB M–21–27). Bolstering the Department of Labor's research and evaluation activities is reflected in our fiscal year 2022–2026 strategic plan, which includes a management goal to "strengthen the Department's commitment and capacity for evidence-based decisionmaking."

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[23] The Department has developed a number of dedicated web-based resources for states, including https://clear.dol.gov/reemployment-services-and-eligibility-assessments-resea and https://rc.workforcegps.org/resources/2016/10/03/06/29/RESEA.

QUESTIONS SUBMITTED BY SENATOR JACK REED

WIOA AND PUBLIC LIBRARIES

Question. Workforce Innovation and Opportunity Act and Public Libraries.—Public libraries are critical but often under-resourced partners in the workforce development system supported under the Workforce Innovation and Opportunity Act. As the nation continues to recover from the COVID–19 emergency, libraries will play a critical role in helping people access benefits and get back to work.

What are the Department's plans to build and strengthen partnerships between the one-stop system and public libraries and ensure that public libraries have the resources necessary to provide these workforce development services?

Answer. States have used WIOA funding for partnerships with public libraries to conduct digital and financial literacy education activities; educate library staff about available in-person and virtual employment and workforce development resources; provide resume writing, interview preparation, and other adult education programs; use the libraries' space to provide career assistance and host job fairs; and share workforce and labor market information. As an example, California's Library Workforce Partnership Initiative (LWPI) recently announced a funding opportunity for ten California public libraries to partner with local Workforce Development Boards to build staff skills and knowledge about workforce development and enhance workforce development efforts in their communities. Local Boards in California will work with public libraries, and together they will promote employment, career development, and skill-building for job seekers.

The Department has partnered with the Institute of Museum and Library Services (IMLS) for several years and continues to collaborate with libraries since the passage of the Workforce Innovation and Opportunity Act. This collaboration has included webinars to ensure both libraries and the workforce development system know about the assets and services they each have available to support jobseekers. The Department published guidance to the workforce system reiterating the importance of library partnerships and continues to make the workforce system aware of the resources available in libraries to support workforce development (See Training and Employment Notice 35–15, "Encouraging Collaborations between the Workforce Investment System and Public Libraries to Meet Career and Employment Needs").

Other ongoing collaborative work with IMLS includes the Performance Partnership Pilot (P3) authorized in 2014, in which pilot sites can test innovative strategies to achieve significant improvements in education, employment, and other key outcomes for disconnected youth. P3 gives the Departments of Education, Labor, Health and Human Services (HHS), and Justice (DOJ), the Corporation for National and Community Service (CNCS), and IMLS authority to waive Federal statutory and regulatory requirements that inhibit access to assistance and effective service delivery for disconnected youth provided certain conditions and requirements are met.

Public libraries play an integral role and are a crucial resource in communities for job seekers. The Department will continue working with libraries and promoting libraries as key partners in the workforce system.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

BLACK LUNG BENEFITS

Question. Black lung is a terrible disease caused by inhaling coal dust and mainly affects coal miners. After years of dedication to providing our nation with energy, America's coal miners continue to face the devastation of black lung disease. We are seeing more and more cases of black lung—particularly in younger miners who have spent less time working in the mines. Today, more than 25,000 coal miners and their dependents rely on the Black Lung Disability Trust Fund to pay for critical medical treatments and basic expenses. The Black Lung Disability Trust Fund is financed primarily by an excise tax on coal produced and sold domestically. In both 2019 and 2020, Congress passed 1 year extensions to ensure revenue streams for the Trust Fund did not plummet. Current rates are set to expire on December 31, 2021, putting an indebted Trust Fund in a precarious financial situation.

How can we ensure these benefits are protected and that our coal miners continue to get the help they need?

Answer. President Biden has consistently expressed his understanding of the harms to individuals and communities impacted by black lung disease. He has also expressed his belief that coal mine companies must be responsible for the occupational harms incurred by their workers.

When the Government Accountability Office evaluated options for improving the Trust Fund's financial condition in May 2018, it examined different options and noted that permanently increasing the excise tax on coal to at least $1.38 per ton for underground-mined coal and $0.69 for surface-mined coal (25 percent higher than the current rates), could keep the Trust Fund solvent through 2050. The Administration is committed to ensuring coal miners continue to receive their benefits in any case, and without a legal change, the Trust Fund will continue to borrow from Treasury in order to finance the benefits. Without increased funding, the GAO estimated that the Trust Fund will accumulate $15 billion of debt by 2050. That debt would be shouldered by taxpayers instead of the responsible coal mine companies. The Administration is eager to work with Congress to protect these critical benefits and ensure that the Black Lung Disability Trust Fund is solvent.

SILICA DUST RULE

Question. The extraction, refining, and transportation of coal generates significant amounts of coal dust, which contains silica. While coal dust is hazardous to miners' health on its own, silica is classed as a carcinogen and is substantially more dangerous. Excessive exposure to silica has been linked to black lung, silicosis, and the most lethal type of black lung, progressive massive fibrosis (PMF). The U.S. Department of Labor's Office of Inspector General (OIG) produced an audit report last year critical of the Mine Safety and Health Administration's (MSHA) inadequate efforts to safeguard coal miners from crystalline silica exposure. The Inspector General's report found that MSHA needs to update its regulations to: (1) Lower the legal exposure limit to silica, (2) Improve the ability of the agency to issue citations and fines for excess exposure to silica, and (3) Increase sampling protocols where were found to be too infrequent to protect miners adequately. These findings are extremely troubling—especially while we continue to grapple with the COVID–19 pandemic.

How far along is the agency in creating a silica dust standard for underground coal mines?

Answer. The Notice of Proposed Rulemaking for MSHA's Respirable Crystalline Silica standard is scheduled for January 2022. MSHA is in the process of developing the proposed rule including the preamble and supporting documentation. Under Section 101 (a) of the Federal Mine and Safety and Health Act of 1977, the proposal must go through the notice and comment process, which includes solicitation of comments from stakeholders. This allows the public opportunity to submit both written comments and to present testimony at public hearings, if requested. The substance of the final rule would take into consideration the comments and testimony received during the rulemaking process.

Question. When do you anticipate releasing a new rule?

Answer. The Notice of Proposed Rulemaking for MSHA's Respirable Crystalline Silica standard is scheduled for January 2022.

MINERS AND COVID–19 PROTECTIONS

Question. In March 2021, the Mine Safety and Health Administration issued Federal guidance for mine operators, but fell short of issuing an enforceable standard that would apply to mines and miners. Last month, the Occupational Safety and Health Administration issued an Emergency Temporary Standard for healthcare workers, which set requirements to protect workers from contracting COVID–19 in healthcare settings. I introduced a bipartisan bill in February, the COVID–19 Mine Worker Protection Act, which would require you as the Secretary of Labor to issue an Emergency Temporary Standard to requires mine operators to protect their workers from COVID–19. This would include development and implementation of a comprehensive infectious disease exposure control plan, provide PPE to miners, and a framework for documenting data. Mining is a dangerous business, we in West Virginia know this all too well. But we should take all appropriate steps to ensure miners are protected against COVID–19, something we know is continuing to spread in our country.

Secretary Walsh, can you provide an update on what are you doing to protect miners from COVID–19 exposure in and around mining sites?

Answer. On March 10, 2021, the Mine Safety and Health Administration issued worker safety guidance to help mine operators and mine workers implement a coronavirus protection program and better identify risks that could lead to exposure. "Protecting Miners: MSHA Guidance on Mitigating and Preventing the Spread of COVID–19" provides updated guidance and recommendations, and outlines existing safety and health standards. The guidance details key measures for limiting the coronavirus's spread, including ensuring infected or potentially infected miners are not in the workplace, implementing and following physical distancing protocols and

using surgical masks or cloth face coverings. It also provides guidance on use of personal protective equipment, improving ventilation, good hygiene and routine cleaning. MSHA announced the guidance to more than 450 stakeholders during a quarterly meeting and answered questions from the mining community.

Question. Will you work with me on this proposal to protect miners from COVID–19 exposure?

Answer. We need to take all appropriate steps to ensure miners are protected from COVID–19. The state of the pandemic is in constant flux and MSHA will follow the science. If it becomes necessary, we will issue an Emergency Temporary Standard for COVID–19 for the mining industry.

ADDICTION AND RETURNING TO WORK

Question. As the opioid epidemic continues to take its toll, there are more and more men and women who face severely limited job opportunities after serving their time for crimes committed as a result of addiction. To help fix this problem, I reintroduced a bill called the Clean Start Act that seeks to help former addicts with criminal records seal those records if they complete a comprehensive addiction treatment program and show that they have turned their lives around. West Virginia has now enacted its own version of the Clean Start Act.

What are some of the key ways the Department of Labor can help in getting those struggling with addiction to get back to work?

Answer. The public workforce system complements health, law enforcement, and social service agencies to address the impact of opioid addiction and other substance use disorders. Since 2018, the Department has issued three grant opportunities addressing the workforce impacts of opioid addiction and other substance use disorders. Under these programs, grantees provide reemployment services for individuals impacted by the crisis; train individuals to transition into professions that can impact the crisis, such as alternative pain management, mental health treatment, and addiction treatment; and create temporary employment opportunities for peer recovery counselors and other positions that have a direct impact on the crisis. States and eligible applicants can continue to apply for National Health Emergency (NHE) Dislocated Worker Grants (DWGs) at www.grants.gov. ETA encourages State Workforce Agencies, local Workforce Development Boards, outlying areas, and tribal organizations to develop comprehensive partnerships to creatively align and deliver career, training, and supportive services that will best serve workers impacted by substance use disorders and opioid addiction. The services that the public workforce system offers complement evidence-based treatment for substance use disorders.

DWG grantees use two main approaches to strengthen enrollment and services for individuals with substance use disorders: bringing individuals into the American Job Center for tailored services, and bringing American Job Center services to providers of behavioral health services. DWG grantees have also reported that courts and justice-related agencies are strong partners. These may include juvenile and family courts, drug courts, as well as prison and probation offices. The workforce system can connect individuals who have been involved in the juvenile and/or adult justice system to Reentry Employment Opportunities grant programs (where available) to receive services and resources. These partnerships help to bridge the gap between recovery services and employment and self-sufficiency.

For further information, ETA issued Training and Employment Notice 2–21, Serving Individuals and Communities Impacted by Opioid Addiction and Other Substance Use Disorders, July 23, 2021. This is in addition to a series of virtual programs in 2021 to train professionals in the workforce system on serving individuals impacted by substance use disorder.

Question. What programs and initiatives, in your experience, will be most effective in assisting former offenders rejoin the workforce?

Answer. The Department's Reentry Employment Opportunities (REO) program, which includes current reentry grants Reentry Projects, Pathway Home, and Young Adult Reentry Partnerships, align with evidence-based practices that result in people involved in the justice system getting employment. Our grant programs include flexibility to support the individualized needs of participants. Supportive services such as transportation, housing, mental health and substance abuse counseling, and assistance with gaining identification necessary for employment are crucial to initial and long-term stable employment for this population. Without these basic supports, it is hard for participants to succeed in training that leads to better employment outcomes. People connected to the justice system also need mentors, especially mentors with similar lived experiences, who can support them through the transition from incarceration to reenter the community. The use of Work Opportunity Tax

Credits and the Federal Bonding Program can also increase employers' hiring of previously incarcerated individuals.

Moreover, connecting participants to work that is legally available to them after release is imperative. Sometimes local or state licensure laws present barriers to employment. The Department is currently developing a tool that will help individuals re-entering their communities learn how license/certification laws align with their employment goals. The tool will be available on https://www.careeronestop.org/
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The Department has used existing evidence to support current initiatives, building off the Linking Employment Activities Pre-Release (LEAP) implementation study to develop the 2020 and 2021 Pathway Home grants. The LEAP pilots provided pre-release services through jail-based American Job Centers and linked participants to post-release services. The study documented effective approaches to serving individuals in jails. The Pathway Home grants further test the identified concepts and link participants in jails and prisons to the workforce system while still incarcerated. Additionally, the participants maintain the same case manager pre- and post-release for seamless reentry into the community. Federal Bonding is also an important tool to help justice-involved individuals overcome existing prejudice and stigma that may prevent potential employers from hiring them due to perceived risks.

The Reentry Projects and Pathway Home initiatives are currently being rigorously evaluated, which will further support the evidence base for connecting people involved with the justice system to gainful employment. Learnings from these projects will inform future grant models for continuous improvement and refinement of reentry employment projects.

UNEMPLOYMENT INSURANCE AND RETURNING TO WORK

Question. Mr. Secretary, it's no question that the COVID–19 pandemic has had a tremendous impact on our country since the start of 2020. Among many actions that were taken to respond to its effects, I was proud to work with my colleagues here in Congress to provide Americans with unprecedented relief in the form of unemployment insurance benefit programs, which has been a needed source of income for many West Virginians and Americans during these trying times. However, we are noticing that in some states and localities, despite our economy steadily returning to full, pre-pandemic capacity, unemployment rates still remain high. This trend is, of course, concerning, especially given the fact that the U.S. economy is adding jobs at rates seen before the COVID–19 pandemic set in. My understanding is that this combination of still elevated unemployment and elevated job growth has led many states, including my state of West Virginia, to end the pandemic unemployment assistance program before its expiration on September 4, 2021. Like many of my colleagues, I want to ensure that folks in my state and our country can return to work and can do so safely. I remain willing to work with anyone and through any means to do so.

Do you believe that the enhanced unemployment insurance programs Congress has implemented have contributed to the inability of some employers to fill employment vacancies?

Answer. I am not aware of evidence that enhanced unemployment insurance programs have contributed to the inability of some employers to fill employment vacancies. The President has said: "I think people who claim Americans won't work, even if they find a good and fair opportunity, underestimate the American people. So we'll insist that the law is followed with respect to benefits. But we're not going to turn our backs on our fellow Americans." And I agree.

Question. What can we do in Congress to support the economy and our returning workforce as we return to pre-pandemic output levels and activity?

Answer. The COVID–19 pandemic created widespread economic disruption and further highlighted pre-existing deficiencies in the availability of opportunities for all Americans to find good-paying, safe employment. While existing WIOA funding amounts to states are set by a statutory formula, the fiscal year 2022 Budget reflects the Department's continued commitment to help American workers and job seekers, particularly those from disadvantaged communities, get back on their feet, access job training, and find pathways to high-quality jobs that can support a middle-class life. The fiscal year 2022 Budget requests $3.7 billion for WIOA programs, a $203 million increase over the fiscal year 2021 funding. The Budget includes increases of approximately $37 million for the Adult Program, $94 million for the Dislocated Worker Formula Program, $100 million for Dislocated Worker Grants (DWG), and $43 million for the Youth Program. This request will make employment services and training available to more dislocated workers, low-income adults, and

disadvantaged youth who have been hurt by the economic impacts of the COVID–19 pandemic.

The fiscal year 2022 Budget also includes the American Jobs Plan, an investment that will create millions of high-quality jobs and rebuild our country's infrastructure. This includes investments in American workers—providing people with the skills they need to succeed, strengthening the pathways to success, and ensuring that the jobs that are created are high quality. Structural racism and persistent economic inequities have undermined opportunity for millions of workers, and these investments will prioritize underserved communities and communities negatively impacted by the transforming economy. The United States currently spends just one-fifth of the average that other advanced economies spend on workforce and labor market programs.

The Department included legislative proposals to implement the American Jobs Plan, totaling $81.5 billion over 10 years, to address these multiple challenges. This investment in proven workforce development models includes:

—Creating and expanding sector-based training programs;
—Providing comprehensive support for dislocated workers to enable their participation in high-quality training programs;
—Expanding Registered Apprenticeship and pre-apprenticeship opportunities;
—Building community colleges' capacity to deliver high-quality job training programs;
—Expanding access to evidence-based intensive, staff-assisted career services;
—Providing subsidized jobs to workers with barriers to employment;
—Expanding workforce development services for justice-involved individuals; and
—Phasing out the subminimum wage provided to workers with disabilities while expanding their access to competitive, integrated employment opportunities.

The Administration also has requested $100 million in the next fiscal year to enable states to overcome the loss of legacy industries or persistent employment challenges and work towards a clean energy economy, helping to ensure steady employment opportunities into the future.

Question. Are there any lessons to be learned with how our unemployment systems have responded over the last year to better prepare them if faced with another economic crisis in the future?

Answer. The Unemployment Insurance system has served as a critical lifeline over the last year, helping nearly 53 million workers stay afloat during the pandemic and the resulting economic crisis infusing over $800 billion into the economy—staving off an even deeper recession. At the same time, this crisis only further exposed long-standing challenges in the UI program. While states mobilized quickly to implement new crucial pandemic unemployment programs, they were hamstrung by outdated technology and a lack of resources that made them vulnerable to fraud from international crime rings. State administrative funding was at a historic low. Recent policy changes in state law are designed to make it more difficult to access UI. These challenges made it difficult for states to quickly and equitably deliver benefits to unemployed workers. Even as economic conditions continue to improve, states face significant backlogs that have delayed benefits to workers, and they have struggled to address fraud perpetrated by sophisticated crime rings that persist in using new techniques to attack UI systems.

The Department welcomes the $2 billion that Congress provided in the American Rescue Plan Act and agrees that UI technology and infrastructure modernization are urgently needed. State systems must operate on a high-quality technology infrastructure that enables them to administer their UI programs equitably and efficiently, so all eligible unemployed workers have timely and meaningful access to this vital benefit. The Administration is fully engaged in developing detailed plans to achieve the goals and purposes set in the American Rescue Plan Act and will keep Congress informed of those plans and progress on the implementation of this important project.

The Department has engaged with states on this topic. The Department conducted an initial webinar with state UI agencies on June 22, 2021, to share some of the current plans and approach on pursuing UI information technology modernization. The webinar also solicited states for engagement and partnership in these activities. Since then, seven states have begun working with the U.S. Department of Labor (DOL) and the U.S. Digital Service in research partnerships designed to help fill in research gaps and provide input on the current and future stages of UI modernization. Also, there have been follow-up virtual office hours offered to states for further conversations on this topic.

All states should benefit from the funding provided in the American Rescue Plan Act. As a state modernizes its IT system, there may be opportunities to take advantage of the central, modular, open technology solutions developed through this DOL/

state partnership. DOL is also deploying teams of experts, initially to six states, on a voluntary basis to help identify process improvements that can speed benefit delivery, address equity, and fight fraud (i.e., Tiger Teams). The Tiger Teams can provide support, including funding, as states like West Virginia look at business processes through a fraud-fighting and equity lens in the course of modernization. Additionally, DOL is making grants to states available to promote equity and fight fraud. These grants will be designed to help states improve worker access to the UI system, while helping states make system improvements that will safeguard them against fraud.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

APPRENTICESHIPS AND NONTRADITIONAL INDUSTRIES

Question. As Chairman of the Subcommittee in fiscal year 2016, I began funding for the Apprenticeship program. I note that while the Administration is requesting an increase of $100 million for the program, the Department is no longer pursuing Industry Recognized Apprenticeship Programs (IRAPs)—which would allow third-party entities to apply for awards without being registered by the Department of Labor. The previous Administration argued that IRAPs are intended to supplement the current system, not replace or weaken it. IRAPs would also allow non-traditional apprenticeship programs to thrive alongside of the more traditional apprenticeships.

During a period when our nation is recovering from the unprecedented strain of COVID–19 on our workforce, it is paramount that we provide the most opportunities to get our country back to work.

How will you work with non-traditional industries to bring them into the Apprenticeship program?

Answer. The Department supports industry-driven and employer-led innovation in the Registered Apprenticeship System, a key strategy to increase the representation of non-traditional industries in Registered Apprenticeship. In fact, expanding Registered Apprenticeship into non-traditional industries has been a Departmental priority for the past 10 years, and we've seen incredible growth due to numerous investments and promotional activities. Since 2015, the number of Registered Apprenticeships in non-traditional industries (non-construction) has grown by over 43 percent.[24]

Industry designs and operates Registered Apprenticeship programs. The Department works in partnership with industry to provide technical assistance to support and ensure programs meet minimum quality standards for apprentice safety, welfare, and equal opportunity. This approach ensures that Registered Apprenticeship programs are employer-led, industry-driven, of high quality, responsive to the changing needs of employers, and capable of producing highly skilled workers that can compete in a highly-competitive global economy.

Over the past 6 years, the Department has made significant investments to support apprenticeship and work-based learning in non-traditional industries. Investments include recent awards to support state-led expansion, equity and innovation grants, innovative approaches to developing consistent standards in non-traditional occupations through competency-based occupational frameworks, as well as the establishment of new Registered Apprenticeship (RA) Technical Assistance (TA) Centers of Excellence. This includes a dedicated RA TA Center to support the development of Registered Apprenticeship Program frameworks (competency-based, hybrid, and other innovative models), national standards including those that include industry-recognized credentials, and supporting industry in meeting Registered Apprenticeship Program design and development requirements in compliance with 29 C.F.R. Part 29, Subpart A.

The Department has also supported employer-led innovation in Registered Apprenticeship through the following mechanisms:

—*Industry Intermediaries:* Since 2016, DOL has funded industry associations, also referred to as "industry intermediaries" to develop National Apprenticeship Programs to meet critical industry needs and lead the expansion of Registered Apprenticeship across a wide range of industries. The most recent round of industry intermediary awards included a focus on expanding registered apprenticeship into non-traditional industries.

—*Growth of National Programs:* To better support national employers and industry-led efforts, the Department has enabled significant growth in the number

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[24] https://www.dol.gov/agencies/eta/apprenticeship/about/statistics/2020.

of organizations that have registered as National Apprenticeship Programs. This growth has nearly doubled over the past several years. Between January 2019 and May 2021, the Department registered approximately 70 National Apprenticeship Programs. These National Apprenticeship Programs allow employers to quickly and easily adopt industry vetted and Departmental-approved Registered Apprenticeship programs into their organization through a simple employer acceptance agreement, reducing paperwork and program duplication.

Question. What resources are needed to ensure that all opportunities for apprenticeships are considered at the Department?

Answer. Dedicated resources for Registered Apprenticeship are critical to expand the program. I urge Congress to enact the President's Budget and the American Jobs Plan. Within the fiscal year 2022 President's Budget, the Administration proposes increasing apprenticeship funding by $100 million, for a total of $285 million. The Department will prioritize investments that expand the apprenticeship model to new sectors and occupations and increase access for historically underrepresented groups, including people of color, women, individuals with disabilities, and justice-involved individuals. The American Jobs Plan provides another opportunity for Congress to ensure support for apprenticeship. The Administration proposes investing $10 billion over 10 years to create between one and two million new Registered Apprenticeship slots.

GREEN JOBS

Question. The budget request includes an increase of $100 million within the Dislocated Worker National Reserve for a new initiative that will target investments for training and employment opportunities in communities for new industries, including those supporting "green jobs".

Additionally, the budget request includes an increase of $20 million for a new competitive grant program to prepare eligible veterans, transitioning service members, and their spouses for careers in "green jobs." This new competitive grant program is proposed to be housed within Training and Employment Services, as opposed to within the Veterans' Employment and Training Service program.

I'm concerned with the notion that the Federal Government is dictating the future of our workforce by tying training dollars to "green jobs." Specifically, the new Power initiative will impose significant restrictions on local economies to focus only on green jobs, and not necessarily jobs their local economy may need. The Department already spends millions of dollars to train workers for jobs that are needed in local communities because of the partnership with state and local workforce boards. Therefore, why is the Federal Government simultaneously determining what industries can prosper in local economies through this new initiative?

Answer. The $100,000,000 requested is part of a new Interagency Working Group on Coal and Power Plant Communities and Economic Revitalization. The Working Group is not an attempt by the Federal Government to determine which industries can prosper. Rather, it is an initiative that will complement other targeted Federal investments to assist workers and transform local economies in communities transitioning into new, sustainable industries, including those supporting new or sustainable energy sources. This targeted program will help energy industry workers who have been adversely impacted by changes in the economy prepare for jobs in demand in states and local communities that choose to apply. The initiative will build on the success of the original POWER initiative and expand beyond the coal industry. It will address changes in the energy economy, and other legacy industries, through strategic planning, partnership development, and reskilling and reemployment activities aligned with longer-term economic transformation efforts. It will support community-led workforce transition, layoff aversion, job creation, and other strategic initiatives designed to ensure economic prosperity for workers and job seekers in the coal, oil, gas, and other industries in decline.

Question. I'm encouraged to see an increase for veterans' programs in the budget request. Many service members leave the military with significant training that can translate to the civilian workforce, and it should be a priority to ensure that our veterans have the resources necessary to transition to civilian life. Our workforce system should be flexible to allow these workers to succeed. However, I'm concerned about the proposal for a new, $20 million program to train our nation's heroes for "clean energy" jobs, only. I do not think we should tie our training dollars to specific jobs, especially jobs for our veterans, nor should the Federal Government be in the position to pick winners and losers in the economy. Why does the Department think that it can better dictate workforce opportunities for our transitioning service men and women, as opposed to our local economies and the local job creators that truly understand the workforce needs of our communities?

Answer. The Veterans' Clean Energy Training Program will be a new competitive grant program to prepare eligible veterans, Transitioning Service Members (TSMs), and their spouses for careers in the clean energy sectors of the energy industry. This program does not dictate workforce opportunities but, instead, allows states and local communities, based on their local workforce needs and in partnership with local businesses, to help veterans prepare for jobs that are in demand. Clean energy job opportunities are expected to grow between now and 2029. Certain occupations are expected to grow rapidly in the next several years or have large numbers of job openings. A skilled workforce is foundational to achieving the President's goal of having 100 percent carbon-free electricity by 2035 while creating a more resilient energy grid, lowering energy bills for middle-class Americans, and improving air quality and public health outcomes. The Department's Employment and Training Administration will develop and implement the program collaboratively with the Department's Veterans' Employment and Training Service and the Department of Veterans Affairs to identify appropriate state, Federal, and industry partners to deliver the education, training, and job placement of program participants.

Grantees will use effective outreach, media, and engagement to recruit a diverse cohort of participants for job training. Grantees will use robust, comprehensive work-based learning strategies, such as On-the-Job Training, customized training, Incumbent Worker Training, Registered Apprenticeship, pre-apprenticeship programs that matriculate to Registered Apprenticeship programs and paid work and internships. Other allowable approaches will include classroom, including competency-based, and technology-based training strategies, culminating in the attainment of an appropriate industry-recognized certificate or credential.

Grantees will also provide technical assistance to this network of employers to successfully employ and retain veterans, TSMs, and military spouses. In addition, grantees will provide participants with supportive services, such as transportation and childcare, to enable them to participate in activities authorized under the program.

The program will engage a wide array of employers, large and small, including Veteran-Owned Small Businesses and Service Disabled Veteran Owned Small Businesses in the adoption and deployment of training and work-based learning. These will be public-private partnerships engaging employers across clean energy sectors, which will help empower local communities and ensure that we are training workers for occupations that are in demand.

The program will develop new or expand existing successful industry sector partnerships and build off of lessons learned from the Department of Energy's Solar Ready Vets program. These partnerships of multiple employers, educational institutions, economic development agencies, workforce development entities, and community-based organizations will identify and collaboratively meet the workforce needs of the growing clean energy sector within a given labor market, incorporating career pathway strategies by aligning education and training programs with industry needs.

JOINT EMPLOYER RULE

Question. In June 2021, DOL sent its proposed rescission of the previous Administration's Joint Employer rule to the Office of Information and Regulatory Affairs for final rule. I am concerned that the Department is moving to rescind the previous Administration's Joint Employer rule and potentially issue another new rule. This Administration's steps will further burden small and local businesses, who are the economic drivers of our economy. As our nation recovers from COVID–19, we need to be encouraging job growth and job creation, not stifling it with further regulations and complicated, ambiguous standards.

What are the Department's substantive plans and timeframe with respect to this rulemaking?

Answer. The Department issued a final rule rescinding the previous Administration's Joint Employer rule on July 30, 2021. The rescission will be effective October 5, 2021.

COVID–19 EMERGENCY TEMPORARY STANDARD

Question. The Occupational Safety and Health Administration (OSHA) published an emergency temporary standard (ETS) relating to COVID–19 protections in the workplace. The requirements of the ETS apply to "all settings where any employee provides healthcare services or healthcare support services." I am concerned that there's ambiguity regarding who and what are exempt from the emergency rule. While retail pharmacies have a blanket exemption, walk-in medical clinics, doctor's offices, dental practices, and other "non-hospital ambulatory care settings" may

qualify for exemptions depending on their screening policies and the type of care performed. To qualify for an exemption, the employer must limit the number of entrances to a facility and have a screening process where people are checked at the entrance or outside of the facility. "Screening" is defined as "asking questions to determine whether a person is COVID–19 positive or has symptoms of COVID–19." Testing is optional.

Workplaces and employers that are not exempt from this emergency rule must develop and implement a COVID–19 plan; provide and ensure the wear of facemasks for employees; provide respirators and other Personal Protective Equipment to employees; ensure social distancing when possible; install physical barriers where social distancing cannot take place; and clean and disinfect all workplace areas in accordance with CDC guidelines.

While I appreciate that hospitals and nursing homes must comply with the provisions of this emergency temporary standard, as those are the settings in which there's an increased risk of coming into contact with an infected person, I am worried that there's too much ambiguity as to who and what are exempt outside of those facilities. Further, the provisions of this emergency standard place a burden on the employer, and I'm concerned that certain workplaces that could be exempt from these provisions may not realize it. Can you detail what settings are exempt from this standard, and will these settings be subject to an OSHA inspection?

Answer. The COVID–19 ETS applies to employers in settings where any employee provides healthcare services or healthcare support services. This includes: Employees in hospitals, nursing homes and assisted living facilities; emergency responders; home healthcare workers; and employees in ambulatory care facilities. The focus of the ETS is on protecting healthcare workers in settings where suspected or confirmed COVID–19 patients are treated. Thus, the standard targets healthcare settings where OSHA has found the elevated risk associated with care of persons with confirmed and suspected COVID–19, and associated activities, constitute a grave danger. Accordingly, it exempts out settings where this elevated risk does not exist.

Paragraph (a)(2) of the standard serves to limit the applicability of the ETS and provides that the ETS does not apply to the following: (i) The provision of first aid by an employee who is not a licensed healthcare provider; (ii) the dispensing of prescriptions by pharmacists in retail settings; (iii) non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID–19 are not permitted to enter those settings; (iv) well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID–19 are not permitted to enter those settings; (v) home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID–19 are not present; (vi) healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); or (vii) telehealth services performed outside of a setting where direct patient care occurs.

The agency has developed numerous compliance assistance materials to help employers understand and apply the ETS to their workplace. These materials can be found at the OSHA website.[25] In particular, the agency has developed a flow chart to help employers determine whether and how their workplace is covered by the COVID–19 Healthcare ETS. The flow chart is available on the website.[26] The agency has also provided responses to many Frequently Asked Questions (FAQs), several of which address scope issues.[27]

Employers that are covered by the ETS can consult the Inspection Procedures for the COVID–19 Emergency Temporary Standard[28] compliance directive for information about inspection procedures and enforcement policies for the ETS. It should be noted that upon opening a COVID–19 related inspection where the ETS could potentially apply, the agency's enforcement personnel are specifically directed to determine if any of the exemptions outlined in sections 29 CFR § 1910.502(a) apply to the whole facility or to well-defined portions to ensure that the ETS is not inappropriately applied to an employer who may be exempt.

Employers not covered by the ETS can consult the Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID–19)[29] for more information about how OSHA is handling COVID–19-related complaints, referrals, and severe illness reports in these workplaces. All employers can also consult the Revised Na-

[25] https://www.osha.gov/coronavirus/ets.
[26] https://www.osha.gov/sites/default/files/publications/OSHA4125.pdf.
[27] https://www.osha.gov/coronavirus/ets/faqs.
[28] https://www.osha.gov/sites/default/files/enforcement/directives/DIR__2021-02__CPL__02.pdf.
[29] https://www.osha.gov/laws-regs/standardinterpretations/2021-07-07.

tional Emphasis Program—Coronavirus Disease 2019 (COVID–19)[30] for more information about how OSHA is targeting specific high-hazard industries or activities where COVID–19 hazards are present in its enforcement activities.

RESTORATION OF DOL STAFFING

Question. The fiscal year 2022 budget request includes an increase of $1.7 billion over the fiscal year 2021 level for the Department. Included in that increase is an increase of an additional 1,949 full-time equivalents (FTE) for the Department, increasing total FTE levels from 14,906 to 16,855. The vast majority of the increases are within Worker Protection components, which will ultimately increase the number of enforcement actions against businesses.

The budget includes an additional 1,949 full-time equivalents for the Department. 362 of those are for OSHA alone, increasing the number of employees by over 13 percent. Most of those personnel won't focus on training individuals to renter the workforce, which is arguably the most important part of the Department's mission, especially as we recover from the unprecedented strain on our economy from COVID–19. Why is the Department not prioritizing training programs over increasing Federal bureaucracy?

Answer. In addition to a much-needed restoration of staffing levels in Worker Protection activities, the fiscal year 2022 Budget renews DOL's commitment to help American workers and job seekers, particularly those from disadvantaged communities, get back on their feet, access job training, and find pathways to high-quality jobs that can support a middle-class life. Significant investments in training include:

—*Apprenticeship:* The Budget requests $285 million, a $100 million increase above the fiscal year 2021 enacted level, to expand Registered Apprenticeship (RA) opportunities while increasing access for historically underrepresented groups, including people of color and women, and diversifying the industry sectors involved.

—*Workforce Innovation and Opportunity Act State Grants:* The fiscal year 2022 Budget also requests $3.7 billion, a $203 million increase over the fiscal year 2021 enacted level, for Workforce Innovation and Opportunity Act State Grants. This request will make employment services and training available to more dislocated workers, low-income adults, and disadvantaged youth hurt by the economic fallout from the pandemic.

—*Training displaced coal workers:* The Budget requests a $100 million investment for DOL's role in the new multi-agency POWER+ Initiative, aimed at reskilling and reemploying displaced coal workers in Appalachian communities. This request would complement other targeted Federal investments in POWER+ to assist workers and transform local economies in communities transitioning away from fossil fuel production.

—*Veterans:* The VETS Budget prepares America's veterans, service members, and their spouses for meaningful careers, provides them with employment resources and expertise, protects their employment rights, and promotes their employment opportunities. The Budget provides funding for the Veterans' Employment and Training Service's (VETS) core programs, which help improve skills and provide employment opportunities for veterans across the country. The request also provides the Employment and Training Administration (ETA) $20 million for a new program, developed in collaboration with VETS and the Department of Veterans Affairs, focused on helping veterans shift to careers in clean energy, which would help combat climate change while preparing veterans for good-paying jobs.

CARES ACT AND AMERICAN RESCUE PLAN SPENDING

Question. The Department of Labor received $385 million in discretionary and mandatory supplemental funds through the CARES Act that was passed in March 2020 and more than $2.2 billion in mandatory funds through the American Rescue Plan (reconciliation bill) that was passed in March 2021.

As of June 30th, a little more than $270 million has been obligated and only $91 million has been drawn-down from the $385 million provided in CARES. Further, of the $2.2 billion provided in the American Rescue Plan, less than $25 million has been obligated and only $5.6 million has been drawn-down. What is the delay in spending this funding and how long will it take you to expend these dollars?

Answer. The CARES Act appropriated to the Department with $345.0 million for National Dislocated Worker Grants (DWGs) and $15.0 million for the Departmental Management account to prevent, prepare for, and respond to coronavirus, including

[30] https://www.osha.gov/sites/default/files/enforcement/directives/DIR__2021-03__CPL__03.pdf.

enforcing worker protection laws and regulations. In addition, the CARES Act appropriated $25.0 million to the Office of Inspector General (OIG) for oversight of the unemployment provisions enacted in the CARES Act.

The Department issued guidance to States explaining how to apply for Disaster Recovery DWGs and Economic Recovery DWGs. The Department accepts applications on a rolling basis. Based on the anticipated large volume of funding requests across the nation, the Department approved reduced initial funding amounts to address the critical community needs in areas hardest impacted by the COVID–19 public health emergency. The amount initially provided was 33 percent of the grant amount requested or a set initial award amount correlated to a severity rating. The Department typically funds DWG awards on an incremental basis, although on rare occasions, it may award funds in full or in larger-than-typical increments, depending on factors such as the severity of the disaster and the viability of a proposed project.

The Department has awarded nearly $398 million in Disaster Recovery and Economic Recovery DWGs related to COVID–19. Of this total, approximately $143 million was obligated from the Program Year 2019 appropriation; the remainder was obligated from the supplemental funds appropriated under the CARES Act. ETA determines the amount to award for subsequent funding opportunities on a recipient's justification for the additional funds and continued demonstrated need, as evidenced by productive performance, enrollments and expenditures. ETA has traditionally considered requests for subsequent funding opportunities when expenditures have reached approximately 70 percent of the total DWG funds awarded to date. ETA works closely with states in determining their needs and identifying when additional resources may be warranted.

Of the $15.0 million appropriated to the Departmental Management account, $1.0 million was transferred to OIG, as required. OIG's funds are available without fiscal year limitation. The remaining $14.0 million was allocated between the Occupational Safety and Health Administration ($5.5 million); the Employment and Training Administration's Program Administration account ($4.0 million); the Wage and Hour Division ($2.5 million); the Employee Benefits Security Administration ($1.0 million); and the Office of the Solicitor ($1.0 million). These funds are available for obligation until September 30, 2022.

As of July 31, 2021, the Department has obligated approximately $11.0 million and $9.9 million has been expended. The Department will obligate the remaining $4.0 million over the remainder of fiscal year 2021 and fiscal year 2022 and expend the funds shortly thereafter.

Of OIG's $25.0 million CARES Act appropriation, as of July 31, 2021, OIG has obligated approximately $9.5 million and expended approximately $5.1 million. These funds are available for obligation until expended. The OIG indicated that it has allocated its CARES Act appropriation to support audits and investigations related to the expansion of the UI program during the pandemic, to include the hiring of more than 50 criminal investigators to combat unprecedented levels of fraud in the program. The OIG's funding will cover activities, salaries, and benefits through the end of fiscal year 2022.

The American Rescue Plan Act (ARPA) appropriated $2.0 billion to detect and prevent fraud, promote equitable access, and ensure the timely payment of benefits with respect to the unemployment compensation program, $8.0 million to carry out Federal activities related to the administration of unemployment compensation programs, and $200.0 million to carry out COVID–19 related worker protection activities.

The unemployment insurance (UI) system provided a critical lifeline for millions of workers during the pandemic. The pandemic also exposed longstanding challenges in the UI system. The funds appropriated under ARPA are critical to helping states address the most acute challenges they have faced this past year. The Department will be using the funds to tackle these acute problems facing the system in the short-term while also working to address long-term challenges. The Department is currently focusing on four key areas: sending multidisciplinary teams to states to provide intensive technical assistance; a comprehensive approach to implementing identify verification; modernizing technology; and directing grants to states to help solve some of these challenges immediately. Regarding the worker protection funding, the Department has set up a website[31] that outlines the planned use of funds for the worker protection activities and a quarterly status of obligations.

[31] https://www.dol.gov/general/american-rescue-plan/worker-protection-supplemental-appropriation.

UNEMPLOYMENT INSURANCE AND CONSUMER FINANCE APPLICATIONS

Question. In your testimony, you stated that you have two key goals for unemployment insurance: decreasing fraud and increasing access to benefits. You mentioned that the Department will have a four-pronged approach to bolstering unemployment insurance, including modernizing technology.

What are your thoughts on utilizing consumer finance applications to assist states in modernizing their unemployment insurance systems and preventing fraud?

Answer. The pandemic has only underscored states' desperate need for technological support and improvements. Many state systems are operating on outdated technology, which made it difficult for them to rapidly respond to changes in law and economic conditions. Part of our plan for the $2 billion appropriated under the American Rescue Plan Act is to address this problem by centrally developing open, modular technology solutions that states may adopt as part of ongoing modernization and improvement efforts. Shared IT solutions will be designed to integrate with state systems and will focus on the needs that are shared across states, while supporting states to implement and continue operating state specific elements. DOL's vision is to provide software to support end-to-end administration of UI, including benefit delivery, employer tools, and appeals. As part of this effort, DOL will consider all possible IT solutions that will assist states in modernizing their systems and preventing fraud, including consumer finance applications. DOL will work with the IT staff in the States to develop and execute a plan that builds resilience in the UI systems across the country.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

FUNDING FOR WEST VIRGINIA GRANTEES

Question. The Employment and Training Administration, an agency within your Department, is the leading agency responsible for providing job training and workforce development. My home state of West Virginia has one of the highest rates of unemployment in the nation, and yet we receive a minimal amount of ETA grant funding to retrain workers in emerging industries as we unfortunately shift away from a coal-dominated economy.

Why is it that we are missing out on this funding and how will you ensure that states like West Virginia, which have a clear need for investment in our workforce development, are adequately supported?

Answer. The Employment and Training Administration (ETA) provides grant awards to eligible entities to carry out a public purpose for the direct benefit or use of the United States Government. Many of these programs are funded through formula grants whereby the law specifies or allows ETA to determine the formula to distribute funding to the recipients. These grants include funding under Title I of the Workforce Innovation and Opportunity Act (WIOA), Unemployment Insurance Administrative Awards, Foreign Labor, Employment Service, and Trade Adjustment Assistance grants to states and territories. The allocation formula and funding allotments for these programs are published in ETA guidance and are made available publicly.[32]

In addition to formula-funded programs, some legislation provides discretionary funding for the Department to improve operations, performance, or knowledge. These competitive grants are typically awarded to eligible entities to create or expand innovative workforce development programs for workers and employers. The Department develops grant competitions and formally issues Funding Opportunity Announcements (FOAs) that convey the application requirements and evaluation considerations. These FOAs are published on the Grants.gov website and provide prospective applicants with the framework for preparing a grant application. The Department will often host a webinar or other event to discuss new FOAs for prospective applicants during the open period. A Technical Review Panel, composed of Federal staff and other workforce development experts, evaluates FOA applications. Reviewers evaluate and score applications based solely upon the evaluation criteria in the published FOA. The ranked application scores serve as the primary basis for the Department's selection of funding applications.

During fiscal year 2020, ETA awarded more than $83.33 million in grant funding to West Virginia, including $78.67 million for formula programs and an additional $4.66 million in discretionary grants. These awards included two grants under the Workforce Opportunities for Rural Communities (WORC) program that enables communities within the Appalachian and Delta regions that have been hard-hit by eco-

[32] https://wdr.doleta.gov/directives/all__advisories.cfm.

nomic transition, with slow recovery, to develop local and regional workforce development solutions that align with economic development strategies. ETA anticipates making a third round of WORC awards this Fall.

Question. On that same note, I was disappointed to learn two YouthBuild programs weren't selected for continued funding. I'd love to learn more about why, this program has helped so many young adults get back on track for a career.

Answer. The Department issues the YouthBuild Funding Opportunity Announcement (FOA) each year. This FOA is a competition open to both previously-funded applicants and entities that never received an award. Since this is a competitive process, not all applicants are selected for funding. Of the 130 applications reviewed this year, due to limited funds available, only 68 were selected. All applicants are contacted with the results of the competition and provided guidance on how to receive evaluative feedback related to their application. This feedback often helps applicants submit a more competitive application in the future.

QUESTIONS SUBMITTED BY SENATOR MIKE BRAUN

DOL FREEDOM OF INFORMATION ACT REQUESTS

Question. The Freedom of Information Act (FOIA), codified at 5 U.S.C. § 552, provides public access to certain Federal agency information.

Please provide the Committee with the Department of Labor's (DOL) budget request specifically for continued administration of and compliance with FOIA requests.

Answer. The DOL's FOIA processing is a decentralized operation such that each of the Agency's components account for their own expected FOIA processing costs within their individual budget requests. In the Agency's last annual FOIA report, completed for fiscal year 2020, DOL reported a total of 120.5 Equivalent Full-Time FOIA Employees and spent $19,103,622 in FOIA related processing costs for the DOL's 23 decentralized FOIA components,

While DOL's President's Budget for fiscal year 2022 does not include a specific request for the aggregate cost of FOIA processing and administration, DOL is able to identify certain items included within its budget request that relate specifically to FOIA processing and administration. First, for fiscal year 2022, the DOL has projected a cost of $1,170,000 for its Office of Information Services (OIS), which supports the statutorily mandated functions of the Department's Chief FOIA Officer (currently the Solicitor) in carrying out Department-level responsibilities under the Freedom of Information Act. 5 U.S.C. § 552. In addition, DOL's Office of the Chief Information Officer (OCIO) has projected fiscal year 2022 FOIAXpress System cost to be $1,121,576, to include $891,210 for FOIA System Costs (Licensing and Hosting), $155,366 for FOIA.

Question. Pertaining to the January 1, 2021 to July 15, 2021 timeframe, please also provide:

1. An update on the volume of FOIA requests;
2. The average time the agency took to fulfill such and the volume of FOIA requests outstanding; and
3. How many requests the agency has utilized a statutory exemption to deny fulfillment of a FOIA request.

Answer.

1. An update on the volume of FOIA requests

Total Number of Initial FOIA Requests Received	7,632
Total Number of Initial FOIA Requests Processed	8,442

"Total Number of Initial FOIA Requests Processed" includes requests received prior to January 1, 2021.

2. The average time the agency took to fulfill such and the volume of FOIA requests outstanding:

Average Number of Days to Process (Simple Queue)	45.8
Average Number of Days to Process (Complex Queue)	72.2
Average Number of Days to Process (Expedited Queue)	79.1
Total Number of Pending Requests (outstanding) request	2,296
Total Number of Backlogged Requests (20 workdays or older)	1,503

"Simple Queue" is based on low volume and/or simplicity of records requested and "Complex Queue" is based on high volume and/or complexity of records requested.

3. How many requests the agency has utilized a statutory exemption to deny fulfillment of a FOIA request: 2

Question. Please also provide a comparison of such FOIA volume and related fulfillment to calendar year 2020.

Answer.

1. An update on the volume of FOIA requests

Total Number of Initial FOIA Requests Received	15,820
Total Number of Initial FOIA Requests Processed	15,645

2. The average time the agency took to fulfill such and the volume of FOIA requests outstanding:

Average Number of Days to Process (Simple Queue)	39
Average Number of Days to Process (Complex Queue)	53.3
Average Number of Days to Process (Expedited Queue)	18.8
Total Number of Pending Requests (outstanding)	2,589
Total Number of Backlogged Requests (20 workdays or older)	1,714

3. How many requests the agency has utilized a statutory exemption to deny fulfillment of a FOIA request: 0

PAYROLL AUDIT INDEPENDENT DETERMINATION PROGRAM

Question. In the Trump Administration, the Department of Labor's Wage and Hour Division (WHD) saw both record-breaking enforcement numbers, and record-breaking outreach efforts. Despite these incredible outcomes for workers, the Biden Administration ended a voluntary compliance program called PAID (Payroll Audit Independent Determination). Will you commit to reviewing and reestablishing the PAID program?

Answer. The Department ended the Payroll Audit Independent Determination (PAID) program in January 2021. Between 2018 and 2021, approximately 70 employers participated in the PAID program. The Department continues to provide outreach and education resources for employers. Employers may continue to contact any of our 200 Wage and Hour Division offices to confidentially discuss their compliance questions, or to self-report violations they would like to resolve.

TELEWORKING

Question. How many of DOL's approximately 15,279 Full Time Equivalent (FTE) person workforce in Washington, D.C. is currently teleworking either (1) part-time or (2) full-time?

Answer. Based on data from the end of July 2021, 99.1 percent of DOL and PGBC employees are teleworking either on a part-time or full-time basis.

Question. For part-time staff, what proportion of their time is spent teleworking, on average?

Answer. Pre-pandemic, part-time employees spent 21 percent of their time teleworking. During the maximum telework posture, part-time employees spent 92 percent of their time teleworking.

Question. What has such teleworking done to decrease commuting and parking reimbursements, energy consumption, and other expenditures compared to years prior to the pandemic?

Answer. Transit subsidy costs have decreased and these funds have been reinvested by agencies in their program activities. There have been some savings in energy consumption related to the reduction in on-premises staff. To comply with safety recommendations from the Centers for Disease Control and Prevention in response to the COVID–19 pandemic, however, the Heating, Ventilation and Air Conditioning system is now run 24 hours a day to increase ventilation in the building. This has increased energy usage overall from prior years.

SECRETARY'S CALENDAR

Question. Previous administrations posted the calendars of their agency head for public inspection. As of July 23, 2021, there is no calendar information available to the public to understand your daily efforts on the public's behalf.

Will you commit to begin sharing your calendar information with the public on the DOL website? Can you provide a date on which your calendar detailing the first several months of your tenure will be published publicly?

Answer. No later than September 29, 2021, Secretary Walsh's calendar will be available at https://www.dol.gov/general/foia/readroom.[33] This will include the Secretary's calendar dating back to March 23, 2021 through July 31, 2021. Moving forward the calendars will be updated on a monthly basis.

UNEMPLOYMENT INSURANCE AND THIRD–PARTY INCOME VERIFICATION

Question. Pandemic Unemployment Assistance (PUA) has brought Unemployment Insurance (UI) eligibility to a significant number of "gig" or 1099 workers. These workers often face the greatest lag between income loss and access to benefits.

Some have suggested using consumer finance applications (apps) to reduce processing overhead, decrease fraud, and enable automation resulting in streamlined access to benefits.

Do you believe that states should use available funds to modernize UI systems and prevent fraud by creating partnerships with such consumer finance apps?

Answer. The pandemic has only underscored states' desperate need for technological support and improvements. Many state systems are operating on outdated technology, which made it difficult for them to rapidly respond to changes in law and economic conditions. Part of our plan for the $2 billion appropriated under the American Rescue Plan Act is to address this problem by centrally developing open, modular technology solutions that states may adopt as part of ongoing modernization and improvement efforts. Shared IT solutions will be designed to integrate with state systems and will focus on the needs that are shared across states, while supporting states to implement and continue operating state specific elements. DOL's vision is to provide software to support end-to-end administration of UI, including benefit delivery, employer tools, and appeals. As part of this effort, DOL will consider all possible IT solutions that will assist states in modernizing their systems and preventing fraud, including consumer finance applications. DOL will work with the IT staff in the States to develop and execute a plan that builds resilience in the UI systems across the country.

Question. Is the Department of Labor considering issuing guidance in regard to the ability of the states to use third-party income verification technology to accurately verify 1099 and gig worker income distribution?

Answer. Within the scope of the temporary Pandemic Unemployment Assistance (PUA) program authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, as amended, DOL has advised states through webinars and individual technical assistance requests regarding the use of third parties when obtaining documentation to verify 1099 income distribution for purposes of eligibility. Because the Department has already provided information to states on using third parties to verify income for PUA claimants and the program will end shortly, the Department does not plan on issuing guidance on using third party income verification technology.

QUESTIONS SUBMITTED BY SENATOR PATRICK J. LEAHY

UNEMPLOYMENT INSURANCE IT MODERNIZATION

Question. The COVID–19 pandemic highlighted the cracks in the foundation of many critical support systems across all levels of government, including the unemployment insurance system. After 15 very long months, Vermont is finally back to its pre-pandemic unemployment levels of 2.6 percent. The State has reinstated its work search requirements, and plans to allocate Federal unemployment benefits through the summer.

In April, your Department contacted the Vermont Department of Labor requesting that they re-process thousands of Federal unemployment benefit claims. During this difficult and unprecedented time, the state was trying to get money out the door to people in need as fast as they could. I, along with the rest of the Vermont congressional delegation, wrote you in late April about the need for flexibility when it came to the reprocessing of unemployment insurance claims given to claimants for the "able and available" eligibility criteria.

While the response from your Department recognized the strain under which state UI programs are operating, and stated that you will continue to provide the state with technical assistance to fulfill the Department's request, the Vermont delegation did not receive a response to our inquiry until last week, on July 7. I appreciate your Department's willingness to work with the state, but this was a long-delayed response. I hope the Department will keep me and my staff updated on this

[33] https://www.dol.gov/general/foia/readroom.

issue, as the state is doing, and in the future, I hope the responses to my office will be received in a timelier manner.

One issue highlighted by the pandemic is how many smaller, rural states including Vermont lack adequate, modern unemployment insurance technology. While trying to process thousands of new unemployment claims, the Vermont Department of Labor, for example, had to work with a 50-year-old computer mainframe that repeatedly froze and crashed the system at the beginning of the pandemic in the spring of 2020. I appreciate your Department's request for $100 million to bolster state Department of Labor's IT systems to administer unemployment, which is on top of the $2 billion committed in the American Rescue Plan for the same purpose.

How will your Department work to ensure that departments of labor with older unemployment insurance IT systems, such as Vermont's 50-year-old mainframe, are prioritized when administering UI modernization funding?

Answer. The Department welcomes the $2 billion that Congress provided in the American Rescue Plan Act and agrees that UI technology and infrastructure modernization is urgently needed. It is critical that state systems operate on a high-quality technology infrastructure that enables them to administer their UI programs equitably and efficiently, so all eligible unemployed workers have timely and meaningful access to this vital benefit. Formulating large scale spending plans across the UI system, which is comprised of 53 different programs operated by the states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, requires multiple complex considerations. The Administration is fully engaged in developing detailed plans to achieve the goals and purposes set in the American Rescue Plan Act and will keep Congress informed of those plans and progress on the implementation of this important project.

The Department has engaged with states on this topic. The Department conducted an initial webinar with state UI agencies on June 22, 2021, to share some of the current plans and approach on pursuing UI information technology modernization. The webinar also solicited states for engagement and partnership in these activities. Since then, seven states have begun working with the U.S. Department of Labor (DOL) and the U.S. Digital Service in research partnerships designed to help fill in research gaps and provide input on the current and future stages of UI modernization. Also, there have been follow-up virtual office hours offered to states for further conversations on this topic.

All states should benefit from the funding provided in the American Rescue Plan Act. As a state modernizes its IT system, there may be opportunities to take advantage of the central, modular, open technology solutions developed through this DOL/state partnership. DOL is also deploying teams of experts, initially to six states, on a voluntary basis to help identify process improvements that can speed benefit delivery, address equity, and fight fraud (i.e., Tiger Teams). The Tiger Teams can provide support, including funding, as states like Vermont look at business processes through a fraud-fighting and equity lens in the course of modernization. Additionally, DOL is making grants to states available to promote equity and fight fraud. These grants will be designed to help states improve worker access to the UI system, while helping states make system improvements that will safeguard them against fraud.

WORKFORCE SHORTAGES

Question. Even as Vermont's unemployment rate has fallen back to pre-pandemic levels, workforce shortages remain and no sector has been spared. Businesses in smaller, more rural states like Vermont, have struggled for decades to address skilled workforce shortages—whether it is in the healthcare, education, child care, or manufacturing industry. Your Department's budget requests $3.7 billion, a 6 percent increase, for the Workforce Innovation and Opportunity Act and Wagner Peyser state formula grants to make employment services and training available to dislocated workers impacted by the COVID–19 pandemic.

How will your Department work to ensure that the DOL's workforce development help dislocated workers in rural states like Vermont that currently lack the services available to provide workers with the skills necessary to re-enter the post-pandemic economy?

Answer. The Department is working to ensure that all American workers and job seekers, including those in Vermont, have access to the services needed to make them ready for good jobs with family-sustaining wages. The COVID–19 pandemic created widespread economic disruption and further highlighted pre-existing deficiencies in the availability of opportunities for all Americans to find good-paying, safe employment. While WIOA funding allotments to states are set by a statutory formula, the fiscal year 2022 Budget reflects the Department's continued commit-

ment to help American workers and job seekers, particularly those from disadvantaged communities, get back on their feet, access job training, and find pathways to high-quality jobs that can support a middle-class life. The fiscal year 2022 Budget requests $3.7 billion for WIOA programs, a $203 million increase over the fiscal year 2021 funding. The Budget includes increases of approximately $37 million for the Adult Program, $94 million for the Dislocated Worker Formula Program, $100 million for Dislocated Worker Grants (DWG), and $43 million for the Youth Program. This request will make employment services and training available to more dislocated workers, low-income adults, and disadvantaged youth who have been hurt by the economic impacts of the COVID–19 pandemic.

The fiscal year 2022 Budget also includes the American Jobs Plan, an investment that will create millions of high-quality jobs and rebuild our country's infrastructure. This includes investments in American workers—providing people with the skills they need to succeed, strengthening the pathways to success, and ensuring that the jobs that are created are high quality. Structural racism and persistent economic inequities have undermined opportunity for millions of workers, and these investments will prioritize underserved communities and communities negatively impacted by the transforming economy. The United States currently spends just one-fifth of the average that other advanced economies spend on workforce and labor market programs.

The Department included legislative proposals to implement the American Jobs Plan, totaling $81.5 billion over 10 years, to address these multiple challenges. This investment in proven workforce development models includes:

—Creating and expanding sector-based training programs;
—Providing comprehensive support for dislocated workers to enable their participation in high-quality training programs;
—Expanding Registered Apprenticeship and pre-apprenticeship opportunities;
—Building community colleges' capacity to deliver high-quality job training programs;
—Expanding access to evidence-based intensive, staff-assisted career services;
—Providing subsidized jobs to workers with barriers to employment;
—Expanding workforce development services for justice-involved individuals; and
—Phasing out the subminimum wage provided to workers with disabilities while expanding their access to competitive, integrated employment opportunities.

There are several current funding sources that may be able to support rural communities in addressing workforce transition.

First, each state may reserve up to 15 percent of their WIOA funding for statewide activities and an additional 25 percent of the Dislocated Worker formula allotment for Rapid Response activities. Both statewide and Rapid Response activities can be focused on prioritizing business engagement activities and layoff aversion efforts. Business engagement helps to develop long-term relationships with the business community. It enables the public workforce system to partner with businesses to play a more significant part in understanding their workforce needs, both currently and in the future. Statewide resources, or other WIOA resources, can then be used to train workers in the specific skills these businesses need.

Second, state or local workforce areas may request additional funding from the Department through the National Dislocated Worker Grant (DWG) program when qualifying events occur, including large layoffs or a number of smaller layoffs that add up to a larger impact. DWG funds supplement the regular WIOA formula resources and allow states to provide critical workforce services to more unemployed workers than would otherwise be the case.

Lastly, the Department funds several other grant programs that may benefit rural states and communities across the country. For example, on June 28, 2021, the Department announced the Comprehensive and Accessible Reemployment through Equitable Employment Recovery (CAREER) DWG. CAREER DWGs are designed to fund strategies and activities to help reemploy dislocated workers most affected by the economic and employment fallout from the COVID–19 pandemic, in particular, those from historically marginalized communities or groups and those who have been unemployed for an extended period or who have exhausted UI or other Pandemic Unemployment Insurance programs.

Another example is the competitive H–1B Rural Healthcare grants. In January 2021, the Department awarded $40 million in funding to rural communities through partnerships of public and private entities to address rural healthcare workforce shortages across the country. This investment is addressing a very specific need that was exacerbated during the pandemic. It aims to increase the number of individuals training in healthcare occupations that directly impact patient care and alleviate healthcare workforce shortages by creating sustainable employment and training programs in healthcare occupations serving rural populations.

The Administration also has requested $100 million in the next fiscal year to enable states to overcome the loss of legacy industries or persistent employment challenges and work towards a clean energy economy, helping to ensure steady employment opportunities into the future.

REGIONAL APPRENTICESHIP PROGRAM

Question. A primary focus of the Department of Labor's budget request for fiscal year 2022 is a significant increase of Federal funding for the Registered Apprenticeship Program of $100 million, totaling $285 million for the program, which is a 154-percent increase from fiscal year 2021. Apprenticeship programs add to the important workforce development role in helping people succeed in learning for the jobs of today and tomorrow. Many states, including Vermont, must connect jobseekers to better paying jobs that are in high-demand in order to continue to have a healthy economy. More than 90 percent of apprentices find employment after completing their programs, with graduates earning an average starting salary of more than $60,000.

The fiscal year 2022 budget request highlights the need for the Registered Apprenticeship Program to focus on expanding access to the model for historically underrepresented groups, including women and people of color, and in high-growth sectors where apprenticeships are underutilized. Despite the need for innovative programs to stem the demographic trends of aging and shrinking rural areas, small rural states such as Vermont have struggled with meeting some of the criteria for the Department's Apprenticeship program. Expanding the Department's partnership with regional commissions would ensure that small rural areas can also build long-term community capacity and increase economic competitiveness.

What is the Department's plan for ensuring that the increased funding request for the Registered Apprenticeship Program also benefits people who live in small rural states where the program's criteria has historically been a barrier to access?

Answer. The Department is acutely aware of the need for improving conditions in rural areas and reaching underserved populations and has previously invested in the expansion of Registered Apprenticeships in states, including small rural states, and is committed to continuing these efforts through future grant funding.

Previously, the Department awarded several grants supporting efforts to address access barriers to Registered Apprenticeship Programs in rural areas. These include Registered Apprenticeship grants awarded to states in 2016, 2018, 2019, and 2020[34] to support building state capacity to expand Registered Apprenticeship. The Vermont Department of Labor was a recipient of these awards in each of those 4 years. Since 2016, according to the Department's records the State of Vermont has seen a nearly 70 percent increase in the number of active apprentices in Registered Apprenticeship programs, including over 2,600 new apprentices during this period. In addition, in January 2021, the Department awarded nearly $40 million in grants as part of the H–1B Rural Healthcare grant program, focused on addressing healthcare workforce shortages by creating sustainable employment and training programs in healthcare occupations serving rural populations. This funding opportunity allowed applicants to propose a wide range of training models, including Registered Apprenticeship Programs (RAPs) to, meet the healthcare workforce needs of rural areas.

Most recently, the Department awarded more than $99 million to states as part of the State Apprenticeship Expansion, Equity, and Innovation[35] grants to bolster states' efforts to expand programming and inclusive recruitment strategies to attract a diverse workforce. The awards include more than $85 million for states that demonstrated a commitment to increasing their diversity, equity and inclusion efforts. These grants also aim to develop partnerships with new industries and non-traditional occupations, including industry sectors hardest hit by the pandemic, and align Registered Apprenticeships with other work-based learning opportunities within state education and workforce systems. In addition, to ensure this funding opportunity could support the diverse needs of small rural states, medium-sized, and large states the funding opportunity allowed for a broad funding request range (from $2 million up to $10 million) with performance outcome targets that were commensurate with the amount of funding requested.

Further, to better facilitate the expansion of Registered Apprenticeship, including in rural areas, the Department also awarded nearly $31 million through cooperative

[34] https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/active-grants-and-contracts.

[35] https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/active-grants-and-contracts.

agreements to establish four Registered Apprenticeship (RA) Technical Assistance (TA) Centers of Excellence[36] to provide technical assistance to key apprenticeship stakeholders. These RA TA Centers of Excellence will provide technical assistance on a national scale focused on: (1) diversity and inclusion; (2) strategic partnership and system alignment; (3) apprenticeship occupations and standards; and (4) data and performance best practices. Rural areas, as well as all states, will benefit from the technical assistance being provided by these centers.

A focus of all of the Department's investments awarded in 2021 is to fund opportunities to support innovation in Registered Apprenticeship expansion efforts allowing states maximum flexibility for determining where they should target resources. Such efforts may include creating access for underrepresented populations; developing distance learning approaches; identifying promising practices with employer incentives that could bring employers on board, especially in rural areas; and ensuring industries or occupations negatively impacted by the COVID–19 pandemic are supported.

In fiscal year 2022, the Department will prioritize investments that continue to expand the capacity of states to build and expand the apprenticeship model to new sectors and occupations, increase access for historically underrepresented groups; and address access barriers to Registered Apprenticeship Programs in rural areas. The Department will continue looking for additional opportunities to further these efforts.

Question. Has the Department considered further utilizing its partnerships with regional commissions and authorities to expand access to vital workforce development programs such as the Regional Apprenticeship Program? How can these partnerships best be utilized?

Answer. The Department believes partnerships that support workforce system integration are critical to expand access to Registered Apprenticeship Programs. This includes building partnerships with governors, workforce agencies, workforce development boards, and interdepartmental Federal leaders to further align registered apprenticeship with other work-based learning opportunities within state education and workforce systems.

As these partnerships are critical to expanding access to Registered Apprenticeship Programs, the Department has and will continue to fund activities that support building strategic partnerships and system alignment. Most recently, the Department awarded more than $99 million to states as part of the State Apprenticeship Expansion, Equity, and Innovation[37] (SAEEI) grants to bolster states' efforts to expand programming and inclusive recruitment strategies to attract a diverse workforce. Under these grants, states must explore new and expanded opportunities with industry, employers, education and training providers, the workforce system, state and local governments, labor organizations, and other entities, to better coordinate and maximize resources and assistance across Federal, state and local funding streams, as well as from the private sector enrollment in and access to apprenticeship opportunities that support workforce system integration.

Additionally, the Department also awarded nearly $31 million through cooperative agreements to establish four Registered Apprenticeship (RA) Technical Assistance (TA) Centers of Excellence[38] to provide technical assistance to key apprenticeship stakeholders. One of the RA TA Centers funded will support strategic partnerships and system alignment. Specifically, this center will focus on establishing, building, and sustaining partnerships that support system alignment of the national workforce and education systems to accelerate Registered Apprenticeship Program adoption and expansion. This RA TA Center of Excellence will provide technical assistance on a national scope to Registered Apprenticeship Program sponsors, and will also support state and local workforce development boards, American Job Center programs and operators, governors and other essential stakeholders that drive and inform economic and workforce development policies and programs.

The Department is constantly striving to find new and better ways to connect with the workforce system and its partners.

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[36] https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/active-grants-and-contracts.

[37] https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/active-grants-and-contracts.

[38] https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/active-grants-and-contracts.

SUBCOMMITTEE RECESS

Senator MURRAY. With that, the subcommittee is adjourned.

[Whereupon, at 11:12 a.m., Wednesday, July 14, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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

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

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on departmental and nondepartmental witnesses. The statements and letters of those submitting written testimony are as follows:]

DEPARTMENTAL WITNESSES

PREPARED STATEMENT OF AMERICA'S PUBLIC TELEVISION STATIONS AND THE PUBLIC BROADCASTING SERVICE

On behalf of America's 158 public television licensees, we appreciate the opportunity to submit testimony for the record on the importance of federal funding for local public television stations and PBS (Public Broadcasting Service). We urge the Subcommittee to support $565 million in two-year advance funding for the Corporation for Public Broadcasting (CPB) in FY 2024, $20 million for the Public Broadcasting Interconnection System in FY 2022 and $30 million for the Ready To Learn program at the Department of Education in FY 2022.

CORPORATION FOR PUBLIC BROADCASTING: $565 MILLION (FY 2024) TWO-YEAR ADVANCE FUNDED

Public television plays a key role in educating our children; providing job training; preserving our diverse, dynamic culture and democracy; and keeping Americans informed, safe and healthy. Public television's essential services have never been more critical than during the COVID–19 pandemic, when local public television stations in all 50 states provided enhanced educational services and content to help support students, families, teachers, and schools with the sudden challenge of virtual learning.

Federal funding for CPB is essential to making these services available to all Americans, including those in rural and underserved areas, and this funding enjoys the overwhelming support of the American people. At about $1.40 per person per year, this funding provides an enormous return on investment for all Americans.

Yet these vital community-based services were level-funded at $445 million for a decade—resulting in an approximate $100 million in lost purchasing power.

Recognizing this loss, we appreciate that Congress increased the forward funded CPB appropriation by $20 million for FY 2022 and an additional $10 million for FY 2023.

While public broadcasting is grateful for these increases, The public broadcasting system is still about $75 million, in inflation-adjusted dollars, behind where the system was 10 years ago, at a time when it is bearing the costly expense of providing access to content on ever emerging platforms and stations continue to offer more and more essential services to their communities.

Public broadcasting respectfully requests that Congress take another substantial step toward securing our current and future public service goals in the FY 2022 appropriations process.

The $565 million that public broadcasting is requesting in FY 2022 for FY 2024 will help restore lost purchasing power and enable local stations to leverage ad-

vancements in technology and make investments in the future that will educate more children and adults, provide additional critical resources and capabilities to teachers and schools, further enhance public safety and expand the civic leadership work of local stations.

Given the success of public media, and its potential to do so much more for so many, it is sound public policy to increase federal funding for this valuable service that provides an exceptional return on investment.

Education

Public media is committed to education and service for all Americans. Public broadcasting allows people at all income levels and from all parts of the country-rural and urban-to have access to consistent, high-quality, diverse content for free. This educational programming is readily available to children, parents, teachers, senior citizens, those pursuing their high school equivalency degrees, and many others.

Since last spring, as schools across the country shifted to remote learning in the face of the COVID–19 pandemic, local public television stations rolled out new education initiatives, including curated At-Home Learning broadcasts, airing instructional lessons created by teachers, and educational datacasting pilots to serve students without internet connectivity. These resources provided critical support to schools, teachers, and parents and helped bridge the digital gap for rural and underserved students. This extraordinary response by public television stations, many of which partnered with state and local education agencies, has provided much needed educational resources and support in communities across the country.

Public television's educational broadcast content has helped more than 90 million pre-school age children get ready to learn and succeed in school. Beyond the iconic, proven educational programming, PBS, in partnership with local public television stations and school districts provides additional content directly to classrooms and homes through PBS LearningMedia—which provides access to tens of thousands of State curriculum-aligned digital learning objects—including videos, interactives, lesson plans and more—for use in K–12 classrooms and at home. Content is sourced from the best of public television in addition to material from the Library of Congress, National Archives, NASA and other high-quality sources. PBS LearningMedia provided teachers and students with critical resources and digital content and the number of users grew by 240% during the pandemic.

Additionally, local public television stations throughout the country have partnered with PBS to bring a first-of-its kind, free PBS KIDS 24/7 channel and live stream to their communities—providing kids throughout the country with the highest level of educational programming, available through local stations any time, over-the-air and streaming. During the COVID–19 pandemic, many stations are using this expanded broadcast capacity to directly serve families and students from Pre-K—12 with state standards aligned educational content and instructional content created by teachers. Last year, 60% of kids ages 2–8 watched PBS KIDS content. Parents also looked to public television for educational resources, with PBS Parents users increasing by 80% during the pandemic.

Public television stations are also leaders in adult education. Public television operates the largest nonprofit GED program in the country, helping tens of thousands of second-chance learners earn their high school equivalency degree. In addition, public television stations are leaders in workforce development, including retraining American veterans, by providing digital learning opportunities for training, licensing, continuing education credits, soft skills and more.

Partners in Public Safety

Public broadcasting stations throughout the country are leading innovators and essential partners to local public safety officers. In partnership with FEMA, PBS WARN uses the public television interconnection system and local stations' broadcast infrastructure to support the Wireless Emergency Alert (WEA) system that enables cell subscribers to receive geo-targeted text messages in the event of an emergency-reaching citizens wherever they are.

The February 2019 Report from the FEMA National Advisory Council on Modernizing the Nation's Public Alert and Warning System specifically recommends, "Encouraging use of public media broadcast capabilities to expand alert, warning, and interoperable communications capabilities to fill gaps in rural and underserved areas."

In addition, and separate from the WEA system, local public television stations' digital infrastructure and spectrum enable them to provide state and local officials with critical emergency alerts, public safety, first responder and homeland security services and information during emergencies through a process known as

datacasting. Datacasting uses broadcast spectrum to send encrypted data and video to first responders with no bandwidth constraints.

In partnership with local public television stations and local law enforcement agencies, the U.S. Department of Homeland Security (DHS) has conducted several successful pilots throughout the country that, in addition to other local initiatives, prove the effectiveness of datacasting in a range of use cases including: flood warning and response; enhanced 911 responsiveness; over-water communications; faster early earthquake warnings; multiagency interoperability; rural search and rescue; high profile, large event crowd control; and assistance with school safety, including in areas that lack broadband or LTE services.

As a result of the successful pilots, the DHS Science and Technology Directorate has partnered with America's Public Television Stations (APTS) to maximize and promote datacasting technology and the opportunity to partner with local public television stations in communities nationwide.

Additionally, stations are increasingly partnering with their local emergency responders to customize and utilize public television's infrastructure for public safety in a variety of critical ways, with many serving as their states' Emergency Alert Service (EAS) hub for weather and AMBER alerts.

Providing Civic Leadership

Public television strengthens the American democracy by providing citizens with access to the history, culture and civic affairs of their communities, their states and their country. Through the pandemic, public television has been providing essential front-line coverage to ensure Americans have the facts they need to stay healthy and local information on where they can turn for help if they need it.

For the 18th year in a row, PBS was ranked the most trusted among national institutions. That trust is more important than ever. Over the last year, when inaccurate information could endanger people's lives, Americans could tune into their local public television station or view their online resources for trusted information that could help keep them safe.

Local public television stations often serve as the state-level "C–SPAN" covering state government actions. As some of the last locally controlled media, public television stations also provide more public affairs programming, forums for discussion of local issues such as the opioid crisis, local history, arts and culture, candidate debates, agricultural news, and citizenship information of all kinds than anyone else. What truly sets public television stations apart is that stations treat their viewers as citizens rather than consumers.

Public Broadcasting is a Smart Investment

All of this public service is made possible by the federal funding to CPB. This federal investment sustains the public service missions of public television, which are distinct from the mission of commercial broadcasting and will not be funded by private sources, as the Government Accountability Office concluded in a 2007 study commissioned by Congress.

The need for federal investment is particularly acute in small-town and rural America, where lower population density, a lack of corporate and philanthropic support, and challenging topography make the economics of local television and public service more challenging. As a result, public broadcasters are sometimes the only local broadcaster serving rural communities-and only with the help of the federal investment.

For all stations, federal funding is the "lifeblood" of public broadcasting, providing indispensable seed money to stations to build additional support from state legislatures, foundations, corporations, and "viewers like you."

For every dollar in federal funding, local stations raise six dollars in non-federal funding, creating a strong public-private partnership providing a valuable return on investment and supporting approximately 20,000 jobs across America.

And yet, until two years ago, this critical funding remained flat for a decade, forcing stations to make difficult programming, staffing and service decisions as operational costs rose with inflation, while CPB funding did not. Despite this severe financial constraint, local public television stations have continued their deep commitments to the communities they serve.

The $565 million that public broadcasting is requesting in FY 2024 is both prudent and necessary for the continued health of local stations and the public broadcasting system as a whole—and for long-delayed enhancements of the essential education, public safety and civic leadership services described above.

Two-Year Advance Funding

Two-year advance funding is essential to the mission of public broadcasting. This longstanding practice, proposed by President Ford and embraced by Congress in

1976, establishes a firewall insulating programming decisions from political interference, enables the leveraging of funds to ensure a successful public-private partnership, and provides stations with the necessary lead time to plan in-depth programming and accompanying educational materials-all of which contribute to extraordinary levels of public service and public trust.

Local stations leverage the two-year advance funding to raise state, local and private funds, ensuring the continuation of this strong public-private partnership. These federal funds act as the seed money for fundraising efforts at every local station, no matter its size. Advance funding also benefits the partnership between states and stations since many states operate on two-year budget cycles.

Finally, the two-year advance funding mechanism gives stations and producers, both local and national, the critical lead time needed to raise the additional funds necessary to sustain effective partnerships with local community organizations and engage them around high-quality programs. Producers like Ken Burns, Henry Louis Gates, Jr. and Stanley Nelson, spend years developing programs like The Vietnam War, Country Music, The Black Church, Tell Them We Are Rising: The Story of Black Colleges and Universities and a documentary on Muhammed Ali airing this fall. It would be impossible to produce this in-depth programming and the curriculum-aligned educational materials that accompany it without the two-year advance funding.

PUBLIC BROADCASTING INTERCONNECTION: $20 MILLION

The public television interconnection system is the infrastructure that connects PBS and national, regional and independent producers to local public television stations around the country. The interconnection system is essential to bringing public television's educational, cultural and civic programming to every American household, no matter how rural or remote. Without interconnection, there is no nationwide public media service. The interconnection system is also critical for public safety, providing key redundancy for the communication of presidential alerts and warnings, and ensuring that cellular customers can receive geo-targeted emergency alerts and warnings.

Congress has always provided federal funding for periodic improvements of the interconnection system. In FY 2018, Congress moved to fund interconnection for public broadcasting on an annual, rather than decennial, basis to enable dynamic, incremental upgrades in accord with increasingly rapid advances in technology. Public television seeks level funding of $20 million for interconnection in FY 2022.

READY TO LEARN: $30 MILLION (DEPARTMENT OF EDUCATION)

The U.S. Department of Education's Ready To Learn (RTL) competitive grant program, reauthorized in the Every Student Succeeds Act, uses the power of public television's on-air, online, mobile, and on-the-ground educational content to build the literacy and STEM skills of children between the ages of two and eight, especially those from low-income families.

Through their RTL grant, CPB and PBS deliver evidence-based, innovative, high-quality transmedia content to improve the math and literacy skills of high-need children. CPB, PBS, and local stations have ensured that the kids and families that are most in need have access to these groundbreaking and proven effective educational resources. In addition to children, this outreach focuses on adults who care for kids to empower and help them understand the important role they play in their children's educational success.

RTL investments have supported the production and academic rigor of PBS KIDS series: Elinor Wonders Why, Peg + Cat, SuperWhy!, Martha Speaks, Odd Squad and Molly of Denali—a curious and resourceful 10-year-old Alaska Native girl who lives in the fictional village of Qyah, Alaska—and other iconic programming for children.

But this investment does not solely rely on trusted, educational children's programming. CPB, PBS, and local public television stations employ a national-local model to reach parents, teachers, and caregivers on-the-ground in communities to help them make the most of these media resources locally. These include television, online and mobile apps, digital technology, mobile learning labs and on the ground events that provide valuable content and support to local school districts, county non-profits, preschools, homeschools, Head Start and other daycare centers, libraries, museums, and Boys and Girls Clubs, among others.

Results

RTL is rigorously tested and evaluated to assess its impact on children's learning and to ensure that the program continues to offer children the tools they need to

succeed in school. Since 2005, more than 100 research and evaluation studies have shown RTL literacy and math content engages children, enhances their early learning skills and allows them to make significant academic gains, helping bridge the achievement gap. Highlights of recent studies show that:

—Children from low-income households who were provided with RTL-funded Molly of Denali videos, digital games, and activities were better able to solve problems using informational text, -oral, written, or visual text designed to inform—a fundamental part of literacy that paves the way for future learning, particularly in social studies and the sciences. After only nine weeks of access, this impact is equivalent to the difference in reading skills a first-grader typically develops over three months.[1]

—Ready To Learn-funded resources from the PBS KIDS series *The Cat in the Hat Knows a Lot About That!* increased science learning in children from low-income households and had a positive impact on children's understanding of core physical science concepts of matter and forces-equivalent to the difference in science knowledge an early elementary student develops over five months.[2]

An Excellent Investment

In addition to being research-based and teacher tested, RTL also provides excellent value for our federal dollars. In the last five-year grant round, public broadcasting leveraged an additional $50 million in non-federal funding to augment the $73 million investment by the Department of Education. RTL exemplifies how the public-private partnership that is public broadcasting can change lives for the better.

A funding level of $30 million is requested in FY 2022 to support current grantees and further enhance the discoverability and impact of Ready To Learn created content and the quantity and scope of local station outreach to the kids, families, teachers and schools that need it the most.

Given the rigorous, thoughtful educational research and evaluation that goes into the creation of Ready To Learn content, Ready To Learn grants are awarded every five years and supported through annual appropriations. Funding in FY 2022 would provide the third year of funding in the latest grant round. Providing $30 million for Ready To Learn in FY 2022 will ensure that CPB, PBS and stations can continue to create the highest quality, proven-effective kids educational media, meeting kids, caregivers and teachers where they are on a variety of platforms, while expanding local, on-the-ground outreach through local partners.

CONCLUSION

Americans across the political spectrum rely on and support federal funding for public broadcasting because we provide essential local education, public safety, and civic leadership services that are not available anywhere else. And none of this would be possible without the federal investment in public broadcasting.

Federal funding is the great equalizer that ensures that the best of public broadcasting is available in both the urban centers of our great cities and in Native American communities in America's heartland and everywhere in between.

Federal funding for CPB is what ensures that young children in Appalachia have the same access to the unparalleled PBS KIDS content as their counterparts in Los Angeles. And federal funding is what ensures that all households, regardless of their ability to pay for cable or streaming subscriptions have access to local programming and the best of *NOVA, Masterpiece, NewsHour, Great Performances,* and so much more.

Public broadcasters are the only broadcasters that reach nearly 97% of U.S. households, and it is CPB funding that makes this possible.

For all of these reasons we request that Congress continue its commitment to the highly successful, hugely popular public-private partnership that is public broadcasting by providing $565 million in FY 2024 for CPB in addition to $20 million in FY 2022 for public broadcasting's interconnection system and $30 million in FY 2022 for the Ready To Learn Program.

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[1] Kennedy, J. L., Christensen, C., Maxon, T., Gerard, S., Garcia, E., Hupert, N., Vahey, P., & Pasnik, S. (2021).

[2] (Grindal, T., Silander, M., Gerard, S., Maxon, T., Garcia, E., Hupert, N., Vahey, P., Pasnik, S. (2019). Early Science and Engineering: The Impact of The Cat in the Hat Knows a Lot About That! on Learning. New York, NY, & Menlo Park, CA: Education Development Center, Inc., & SRI International.)

PREPARED STATEMENT OF THE NATIONAL PUBLIC RADIO

Chairwoman Murray, Ranking Member Blunt and Members of the Subcommittee,

Thank you for this opportunity to urge the Subcommittee's support for a robust annual federal investment of $565 million in FY 2024 in public broadcasting through the Corporation for Public Broadcasting (CPB) and $20 million in FY 2022 to continue upgrading the public broadcasting interconnection system and other technologies and services that create system efficiencies.

As the President and CEO of National Public Radio (NPR), I offer this statement on behalf of the public radio system, a nonprofit public service media enterprise that includes NPR, more than 1,000 public radio stations, other producers and distributors of public radio programming, and many stations, large and small, that create and distribute content through the Public Radio Satellite System(r) (PRSS(r)). Every day, public radio connects with millions of Americans on the air, online, through smart speakers and mobile devices, and in person to explore current news, music, enduring ideas, and what it means to be human. About 98.5% of the U.S. population is within the broadcast listening area of one or more public radio stations.

Federal funding provided by Congress to the CPB enables local, noncommercial radio stations to provide news, information, and cultural programming to meet the needs of local communities and offer diverse perspectives. This funding is the bedrock of the public broadcasting system. On average, for every $1 in federal grant money that a public radio station receives, it raises $10 locally from audiences and local sponsors. Public radio stations are locally owned and managed, and thereby accountable to the local leaders and listeners they serve.

Many newspapers have lost circulation and advertisers, and are closing their doors, eliminating sources of local news. More than 3,100 journalists at local public radio stations help to fill this need—bringing trusted, reliable, independent news and information of the highest editorial standards to keep communities connected. On May 6, 2021, the Radio Television Digital News Association recognized this quality journalism by awarding public radio 277 Regional Edward R. Murrow Awards—80 percent of the 343 awards in U.S. radio categories.

Continued investments in newsgathering capacities at public radio stations will help ensure that public media can continue to fill the gap for news and information in America's communities with expanded local and regional coverage and digital services. CPB is helping to fund public radio collaboration across key regions. In 2019, NPR and public radio stations in Texas joined together to launch the first regional reporting hub. In 2020, NPR and local stations launched a Gulf states hub covering Mississippi, Alabama, and Louisiana—one of the most news deprived regions in the country—as well as hubs in California and the Midwest. Another NPR collaboration funded by CPB—the Stations Investigations Team-supports local stations' investigative journalism, helping with technical skills such as data collection and analysis, as well as training. These collaborative arrangements allow stations to utilize resources more efficiently, increase the scope of regional coverage, and promote journalistic skills and mentoring.

Public radio stations play an important role in civics—supporting state house coverage, reporting on local elections, and fostering dialogue among communities. On a broader scale, public radio seeks to connect Americans, including students, through coverage of national civics issues and questions. For example, with CPB support, New Hampshire Public Radio produces Civics 101: A Podcast, exploring topics such as types of civic action, electoral processes, fundamental rights, landmark Supreme Court cases, and key documents, such as the Magna Carta. NHPR also provides resources for educators, including teacher created lesson plans, to use these audio resources in the classroom. By inspiring audiences of all ages to engage with foundational civics topics, public radio can support the search for common ground across the political spectrum.

Throughout the COVID–19 pandemic, public radio stations have provided life-saving information and documented stories of how the pandemic affected communities across the nation. In May 2020, a collaborative reporting project from NPR and The Texas Newsroom found that COVID–19 testing sites in four major cities in Texas were located in predominately white neighborhoods, and through the examination of available testing data, revealed that it was harder for people of color to find test sites near where they lived. Following this exclusive report, Dallas County opened two walk-up testing sites in Southern Dallas, and Governor Greg Abbot announced that the state would bring more testing to underserved communities. In 2021, NPR and reporters from The Texas Newsroom and The Gulf States Newsroom teamed up to examine the availability of COVID–19 vaccination sites, again identifying disparities in the location of vaccination sites in major cities in the Southern United States.

At the beginning of the pandemic, as listeners transitioned to working and living in quarantine, public radio's digital audiences grew 250 percent. Audiences sought insight into the nation's response to the coronavirus and how their local communities were affected. Public radio stations provided live blogs on the coronavirus, explanations of public health orders, and information on the development and distribution of vaccines. By the end of 2020, public radio station websites demonstrated continued audience growth, showing a 31 percent year-over-year growth in average monthly users and a 67 percent increase in monthly newsletter traffic.

Madam Chairwoman, Ranking Member, and members of the subcommittee, I would be remiss if I did not thank you for the support you provided to public radio, and the entire public broadcasting system, through the Coronavirus Aid, Relief, and Economic Security ("CARES") Act in 2020 and the American Rescue Plan Act earlier this year. Your support during this crisis ensured that local public radio stations received needed resources to maintain essential programming and services for the communities that depended upon them.

We have seen that the COVID–19 pandemic further demonstrated the value of public radio embracing the challenges of a multi-platform media marketplace, while continuing to hold a dominant position in traditional radio broadcasting. Public radio stations offer original content through a variety of platforms and channels to reach new audiences, including terrestrial radio, satellite radio, the web (desktop and mobile), smart speakers, and podcasts—and application-driven mobile services on iOS and Android (both phone and tablet) and via aggregators such as Apple Music, Facebook News, Stitcher, and TuneIn. The strength of this multi-platform approach is that public radio can reach listeners wherever they are and attract new and diverse listeners. For example, Southern California Public Radio—with CPB support—is reaching out to younger, Latino audiences by producing innovative, on-demand content and increasing the diversity of its on-air hosts, producers and production staff. NPR has also partnered with classrooms across the country in the annual Student Podcast Challenge, which invites middle school and high school students to work with their teachers to develop and produce a podcast for the opportunity to be featured on NPR; a similar challenge is available for college students. Thousands of students and teachers have participated across all 50 states, utilizing resources designed to support the process in the classroom, develop journalism and broadcast skills, and connect public radio to youth audiences.

Public radio is more than journalism. Stations offer communities access to innovative music, arts, entertainment, and other cultural programming. Public radio music-format stations play a key role in supporting noncommercial music in the United States, playing a broad collection of sounds and styles including jazz, blues, classical, folk, alternative, bluegrass, zydeco, roots, and other eclectic genres. Public radio stations make this wide variety of music accessible to listeners through traditional broadcasts, streaming, live performances, and music journalism. This programming supports discovery and creativity, and connects local and national audiences to a broader cultural conversation thus enriching both hearts and minds. Funding for CPB plays a key role in enabling stations and program producers to provide these cultural opportunities.

Public radio would not be possible without the federal funding provided for the PRSS—the satellite content distribution system on which the public radio system—including almost all stations, networks, and producers—generally depends. The federal appropriation would allow the current satellite-and-internet delivery system to continue to be modernized and maintained with next-generation equipment and software.

The PRSS is open to all public telecommunications entities, including independent producers; program syndicators and distributors; national, state, and local organizations; and public radio stations. Stations that receive programming distributed by the PRSS range from those located in remote villages in northern Alaska and on Native American reservations in the Southwest, to major market stations such as WNYC in New York City and KUSC in Los Angeles. Through almost 400 downlinks, PRSS transmits programs distributed from NPR, other major content producers, and more than 100 independent radio producers and organizations with a variety of formats that include news, public affairs, documentaries, classical music, and jazz.

CPB's support of interconnection for the PRSS facilitates the cost-effective and efficient distribution of high-quality, educational programming to this country's increasingly diverse population. As part of that mission, the PRSS provides free, or "in kind," satellite transmission services to distribute programming to un-served or under-served audiences. Currently, full-time support is given to three program service groups: Native Voice One serving Native American listeners; Satélite Radio

Bilingüe, a Spanish-language service; and the African American Public Radio Consortium.

The PRSS also plays a vital role in the nation's emergency alert system by receiving Presidential alerts (also called Emergency Action Notification (EAN) alerts) fed directly from FEMA, which it can transmit to public radio stations in the event of a nationwide crisis. In addition, the PRSS MetaPub service enables local public radio stations equipped with this technology to issue emergency text and graphic alerts—such as tornado and hurricane warnings, evacuation routes, and COVID–19 information—that are visible on screens and synched with over-the-air broadcasts to mobile phones, HD radios, "connected car" smart dashboards, Radio Data System displays, and via online audio streaming. To date, about 10 percent of interconnected public radio stations have the capability to issue live text alerts using the MetaPub system in the event of a natural or humanmade disaster, such as a chemical spill.

In closing, public radio provides an essential public service for local communities across the nation—embracing their diversity, telling their stories, and keeping them informed with trustworthy, independent news, information, and public safety alerts upon which they rely. Your support for the CPB appropriation will ensure that public media can continue to provide these critical services and be positioned to embrace the future of the media landscape. Thank you for your support of the public broadcasting system.

[This statement was submitted by John F. Lansing, President and CEO, National Public Radio.]

NONDEPARTMENTAL WITNESSES

PREPARED STATEMENT OF THE ACADEMY FOR RADIOLOGY & BIOMEDICAL IMAGING RESEARCH

Madam Chair and members of the Subcommittee, I am Mitchell Schnall, President of the Academy for Radiology & Biomedical Imaging Research (Academy), and the Eugene P. Pendergrass Professor of Radiology and Chair of the Radiology Department at the Perelman School of Medicine at the University of Pennsylvania. The Academy is more than 200 academic research departments, patient advocacy groups, industry partners, and imaging societies that represents thousands of radiologists and researchers in all 50 states. The Academy is the only advocacy organization representing the broad spectrum of the imaging research community by collectively advocating for robust and consistent federal research funding.[1] It is my pleasure to submit this testimony on behalf of the Academy. We strongly support the President's request of $52 billion for the National Institutes of Health and ask that no less than $46.111 billion of that be for the NIH's base program budget for FY2022. Investigator-initiated research continues to be the foundation of basic science and discovery. The latter figure represents an increase of $3.177 billion over the FY2021 enacted levels. Moreover, the Academy supports a proportional increase to the National Institute of Biomedical Imaging and Bioengineering (NIBIB), resulting in at least $441.1 million for FY2022—a $30.4 million increase over FY2021. These base increases reflect approximately 5% above the biomedical research and development price index (BRDPI). Through consistent, strong funding for NIH and our national research infrastructure we can continue to make advancements that will improve the lives of patients with a wide spectrum of diseases and disorders. The Academy is grateful for the Subcommittee's past support of NIH and encourages you to continue advancing biomedical research and radiology and imaging science.

Imaging is not limited to any one disease or condition. Instead, it serves as a necessary diagnostic tool that researchers and clinicians of all types use to help advance our understanding of biological systems and how best to develop and deliver treatments benefitting patients. By improving our imaging tools and techniques, we broaden the resources available to address many challenging conditions. In my own work as a clinician-scientist, I use state-of-the-art technologies like specialized magnetic resonance imaging (MRI) and 3-dimensional mammography (digital breast tomosynthesis) to improve the diagnosis and treatment of cancer types, including breast, prostate, and pancreatic, while also researching rare and orphan diseases.

Imaging Innovation to Help Patients

Imaging tools can apply to a wide range of diseases and disorders and can have very real impacts on patient outcomes. This results from Congress's sustained federal investment in biomedical research at NIH over the last several years. Over time, basic science advancements translate into a variety of clinical settings, ultimately benefitting patients. This Subcommittee's continued support of NIH, and specifically NIBIB and the other Institutes and Centers that support imaging research, will help generate future breakthroughs across many biomedical challenges. Moreover, these innovations can be translated into the commercial products, supporting the biotechnology industry and jobs. Below are examples of the community's response to the COVID–19 pandemic, advances in detecting and treating cancer, and the role of imaging in detecting and treating neurodegenerative diseases.

Medical Imaging and Data Resource Center: Merging Diagnostics and Machine Learning

In the first of a two-year effort launched in 2020, the goal of the Medical Imaging and Data Resource Center (MIDRC) is "to foster machine learning innovation through data sharing for rapid and flexible collection, analysis, and dissemination of imaging and associated clinical data...in the fight against COVID–19."[2] MIDRC is an NIBIB-funded collaboration between the American College of Radiology (ACR), the Radiological Society of North America (RSNA), the American Association of Physicists in Medicine (AAPM), and the University of Chicago. These partners are building an accessible and shareable database that can be used to accelerate clinical diagnosis, monitoring, and treatment of COVID–19. Datasets are now being released for public use. Moreover, MIDRC is developing machine learning tools for evaluating medical images to determine the likelihood and future severity of infection, as well

[1] https://www.acadrad.org/about-the-academy/.
[2] https://www.midrc.org/.

as the prognosis for recovery. While currently focused on Covid–19, the methods can be applied to any large set of biomedical images to analyze and identify the likelihood of disease or disorder. Leveraging these innovations and computational tools augments human evaluation. This technology, using nationwide data, also improves predictive tools for identifying serious conditions and recovery prognoses while serving as an "early warning" system for future outbreaks.

Combining Diagnostics and Therapy to Treat Cancer

Recent technological advances in imaging have transformed the landscape for detecting and treating many types of cancer. Today, diagnostics and therapeutics can be combined into one action. The evolving field of theranostics—therapy-diagnostics—uses imaging agents, called radiotracers, to simultaneously diagnose and deliver therapy to affected cells. These targeted molecules are engineered to seek out specific types of cancer cells, which may be part of primary tumors or circulating throughout the body as metastases. Imaging for prostate cancer is now 100 times more effective than it was only 15 years ago. And now, these same agents can be loaded with radioisotopes designed to kill cells, becoming "smart bombs" aimed at cancer. Extensive work is underway to develop smart radiotherapy agents for numerous cancers including prostate cancer. Other targeted agents recently approved by the FDA can simultaneously seek out and destroy neuroendocrine cancer cells, a form of pancreatic cancer. These advances are helping physicians become much more effective in diagnosing and treating these and many other types of cancer, including lymphoma and thyroid cancer. Consequently, the patient receives very real benefits—the ability to find and treat cancer in a single action rather than requiring repeated visits, evaluations, and more invasive procedures. Theranostics, built on research funded by multiple institutes at NIH, has the potential to further advance society's goal of making cancer a treatable disease across a broad array of tumor types.

Detecting Neurodegeneration to Manage Treatments

Every American knows at least one family with a member afflicted by a neurodegenerative condition such as Alzheimer's disease or another form of dementia. The inexact and sometimes subtle symptoms of these conditions in their early stages, combined with the challenges of studying a living human brain, can make effective diagnoses challenging. Recent breakthroughs in imaging provide alternative, more precise tools physicians can use to diagnose and manage the care of affected patients. New imaging agents allow investigators to detect and quantify amyloid plaques and Tau proteins in the brains of patients—two leading indicators for Alzheimer's disease. This ability informs and accelerates the search for new treatments and methods to predict which patients may benefit from such therapies. In fact, a recent clinical trial investigated a new treatment for the removal of amyloid plaque from patients, an approach enabled by an approved imaging agent supported by an NIH grant.

Treatment of another neurological condition, Parkinson's disease, has also advanced because of emerging imaging research. Patients suffering from essential tremor symptoms, including those with Parkinson's, can now benefit from therapies in which magnetic resonance imaging (MRI) images are used to direct sound waves—High-intensity Focused Ultrasound—in a non-invasive way to alter neuronal connections and activities. This intervention often leads to instantaneous improvement in patient symptoms. While not a cure, alleviation of tremor symptoms allows patients to continue managing their condition by caring for themselves through actions such as dressing, eating, and other activities that require fine motor skills.

SUMMARY AND CONCLUSION

Sustained and robust NIH funding is crucial to advancing our efforts to understand and ultimately treat a myriad of diseases and disorders across human systems. NIH investments are also a key economic driver at local research institutions, and NIH funds flow to every state in the nation.[3] If we are to remain a global leader in biomedical research and innovation, continued, strong support for NIH is essential. Funding NIH's base program with at least $46.111 billion will provide the robust support needed to sustain growth for biomedical research.

Thank you for your strong, continued support of NIH, NIBIB, and all the Institutes and Centers working to advance our biomedical research efforts and to improve the lives of patients worldwide. On behalf of the Academy, I urge you to continue your strong support of our nation's research and innovation enterprise.

[3] https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf.

[This statement was submitted by Mitchell Schnall, M.D., Ph.D., President, Academy for Radiology & Biomedical Imaging Research.]

PREPARED STATEMENT OF THE ACADEMY OF NUTRITION AND DIETETICS

Dear Chair Murray and Ranking Member Blunt,

The Academy of Nutrition and Dietetics appreciates the opportunity to submit testimony to the subcommittee for FY22 appropriations. Representing more than 112,000 credentialed nutrition and dietetics practitioners, the Academy is the world's largest organization of food and nutrition professionals and is committed to improving the nation's health with nutrition services and interventions provided by registered dietitian nutritionists.

For FY22, we strongly urge you to provide funding for the promotion of the 2020–2025 Dietary Guidelines for Americans by the HHS Office of Disease Prevention and Health Promotion; the CDC Division of Nutrition, Physical Activity, and Obesity; and for Americans Older Americans Act senior nutrition programs. In the Department of Education, we support the Health Professionals of the Future program proposed in the President's budget.

Funding: DGA Promotion by the HHS Office of Disease Prevention and Health Promotion—FY2022 Request: $3 million

The 2020–2025 Dietary Guidelines for Americans were released in December 2020 and featured new nutrition recommendations for children from birth through 24 months and pregnant and lactating women. For the Dietary Guidelines for Americans to achieve their intended reach and impact, it is essential that the federal government invest in educating consumers and health care professionals on these new guidelines.

The HHS Office of Disease Prevention and Health Promotion (ODPHP) and the USDA Center for Nutrition Policy and Promotion (CNPP) and they should jointly work to develop materials for comprehensive education campaigns aimed at: (1) educating consumers on how to use the new Dietary Guidelines to inform their dietary choices; and (2) health care professionals to align their dietary guidance with the new Guidelines.

The campaign should be informed by scientific research on health behavior change, as well as input from key stakeholder groups, including nutrition assistance program participants and administrators, health care providers, community leaders, and health and nutrition advocates. The campaign should incorporate educational materials representing wide diversity of cultural food preferences and should be available in languages that meet the needs of populations at risk for diet-related disease.

Funding: Older Americans Act Nutrition Programs (HHS ACL)

The Older Americans Act authorizes a wide array of service programs that are overseen by the HHS Administration for Community Living and delivered through a national network of state agencies, area agencies on aging, and nearly 20,000 service providers.[1] Most program participants have household incomes below 100% of the federal poverty level.[2] In addition to directly combatting senior hunger during this time of uncertainty, senior meals programs have also reduced the need for seniors to leave their homes to get food, helping to limit their exposure to COVID–19. A significant increase in funding for these programs would not only allow more seniors to be served but would free up money for the nutrition assessment and educational components of these programs that are often sacrificed in order to reduce wait lists for meals.

Congregate Nutrition Services

Congregate Nutrition Services funds nearly 80 million meals per year for 1.5 million participants and gives seniors access to socialization. More than one-fifth of participants have been deemed to be at high nutrition risk. These funds are also used to provide nutrition screening and counseling to seniors who may be at risk of malnutrition, food insecurity or other issues. For the duration of the COVID–19 public health emergency, service agencies have been given the flexibility to convert their congregate meals programs into drive-up or grab-and-go programs and to use any surplus funds from their congregate nutrition services budget to provide home-delivered meals.

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[1] https://acl.gov/about-acl/authorizing-statutes/older-americans-act.
[2] https://fas.org/sgp/crs/misc/IF10633.pdf.

Home-Delivered Nutrition Services

Home-Delivered Nutrition Services provides more than 145 million meals per year to 867,000 participants, with more than half of program participants categorized as being at high nutrition risk.[3] The program also serves as a welfare check for isolated seniors and as a primary access point for other home- and community-based services. The demand for this crucial nutrition security program has been unprecedented during the COVID–19 pandemic.

Funding: CDC Division of Nutrition, Physical Activity, and Obesity—Division of Nutrition, Physical Activity and Obesity—FY2022 Request: $125 million

The CDC Division of Nutrition, Physical Activity, and Obesity (DNPAO) oversees grant programs that provide funds to states and localities to address the obesity epidemic in their communities.[3] Adult obesity prevalence is at over 42% in 2017–2018.[4] Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death. In 2008, the annual medical cost of obesity in the United States was estimated to be $147 billion; the medical cost for people who have obesity was $1,429 higher than those of normal weight. Having obesity is a top risk factor for severe disease, hospitalization and death from COVID–19. Minority and low-income communities often lack access to healthful foods and safe places to be active, and these inequities contribute to obesity and other chronic disease disparities that are contributing to disproportionate COVID–19 morbidity and mortality.

State Physical Activity and Nutrition Program—FY2022 Request: $60 million

The State Physical Activity and Nutrition (SPAN) grant program at DNPAO awards competitive grants to states to implement multi-component, evidence-based strategies at the state and local level to improve nutrition and physical activity.[5] With its current funding level, SPAN is only able to fund 16 states, which is does via five-year grants (currently FY18–22). DNPAO estimates that it would cost an additional $1.2 million per state to expand the program, so we are requesting $60 million of the $125 million for DNPAO to go to SPAN to allow every state to receive SPAN grant funding.

Funding: Health Professionals of the Future (ED)—FY2022 Request: $200 million

COVID–19's disproportionate impact on communities of color has made the need for health professional workforce diversity and culturally competent care more urgent than ever. Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), and other Minority Serving Institutions (MSIs) have long been leaders in addressing health equity in America. Specifically, HBCUs graduate 43% of all African Americans with postsecondary degrees in STEM fields and roughly 15% of all African American physicians. Despite these successes, gaps remain, particularly among registered dietitian nutritionists.

The Health Professionals of the Future proposal[6] put forth in the FY22 President's budget would help close these gaps by creating and funding a competitive grant program that provides funding to MSIs to create or expand graduate programs that prepare students for high-skilled jobs in the health care sector and help diversify the healthcare sector pipeline. Authorized activities would include the development of a career and educational pathways exploratory system to assist undergraduate and graduate students in learning about career opportunities in these fields and connecting students to internships and jobs; support services to help students complete graduate programs; scholarships or fellowships for tuition or to support on-the-job training.

Contact

Please feel free to contact me at hmartin@eatright.org with any questions on these important issues. Thank you for the opportunity to submit our recommendations to the subcommittee.

Sincerely.

[This statement was submitted by Hannah Martin, MPH, RDN, Director, Legislative and Government Affairs, Academy of Nutrition and Dietetics.]

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[3] https://www.cdc.gov/nccdphp/dnpao/state-local-programs/funding.html.
[4] https://www.cdc.gov/obesity/data/adult.html.
[5] https://www.cdc.gov/nccdphp/dnpao/state-local-programs/span-1807/index.html.
[6] https://www2.ed.gov/about/overview/budget/budget22/justifications/t-highered.pdf#page=147.

PREPARED STATEMENT OF THE AD HOC GROUP FOR MEDICAL RESEARCH

The Ad Hoc Group for Medical Research is a coalition of nearly 400 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry. We appreciate the opportunity to submit this statement in support of strengthening the federal investment in biomedical, behavioral, social, and population-based research conducted and supported by the National Institutes of Health (NIH) through a recommendation of at least $46.1 billion for NIH's base program level budget in FY 2022.

As a result of the strong, bipartisan vision of the House and Senate Labor-HHS-Education Subcommittees over the last six years, Congress has helped the agency regain some of the ground lost after years of effectively flat budgets. That renewed investment in NIH has advanced discovery toward promising therapies and diagnostics, reenergized existing and aspiring scientists nationwide, and restored hope for patients and their families. As the Subcommittee has recognized, to remain a global leader in accelerating the development of life-changing cures, pioneering treatments, and innovative prevention strategies, and in this time of unprecedented scientific opportunity, it is essential that Congress sustain long-term robust increases in the NIH budget.

In FY 2022, the Ad Hoc Group for Medical Research supports at least $46.1 billion for the NIH base program level budget, including funds provided through the 21st Century Cures Act Innovation Fund for targeted initiatives, a $3.2 billion increase over the NIH's program level funding in FY 2021. This funding level, supported by nearly 400 stakeholder organizations, would provide 5% growth in the base budget above inflation, expanding NIH's capacity to support promising science in all disciplines. We are grateful for President Biden's enthusiasm for medical research investments and welcome opportunities to engage with the Congress and the Administration regarding the proposed Advanced Research Projects Agency for Health (ARPA–H). Robust growth in the foundational research that NIH supports will be key to this vision, and we urge lawmakers to ensure no less than $46.1 billion for the NIH's base and that any additional funds for ARPA–H or other targeted initiatives supplement, rather than supplant, this core investment.

We further recommend a funding allocation for the Labor-HHS-Education Subcommittee in FY 2022 that allows for the necessary investment in NIH and other agencies that promote the health of our nation. We believe that science and innovation are essential if we are to continue to meet current and emerging health challenges, improve our nation's physical and fiscal health, and sustain our leadership in medical research.

In addition, we remain concerned about the lingering $16 billion impact of the coronavirus pandemic on medical research progress in all disease areas, and especially on the research workforce, as highlighted by NIH Director Dr. Francis Collins' recent testimony before this Subcommittee. The supplemental funding Congress has provided over the last year has been instrumental in advancing research on COVID–19, with tremendous success in the form of multiple safe and effective vaccines to combat SARS–CoV–2 and other advances. But the pandemic has threatened progress across numerous other areas, with particular challenges for women, minorities, and early career investigators in the research workforce. We continue to urge support for emergency resources, as outlined in the RISE Act (H.R. 869/S. 289), that will allow the NIH to rebuild the nation's strong and diverse research workforce infrastructure and continue to invest in broad and new research areas that will provide better health for patients in the future.

NIH: A Partnership to Save Lives and Provide Hope. The partnership between NIH and America's scientists, medical schools, teaching hospitals, universities, and research institutions is a unique and highly productive relationship, leveraging the full strength of our nation's research enterprise to translate this knowledge into the next generation of diagnostics, therapeutics, and cures. More than 80 percent of the NIH's budget is competitively awarded through nearly 50,000 research and training grants to more than 300,000 researchers at over 2,500 universities and research institutions located in every state and Washington, D.C. The federal government has an essential and irreplaceable role in supporting medical research. No other public, corporate or charitable entity is willing or able to provide the broad and sustained funding for the cutting-edge basic research necessary to yield new innovations and technologies of the future.

NIH has supported biomedical research to enhance health, lengthen life, respond to emerging health threats, and reduce illness and disability for more than 100 years. For patients and their families, NIH is the "National Institutes of Hope." The following are a few of the many examples of how NIH research has contributed to improvements in the nation's health.

—NIH-funded basic research laid the groundwork for the novel mRNA vaccine technology used in the first two FDA approved SARS–CoV–2 vaccines. Vaccines continue to be one of our most cost-effective public health tools with every $1 spent on routine childhood vaccinations estimated to save $5 in direct costs, and $11 in broader costs to society.
—Following nearly three decades of NIH-funded research into novel mechanisms of drug action, breakthroughs in the treatment of depression came in 2019 with two new FDA-approved drugs—one for treatment-resistant depression and the first ever treatment for postpartum depression.
—In 2007, induced pluripotent stem cells (iPSC) were discovered when adult cells were re-engineered into early non-differentiated versions of themselves. In 2019, the National Eye Institute launched a first-in-human clinical trial to test the safety of a novel patient-specific iPSC therapy to treat the most common form of Age-related Macular Degeneration, and the leading cause of vision loss in the age 65+ population.
—NIH-supported researchers continue to work toward strategies to better prevent, identify, and treat pain and substance use disorders through the HEAL (Helping to End Addiction Long-term) Initiative. HEAL aims to support research into new, non-addictive medication and to establish public and private partnerships to develop best practices in communities.
—Today, treatments can suppress HIV to undetectable levels, and a 20-year-old HIV-positive adult living in the U.S. who receives these treatments is expected to live into his or her early 70s, nearly as long as someone without HIV.
—The death rate for all cancers combined has declined in adults since the early 1990s and since the 1970s for children. Overall cancer death rates have dropped by 29% including a 2.2% drop from 2016 to 2017, the largest single-year drop in cancer mortality ever reported.

Sustaining Scientific Momentum Requires Sustained Funding Growth. The leadership and staff at NIH and its Institutes and Centers have engaged the broader community to identify emerging research opportunities and urgent health needs and to prioritize precious federal dollars to areas demonstrating the greatest promise. Sustained robust increases in NIH funding are needed if we are to continue to take full advantage of these opportunities to accelerate the development of pioneering treatments and innovative prevention strategies.

One long-lasting potential impact of investments in NIH is on the next generation of scientists. Sustained increases in NIH funding over the last six years have allowed NIH to more than double the investment in early stage investigators (ESIs). In 2015, NIH only funded about 600 grants for ESIs and the career outlook for early career researchers seemed grim. In FY 2020, NIH was able to fund more than 1,400 grants for ESIs, reinvigorating the spirits of researchers in the biomedical workforce. Sustained increases are needed to allow NIH to continue support of new talent and innovation in medical research.

Even with recent investments in NIH, nearly 4 of every 5 research ideas that are proposed to NIH every year cannot be funded. Additional funding is needed if we are to strengthen our nation's research capacity, ensure a medical research workforce that reflects the racial and gender diversity of our citizenry, and inspire a passion for science in current and future generations of researchers.

NIH is Critical to U.S. Competitiveness. Our country still has the most robust medical research capacity in the world; however, other countries have significantly increased their investment in biomedical science, which leaves us vulnerable to the risk that talented medical researchers from all over the world may return to better opportunities in their home countries. We cannot afford to lose that intellectual capacity, much less the jobs and industries fueled by medical research. The U.S. has been the global leader in medical research because of Congress's bipartisan recognition of NIH's critical role. To continue our dominance, we must reaffirm this commitment to provide NIH the funds needed to maintain our competitive edge.

NIH: An Answer to Challenging Times. Research supported by NIH drives local and national economic activity, creating skilled, high-paying jobs and fostering new products and industries, and catalyzes increases in private sector investment. A $1 increase in public basic research stimulates an additional $8.38 investment from the private sector after eight years. A $1 increase in public clinical research stimulates an additional $2.35 in private sector investments after three years. According to a United for Medical Research report, in FY 2020, NIH-funded research supported more than 536,000 jobs across the U.S. and generated more than $91 billion in economic activity.

The Ad Hoc Group's members recognize the tremendous challenges facing our nation and acknowledge the difficult decisions that must be made to restore our country's fiscal health. Robust funding of the NIH, and strengthening our commitment

to medical research, is a critical element in ensuring the health and well-being of the American people and our economy. Therefore, for FY 2022, the Ad Hoc Group for Medical Research recommends that NIH receive at least $46.1 billion in base funding to advance the foundational research NIH supports and continue the momentum in our nation's investment in medical research.

PREPARED STATEMENT OF THE AIDS INSTITUTE

Dear Chairwoman Murray and Members of the Subcommittee:

The AIDS Institute, a national public policy, research, advocacy, and education organization, is pleased to offer testimony in support of domestic HIV and hepatitis programs in the FY2022 Labor, Health and Human Services, Education, and Related Agencies (L–HHS) appropriation measure. This year's L–HHS bill is more important than ever, as it will set up critical funding streams to help rebuild and reinvest in our nation's public health infrastructure, which has been decimated by COVID–19. As you craft the FY2022 L–HHS appropriations bill, we urge you to significantly increase funding for the Ending the HIV Epidemic Initiative, as well as appropriate additional funds for core public health programs that work to treat and prevent HIV and viral hepatitis in the United States. These programs, many of which are a part of the safety net health system, will be key tools in recovering from COVID–19, and ensuring those most impacted by the COVID pandemic's economic fallout can still access critical care.

HIV IN THE UNITED STATES

Approximately 1.2 million people are living with HIV in the U.S. Since the height of the epidemic, there have been tremendous advancements in HIV treatment and prevention. A person living with HIV on treatment can expect to live a near full life, and if they achieve an undetectable viral load, are unable to pass HIV on to a partner. The toolbox for HIV prevention is ever expanding, with pre-exposure prophylaxis (PrEP) being the newest tool that couples with traditional prevention techniques like condoms and syringe service programs. Despite these advancements, new cases of HIV have been stagnant at around 38,000 cases a year since 2013. Over the last year, COVID–19 has severely impacted HIV prevention and treatment programs, many of which have had to reduce services, suspend in-person testing, transition to telehealth, and detail staff to COVID response. These programs have been forced to innovate during COVID, and we hope some of the lessons learned can be sustained after the pandemic has ended, such as expansion of at-home HIV testing and increased utilization of telemedicine for HIV treatment and PrEP expansion. It is extremely important that additional funding goes to these programs this year so that we can again start reducing new HIV infections while allowing programs to refocus on core HIV prevention and treatment programs that are vital to making progress against this epidemic.

Additionally, we believe that ending HIV is a racial justice issue. Three quarters of new HIV infections are among people of color because of racism and structural barriers in the healthcare system. To end HIV, these barriers must be broken down, and we believe people living with HIV and the communities they live in must be the drivers behind eliminating racism in healthcare.

ENDING THE HIV EPIDEMIC INITIATIVE

The Ending the HIV Epidemic Initiative (EHE), which began in 2019, is focused on reducing new HIV infections by 90 percent over ten years. In the last two years, your Committee provided $260 million and $404 million respectively for the EHE Initiative, which is run by the CDC, the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH). The resources were focused on 57 jurisdictions with the greatest share of HIV incidence, enabling these jurisdictions to craft and implement community-specific plans to reduce the spread of HIV. HRSA's EHE funding for Community Health Centers has already shown promising results, with more than 10,000 new clients being treated for HIV, nearly 865,000 HIV tests administered, and 63,000 new PrEP prescriptions for people at risk for HIV. With greater funding and continued commitment from the Biden Administration to grow the EHE Initiative, The AIDS Institute believes this nation can make significant progress toward the goal of ending the HIV epidemic.

We urge you to fund year three of the EHE Initiative at the following levels: $371 million for the CDC Division of HIV/AIDS Prevention to conduct targeted testing, connection to treatment, and robust surveillance; $212 million for the Ryan White HIV/AIDS Program to increase access to high-quality HIV care and treatment; $152

million for HRSA's Community Health Center program to provide prevention services emphasizing PrEP; $16 million for NIH's Centers for AIDS Research to provide best practices to guide the plan; and $27 million for the Indian Health Service to provide HIV prevention, treatment, education, and hepatitis C (HCV) elimination in Indian Country. In order for jurisdictions to better plan for years four through ten of the Initiative, we urge the Committee to work with HHS, OMB and the White House Office of HIV/AIDS Policy to make public out-year funding projections for appropriations needed to accomplish the goals of the Initiative by 2030.

CDC HIV PREVENTION

CDC's Division of HIV/AIDS Prevention focuses resources on those populations and communities most affected by investing in high-impact prevention. One in seven people living with HIV in the United States are unaware of their status, so it is critical that HIV testing and prevention programs are in place to help connect people to care. There is no single way to prevent HIV, but jurisdictions use a combination of effective evidence-based approaches including testing, linkage to care, education, condoms, syringe service programs, and PrEP. We urge the Subcommittee to fund CDC's HIV Prevention program at $1.293 billion, which includes $100 million for school-based HIV prevention efforts and $371 million for the Ending the HIV Epidemic Plan.

THE RYAN WHITE HIV/AIDS PROGRAM

The Ryan White HIV/AIDS Program provides medications, medical care, and essential coverage completion services to almost half of all people living with HIV in the United States, many of whom are uninsured or underinsured. The Ryan White Program successfully engages individuals in care and treatment, increases access to HIV medications, and helps over 88 percent of clients achieve viral suppression (which is critical for HIV prevention, because people who have achieved viral suppression cannot transmit HIV to others). Increased funding is required in FY2022 because COVID–19 has strained and will continue to strain Ryan White programs, which have had to respond to increased demand from people living with HIV who lost their jobs and their health insurance because of the pandemic.

The AIDS Institute requests that the Subcommittee fund the Ryan White HIV/AIDS Program at a total of $2.776 billion in FY2022, distributed in the following manner: Part A at $686.7 million; Part B (Care) at $444.7 million; Part B (ADAP) at $943.3 million; Part C at $225.1 million; Part D at $85 million; Part F/AETC at $35.5 million; Part F/Dental at $18 million; and Part F/SPNS at $34 million; Ending the HIV Epidemic Plan at $212 million.

MINORITY AIDS INITIATIVE

As racial and ethnic minorities in the U.S. are disproportionately impacted by HIV/AIDS, it is critical that the Subcommittee continue to fund the Minority HIV/AIDS Fund and Minority AIDS programs at SAMHSA. We urge the Subcommittee to appropriate $105 million for the Minority HIV/AIDS Fund; and $160 million for SAMHSA's Minority AIDS Initiative Program.

VIRAL HEPATITIS IN THE U.S

There has been significant increase in the number of new cases of hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV) in the U.S. over the past decade, despite medical advances that make preventing and treating viral hepatitis more effective. There are highly effective vaccines for both HAV and HBV, yet cases of HAV have increased 1,300 percent since 2015 and the number of new cases of HBV have remained stable for the past decade. There are several curative treatments for HCV, yet the number of new HCV cases has increased by 484 percent over the past decade with no signs of slowing. The increased incidence of viral hepatitis is largely due to increased injection drug use related to the opioid epidemic. Moreover, the CDC estimates that as many as half of the people who are living with chronic HBV and HCV (400,000 and 1.2 million people respectively) may be unaware that they have contracted the conditions. Left untreated, viral hepatitis causes liver damage, liver disease, cancer, and death. It also contributes to or exacerbates other serious and chronic conditions, increasing health care costs. We also expect to see even greater increases in viral hepatitis cases when data become available for 2020, as we know that many state public health systems were unable to maintain outreach, testing, and treatment services for viral hepatitis while also battling COVID–19, and many harm reduction programs were also unable to operate at full capacity during the pandemic. We can eliminate viral hepatitis, but doing so will require

substantially increased investment in the public health infrastructure for prevention, screening, and treatment.

INFECTIOUS DISEASE IMPACT OF THE OPIOID CRISIS

The recent explosion of opioid use has created tremendous risk for viral hepatitis and HIV outbreaks and increasing infection rates among new groups and undoing progress toward curbing transmissions. The COVID–19 pandemic has caused another surge in injection drug use, with 2020 poised to have the highest overdose death total on record. The systems built to respond to HIV and viral hepatitis are well poised to conduct outreach, engagement, and early intervention services with individuals who use drugs. A comprehensive response to the opioid epidemic must include infectious disease prevention efforts to reduce the infectious disease consequences of the epidemic.

Starting in FY19, Congress allocated new funding to surveil, prevent and treat infectious diseases commonly associated with injection drug use, including viral hepatitis and HIV. We urge the Subcommittee to appropriate $120 million for the CDC's infectious diseases and opioid epidemic efforts.

CDC VIRAL HEPATITIS PREVENTION

The CDC's Viral Hepatitis program funding level is only $39.5 million, which is not nearly sufficient to address the increasing scope of the epidemic. In 2016, the agency suggested it would need 10 times that amount annually to establish a comprehensive national program to effectively combat the spread of viral hepatitis. This year, we request that the Subcommittee appropriate $134 million to the CDC to address the rise in viral hepatitis and combat the impact of the opioid crisis.

SYRINGE SERVICE PROGRAMS

Syringe service programs (SSPs) are a critical tool in the fight to end the opioid epidemic and eliminate viral hepatitis. These important public safety programs reduce the spread of infectious disease, prevent overdose deaths, and connect clients to treatment. The presence of SSPs has been associated with a 50 percent decline in new HIV and viral hepatitis incidence, and when combined with medication-assisted treatment, there is a two-thirds reduction in HIV and HCV transmission. Extensive research shows that these programs save money and that they do not increase drug use. But there are not enough SSPs to meet the growing need, and appropriations language prohibiting them from using federal funds to purchase sterile syringes makes it difficult for many programs to meet their biggest expense. We urge your Subcommittee to increase funding for SSPs and to remove all restrictions on federal funding for syringe service programs, including for the purchase of sterile syringes. The President's FY22 Budget Request and the House's FY21 appropriations bill both removed the restrictions for the purchase of sterile syringes.

PUBLIC HEALTH INFRASTRUCTURE

Decades of chronic underfunding of public health infrastructure programs have left the United States extremely vulnerable to public health disasters, as evidenced by the untold physical and economic harm COVID–19 has wrought on our nation, with more than 33 million Americans sickened and over 600,000 deaths to date. Pandemics are a threat to our nation's safety and health, and we urge the Committee to fund public health programs with the same priority as traditional defense programs. Billions in increased funding is needed annually to ensure that public health programs are modernized, fully staffed, and prepared for public health emergencies. Yearly appropriations have fallen far short of what is needed to protect America's health, which has allowed emerging threats like COVID–19 to wreak havoc.

The AIDS Institute thanks Chairwoman Murray for reintroducing the Public Health Infrastructure Saves Lives Act (S.674), which would create the Core Public Health Infrastructure Program withing the CDC. We believe that this program, if fully funded, will start to rebuild and bolster critical infrastructure needed to prepare for the next public health threat. We thank the Committee and your colleagues for significant increases in emergency funding approved during COVID–19, but we also urge you to ensure that this funding is sustained to forestall future emergencies. We urge the Committee Members and your colleagues to support S. 674, and once signed into law, ensure that the authorized programs are fully funded by your Committee.

Thank you for your consideration of this written testimony. If you have questions or would like to discuss these issues further, please do not hesitate to contact Nick Armstrong at narmstrong@taimail.org or Frank Hood at fhood@taimail.org.

[This statement was submitted by Rachel Klein, Deputy Executive Director, The AIDS Institute.]

PREPARED STATEMENT OF AIDS UNITED

Dear Chairman Leahy, and Vice Chairman Shelby:

As the committee continues its important deliberations on the Fiscal Year (FY) 2022 Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) appropriation bill, we thank you for your commitment to ending the HIV/AIDS epidemic in the United States and request that you increase the federal government's financial commitment to meet the goals of the federal ending the epidemic initiative and support safety net programs that protect the public health.

Our scientific knowledge of HIV treatment, prevention and epidemiology has never been stronger, but progress, until recently, has stalled. Over the past three years, a concerted effort to target resources where they can be most effective has occurred through the Ending the HIV Epidemic Initiative (EHE Initiative), which has the goal of reducing new HIV infections by 90% by 2030. Additionally, the HIV National Strategic Plan: A Roadmap to End the Epidemic has been developed. We urge Congress to capitalize on the expertise developed by communities as part of the EHE Initiative so that we can improve and expand the Initiative. Ending HIV by 2030 is possible, but resources are needed to achieve this goal.

The COVID–19 pandemic has shown a light on the impact of decades of underfunding our Nation's public health infrastructure, resulting in an inadequate response to an incredibly destructive pandemic. Below are detailed domestic HIV funding requests that we join our coalition partners in the Federal AIDS Policy Partnership in urging committee to include in the FY2022 appropriations bills. A chart detailing each request as well as previous fiscal year funding levels for each program is available here: http://federalaidspolicy.org/fy-abac-chart/.

ENDING THE HIV EPIDEMIC INITIATIVE

Over the last two years, on a bipartisan basis, Congress has appropriated additional funding for the Ending the HIV Epidemic Initiative, which sets the goal of reducing new HIV infections by 50% by 2025, and 90% by 2030. We ask Congress to increase funding in FY2022 for the Ending the HIV Epidemic Initiative by at least the amounts listed below in the following operating divisions:

—CDC Division of HIV/AIDS Prevention for testing, linkage to care, and prevention services, including pre-exposure prophylaxis (PrEP) (+$196 m);
—HRSA Ryan White HIV/AIDS Program to expand comprehensive treatment for people living with HIV (+$107 m);
—HRSA Community Health Centers to increase clinical access to prevention services, particularly PrEP (+$34.7 m);
—The Indian Health Service (IHS) to address the combat the disparate impact of HIV on American Indian/Alaska Native populations (+$22 m); and
—NIH Centers for AIDS Research to expand research on implementation science and best practices in HIV prevention and treatment.

THE RYAN WHITE HIV/AIDS PROGRAM

The Ryan White Program provides comprehensive care to populations disproportionately impacted by the HIV epidemic. Over three quarters of Ryan White clients are racial and ethnic minorities, and nearly two thirds are under the federal poverty level. With 88% of Ryan White clients achieving viral suppression, the program has a proven track record of success.

The Ryan White Program provides services critical to managing HIV, often inadequately covered by insurance, including case management; mental health and substance use services; adult dental services; and transportation, legal, and nutritional support services. Many Ryan White Program clients live in states that have not expanded Medicaid and must rely on the Ryan White Program as their only source of HIV/AIDS care and treatment. While increasingly clients have access to insurance, patients still experience cost barriers, such as high premiums, deductibles, and other patient cost sharing. The Ryan White Program, particularly the AIDS Drug Assistance Program (ADAP), assists with these costs so that clients can access comprehensive treatment.

Currently ADAPs are experiencing increased demand, particularly as people have lost health coverage and incomes due to the economic impact of COVID–19 and state and local budgets have been increasingly stressed. We urge Congress to fund the Ryan White HIV/AIDS Program at a total of $2.768 billion in FY2022, an increase of $345 million over FY2021, distributed in the following manner:

—Part A: $731.1 million
—Part B (Care): $437 million
—Part B (ADAP): $968.3 million
—Part C: $225.1 million
—Part D: $85 million
—Part F/AETC: $58 million
—Part F/Dental: $18 million
—Part F/SPNS: $34 million
—EHE Initiative: $212 million

CDC PREVENTION PROGRAMS

CDC HIV Prevention and Surveillance

Increasing funding for high-impact, community focused HIV prevention services has proven to result in a strong return on investment. Not only are these prevention tools effective at halting new HIV infections, but in the long term they result in decreased lifetime medical costs that are associated with HIV treatment. HIV prevention tools that meet the special prevention needs of these populations must be expanded. HIV will not be eliminated unless we focus resources on those most impacted.

The CDC's Division of HIV Prevention is the federal leader in creating new and innovative strategies for HIV prevention. Through partnerships with state and local public health departments and community-based organizations, the CDC has expanded targeted, high-impact prevention programs that work to address racial and geographic health disparities. We urge you to fund the CDC Division of HIV Prevention at $822.7 million in FY2022, an increase of $67 million over FY2021. This is in addition to the $371 million for EHE Initiative work within the Division.

CDC STD Prevention

Our nation faces a compounded public health crisis. STI rates are at an all-time high for the sixth year in a row. STI data from 2018 shows that combined cases of chlamydia, gonorrhea, and syphilis infections are nearing 2.4 million cases a year—up 30%. STIs have life-changing and life-threatening consequences that include infertility, cancer, ectopic pregnancy, pelvic inflammatory disease, and transmission of HIV. More than 17 years of level funding for STI programs has resulted in a more than 40% reduction in buying power. The STI health infrastructure is part of the public health infrastructure and the need to rebuild is higher than ever. While STI rates peak, the same people who work to prevent the spread of sexually transmitted diseases—contact tracers and disease intervention specialists—have been redeployed to address the current COVID–19 pandemic. Consequently, 80% of sexual health screening clinics being forced to reduce hours or shut down because of understaffing. We urge you to fund the CDC Division of STD Prevention at $252.9 million to rebuild its infrastructure and respond to the dramatic rise in STIs across the country.

Congenital Syphilis is a fully preventable disease if women are provided early, accessible prenatal care that includes STI testing. Despite this, the transmission of congenital syphilis from mother to child during birth increased by 185% between 2014–2018 with an increase more than 40% between 2017 and 2018 alone. The result: a 22% increase in newborn deaths. Twenty million dollars should be allocated to activate a new congenital syphilis elimination initiative at the CDC Division of STD Prevention (DSTDP)—with funds distributed to all STI-funded health departments—to increase prenatal outreach and screenings for congenital syphilis and postnatal follow up for both mothers and babies to ensure that congenital syphilis is detected at the earliest possible stage. We urge you to fund the CDC Division of STD Prevention at $272.9 million in FY2022, an increase of $91.1 million over FY2021.

CDC Viral Hepatitis Prevention

The ongoing opioid crisis and increased injection drug has drastically increased the number of new viral hepatitis cases in the U.S. The CDC estimates that between 2010 and 2017 the country experienced a 374% increase in new hepatitis C (HCV) infections, with an estimated 44,600 new cases in 2017. The number of new cases of hepatitis B (HBV) has also increased over the past several years, with 22,200 new cases in 2017, ending years of declining rates. Of the more than 3.2 mil-

lion people now living with HBV and/or HCV in the U.S., as many as 65% are not aware of their infection.

The CDC's Division of Viral Hepatitis (DVH) remains the lead agency combating viral hepatitis at the national level by providing important information and funding to the states. The division is currently funded at only $39.5 million. This is nowhere near the nearly $393 million CDC estimates is needed for a national viral hepatitis program focused on decreasing mortality and reducing the spread of the disease. We have the tools to prevent this growing epidemic and the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021—2025). However, only with significantly increased funding can there be an adequate level of testing, education, screening, treatment, surveillance, and on-the-ground syringe service programs needed to reduce new infections and put the U.S. on the path to eliminate hepatitis as a public health threat. We urge you to fund the CDC's Division of Viral Hepatitis at $134 million in FY2022, an increase of $94.5 million over FY2021.

CDC Infectious Diseases and Opioid Epidemic Funding

The FY2019 budget included new funding for the CDC to combat infectious diseases commonly associated with injection drug use in areas most impacted by the opioid crisis. The United States is experiencing an ongoing overdose crisis and some experts have estimated that the U.S. surpassed 100,000 deaths from opioid overdose in 2020, a more than 40% increase from 2019 itself a record year. Outbreaks or significant spikes in infections of viral hepatitis, as well as HIV, in a short period of time among people who inject drugs continue to occur throughout the country. Syringe Services Providers (SSPs) are first responders to the opioid and infectious diseases crisis effectively help prevent drug overdoses and new HIV and hepatitis infections. They have the knowledge, contacts, and ability to reach people who use drugs; they provide naloxone and other overdose prevention resources; and they connect people to medical care and support, including Substance Use Disorder treatment. This program, which is only funded at $13 million, increases prevention, testing, and linkage to care efforts to combat increasing new infections and is strongly needed to provide a strong on the ground response to this crisis. These services are urgently needed, and adequate funding would provide a critical down payment for services needed to help stop the spread of opioid-related infectious diseases. We urge you to fund the CDC's Infectious Diseases and Opioid Epidemic program in FY2022 at the $120 million requested in the president's FY2021 budget, an increase of $107 million over FY2021.

Syringe Services Programs

The Department of Health and Human Services has said that syringe service programs (SSPs) are a proven, evidence-based, and effective tool in HIV and hepatitis prevention. Beyond providing access to sterile syringes, SSPs connect people to substance use treatment, HIV and hepatitis testing, and other supportive services. These cost-effective programs must be expanded, especially in areas hardest hit by the opioid epidemic. SSPs have also been providing COVID–19 related services to vulnerable populations during the pandemic. The FY2021 appropriations bill continued a harmful policy rider that restricts the use of federal funds for the purchase of sterile syringes, which negatively impacts the ability of state and local public health groups from expanding SSPs. We urge you to remove all restrictions on federal funding for syringe service programs in those jurisdictions that are experiencing or at risk for a significant increase in HIV or hepatitis infections due to injection drug use.

Minority HIV/AIDS Initiative (MAI)

Racial and ethnic minorities in the U.S. are disproportionately impacted by HIV/AIDS. African Americans, more than any other racial/ethnic group, continue to bear the greatest burden of HIV in the U.S. Three out of four new HIV infections occur among people of color. While there have been consistent decreases in new HIV infections among certain populations, HIV infections are not decreasing among Black and Latinx gay and bisexual men.

The Minority HIV/AIDS Fund supports cross-agency demonstration initiatives to support HIV prevention, care and treatment, and outreach and education activities across the federal government. MAI programs at the Substance Abuse and Mental Health Administration target specific populations and provide prevention, treatment, and recovery support services, along with HIV testing and linkage service when appropriate, for people at risk of mental illness and/or substance abuse. We urge you fund the Minority HIV/AIDS Fund at $105 million, and SAMHSA's MAI program at $160 million in FY2022, an increase of $49.6 million and $44 million

over FY2021 levels, respectively. We also urge you to fund Minority AIDS Initiative programs across HHS agencies at $610 million in FY2022.

We thank you for your continued leadership and support of these critical programs for so many people living with HIV, and the organizations and communities that serve them nationwide.

Please do not hesitate to be in touch for more information regarding HIV appropriations with our Vice President and Chief Advocacy Officer, Carl Baloney, Jr., at cbaloney@aidsunited.org.

Sincerely.

[This statement was submitted by Jesse Milan, Jr., President & CEO, AIDS United.]

PREPARED STATEMENT OF THE ALZHEIMER'S ASSOCIATION AND ALZHEIMER'S IMPACT MOVEMENT

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit outside witness testimony on the Fiscal Year (FY) 2022 appropriations for Alzheimer's and other dementia research and public health activities at the U.S. Department of Health and Human Services. Specifically, we respectfully request a $289 million increase for Alzheimer's research at the National Institutes of Health (NIH) and $20 million for implementation of the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act (P.L. 115–406) at the Centers for Disease Control and Prevention (CDC).

The Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. It is the nonprofit with the highest impact in Alzheimer's research worldwide and is committed to accelerating research toward methods of treatment, prevention, and, ultimately, a cure. AIM is the advocacy affiliate of the Alzheimer's Association, working in strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and development of approaches to reduce the risk of developing dementia.

ALZHEIMER'S IMPACT ON AMERICAN FAMILIES AND THE ECONOMY

Alzheimer's is a progressive brain disorder that damages and eventually destroys brain cells, leading to a loss of memory, thinking, and other brain functions. Ultimately, Alzheimer's is fatal. We have yet to celebrate the first survivor of this devastating disease.

In addition to the suffering caused by the disease, Alzheimer's is also creating an enormous strain on the health care system, families, and federal and state budgets. The annual cost for all individuals with Alzheimer's or other dementia will total $355 billion for health care, long-term care, and hospice care in 2021. This does not include the over $250 billion in unpaid caregiver costs. The U.S. taxpayer-funded federal health care programs Medicare and Medicaid are expected to cover about $239 billion, or 67 percent, of these costs this year. While an estimated 6.2 million Americans age 65 and older are currently living with Alzheimer's, nearly 13 million Americans will have Alzheimer's by 2050 and costs will exceed $1.1 trillion (in 2021 dollars). Alzheimer's and other dementia threaten to bankrupt families, businesses, and our health care system.

INVESTING IN ALZHEIMER'S TREATMENTS

The Food and Drug Administration (FDA) recently approved the first treatment for Alzheimer's disease since 2003 and the first to address the underlying biology of Alzheimer's disease. The FDA determined there is substantial evidence that aducanumab (marketed as Aduhelm) reduces amyloid plaques in the brain and that the reduction in these plaques is reasonably likely to predict important benefits to patients.

This approval represents an important step forward in Alzheimer's research. This new treatment is pivotal, while not a cure. This is the first of a number of new treatments to come. We recognize the drug may work differently for everyone who takes it, and may not work for some individuals. Importantly, aducanumab was studied in and appropriate for people living with early Alzheimer's dementia and mild cognitive impairment (MCI) due to Alzheimer's who showed evidence of a buildup of amyloid plaques in the brain. The therapy has not yet been tested on people with more advanced cases of dementia or Alzheimer's disease.

The recent years of increased investment provided by Congress to NIH have been integral to this and other promising therapeutic approaches to treating Alzheimer's disease. For example, NIH supported basic science investigations behind the discovery of immunotherapies like aducanumab, as well as translational research for next-generation immunotherapies. Additionally, the selection of participants for aducanumab clinical trials hinged on amyloid PET imaging, a technology that would not exist today without the publicly-funded research supported by NIH. The federal commitment, combined with unprecedented philanthropic support, provides the foundation for an optimistic view of the future, which is needed because there is much work to be done.

This is just the beginning of meaningful treatment advances. History has shown us that approvals of the first drug in a new category invigorates the field, increases investments in new treatments, and encourages greater innovation. We are hopeful that this drug is just the beginning for better treatments to come. Looking at the big picture of science, there is a crucial need for effective treatment options for diverse populations living in all stages of Alzheimer's. Alzheimer's must be addressed through multiple different pathways—more than just amyloid—with an eye toward effective combination therapies, pharmacological and nonpharmacological, that work at different stages of the disease.

While recent NIH funding increases have laid the foundation for breakthroughs in diagnosis, treatment, and prevention, and enabled significant advances in understanding the complexities of Alzheimer's, there is still much left to be done. We cannot leave any stone unturned. Investment in Alzheimer's research is only a fraction of what's been applied over time, with great success, to address other major diseases. Between 2000 and 2017, the number of people dying from Alzheimer's increased by 145 percent while deaths from other major diseases have decreased significantly or remained approximately the same. It is vitally important that NIH continues to build upon promising research advances. An increase of $289 million in Alzheimer's research at NIH in FY2022 would enable scientists to conduct more inclusive, efficient, and practical clinical trials; increase knowledge of risk and protective factors in individuals and across diverse populations; discover better biomarkers to detect disease and monitor treatment response; pursue a precision medicine approach to detect the disease earlier and tailor treatment plans to an individual's unique symptoms and risk profile; and leverage emerging digital technologies and big data to speed discoveries. We need to continue to increase investment in Alzheimer's and dementia research to maximize every opportunity for success.

ADDRESSING ALZHEIMER'S AS A PUBLIC HEALTH CRISIS

As scientists continue to search for ways to cure, treat, or slow the progression of Alzheimer's through medical research, public health plays a critical role in promoting cognitive function and reducing the risk of cognitive decline. Now more than ever it is apparent how crucial it is to have an established infrastructure in place to respond to public health threats.

In 2018, Congress acted decisively to address Alzheimer's as an urgent and growing public health threat through the passage of the bipartisan BOLD Act. This law authorizes $100 million over five years for CDC to build a robust Alzheimer's public health infrastructure across the country focused on public health actions that can allow individuals with Alzheimer's to live in their homes longer and delay costly long-term nursing home care. Congress appropriated $10 million for the first year of BOLD's implementation in FY20, which allowed CDC to award funding to three Public Health Centers of Excellence (PHCOE), focused on risk reduction, caregiving, and early detection, and 16 public health departments across the country. These state, local, and tribal public health department recipients are creating statewide dementia coalitions, hiring dementia coordinators, and developing or updating Alzheimer's and other dementia strategic plans. The $15 million Congress appropriated for the second year of BOLD's implementation in FY21 will help fund additional public health departments and expand the impact of this crucial work into more communities across the country.

The Alzheimer's Association is grateful to be leading the Dementia Risk Reduction PHCOE, focusing on community-level actions to reduce the risk of developing Alzheimer's and other dementia. Researchers are increasingly studying the impact that lifestyle behaviors may have on the risk of developing Alzheimer's and other dementia. The future of reducing Alzheimer's could be in treating the whole person with a combination of drugs and modifiable risk factor interventions, as we do now with heart disease. The Center will work with public health agencies on addressing social determinants of health with respect to dementia risk; capacity building to enable

smaller public health agencies to engage in dementia risk reduction activities; and partnering with health systems in their communities to advance risk reduction.

Over 65 percent of American adults have at least one risk factor for dementia. Although risk factors like age, genetics, and family history cannot be changed, other risk factors can be modified to reduce the risk of cognitive decline and dementia. Examples of modifiable risk factors are physical activity, smoking, education, staying socially and mentally active, blood pressure, and diet. In fact, the 2020 recommendations of The Lancet Commission on dementia prevention, intervention, and care suggest that addressing modifiable risk factors might prevent or delay up to 40 percent of dementia cases.

The Alzheimer's Association is leading a five-year clinical trial to evaluate a two-year intervention to see whether lifestyle interventions that simultaneously target multiple risk factors can protect cognitive function in older adults at increased risk for cognitive decline. The U.S. Study to Protect Brain Health Through Lifestyle Intervention to Reduce Risk (U.S. POINTER) will evaluate the effects of lifestyle interventions, like physical exercise, a healthier diet, cognitive and social stimulation, and self-management of heart and vascular health, on changes in cognitive function. It is crucial that forthcoming findings from studies like U.S. POINTER are translated into public health interventions across the country. Investing now in a robust public health infrastructure ensures cutting edge research can be effectively and efficiently disseminated into local communities.

While these BOLD implementation efforts are important steps forward, and we are grateful to this Subcommittee and Congress for the initial funding, CDC must receive the full $20 million authorized in the law for FY2022 to ensure the meaningful impact that Congress intended. The Alzheimer's Association and AIM urge Congress to include the full $20 million for the third year of BOLD's implementation at CDC in FY2022. Activities supported by the requested $20 million in FY22 would enable CDC to award additional PHCOEs, focused on important priorities such as Tribal Health and avoiding preventable hospitalizations, and expand the number of state, local, and tribal public health departments across the country that receive funding for Alzheimer's public health activities. Finally, as Alzheimer's is one of the most prevalent chronic diseases facing our nation, we look forward to the day that the Subcommittee and CDC elevate Alzheimer's and other dementia to the Division level as with other major chronic diseases.

CONCLUSION

The Alzheimer's Association and AIM appreciate the steadfast support of the Subcommittee and its priority setting activities. We urge the Subcommittee and Congress to provide an additional $289 million for Alzheimer's research activities at NIH and $20 million for full implementation of the BOLD Infrastructure for Alzheimer's Act at CDC in FY 2022.

PREPARED STATEMENT OF THE ALZHEIMER'S FOUNDATION OF AMERICA

On behalf of the Alzheimer's Foundation of America (AFA), a national nonprofit that unites more than 2,000 member organizations in the goal of providing support, services and education to individuals, families and caregivers affected by Alzheimer's disease and related dementias nationwide, I am submitting the following budget requests for your consideration as you prepare fiscal year (FY) 2022 appropriations levels for the federal budget.

For federal programs that impact those living with dementia and their family caregivers, AFA recommends the following budget allocations for FY '22:

—an additional $289 million for a total $3.4 billion for Alzheimer's disease clinical research at the National Institutes of Health/National Institute on Aging (NIH/NIA);

—$560 million to fund the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative, a trans-agency effort to arm researchers with revolutionary tools to fundamentally understand the neural circuits that underlie the healthy and diseased brain;

—$46.1 billion (a $3.2 billion increase over FY '21) for total spending at the NIH;

—support for President Biden's call for $6.5 billion to launch the Advanced Research Projects Agency for Health (ARPA–H) at NIH;

—an additional $50 million to fund caregiver supports and services provided by Older Americans' Act (OAA) programs administered by the Administration for Community Living (ACL), including a $7.5 million increase for the Alzheimer's Disease Program for a total expenditure of $35 million in FY '22; and

—$20.5 million to support BOLD Act initiatives, including a $500,000 increase for the Healthy Brain Initiative and $4 million for fall prevention at the Centers for Disease Control and Prevention (CDC).

National Institutes of Health/National Institute on Aging (NIH/NIA):

NIA sponsors and conducts the lion's share of federal aging-related research, including research into Alzheimer's disease and related dementias, and this pioneering science contributes significantly to the improved care and quality of life of older adults. A key NIA priority is translating research into better and more efficient care through the development of effective interventions that are disseminated to health care providers, patients, and caregivers. These interventions for the prevention, early detection, diagnosis, and treatment of disease will help reduce the burden of illness for older adults and lower cost of care.

AFA is extremely grateful to the Subcommittee for recent increases in federal funding for Alzheimer's disease research at NIH/NIA. Additional resources for fighting Alzheimer's disease and related dementias at NIH have greatly increased our chances that promising research gets funded as we move closer to the goal of finding a cure or disease-modifying treatment by 2025 as articulated in the National Plan to Address Alzheimer's Disease.

Yet, meaningful treatment is still some ways off and basic science into dementia—the type of research funded through NIH—remains vital to finding a cure.

AFA asks the Subcommittee to build upon past progress and continue making the battle against Alzheimer's disease a national priority. To this end, AFA urges the Subcommittee to provide an additional $289 million, for a total of approximately $3.4 billion for Alzheimer's disease clinical research at NIH in FY '22.

The BRAIN Initiative is a large-scale effort to accelerate neuroscience research by equipping researchers with the tools and insights necessary for treating a wide variety of brain disorders, including Alzheimer's disease, schizophrenia, autism, epilepsy, and traumatic brain injury. By mapping whole brains in action, the ability to identify thousands of brain cells at a time and development of innovative brain scanners, BRAIN Initiative research advances and tools are needed to better understand the brain and cognitive functioning. AFA is asking that $560 million be allocated to conduct BRAIN Initiative research for FY '22.

AFA also urges the Subcommittee to budget at least $46.1 billion for total NIH spending in FY '22, a $3.2 billion increase over the NIH's program level funding in FY '21, as recommended by the Ad Hoc Group for Medical Research. This funding level would allow for meaningful growth above inflation in the base budget that would expand NIH's capacity to support promising science in all disciplines. It also would ensure that funding from the Innovation Account established in the 21st Century Cures Act would supplement the agency's base budget, as intended, through dedicated funding for specific programs.

AFA also supports the President's call for an additional $6.5 billion to launch the Advanced ARPA–H at NIH. ARPA–H would leverage existing public sector basic science research programs along with private sector efforts to accelerate development of new capabilities for disease prevention, detection, and treatment and overcome bottlenecks that have limited progress in areas such as Alzheimer's disease. Any funding for ARPA–H, however, should not come from the existing programming budget for NIH and should be considered an additional appropriation to AFA's $46.1 billion request for all of NIH.

Centers for Disease Control and Prevention (CDC):

The Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act requires CDC to establish Centers of Excellence in Public Health Practice dedicated to promoting Alzheimer's disease management and caregiving interventions, as well as educating the public on Alzheimer's disease and brain health, will establish Alzheimer's disease as a public health issue, increasing American awareness and care training around the disease. To fund BOLD Act initiatives at CDC, AFA is requesting $20 million in funding for FY '22.

For older adults—especially for those living with dementia—falls are common, costly, and often preventable. They represent the leading cause of injury-related death among adults age 65 years of age and older. CDC's National Center for Injury Prevention and Control developed tools for clinicians and other health care partners to identify and address falls and fall risk. AFA urges a continued investment of $4 million to continue funding fall prevention programs at CDC.

Administration for Community Living (ACL):

AFA is requesting a $50 million increase for vital ACL programming impacting those living with dementia, including a $7.5 million increase to the Alzheimer's Disease Program for a total funding of $35 million in FY '22. In addition, AFA is re-

questing that the following amounts be allocated to the following Older Americans' Act (OAA) programs administered by ACL:

—*National Family Caregiver Support Program (NFCSP):* NFCSP provides grants to states and territories, based on their share of the population aged 70 and over, to fund a range of supportive services that assist family and informal caregivers in caring for those with dementia at home for as long as possible, thus providing a more person-friendly and cost-effective approach to institutionalization. AFA urges that an additional $24.5 million (for a total of $213.6 million) be allocated in FY '22 to support this important program.

—*Lifespan Respite Care Program (LRCP):* AFA urges the Subcommittee to allocate a minimum of $10 million—a $2.9 million increase—to LRCP in FY '22. LRCP provides competitive grants to state agencies working with Aging and Disability Resource Centers and non-profit state respite coalitions and organizations to make quality respite care available and accessible to family caregivers regardless of age or disability.

—*Falls Prevention:* In response to COVID, several community-based fall prevention interventions, supported with ACL investments, have transitioned to a digital environment in cases where they can safely be implemented in the home. AFA, therefore, urges $10 million, a $5 million increase over FY '21 funding, be allocated so ACL can continue vital fall prevention activities at ACL.

—*Home Delivered Nutrition Program:* This vital program provides grants to states for nutrition services for older people, including many living with dementia. In addition to healthy meals, the programs provide a range of services including being an important link to in-home and community-based supports such as homemaker and home-health aide services, transportation, home repair and modification, and falls prevention programs. AFA calls for a $10.1 million increase, or $286.3 million, for home delivered nutrition programs in FY '22.

AFA understands that during this time of crisis, Congress is working hard to stem fallout of both the human and fiscal toll of COVID–19. We are grateful for your work and urge that the Subcommittee continues making services and supports available to our nation's most vulnerable populations—including those older Americans with chronic conditions like Alzheimer's disease—a priority. We know that through determination, sacrifice and resilience, Americans will rise to the challenge and take the necessary steps to mitigate the fallout of this public health emergency.

AFA thanks the Subcommittee for the opportunity to present our recommendations and looks forward to working with you and your staff through the appropriations process. Please contact me at cfuschillo@alzfdn.org or Eric Sokol, AFA's senior vice president of public policy, at esokol@alzfdn.org, if you have any questions or require further information.

Sincerely.

[This statement was submitted by Charles J. Fuschillo, Jr., President and CEO, Alzheimer's Foundation of America.]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF ALLERGY, ASTHMA & IMMUNOLOGY

Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee, the American Academy of Allergy, Asthma, & Immunology (AAAAI) thanks you for the opportunity to submit written testimony on the U.S. Department of Health and Human Services (HHS) Fiscal Year (FY) 2022 appropriations bill. AAAAI respectfully requests the subcommittee to include $12.2 million in funding for the Consortium on Food Allergy Research (CoFAR) within the National Institute of Allergy and Infectious Disease (NIAID) at the National Institutes of Health (NIH). In addition, we request report language reflecting the importance of NIH engaging in trans-NIH research on food allergies. Also, the AAAAI supports funding of $100 million for the National Healthcare Safety Network which enables the Centers for Disease Control and Prevention (CDC) to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing.

Established in 1943, AAAAI is a professional organization with more than 7,000 members in the United States, Canada, and 72 other countries. This membership includes board certified allergist/immunologists, other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunological diseases.

FOOD ALLERGIES

Food allergies affect 32 million Americans, including 6 million children. Each year, more than 200,000 Americans require emergency medical care for allergic reactions to food—equivalent to one trip to the emergency room every three minutes.

The Consortium on Food Allergy Research (CoFAR) was established by the National Institutes of Health (NIH) within the National Institute of Allergy and Infectious Disease (NIAID) in 2005. Over the following 16 years, CoFAR discovered genes associated with an increased risk for peanut allergy and has also identified the most promising potential treatments for egg and peanut immunotherapy, among many other accomplishments. Breakthroughs like these, scaled across other major food allergies, can significantly improve the quality of life for tens of millions of Americans. Its annual $6.1 million budget is a relatively small portion within NIH's almost $40 billion budget, yet CoFAR has been able to achieve massive strides in the study of food allergy prevention and treatment.

AAAAI enthusiastically supports an increase in funding for CoFAR of $6.1 million, annually, bringing its yearly budget up to $12.2 million. With its relatively low current level of funding, CoFAR has been able to accomplish breakthroughs in the under-researched field of food allergies. It is crucial that we continue investing at proportional levels given the scale of this condition which impacts 10.8 percent of the U.S. population.

AAAAI also requests that the Subcommittee's report accompanying the FY22 Labor/HHS appropriation reflects the importance of trans-NIH research on food allergies. AAAAI strongly supports the following NIAID report language submitted by Senator Blumenthal that acknowledges the groundbreaking work of CoFAR and encourages robust investment to expand its research breadth and network.

> *Food Allergies*.—The Committee recognizes the serious issue of food allergies which affect approximately eight percent of children and ten percent of adults in the U.S. The Committee commends the ongoing work of NIAID in supporting a total of 17 clinical sites for this critical research, including seven sites as part of the Consortium of Food Allergy Research (CoFAR). The Committee includes $12,200,000, an increase of $6,100,000, for CoFAR to expand its clinical research network to add new centers of excellence in food allergy clinical care and to select such centers from those with a proven expertise in food allergy research.

In addition to the AAAAI, the CoFAR funding request and report language are supported by the American College of Allergy, Asthma & Immunology; Allergy & Asthma Network; Asthma and Allergy Foundation of America; Food Allergy & Anaphylaxis Connection Team; Food Allergy Research and Education; and International FPIES Association.

ANTIMICROBIAL RESISTANCE (AMR) AND PENICILLIN ALLERGY

The growing threat of antimicrobial resistance, combined with the dwindling pipeline of novel antibiotic research, requires policies that prevent inappropriate use of antibiotics. One of the primary ways to combat this threat begins with penicillin—the most commonly reported drug allergy. According to the CDC, approximately 10 percent of the U.S. population report being allergic to penicillin, yet 9 out of 10 patients reporting a penicillin allergy are not truly allergic when formally evaluated, such that fewer than one percent of the population is truly allergic to penicillin. More recently, the CDC cited the importance of correctly identifying if patients are penicillin-allergic in decreasing the unnecessary use of broad-spectrum antibiotics in its 2018 update of Antibiotic Use in the United States: Progress and Opportunities. The AAAAI strongly supports more widespread and routine use of penicillin allergy evaluation for patients with a self-reported history of allergy to penicillin. Evaluation can accurately identify patients who, despite reporting a history of penicillin allergy, can safely receive penicillin.

The AAAAI supports funding of $100 million for the National Healthcare Safety Network which enables CDC to target prevention of healthcare acquired and antimicrobial resistant infections and improve antibiotic prescribing. The Antibiotic Resistance Solutions Initiative will benefit from significant new resources to achieve the goals outlined in the National Action Plan for Combating Antibiotic-Resistant Bacteria, including strengthening antibiotic stewardship to promote best practices for prescribing antibiotics such as penicillin.

AAAAI also wishes to express its appreciation to the subcommittee for the inclusion of language regarding the importance of penicillin allergy testing in the FY20 appropriations bill. The discovery of penicillin opened the door to medical innovation allowing surgeries to be performed, organs to be transplanted, as well as combat wounds and burn victims to be treated. AAAAI encourages more widespread and

routine penicillin allergy evaluation for patients with a history of allergy to penicillin or another beta-lactam drug (e.g., ampicillin or amoxicillin). Penicillin allergy evaluation can accurately identify patients who, despite reporting a history of penicillin allergy, can safely receive penicillin. On behalf of the patients we serve, thank you for your leadership in giving penicillin allergy testing the attention it deserves.

Thank you for your consideration of these FY22 appropriations requests. Please contact Sheila Heitzig, JD, MNM, CAE, AAAAI Director of Practice and Policy, at sheitzig@aaaai.org if you have any questions or would like additional information.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to submit this statement for the record in support of strong federal investments in children's health in Fiscal Year (FY) 2022 and beyond.

AAP urges all Members of Congress to put children first when considering short and long-term federal spending decisions, and supports funding levels for the following programs: $50 million for Pediatric Subspecialty Loan Repayment (HRSA), $50 million for Firearm Injury and Mortality Prevention Research (CDC/NIH), $10 million for Pediatric Mental Health Care Access Grants (HRSA), $12 million for implementation of Scarlett's Sunshine Act (CDC/HRSA), $22.334 million for Emergency Medical Services for Children (HRSA), $280 million for the National Center for Birth Defects and Developmental Disabilities (CDC), $271.2 million for Global Immunizations (CDC), and $15 million and report language for the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act (CDC).

Pediatric Subspecialty Loan Repayment Program (HRSA):

FY 22 Request: $50 Million; FY 21 Level: Never Funded.—The AAP requests $50 million in initial funding for the Pediatric Subspecialty Loan Repayment Program, a Title VII health professions program to improve access to care for children with special health care needs by offering loan repayment to pediatric subspecialists and child mental health providers who agree to serve in an underserved area. The United States' supply of pediatric subspecialists is inadequate to meet children's health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist, and approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in certain subspecialties such as developmental behavioral pediatrics. Spotlighting the needs of children with autism spectrum disorder (ASD), as an example, there are approximately 1.5 million children with ASD but there are only about 700 practicing board-certified developmental-behavioral pediatricians. The national wait time for a pediatric developmental evaluation is 5.4 months. In terms of equity, ASD prevalence among Hispanic children is about 16% lower than among white and black children, which suggests that more Hispanic children with autism are not being identified. In addition, black children with ASD are significantly less likely than white children to have a first evaluation by the age of three.

Firearm Injury and Mortality Prevention Research (CDC/NIH):

FY 22 Request: $50 Million Total; FY 21 Level: $25 Million Total.—The AAP is tremendously appreciative of and applauds Congress for continuing to provide $25 million total, split evenly between CDC and NIH, for firearm injury and mortality prevention research in FY 21. In the midst of the COVID–19 pandemic, communities across the U.S. continue to suffer from the public health crisis of firearm-related injuries and deaths with early data showing 2020 being a record-breaking year for gun violence, injuries, and deaths. A public health approach to firearm violence prevention is urgently needed to promote health equity and address the disproportionate burden of this epidemic on communities of color. The foundation of this approach is rigorous research that can accurately quantify and describe the facets of an issue and identify opportunities for reducing its related morbidity and mortality. The initial investments in FY20 and FY21 are important, but increased funding is still needed to overcome the decades-long lack of federal funding that set back our nation's response to the public health issue of firearm-related morbidity and mortality. Over time, additional funding can generate research into important issues such as the best ways to prevent unintended firearm injuries and fatalities among women and children; the most effective methods to prevent firearm-related suicides; the measures that can best prevent the next shooting at a school or public place;

and numerous other vital public health questions. Continued and expanded investments are essential to the success of this important work.

Pediatric Mental Health Care Access Grants (HRSA):

FY 22 Request: $10 Million; FY 21 Level: $10 Million.—The AAP appreciates the additional funds included in the American Rescue Plan for the Pediatric Mental Health Care Access Grants, in recognition of the impact of COVID–19 on child and adolescent mental health, and urges Congress to continue providing $10 million for FY 22 appropriations. This program supports the development of new statewide or regional pediatric mental health care telehealth access programs, as well as the improvement of already existing programs. Research shows pervasive shortages of child and adolescent mental/behavioral health specialists throughout the U.S. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve costs savings.

Activities Authorized under Scarlett's Sunshine Act (CDC/HRSA):

FY 22 Request: $12 Million; FY 21: Level: N/A.—The AAP urges Congress to provide first-time appropriations of $12 million to implement the Scarlett's Sunshine Act. Little is known about the tragic, sudden and unexpected deaths of young children because of variations in investigations and death certifications. Enacted in December 2020, this law will help states better understand sudden unexpected infant death and sudden unexpected death in childhood, facilitate data collection and analysis to improve prevention, and support grieving families. Funds should support work at both CDC and HRSA's Maternal Child Health Bureau given their complementary efforts on this issue.

Emergency Medical Services for Children (HRSA):

FY 2022 Request: $22.334 Million; FY 21 Level: $22.334 Million.—The AAP urges the committee to maintain $22.334 million in funding for the Emergency Medical Services for Children (EMSC) Program in FY 22. EMSC is the only federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. EMSC aims to ensure state of the art emergency medical care is available for the ill and injured child or adolescent, pediatric services are well integrated into an EMS system backed by optimal resources, and that the entire spectrum of emergency services is provided to all children and adolescents no matter where they live.

National Center for Birth Defects and Developmental Disabilities (CDC):

FY 22 Request: $280 Million; FY 21 Level: $167.8 Million.—The AAP requests $280 million for FY 22 for the National Center for Birth Defects and Developmental Disabilities (NCBDDD), including $100 million for Surveillance for Emerging Threats to Mothers and Babies (SET–NET). This would allow the program to scale nationally and serve as the nationwide preparedness and response network the United States needs to protect pregnant individuals and infants from emerging public health threats. According to the CDC, birth defects affect 1 in 33 babies and are a leading cause of infant death in the United States. NCBDDD conducts important research on fetal alcohol syndrome, infant health, autism, attention deficit and hyperactivity disorders, congenital heart defects, and other conditions like Tourette Syndrome, Fragile X, Spina Bifida and Hemophilia. NCBDDD supports extramural research in every State and has played a crucial role in the country's response to the Zika virus, as well as COVID–19.

Global Immunization—Polio and Measles/Other (CDC):

FY 22 Request: $271.2 Million ($176 Million for Polio and $50 Million for Measles/Other); FY 21 Level: $226 Million ($176 Million for Polio and $50 million for Measles/Other).—Vaccines are one of the most cost-effective and successful public health solutions available. The CDC provides countries with technical assistance and disease surveillance support, with a focus on eradicating polio, reducing measles deaths, and strengthening routine vaccine delivery. Global mortality attributed to measles declined by 79% between 2000 and 2015 thanks to expanded immunization, saving an estimated 20.3 million lives. Unfortunately, the gains from global immunization are in jeopardy. During the COVID–19 pandemic, many countries diverted resources set aside for polio and routine immunizations to fight the pandemic. To finance immunization gaps in countries and recover from pandemic-related disruptions requires an additional $255 million over the next three years. Failing to close these gaps will leave millions of children at risk and will compromise U.S. global health security due to increased possibility of importing highly infectious diseases like measles into the U.S.

Activities Authorized under the VACCINES Act (CDC):

FY 22 Request: $15 Million; FY 21 Level: N/A.—The AAP is very appreciative that Congress specifically included the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act as part of Section 2302 of the American Rescue Plan that provided $1 billion to improve vaccine confidence for both COVID–19 and routine immunizations. We urge Congress to include $15 million authorized by the VACCINES Act for CDC to research vaccine hesitancy and establish an evidence-based public awareness campaign to help improve vaccination rates across the lifespan. We also urge Congress to request a report on the progress of these activities at the CDC.

There are many ways Congress can help meet children's needs and protect their health and well-being. Adequate funding for children's health programs is one of them. The American Academy of Pediatrics looks forward to working with Members of Congress to prioritize the health of our nation's children in FY 2022 and beyond. If we may be of further assistance, please contact the AAP Department of Federal Affairs at pjohnson@aap.org. Thank you for your consideration.

[This statement was submitted by Lee Savio Beers, MD, FAAP, President, American Academy of Pediatrics.]

PREPARED STATEMENT OF THE AMERICAN ALLIANCE OF MUSEUMS

Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee, thank you for the opportunity to submit this testimony. My name is Laura Lott, and I am President and CEO of the American Alliance of Museums (AAM). I urge you to provide the Office of Museum Services (OMS) within the Institute of Museum and Library Services (IMLS) with $80 million for fiscal year (FY) 2022, an increase of $39.5 million. We request that $2.5 million of this increase be directed to explore establishing, and to fund projects related to, a roadmap to strengthen the structural support for a museum Grants to States program administered by OMS, as authorized by the Museum and Library Services Act, in addition to the agency's current critical direct grants to museums.

AAM—representing more than 35,000 individual museum professionals and volunteers, museums of all types, and corporate partners serving the museum field—stands for the broad scope of the museum community.

I want to express the museum field's gratitude for the $40.5 million in funding for OMS in FY 2021, and we applaud the bipartisan group of 41 Senators who recently wrote to you in support of FY 2022 OMS funding. We also applaud the President's budget proposal for additional funding for OMS for the grants program authorized by the African American History and Culture Act and the grants program authorized by the National Museum of the American Latino Act as steps in the right direction. OMS is a vital investment in protecting our nation's cultural treasures, educating students and lifelong learners alike, and bolstering local economies. During the COVID–19 pandemic, OMS has provided critical leadership to the museum community through its CARES Act grants. For example, the agency has been providing science-based information and recommended practices to reduce the risk of transmission of COVID–19 to staff and visitors engaging in the delivery of museum services.

Through the IMLS CARES Act Grants to Museums and Libraries, IMLS awarded $13.8 million to 68 museums and libraries to support their response to the coronavirus pandemic. IMLS received 1088 applications from museums but was only able to fund 39 awards, fewer than 4 percent of the applications, for a total of $8.28 million—far below the $261.5 million requested. Unfortunately, none or very little of the $200 million allocated to IMLS in the American Rescue Plan is expected to be awarded to museums.

Museums are a robust and diverse business sector, including African American museums, aquariums, arboreta, art museums, botanic gardens, children's museums, culturally-specific museums, historic sites, historical societies, history museums, maritime museums, military museums, natural history museums, planetariums, presidential libraries, public gardens, railway museums, science and technology centers, and zoos.

Museums are economic engines and job creators: According to *Museums as Economic Engines: A National Report,* pre-pandemic U.S. museums supported more than 726,000 jobs and contributed $50 billion to the U.S. economy per year, including significant impact on individual states. For example, the total financial impact that museums have on the economy in the state of Washington is $1.01 billion, supporting 14,145 jobs. For Missouri it is a $852 million impact, including 13,653 jobs.

Nationally, museums spend more than $2 billion yearly on education activities and the typical museum devotes 75% of its education budget to K–12 students.

IMLS is the primary federal agency responsible for helping museums connect people to information and ideas. OMS supports all types of museums—from art museums to zoos—by awarding grants that help them better serve their communities. OMS awards grants in every state to help museums digitize, enhance, and preserve collections; provide teacher professional development; and create innovative, cross-cultural, and multi-disciplinary programs and exhibits for schools and the public. Congress reauthorized IMLS at the end of 2018, with wide bipartisan support. OMS grants to museums are highly competitive and decided through a rigorous peer-review process. In addition to the dollar-for-dollar match generally required of museums, grants often spur more giving by private foundations and individual donors.

There is high demand for funding from OMS. In FY 2020 OMS received 784 applications requesting nearly $146 million, but current funding has allowed the agency to fund only a small fraction of the highly rated grant applications it receives. $80 million would allow OMS to double its grant capacity for museums, funds that museums will need to help recover from the pandemic and continue to serve their communities. This substantial funding increase would still be greatly shy of the high demand of $146 million in highly rated grant applications. A Grants to States program administered by OMS, in addition to the agency's current direct grants to museums, would merge federal priorities with state-defined needs, expand the reach of museums, and increase their ability to serve their communities, address underserved populations, and meet the needs of the current and future museum workforce.

Museums are vital to our nation's recovery from this pandemic, and after sudden and long-term closures, they will require financial assistance to reopen, maintain their staffs, provide educational programs to communities, and assist in rebuilding local tourism economies. PPP 1 and PPP 2, and Shuttered Venue Operators Grants (limited to museums with theatres with fixed seating) have and will provide a critical lifeline for many museums. But the museum field will need robust ongoing support from IMLS, especially as not all museums were eligible for pandemic relief funds. According to a report by McKinsey and Company, the arts, entertainment, and recreation sectors will not fully recover from this public health crisis and muted economy until 2025.

Recent survey data confirmed that the dire economic harm to museums caused by the COVID–19 pandemic will result in a long road to recovery for the field. Three-quarters of museums (76 percent) report that their operating income fell an average of 40 percent in 2020 while their doors were closed to the public for an average of 28 weeks due to the pandemic. Museums have largely been unable to offset losses by cutting expenditures. Fifteen percent (the equivalent of more than 5,000 US museums) confirmed there was a "significant risk of permanent closure" or they "didn't know" if they would survive the next six months absent additional financial relief. Nearly half (46 percent) of museums surveyed report that their total staff size has decreased by an average of 29 percent compared with pre-pandemic levels. Only 44 percent of all respondents plan to rehire or increase their staff size in the coming year. Pre-pandemic museums supported 726,000 jobs. Fifty-nine percent of responding museums were forced to cut back on education, programming, and other public services due to budget shortfalls and/or staff reductions during the pandemic. Thirty-nine percent of responding museums require investments in their building, HVAC equipment, and other infrastructure to improve energy efficiency and reduce the environmental impact of their operations. The average anticipated cost of these improvements is $668,000 per museum.

Despite economic distress, museums have been filling critical gaps in our communities. During the pandemic, museum professionals—severely impacted by the pandemic themselves-stepped up by serving the needs of their communities. They are addressing education gaps and contributing to the ongoing education of our country's children by providing free lesson plans, online learning opportunities, and drop-off learning kits to teachers and families. Museums are using their outdoor spaces to grow and donate produce to area food banks and are maintaining these spaces for individuals to safely relax, enjoy nature, and recover from the mental health impacts of social isolation. They have donated their PPE and scientific equipment to fight COVID–19, and provided access to child care and meals to families of health care workers and first responders. In the midst of financial distress, they are even raising funds for community relief and providing reliable information on COVID–19 and vaccinations, some even serving as vaccination sites themselves. Museums are pivotal to our nation's ability to manage through the pandemic and recover from it as our nation opens back up.

Here are just a few examples of how OMS helps museums better serve their communities:

In 2021, the Suquamish Indian Tribe of the Port Madison Reservation in Washington was awarded a $85,400 Native American/Native Hawaiian Museum Services grant to update an oral history project conducted from 1981–83 that has guided the development of the Suquamish Museum for over 30 years. The project will engage the 78 Suquamish elders who are 70 years of age and older to document their biographical, cultural, and personal knowledge for use in more contemporary programming and museum exhibits. Although the tribe recognized the need to gather oral histories during a retreat in 2018, the COVID–19 pandemic not only increased the sense of urgency but provided time to consider a plan for the project. Collecting oral histories of experiences in the more recent past will guide long range planning and help the museum focus its collections acquisitions for the next foreseeable decades.

In 2020, the Seattle Art Museum in Washington was awarded a $216,970 Museums for America grant to expand its early learner initiative known as Artful Beginnings to create increased opportunities for hands-on arts learning and engagement for children ages 2 through 6, their caregivers, and educators. The focus is on three core Artful Beginnings programs: Tiny Tots Workshops and Family Fun Storytime, Art Adventures, and an art-based outdoor preschool curriculum with Tiny Trees. The museum's three locations—as well as community partner facilities in South Seattle and South King County—will host the programs. Programming will focus on engaging traditionally underserved and lower-income audiences. The project underscores the museum's commitment to equity and inclusion and will work to engage all audiences more deeply.

In 2020, Port Townsend Marine Science Society in Washington was awarded a $49,613 Program Inspire! Grants for Small Museums grant to complete an exhibition master plan as part of a larger facility improvement project. The expanded and renovated facility will create an accessible, unified, cohesive exhibition experience with strong content linkages and seamless indoor-outdoor integration that gives the feeling of a journey into the Salish Sea. The process of developing the exhibition master plan will involve formative evaluation, including site visits, surveys, focus groups, and consultations with professionals. Representatives of key stakeholder groups, including educators and students, volunteers, marine conservation professionals, and other Salish Sea environmental organizations will provide input on the plan concept and exhibition content. The center intends to inspire responsible stewardship of global oceans through the development of immersive, informative content.

In 2020, the Walt Disney Hometown Museum in Marceline, Missouri, was awarded a $38,240 Program Inspire! Grants for Small Museums grant to expand its education and professional development programs for rural educators. The initiative is the result of a collaborative partnership that includes museum staff, K–16 educators, and others from the local community. Educators will have the opportunity to participate in an immersive learning workshop program where they will experience and explore place-based learning opportunities alongside guided instructional planning. The initiative will solidify bonds between the museum and the community, as educators and museum personnel collaborate to strengthen their understanding of how local culture connects to learning.

In 2020, the Missouri Botanical Garden in Saint Louis, Missouri, was awarded a $202,220 Museums for America grant to create a Butterfly House Entomology Lab to serve as a functional space for staff and volunteers to properly care for their invertebrate animal collection while providing guests an interactive experience. This exhibition will promote learning experiences focused on the butterfly life cycle, invertebrate animal conservation, and the field of entomology. The project also will include the addition of digital components such as monitors that highlight the characteristics of each display species and their region of origin. The addition of technology also will allow virtual field trips to the Butterfly House Entomology Lab.

In closing, I highlight recent national public opinion polling that shows that 95% of voters would approve of lawmakers who acted to support museums and 96% want federal funding for museums to be maintained or increased. Museums have a profound positive impact on society.

If I can provide any additional information, I would be delighted to do so. Thank you again for the opportunity to submit this testimony.

[This statement was submitted by Laura L. Lott, President/CEO, American Alliance of Museums.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH

Chair Murray, Ranking Member Blunt, and members of the subcommittee and staff, thank you for the opportunity to submit testimony. I am Dr. David Tuveson, Director of the Cold Spring Harbor Laboratory Cancer Center and Chief Scientist for the Lustgarten Foundation, the largest pancreatic cancer research philanthropic organization. I am submitting testimony as President of the American Association for Cancer Research (AACR). On behalf of the AACR's 48,000 members, I ask for your support for at least $46.1 billion in FY 2022 funding for the National Institutes of Health (NIH), and $7.6 billion for the National Cancer Institute (NCI).

We are in an era of unprecedented progress against cancer, including advances in immunotherapies and targeted anti-cancer therapies that led to spectacular decreases in cancer mortality. Thanks to investments at the NCI, we have new tools at our disposal that could only be dreamed of decades ago to maximize advances in early diagnosis of many types of cancer and offer highly effective treatments that improve health outcomes and reduce health disparities. Additionally, the funding that NCI provides to the NCI-designated cancer centers that are located all throughout the country is supporting pioneering new research, serving patients in their communities, and training the next generation of cancer scientists.

There are so many breakthroughs within our grasp, but to achieve them, we need federal investments to keep up with demand on basic research for cancer.

Since FY 2015, thanks to your leadership, NIH funding has increased by nearly 42%. But due to other funding needs at NIH, including worthy initiatives that take away from the top line, and a nearly 50% increase in applications at NCI since 2013, the funding increases have not kept up with demand.

Even with the significant funding you have provided, the percent of NCI grant applications that are funded, referred to as the success rate, is among the lowest of all institutes at NIH. In FY 2020, the NIH-wide success rate for competing research project grants, or RPGs, was nearly 21%. For NCI, it was only 12.8%, and that's the highest NCI's success rate has been in six years.

NCI has been stretching dollars to fund more grants. NCI Director, Dr. Sharpless, released his 15-by-25 milestone, an effort to increase the number of R01 grants funded until it reaches the 15th percentile in 2025. The AACR strongly supports this important mission, but to achieve the goal of funding more meritorious research, more funding will be needed.

While the success rate of an RPG at NHLBI is 22.2%, and NIDDK is 23%, NIAID is 23.9%, and the National Institute on Aging is 25.8%, NCI's rate of 12.8% is not sustainable to meet our pledge to apply new cancer science and medicine towards improving patient outcomes. With the low success rate, I worry the best and the brightest, in particular early-stage researchers, will choose other career paths. The United States cannot lead the world in cancer discoveries if the NCI success rate is so low that researchers choose another field.

Thanks to your leadership, language was included in the last two explanatory statements to prioritize competing grants and sustain commitments to continuing grants. I humbly ask you to continue these efforts in FY 2022 and provide funding to meet Dr. Sharpless' goal so the cancer research community can accelerate the path to discoveries and save lives.

I know cancer is personal for you, as it is for me. Thank you for this opportunity and for your commitment to bringing us closer to our mutual goal of conquering cancer.

[This statement was submitted by David A. Tuveson, MD, PhD, FAACR, President, American Association for Cancer Research.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY

The American Association for Clinical Chemistry (AACC) welcomes the opportunity to provide testimony to the Senate Appropriations Subcommittee on Labor, Health & Human Services, and Education regarding our nation's fiscal year (FY) 2022 budget priorities. AACC and its partners are urging the subcommittee to support two initiatives vital to improving the quality and efficacy of healthcare in the United States:

—Improving Pediatric Reference Intervals—$10 million for the Centers for Disease Control and Prevention, Division of Laboratory Services, Environmental Health Laboratory to improve the quality of pediatric reference intervals used by health practitioners to diagnose, monitor, and treat children.

—Harmonizing Clinical Laboratory Test Results—an additional $7.2 million ($9.2 million in total) for the Centers for Disease Control and Prevention, Division

of Laboratory Services, Environmental Health Laboratory to continue its ongoing efforts to harmonize the reporting of clinical laboratory test results, which is the vital to providing better, more consistent healthcare in the United States.

IMPROVING PEDIATRIC REFERENCE INTERVALS

AACC, the American Academy of Pediatrics, the Children's Hospitals Association, and 30 other organizations have written to the subcommittee urging additional funding for the Centers for Disease Control and Prevention (CDC) to improve the quality of pediatric reference intervals (PRIs)—the range of numeric values expected in a healthy child—available to health practitioners to care for their young patients.

When making a diagnosis, the healthcare professional considers a laboratory test value within the context of a reference interval. If the test result falls outside of the defined reference interval for a healthy child—either higher or lower—the practitioner may order a medical intervention to address a health condition or change an ongoing treatment protocol. If the diagnosis or treatment change is incorrect for any reason, including an inaccurate reference interval, it could result in patient harm. Therefore, it is critical that the range of values used by practitioners to interpret test results are accurate.

Whereas the reference intervals for adults are generally reliable, there is considerable inconsistency and large gaps in the ranges available for children. Healthcare practitioners need reference intervals reflective of healthy children at each unique stage of physical development from birth through adolescence to adulthood. In addition, the intervals must also take into consideration any variations due to biological factors, such as ethnicity and gender.

Accurate and actionable PRIs are particularly important for our youngest patients, who are often unable to verbally communicate their symptoms. Unfortunately, most laboratories are unable to obtain enough samples from a diverse, healthy population of children to develop their own reference intervals.

Congress recognized the importance of this issue when in the accompanying report language to the Further Consolidated Appropriations Act of 2020 it requested CDC to develop and submit a plan for improving PRIs. The agency outlined its plan in the Department of Health and Human Services fiscal year 2021 congressional justification to Congress. The plan calls for the CDC to employ its existing infrastructure to initiate and advance this vital work. According to CDC, it can:

—collect clinical samples through its National Health and Nutrition Examination Survey (NHANES), which has the organization and expertise to collect specimens from healthy children; and

—utilize its Environmental Health Laboratory (EHL) to generate the reference intervals for children and disseminate the information to clinical laboratories. EHL has developed reference intervals in the past.

AACC and its partners support providing CDC with an additional $10 million to improve the quality of PRIs critical to caring for our nation's children.

HARMONIZING CLINICAL LABORATORY TEST RESULTS

Another issue that AACC and its allies request your assistance with is the harmonization of clinical laboratory test results. Laboratory test methods provide accurate test results, but different methods generate different numeric values. With different methods in use across the healthcare system, lack of harmonization makes it difficult to develop widely applicable clinical guidelines or performance measures. It also complicates data aggregation, which limits the development of tools to better inform health decision-making.

Tests that are harmonized (or standardized) provide the same numeric value for a condition regardless of the method or instrument used or the setting where the tests are performed. An early example of harmonization is cholesterol, which is widely utilized by the medical community to diagnose heart disease. A 2011 study published in Preventing Chronic Disease reports that early drug intervention based on cholesterol levels saved the health system $338 million to $7.6 billion annually between 1980—2000.[1] Harmonization can improve patient care while also saving money.

In recent years, Congress has supported the expansion of CDC's harmonization efforts, resulting in new activities to improve the detection and management of hormone disorders, kidney disease, cancer, and heart disease. With additional funding, the agency will be able to expand its harmonization activities to develop materials for non-traditional biomarkers, such as apolipoproteins, and the assessment of point

[1] Hoerger TJ, Wittenborn JS, Young W. A cost-benefit analysis of lipid standardization in the United States. Preventing Chronic Disease 2011; 8: A136.

of care testing devices that are increasingly being used by healthcare providers and patients.

AACC and its partners respectfully request that the subcommittee provide an additional $7.2 million ($9.2 million in total) for the CDC to continue and advance its harmonization activities. Congress has provided $2 million annually for this program since FY18.

AACC is a global scientific and medical professional organization dedicated to clinical laboratory science and its application to healthcare. We look forward to working with the subcommittee on these most important issues as it goes through the FY22 budget process. If you have any questions, please email Vince Stine, PhD, AACC's Senior Director of Government and Global Affairs, at vstine@aacc.org.

[This statement was submitted by David Grenache, PhD, D(ABCC), President, American Association for Clinical Chemistry.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR DENTAL RESEARCH

On behalf of the American Association for Dental Research (AADR), I am pleased to submit testimony describing AADR's funding requests for fiscal year (FY) 2022. I currently serve as the chair of the Board of Directors and president of the Association. I am a professor in the Department of Diagnostic and Biological Sciences at the University of Minnesota School of Dentistry, where I also serve as the director emeritus of the Minnesota Craniofacial Research Training Program (MinnCResT).

For FY 2022, the American Association for Dental Research—along with our colleagues in the oral health community—is seeking at least $520 million for the National Institute of Dental and Craniofacial Research (NIDCR) and at least $46.111 billion for all of the Institutes and Centers at the National Institutes of Health (NIH). Funding at these recommended levels will allow for the entities' base budgets to keep pace with the biomedical research and development price index (BRDPI) and provide meaningful growth of 5%.

As our nation continues to respond to the global COVID–19 pandemic, we are reminded of the importance of the federal investment in science, and in particular, biomedical research. AADR is grateful to Congress for consistently prioritizing this research at NIH by providing steady and meaningful funding increases, which will be more important than ever to carry forward in the wake of the pandemic. While we recognize there will be funding challenges in FY 2022 given the tremendous resources allocated to COVID–19 relief, we cannot afford to underfund our nation's research agencies now. Underfunding will leave us ill-equipped to complete our exit from the current pandemic, deal with future pandemics, and risk losing the progress that has been made by congressional investment in biomedical research.

The requested 5% growth above BRDPI would provide critical support for these research agencies, which have been among the many enterprises negatively impacted by this public health crisis. The ongoing pandemic caused closures of university campuses and forced laboratories to scale back or halt research projects. It also required research agencies to shift existing resources and funding to coronavirus-related research at the expense of other important scientific inquiries about health and disease.

NIDCR—the largest institution dedicated exclusively to research to improve dental, oral and craniofacial (skull and face) health—is one the NIH Institutes and Centers that has prioritized COVID–19 research. To date, NIDCR has funded approximately $3.9 million of immediate and high impact research to protect and ensure the safety of personnel and patients in dental practices during the COVID–19 pandemic. The Institute will soon release a second round of funding related to COVID–19.[1] Funding for NIDCR COVID–19 research is critical to the nation's public health, supporting work that includes the use of personal protective equipment (PPE) in dental settings, aerosol and droplet transmission in dental settings, the infection of salivary glands and oral tissues by SARS–CoV–,[2] and the use of biosensors to detect SARS–CoV–2 in saliva.

This important research agenda with broad public health impact notwithstanding, NIDCR was not included among the NIH Institutes and Centers to receive targeted

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[1] National Advisory Dental and Craniofacial Research Council—January 2021. National Institutes of Health, 2021. https://videocast.nih.gov/watch=38984.

[2] Scientists Find Evidence that Novel Coronavirus Infects the Mouth's Cells. Press Release, NIDCR. https://www.nidcr.nih.gov/news-events/nidcr-news/2021/scientists-find-evidence-novel-coronavirus-infects-mouths-cells; Huang, N., Pérez, P., Kato, T. et al. SARS–CoV–2 infection of the oral cavity and saliva. Nat Med 27, 892–903 (2021). https://doi.org/10.1038/s41591-021-01296-8.

supplemental funding in COVID–19 relief legislation—nor has the annual investment in NIDCR kept pace with the overall funding increases provided to NIH over the past several years. Funding of at least $520 million in FY 2022 would help bring NIDCR funding into alignment with the overall NIH request and allow NIDCR to build on its myriad successes in its mission to improve dental, oral and craniofacial health.

Oral health—too often considered in isolation—is integral to overall health. The research being conducted at, and supported by, NIDCR impacts the lives of millions of Americans. Oral health can affect activities that may be taken for granted: the ability to eat, drink, swallow, smile, speak, and maintain proper nutrition. The oral cavity also serves as a window into potential health issues, including but not limited to systemic diseases, such as diabetes, HIV/AIDS and Sjögren's, an autoimmune disease that causes one's immune system to attack parts of its own body.

Coronavirus research shows that the virus can infect more than the upper airways and lungs, but also cells in other parts of the body. In fact, recent NIDCR-supported research has also shown that the novel coronavirus can infect cells in the mouth. As the study's authors explain.[2] :

"The potential of the virus to infect multiple areas of the body might help explain the wide-ranging symptoms experienced by COVID–19 patients, including oral symptoms such as taste loss, dry mouth and blistering. Moreover, the findings point to the possibility that the mouth plays a role in transmitting SARS–CoV–2 to the lungs or digestive system via saliva laden with virus from infected oral cells."

According to NIDCR's press release on the study, this research is contributing to our understanding of COVID–19, including oral transmission, and could inform interventions to help combat the virus and alleviate the associated oral symptoms. Indeed, this seminal research may have important implications to explain why super-spreader events occur in places where people sing, speak loudly, or party.

Dental, oral and craniofacial research presents vast research opportunities, and we know NIDCR will continue to be the key player in advancing our understanding of the role of the mouth and oral tissues in many scientific frontiers going forward. One path to highlighting the Institute's work and the future of this research in the United States is through the U.S. Surgeon General's Report on Oral Health, a critical update to the seminal "Oral Health in America" report from July 2000. The report—originally set to be released in the fall of 2020—will document the progress in the improvement of oral health since 2000, provide insight into issues currently affecting oral health, and identify opportunities and challenges that have emerged over the past 20 years. The 2000 report shifted perspectives among the public and policymakers by showing that oral health goes beyond healthy teeth and gums and that it is essential to our general health and well-being. We believe the 2020 report will also have a significant impact, and we have encouraged the administration to swiftly review and release the report. The long-awaited report is a critical public health document and is essential to moving our nation's health forward.

In addition to the important work of NIDCR, AADR recognizes that federal research and public health efforts work in concert and that success in one area can benefit another. Therefore, we encourage Congress—in addition to supporting NIH and NIDCR in FY 2022, to support the full breadth of federal agencies supporting oral health. Complementing our NIDCR and NIH requests, we urge you to provide $30 million for the CDC's Division of Oral Health, $46 million for the Title VII Health Resources and Services Administration (HRSA) programs that train the dental health workforce, at least $500 million for the Agency for Healthcare Research and Quality (AHRQ), and at least $200 million for the National Center for Health Statistics (NCHS).

The COVID–19 crisis shook our nation and reminded us of the critical role biomedical and public health research play in our society. Over the course of 2020 and 2021, we saw how the research enterprise can safeguard public health, national security and economic growth. We urge Congress to continue to prioritize biomedical research, including dental, oral and craniofacial research in FY 2022 so our nation's citizens can continue to enjoy the benefits of state-of-the-art, world-leading health care.

We appreciate the opportunity to submit this testimony and thank the Subcommittee for considering our request of at least $520 million in funding for NICDR and at least $46.111 billion for the Institutes and Centers at NIH. AADR stands ready to assist the Congress in any way we can and to answer any questions you may have.

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[1] National Advisory Dental and Craniofacial Research Council—January 2021. National Institutes of Health, 2021. https://videocast.nih.gov/watch=38984.

[This statement was submitted by Mark C. Herzberg, D.D.S., Ph.D., President, American Association for Dental Research.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

STRENGTHENING THE CURRENT AND FUTURE NURSING WORKFORCE

On behalf of the American Association of Colleges of Nursing (AACN), we want to thank the Subcommittee for its leadership and continued support of nursing education, the nursing profession, and nursing research, especially during this unprecedented time. As the national voice for academic nursing, AACN represents nearly 840 schools of nursing at private and public universities, who educate more than 580,000 students and employ more than 52,000 faculty.[1] Collectively, these institutions play a critical role in protecting the health of our nation by graduating registered nurses (RN), advanced practice registered nurses (APRN), educators, researchers, and other frontline providers. As we work to combat current public health challenges, such as COVID–19, and prepare for the future, ensuring a robust supply of nursing professionals requires a strong and sustained federal investment. For Fiscal Year (FY) 2022, AACN respectfully requests that you provide bold support of at least $530 million for the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] administered by HRSA and at least $199.755 million for the National Institute of Nursing Research (NINR), which was included in the President's FY 2022 Budget.

THE GROWING NURSING WORKFORCE DEMAND

Nurses comprise the largest sector of the healthcare workforce with more than four million RNs and APRNs, which include Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), and Clinical Nurse Specialists (CNSs).[2] Nurse educators, students, and practitioners are leaders within their institutions and communities; many of whom are also serving on the frontlines of the COVID–19 public health emergency. Even prior to COVID–19, our nation was in need of additional nurses. This demand is only expected to grow as we continue to combat the pandemic and address the healthcare needs of all patients, including those in rural and underserved areas. In fact, the Bureau of Labor Statistics' outlook for RN workforce demand projected an increase of 7% by 2029, representing the need for an additional 221,900 jobs.[3] Additionally, the need for most APRNs is expected to grow by 45%.[4] This increasing demand in the nursing workforce can be attributed to several factors such as an aging population, nursing retirements, and an increase in workplace stress.[5] Bold investments in Title VIII Nursing Workforce Development Programs and NINR would help prepare a highly educated nursing workforce and strengthen the foundation of nursing science, not only as we confront existing health challenges, but as we provide tomorrow's equitable and innovative healthcare solutions.

NURSING WORKFORCE INVESTMENTS: SUSTAINING EDUCATION TO SECURE A STRONG NURSING WORKFORCE

Our ongoing efforts to combat COVID–19 have made it abundantly clear that a well-educated nursing workforce is essential. For over fifty years, Title VIII Nursing Workforce Development Programs have been a catalyst for strengthening nursing education at all levels, from entry-level preparation through graduate study. Through grants, scholarships, and loan repayment programs, Title VIII federal investments positively impact the profession's ability to serve America's patients in all areas, bolster diversity within the workforce, and increase the number of nurses, in-

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[2] Scientists Find Evidence that Novel Coronavirus Infects the Mouth's Cells. Press Release, NIDCR. https://www.nidcr.nih.gov/news-events/nidcr-news/2021/scientists-find-evidence-novel-coronavirus-infects-mouths-cells; Huang, N., Pérez, P., Kato, T. et al. SARS–CoV–2 infection of the oral cavity and saliva. Nat Med 27, 892–903 (2021). https://doi.org/10.1038/s41591-021-01296-8.

[1] American Association of Colleges of Nursing. (2021) Who We Are. Retrieved from: https://www.aacnnursing.org/About-AACN/Who-We-Are.

[2] National Council of State Boards of Nursing. (2021). Active RN Licenses: A profile of nursing licensure in the U.S. as of April 23, 2021. Retrieved from: https://www.ncsbn.org/6161.htm.

[3] U.S. Bureau of Labor Statistics. (2021). Occupational Outlook Handbook-Registered Nurses. Retrieved from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

[4] U.S. Bureau of Labor Statistics. (2021). Occupational Outlook Handbook-Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.

cluding those at the forefront of public health emergencies and caring for our aging population.

Each Title VIII Nursing Workforce Development Program provides a unique and crucial mission to support nursing education and the profession. For example, the Advanced Nursing Education (ANE) programs help increase the number of APRNs in the primary care workforce and supported more than 8,200 students in Academic Year 2019–2020 alone.[6] In addition, the Nurse Faculty Loan Program (NFLP) awarded 45 grants to schools that supported 2,270 graduate nursing students in Academic Year 2019–2020.[7] According to AACN's Annual Survey, student enrollment in entry-level baccalaureate nursing programs increased by 5.6% in 2020.[8] While this heightened interest in nursing education is promising news, we need to ensure these students have ample nursing faculty to guide them through their clinical and didactic education and prepare them to respond to our nation's ever-changing healthcare environment.

As we address social determinants of health and work to build an equitable healthcare system for all patients, it is imperative that we recruit individuals from diverse backgrounds to the nursing profession. Increasing diversity in the profession will not only create lifelong career pathways, but will also improve care quality and access to population-centered care. The Nursing Workforce Diversity (NWD) program serves as a glowing example of a successful Title VIII initiative that accomplishes this goal. In fact, in Academic Year 2019–2020, the NWD program awarded grants supporting 11,620 nursing students from disadvantaged backgrounds.[9] The recruitment of underrepresented racial and ethnic individuals and those from economically diverse backgrounds to nursing positively impacts the classroom, professional practice environments, and ultimately patients.

As such, to ensure the stability of our nursing workforce now and in the future, we request at least $530 million for Title VIII Nursing Workforce Programs.

FROM RESEARCH TO REALITY: NURSING SCIENCE PROTECTS AMERICANS' HEALTH

AACN recognizes how scientific research and discovery is the foundation on which nursing practice is built and is essential to advancing evidence-based interventions, informing policy, and sustaining the health of the nation. As one of the 27 Institutes and Centers at NIH, NINR plays a fundamental role in improving care and is on the cutting edge of new innovations impacting how nurses are educated and how they practice. In fact, 80% of research-focused educational training grants at nursing schools are funded by NINR.[10] Through these grants and others, nurse scientists, often working collaboratively with other health professionals, are generating and translating impactful new research in areas such as big data and data science, precision health, and genomics.[11] Despite the critical research these grants support, NINR was only able to fund 8.9% of grant applications in 2017, due to insufficient funding.[12] This is the lowest research project grant (RPG) success rate among all NIH institutes and centers, and is significantly lower than the overall NIH RPG

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[6] Department of Health and Human Services Fiscal Year 2022 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. Pages 153–155. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf.

[7] Department of Health and Human Services Fiscal Year 2022 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. Page 167. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf.

[8] American Association of Colleges of Nursing. (2021). Student Enrollment Surged in U.S. Schools of Nursing in 2020 Despite Challenges Presented by the Pandemic. Retrieved from https://www.aacnnursing.org/News-Information/Press-Releases/View/ArticleId/24802/2020-survey-data-student-enrollment%20%20%20%20%20.

[9] Department of Health and Human Services Fiscal Year 2022 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. Page 159. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf.

[10] Schnall, R. (2020) National Institute of Health (NIH) funding patterns in Schools of Nursing: Who is funding nursing science research and who is conducting research at Schools of Nursing? Journal of Professional Nursing, 36(1), 34–41. Retrieved from https://www.sciencedirect.com/science/article/pii/S8755722319301164?via=ihub#.

[11] National Institutes of Health, National Institute of Nursing Research. The NINR Strategic Plan: Advancing Science, Improving Lives. Retrieved from: https://www.ninr.nih.gov/sites/www.ninr.nih.gov/files/NINR__StratPlan2016__reduced.pdf.

[12] Federal Funding of Nursing Research by the National Institutes of Health (NIH): 1993–2017 Kiely, Daniel P. et al. (2019) Page 9. Retrieved from: https://www.nursingoutlook.org/article/S0029–6554(19)30315–X/addons.

success rate of 18.7%.[13] To further this vital work, we are requesting a total of at least $199.755 million for the National Institute of Nursing Research.

From the classroom to the frontlines, nurses and nursing students are integral members of the healthcare team. Strong investments in Title VIII Nursing Workforce Development Programs and NINR have a direct impact on sustaining pathways into nursing and patient access to high-quality, evidence-based care in all communities across the nation. During these unprecedented times, AACN respectfully requests bold support in FY 2022 of at least $530 million for the Title VIII Nursing Workforce Development Programs and at least $199.755 million for the National Institute of Nursing Research. Together, we can ensure that such investments promote innovation and improve health and healthcare in America.

[This statement was submitted by Susan Bakewell-Sachs, PhD, RN, FAAN, Board Chair, American Association of Colleges of Nursing.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

The American Association of Colleges of Osteopathic Medicine (AACOM) strongly supports fiscal year (FY) 2022 funding for the following programs important to the osteopathic medical education (OME) community:

—$46.1 billion for the National Institutes of Health (NIH)
—$6.1 billion for the Teaching Health Centers Graduate Medical Education (THCGME) Program
—$9.2 billion for discretionary Health Resources and Services Administration (HRSA)
—$980 million for the Title VII health professions workforce development programs under the Public Health Service Act
—Permanent funding for the Rural Residency Planning and Development (RRPD) Program
—$130 million for discretionary National Health Service Corps (NHSC) Scholarship and Loan Repayment programs
—$67 million for the Area Health Education Center (AHEC) Program
—$125 million for the Primary Care Training and Enhancement (PCTE) Program
—$500 million for the Agency for Healthcare Research and Quality (AHRQ)
—$10 billion for the Centers for Disease Control and Prevention (CDC)

AACOM leads and advocates for the full continuum of OME to improve the health of the public. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents all 37 accredited colleges of osteopathic medicine—educating nearly 31,000 future physicians, 25 percent of all U.S. medical students—at 58 teaching locations in 33 U.S. states, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics, and health systems.

Osteopathic medicine plays an essential role in our nation's healthcare delivery system and is a growing field. According to recent data, AACOM received more than 28,000 applicants to osteopathic medical school for the 2020–2021 application cycle, representing a 19.26 percent increase over the previous year. Osteopathic physicians focus on treating the whole person, and over half practice in the primary care specialties of family medicine, internal medicine, and pediatrics. Importantly, osteopathic medical students receive 200 hours of additional training in osteopathic manipulative treatment, a hands-on treatment used to diagnose and treat illness and injury, giving us a unique voice and perspective in the medical community. However, the clinician workforce and scientists at osteopathic medical schools are underutilized in NIH funding opportunities and underrepresented on NIH Advisory Councils and standing study sections.

AACOM urges Congress to overcome the historic bias against osteopathic medical research by expanding representation on NIH Councils and study sections and increasing NIH funding. Expanding engagement by osteopathic medical schools and professionals will result in innovative healthcare delivery solutions, expanded evidence-based research, and broader community-focused treatment models. OME investment will advance research in primary care, prevention, and treatment and employ an already diverse physician population that is enriched in socioeconomically disadvantaged rural communities. AACOM's request of $46.1 billion for NIH will support scientific advancements that incorporate the osteopathic philosophy and

[13] Ibid.

strengthen the United States position as the world's research and development leader.

OME has a proven history of establishing educational programs for medical students and residents that target the healthcare needs of rural and underserved populations. With health disparities on the rise, and worsening because of the COVID–19 pandemic, we are proud to help make healthcare access more equitable for all our country's patients and communities. In fact, recent AACOM data show that 40 percent of graduating 2019–2020 osteopathic medical students plan to practice in a medically underserved or health shortage area; of those, 45 percent plan to practice in a rural community.

AACOM expresses its strong support for $6.1 billion for the THCGME Program and our desire for permanent, mandatory funding for this critical program. According to HRSA, physicians who train in Teaching Health Centers (THCs) are three times more likely to work in such centers and more than twice as likely to work in underserved areas. The continuation of this program is critical to addressing primary care physician workforce shortages and delivering health care services to underserved communities. AACOM is pleased that Congress supported this highly successful bipartisan program through the Consolidated Appropriations Act, 2021 and American Rescue Plan Act of 2021, which extended the THCGME Program through fiscal year 2023 and provided additional funding. However, new funding is needed to extend the THCGME Program to meet economic challenges caused by the COVID–19 pandemic and support additional expansion to underserved areas that face existing shortages of primary care physicians.

AACOM appreciates the opportunity to submit its views and looks forward to continuing to work with the Subcommittee on these important matters.

[This statement was submitted by Robert A. Cain, DO, FACOI, FAODME, President and Chief Executive Officer, American Association of Colleges of Osteopathic Medicine.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists (AAI), the nation's largest professional association of research scientists and physicians who are dedicated to understanding the immune system through basic, translational, and clinical research, respectfully submits this testimony regarding fiscal year (FY) 2022 appropriations for the National Institutes of Health (NIH). AAI recommends an appropriation of $52 billion for NIH for FY 2022, including at least $46.1 billion for the regular NIH budget, to enable the agency to fund needed research to prevent dangerous infectious diseases and treat debilitating chronic illnesses, support meritorious scientists at all career stages, and ensure a robust research enterprise that maintains U.S. preeminence in biomedical science and innovation. Because the COVID–19 pandemic has posed difficult challenges, including lab closures and other interruptions, to many biomedical (particularly early career) scientists, NIH needs, and AAI strongly supports, an infusion of additional funding that would likely be considered outside of the annual appropriations process.

AAI also supports the appropriation of substantial funding to launch the newly proposed Advanced Research Projects Agency for Health (ARPA–H). While AAI is enthusiastic about ARPA–H's potential, we believe that any funding provided must supplement, and not supplant, the NIH regular budget, and that this new agency must enhance, and not interfere with, NIH's historic commitment to funding basic research. AAI also urges that NIH solicit stakeholder input to help answer many outstanding questions, including whether existing programs—and which research areas—will be integrated into ARPA–H. Finally, AAI believes that funding for ARPA–H projects should be provided for longer than three years to ensure sufficient time for the kind of innovative, collaborative, and transformative research that is contemplated.

ILLUSTRATING THE IMPORTANCE OF UNDERSTANDING THE IMMUNE SYSTEM: COVID–19

The COVID–19 pandemic has highlighted both the importance, and high stakes, of biomedical research. Our lives, health, security, and prosperity depend on scientific understanding and advances. What felt remote to many people—scientists toiling away unseen in their laboratories—has become urgent, everyday news. The surge of interest in immunology—and scientists' ability to meet this historic moment—have been bright spots in an otherwise tragic, painful, and unprecedented year, and rapidly developed vaccines to prevent COVID–19 infection have been a historic success story.

But SARS–CoV–2, the virus that causes COVID–19, continues to mutate, giving rise to new variants. We know that this is what viruses do, and we know that this is what our immune systems must be primed to fight. Despite excellent news on the vaccine front, the regular appearance of new variants, our paucity of therapeutics for those who contract COVID–19, and our lack of understanding of, and treatments for, Post-Acute Sequelae of SARS–CoV–2 infection (PASC, or "long COVID") all render as premature any declaration of victory. We must continue to invest robustly not only in a deeper understanding of how the immune system responds to this virus and these vaccines, but also in research devoted to the basic understanding of the immune system. Such research will help us both emerge from this pandemic and prevent—and more rapidly extinguish—any future ones.

But the study of immunology is about much more than infectious diseases. Research on the immune system has taught us how to harness it to kill malignant tumors and treat other chronic diseases (immunotherapy); how it prevents or exacerbates chronic conditions such as Alzheimer's, multiple sclerosis, and cardio-vascular disease; how it enables—or prevents—the successful transplantation of a lifesaving organ; and how it can protect its host from (natural or man-made) agents of bioterrorism.

HOW BASIC IMMUNOLOGY RESEARCH LED TO RAPID APPROVAL OF VACCINES AND TREATMENTS FOR COVID–19

In this pandemic era, there is no better way to illustrate the importance of a long-term commitment to biomedical research, and specifically to immunological research, than to describe how science achieved the near-impossible: the successful testing, manufacture, and distribution of multiple, highly effective, and safe vaccines against COVID–19 in less than a year after the identification of the causative agent. The development of both treatments and vaccines for SARS–CoV–2 infection and COVID–19 was a result of decades of basic research, much of which was funded by, or performed at, NIH. This work includes understanding the virus, identifying good antigens for a vaccine, and defining immune system responses to infection.

SARS–CoV–2 is a member of the beta-coronavirus family responsible for two other recent outbreaks, SARS–CoV–1 (2003) and MERS (2012) and is related to the coronaviruses that cause 15–30% of common colds. More than 50 years of research on this virus family has allowed us to understand key portions of the viral genome and viral life cycle, as well as the importance of the spike protein for infection. While work at NIH's National Institute of Allergy and Infectious Diseases' Vaccine Research Center identified how to manipulate the spike protein so it could be used in a vaccine, work on other infectious diseases and some cancers facilitated the implementation of the mRNA platform into a ready-to-use state. After developing mRNA vaccines for 10–15 years, scientists launched some of the first clinical trials using the mRNA platform against Zika virus and influenza. As a result, the platform was ready to be quickly adapted to target the SARS–CoV–2 spike protein.

In other work, scientists rapidly characterized immune responses in people who experienced SARS–CoV–2 infection. Patients with poor outcomes had over exuberant immune responses; blocking these responses with steroids improved survival. Immunologists also identified several immune molecules that are at too high levels (e.g., IL–6) or too low levels (e.g., interferon). Work is ongoing to understand what protective immunity looks like, including the types of antibodies and cellular immunity that prevent reinfection and characterize immunity after vaccination. These studies will support the generation of booster vaccines and give us insight into how well current vaccines protect against new viral variants.

Finally, because of this longstanding research into coronaviruses, scientists can reasonably infer how long protective immunity will last following infection with, or vaccination against, SARS–CoV–2, giving the public confidence to resume their daily activities while providing the scientific community with a needed window in which to develop booster vaccines that will protect against circulating viral variants.

VACCINES AGAINST OTHER INFECTIOUS DISEASES AND NEWLY EMERGING THREATS

Vaccines remain the most effective method of disease prevention. Vaccination against more than two dozen viral, bacterial, and fungal diseases prevents about 2.5 million deaths globally and reduces the severity of illness for millions of people annually.[1] As the world's population grows and as travel enables people to become even more interconnected, we will continue to experience the very real threat of new emerging pathogens causing a deadly pandemic. Lessons we learn from developing

[1] https://www.who.int/immunization/global__vaccine__action__plan/GVAP__doc__2011__2020/en/.

and administering vaccines against SARS–CoV–2 will be essential to protecting against other infectious diseases and a future pandemic.

Last year, I testified that there was no approved vaccine against SARS–CoV–2, but that NIH-funded research conducted on other causative pathogens in recent epidemics, including SARS and MERS, had made possible the rapid development of vaccine candidates against SARS–CoV–2.[2] Since then, three vaccine candidates have received an Emergency Use Authorization (EUA) from the Food and Drug Administration (FDA), and two will be considered soon for licensure.[3] AAI is confident that previously conducted research, together with new research now being urgently pursued, will result in additional vaccines and treatments to prevent and/or reduce both the lethality of, and long-term symptoms caused by, COVID–19.

NIH: THE ESSENTIAL ROLE OF THE NATION'S LEADING BIOMEDICAL RESEARCH AGENCY

As the nation's major funding agency for biomedical research, NIH is an indispensable scientific leader both in the U.S. and around the world. The steward of nearly $43 billion in federal funds, NIH distributes more than 80% of its budget via a competitive peer review process to more than 300,000 researchers at ~2,500 universities, medical schools, and other research institutions across the nation and internationally.[4] About 10% of its budget supports ~6,000 additional researchers and clinicians who work at NIH facilities around the country.[5] By funding these researchers and laboratories, NIH not only advances scientific achievement, it also helps strengthen state and local economies; in 2020, NIH funding supported more than 536,000 jobs and accounted for $91 billion in economic activity across the U.S.[6] The basic research that NIH funds is an essential and irreplaceable part of the biomedical research pipeline; data show that it contributed to all 210 of the new drugs approved by the FDA from 2010–2016.[7]

NIH plays an essential role in responding to emerging health threats; throughout the coronavirus pandemic, NIH leaders and researchers have provided critically needed scientific advice to the President, Congress, and the American public while also utilizing their expertise to help develop a vaccine and treatments. NIH also regularly apprises our nation's leaders about other scientific advancements and research priorities, and its unparalleled peer review process fosters the wise distribution of taxpayer dollars.

CONTINUED FUNDING INCREASES NEEDED TO REBUILD AND GROW NIH CAPACITY

Leadership by this subcommittee has helped Congress provide generous increases to the NIH budget over the last six years. Although these increases have helped restore much of the purchasing power that NIH lost after years of inadequate budgets and erosion from biomedical research inflation, NIH's purchasing power remains below its 2003 peak funding level. Meaningful budget growth will help close this gap and allow NIH to invest not just in important research priorities across its Institutes and Centers, but also in the research workforce. While NIH should continue to support meritorious senior scientists, it is urgent to ensure that we will have sufficient mid- and early career scientists ready to take on increasingly complex scientific challenges. We must provide NIH with the resources needed to provide a dynamic research environment that allows for the training, development, and support of our next generation of researchers, doctors, professors, and inventors—and give them the confidence to pursue these careers.

CONCLUSION

AAI greatly appreciates the subcommittee's strong support for NIH and urges a budget for NIH of $52 billion for FY 2022. Within that, AAI recommends an appropriation of at least $46.1 billion for the regular NIH budget to help the agency grow its ability to invest in critically important research, including vital immunologic research, support meritorious scientists at all career stages, and help scientists discover new ways to prevent, treat, and cure deadly and debilitating diseases that af-

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[2] https://www.niaid.nih.gov/diseases-conditions/coronaviruses.

[3] https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines; https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-initiate-rolling-submission-biologics; https://investors.modernatx.com/news-releases/news-release-details/moderna-announces-initiation-rolling-submission-biologics.

[4] https://www.nih.gov/about-nih/what-we-do/budget; https://report.nih.gov/award/index.cfm.

[5] https://irp.nih.gov/about-us/research-campus-locations.

[6] https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf.

[7] https://directorsblog.nih.gov/2018/02/27/basic-research-building-a-firm-foundation-for-biomedicine/.

flict people in the U.S. and throughout the world. AAI also urges a substantial appropriation to launch the new ARPA–H, which could greatly advance human immunology at a time in our history when pressing public health needs, and unprecedented scientific opportunities, have converged.

[This statement was submitted by Ross M. Kedl, Ph.D., Chair of the Committee on Public Affairs, American Association of Immunologists.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROMUSCULAR & ELECTRODIAGNOSTIC MEDICINE

FISCAL YEAR 2022 RECOMMENDATIONS

—Please continue to provide meaningful, annual funding increases for healthcare fraud and abuse programs at the Centers for Medicare and Medicaid Services (CMS) while allowing for flexibility and innovation to address emerging challenges.
—Please continue to include timely recommendations in the Committee Report accompanying the annual Labor-Health and Human Services-Education (LHHS) Appropriations Bill encouraging CMS to take substantive action to systematically address fraud, abuse, and the quality of patient care in electrodiagnostic (EDX) medicine.
—Please provide the National Institutes of Health (NIH) with $46.1 billion in discretionary funding, an increase of $3.2 billion over FY 2021. Please also provide proportional increases for various NIH Institutes and Centers, including the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), the National Institute of Allergy and Infectious Diseases (NIAID), and the National Institute of Neurological Disorders and Stroke (NINDS).
—Please support adequate funding to establish the new Advanced Research Projects Agency for Health (ARPA–H) at NIH to facilitate robust and swift scientific progress on a variety of neuromuscular conditions.

Chairwoman Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee, thank you for the opportunity to present the views of the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) during the consideration of FY 2022 L–HHS appropriations. First and foremost, thank you for the ongoing investment in medical research and patient care programs. Please continue this investment in FY 2022.

In regards to fraud and abuse, the challenges and opportunities that I will review today are not unique to AANEM, but impact a variety of medical professional societies and patient communities who rely on proper EDX testing. My comments are provided in the interest of spotlighting serious issues that continue to undermine patient care and waste federal healthcare resources, while advancing policy tools to efficiently and effectively address these issues. In this regard, please consider the AANEM a resource moving forward. Thank you again for this important opportunity.

ABOUT AANEM

AANEM is a nonprofit membership association dedicated to the advancement of neuromuscular, musculoskeletal, and EDX medicine. Our members—primarily neurologists and physical medicine and rehabilitation (PMR) physicians—are joined by allied health professionals and PhD researchers working to improve the quality of medical care provided to patients with muscle and nerve disorders. Founded in 1953, AANEM currently has over 5,400 members across the country. Our mission is to improve quality of patient care and advance the science of neuromuscular (NM) diseases and EDX medicine by serving physicians and allied health professionals who care for those with muscle and nerve disorders. Our members are dedicated to diagnosing and managing a variety of nerve and muscle disorders including, but not limited to, amyotrophic lateral sclerosis, muscular dystrophies, and neuropathies, as well as more common conditions, such as pinched nerves and carpal tunnel syndrome.

ABOUT EDX MEDICINE

When functioning properly, nerves send electrical impulses to the muscles to activate them. A nerve disorder means that signals are not getting through like they

should. A muscle disorder means that muscles aren't responding to the signals correctly. To determine whether your nerves and muscles are working properly, your doctor may recommend you have EDX testing, which generally includes both a nerve conduction study (NCS) and needle electromyography (EMG) testing. Other tests may include imaging, genetic testing, biopsies, biochemical tests, and strength testing. The results of these tests help your doctor diagnose your condition and determine the best treatment.

NCS.—These studies evaluate how quickly and efficiently electrical impulse move through the nervous system. While it may sound straight-forward, proper testing requires sophisticated equipment, an understanding of the patient's health history, and, most importantly, the ability to design/perform the study and interpret the results.

EMG.—These tests evaluate muscles and nerves through the use of electrodes under the skin. Since the procedure is invasive and highly technical, it is considered to be the practice of medicine by the American Medical Association, requiring training, study, and experience to ensure patient safety and testing efficacy.

ABOUT EDX FRAUD AND ABUSE

In 2014, the HHS OIG published a report entitled, Questionable Billing for Medicare Electrodiagnostic Tests, which found roughly $140 million in suspicious activity annually. But experience tells us that this is just the tip of the iceberg. And the toll of patient suffering and hardship as the result of fraudulent EDX testing is incalculable. Unfortunately, since this report was released, the situation has deteriorated rather than improved. Our members have anecdotally noted an increase in fraud activity (both through solicitations and by re-testing patients that were victims of improperly performed tests), which appears to be supported by CMS utilization data. CMS revised the EDX codes in 2013 which has actually made it harder to identify systematic fraud and abuse in this area. Bad actors are aware of the gaps in the current CMS regulatory and enforcement framework that create unique blind spots for EDX testing, and this deficiency continues to be exploited with many criminal endeavors operating in the open for years as sham professional service providers (the small number that are caught and convicted annually has not served as a deterrent). To be clear, the victims continue to be the patients that are improperly tested, subjected to a battery of studies, and over-billed, with no intention of receiving an accurate diagnosis or who were never in need of testing in the first place.

CURRENT OPPORTUNITIES

CMS, the FBI, and the HHS OIG have been doing tremendous work to root out fraud and abuse in EDX medicine, but these dedicated public servants are limited by the constraints of the current pay-and-chase model. Additional resources for ongoing CMS efforts to address healthcare fraud and abuse will facilitate incremental improvements and further protect patients, but modernization is needed as well. Over recent appropriations cycles, Congress has called on CMS to work with the EDX community on innovative solutions that could better identify bad actors conducting EDX testing or simply prevent payments for improper studies before they are made. Please continue to work with CMS through the FY 2022 appropriations process to recommend greater community collaboration and to encourage meaningful and timely progress in the area of EDX fraud and abuse.

STATEMENT OF AANEM MEMBER DR. VINCE TRANCHITELLA

New NCS codes became effective on January 1, 2013. The new codes were developed as a direct response to fraudulent activity that resulted in the exponentially increased billing for NCSs. Unfortunately, the new NCS codes failed to have the desired effect. My most recent case involved 56 EDX studies, all of which were performed AFTER the NCS codes were changed in 2013, and every single one of the reports were deemed so far below the standard of care that none of them could be considered a reliable representation of the true medical status of the patients who received those tests. Therefore, none of those tests should have been billed or reimbursed.

RECENT EXAMPLES FROM DR. PETER GRANT

EDX fraud not only wastes healthcare dollars, but, more importantly, the quality of patient care suffers severely. As an example, a recent case in which I testified in Houston working for the FBI and the US Attorney's Office, many patients' insurance companies were being billed more than $30,000 for a study that should cost $800 to $1200. Of note, when a detailed review was performed, more than 85% of

the diagnoses arrived at with these fraudulent studies were incorrect and unreliable. These inappropriate and inaccurate studies did not help these patients in finding appropriate treatments or solutions to their medical problems. In fact, they often sent the patients down costly and ineffective paths of treatment. In this case alone the perpetrators were convicted of EDX fraud totaling nearly $5 million.

As is invariably the case with mobile EDX laboratories, quality of care suffers while costs skyrocket and the real losers are, unfortunately, the patients. In a case I had in California, a 47 year old man had a mobile EDX study done that cost him (and his insurance company) more than $7,500 and told him his symptoms were from a "pinched nerve in his leg". When I performed the correct study (charging about $750) I found his true diagnosis to be ALS (or Lou Gehrig's disease).

[This statement was submitted by Peter A. Grant, MD, EDX, Fraud and Abuse Consultant for FBI/OIG, American Association of Neuromuscular & Electrodiagnostic Medicine.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF UNIVERSITY PROFESSORS

Dear esteemed Members of Congress:

The American Association of University Professors (AAUP) is the oldest organization of its kind, representing faculty and graduate employees in institutions of higher education. Since its founding in 1915, the AAUP has been an active and influential voice in higher education. The AAUP defines and develops fundamental professional values, standards, and procedures for higher education; advances the rights of academics, particularly as those rights pertain to academic freedom and shared governance; and promotes the interests of higher education teaching and research.

On behalf of all faculty, and our chapters across hundreds of institutions, we write to thank you for your historic investments in higher education over the course of the past year. Across the country, funding provided by the CARES Act and subsequent COVID–19 relief bills have stopped the worst financial impacts from hitting our campus communities. However, as appreciated as the unprecedented $135 billion has been, faculty and staff have not shared in all the benefits, to the detriment of the student experience. According to a survey we recently ran of faculty senate chairs, 10 percent of institutions had laid off tenured faculty and 28 percent had laid off contingent faculty in the past year,[1] despite the influx of federal funds that explicitly said that they could be used to meet payroll budget gaps. Faculty working conditions are student learning conditions. To us, it is clear that our institutions need sustained, increased funding to invest more in the people and infrastructure that make them run.

We are pleased to see the historic levels of funding proposed in the American Families Plan and the President's FY22 budget. This funding makes meaningful progress towards our call for a New Deal for higher education,[2] which calls for free college, faculty and staff job security, and student debt cancellation. These planks of our New Deal platform will provide institutions the resources they need to better foster innovation and ensure high quality instruction. Beyond that, in a time of political division and heightened social tension, open access to a college education might also help us strengthen civic engagement and advance racial and economic justice. However, as ambitious and appreciated as the President's proposals have been, in some ways they fall short of what students need—and don't go far enough to equitably fund our institutions.

The AAUP recommends that the Appropriations Committee prioritize the following to better meet the needs of faculty and students:

1. Double the Pell Grant, the purchasing power of which has fallen to less than a third of the annual cost of tuition at the average public institution. More than a thousand organizations have called on Congress to increase Pell Grant funding dramatically, and that call seems more urgent than ever given increased student need during the pandemic. Furthermore, we strongly encourage you to maintain the Pell Grant reserve, and not rescind it to fund other programs within the Labor-HHS-Education budget.

2. Increase funding for programs that support students of color, non-traditional students, and low-income students, such as but not limited to Title III funds to minority serving institutions, TRIO, SEOG, work study, and CCAMPIS. These programs ought to see more generous funding to help close equity gaps between non-traditional students and their peers, and to begin to address historic underfunding that minority-serving institutions have faced.

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[1] https://www.aaup.org/report/survey-data-impact-pandemic-shared-governance.

[2] https://newdealforhighered.org/.

3. Increase funding to scientific research programs, which are a significant source of funding to support graduate students in their pursuit of knowledge and a degree. The cutting-edge academic and scientific discoveries made by researchers at American institutions makes our higher education system one of the most respected in the world. Many of these discoveries lead to robust partnerships with private industry that result in job creation and economic growth. And, the scientific breakthroughs of the past year make a clear case for increased funding for broad and exploratory research.

4. Create a federal-state partnership to make college free, so that any qualified student might pursue an associate's or bachelor's degree at the institution of their choice. Congress should also consider how to increase funding to private institutions so that they too can offer reduced costs, such as Title III programs and noting in report language that states may use these funds for student grant aid to subsidize the cost of attendance at private institutions in their home state.

5. As a condition of this new funding, it ought to protect faculty and staff job security by setting a baseline of support for workers. Gig work and the exploitation of contingent faculty erodes the foundations of what makes American higher education so respected internationally. Beyond supporting an increase in the share of faculty on the tenure track, where applicable, positions on college campuses should provide a guarantee of good pay, continuity of employment, and parity in wages and benefits between full and part time positions. Institutions should work as much as possible to convert existing short-term contracts with employees to longer-term or tenure-track appointments.

6. Promote shared governance, by making clear in bill and report language that federal funding to institutions and states in the aftermath of the COVID–19 pandemic ought to maintain instructional spending levels and faculty jobs, ahead of administrative costs or debt financing. Furthermore, faculty and staff must have meaningful input when administration seek to cut costs in moments of financial uncertainty.

We would again like to thank you for your generous and historic funding to meet the needs of students and institutions of higher education during the pandemic. We look forward to working with you to help our country recover from the pandemic, strengthen our communities and civil society, and create thousands more good-paying jobs on campus in the process.

[This statement was submitted by Kaitlyn Vitez, Government Relations Officer, and John McNay, Government Relations Committee Chair, American Association of University Professors.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology (ACC) commends Congress for boosting funding for the National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) in FY21. To continue this important progress in FY22 and beyond, and to adequately fund public health and research infrastructure in response to the COVID–19 pandemic, ACC urges members of Congress to appropriate the following funds toward agencies doing vital work in cardiovascular disease (CVD) treatment and prevention: $3.963 billion for the National Heart Lung & Blood Institute (NHLBI) to increase the NIH's purchasing power and preserve U.S. leadership in research; $160 million toward the CDC's Division for Heart Disease and Stroke Prevention to strengthen heart disease prevention efforts at state and local levels, $10 million toward CDC's Million Hearts to prevent 1 million heart attacks and strokes, $46.7 million toward CDC's WISEWOMAN to help uninsured or under-insured women prevent or control heart disease, $10 million toward CDC congenital heart research to study its effects over the patient's lifespan, and $310 million toward CDC's Office on Smoking and Health to maintain the program's cost-effective tobacco control efforts. ACC asks for the inclusion of report language promoting valvular heart disease research at the NHLBI since clinical predictors of patients at higher risk of sudden cardiac death are still lacking.

ACC envisions a world where innovation and knowledge optimize cardiovascular care and outcomes. As the professional home for the entire cardiovascular team, the mission of the College and its more than 52,000 members is to transform cardiovascular care and improve heart health. The ACC bestows credentials upon cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards and guidelines. The College also provides professional medical education, disseminates cardiovascular research through its world-re-

nowned JACC Journals, operates national registries to measure and improve care, and offers cardiovascular accreditation to hospitals and institutions.

CVD, a class of diseases that includes diseased blood vessels, structural problems, and blood clots, continues to be the leading cause of death among men and women in the United States and is responsible for 1 in every 4 deaths.[1] More than 92 million Americans currently suffer from some form of CVD—nearly one-third of the population—but it remains one of the most underfunded deadly diseases, as the NIH only invests 4 percent of its research dollars on heart research.[2] The heart disease death rate has continued to drop since the 1970s[3] due to scientific advances and improved heart medications and procedures—but to meet the challenges of an aging population, rising obesity rates and the long-term complications of COVID–19 and patients with heart disease, the NIH must maintain its place at the forefront of medical innovation for years to come. The NHLBI, the third-largest institute at the NIH, conducts research related to heart, blood vessel, lung, and blood diseases, generating drugs for lowering cholesterol, controlling blood pressure, and dissolving blood clots. These biomedical advancements have contributed to a 71 percent[4] decrease in death rates due to cardiovascular disease.

Preventing and treating CVD applies to long-term COVID–19 patients. Recent studies have shown that cardiovascular consequences of COVID–19 extend beyond initial infection, and many COVID–19 survivors experience some type of heart damage, even if they did not have underlying heart disease and were never hospitalized. Imaging tests taken months after recovery from COVID–19 have shown lasting damage to the heart muscle in people who experienced only mild symptoms, which may increase the risk of heart failure or other heart complications in the future.[5] As CVD continues to be the country's leading cause of death while COVID–19 infections also present risks to cardiovascular health, we recommend the NHLBI be funded at $3.965 billion to support research on COVID–19 by leveraging existing NIH-funded studies and infrastructure, and to maintain current activities and investment toward new research and emerging technologies related to heart disease.

More than 11 million Americans have heart valve disease (HVD) which involves damage to one or more of the heart's valves and leads to disrupted blood flow by not opening or closing properly.[6] HVD can lead to major complications and some people with HVD do not always have symptoms, even if their disease is severe. ACC recommends that the NHLBI address gaps in understanding heart valve disease to better recognize indicators of patients at higher risk of sudden cardiac death. We propose report language to better understand and develop guidelines for treatment of high-risk patients: The committee recognizes that heart valve disease involves damage to one or more of the heart's valves, and symptoms can be difficult to detect and lead to major complications. The committee encourages the NHLBI to expand research on valvular disease to better understand and develop guidelines for treatment of high-risk patients by using precision medicine and advanced technological imaging to generate data, identifying and developing a cohort of individuals with valvular heart disease and available data, and corroborating data generated through clinical trials to develop a prediction model to identify patients at high risk for sudden cardiac arrest or sudden cardiac death from valvular disease.

The CDC plays a vital role in protecting public health through healthy lifestyle promotion and educational activities designed to curb non-infectious diseases such as obesity, diabetes, stroke, and heart disease. The CDC Division for Heart Disease and Stroke Prevention supports efforts to improve cardiovascular health by promoting healthy lifestyles and behaviors, healthy environments, and access to early detection and affordable treatment. The division engages with local and state health departments, and a variety of other partners, to provide funding and resources, conduct research, track risk factors, and evaluate current programs and policies relating to heart disease. We recommend that the CDC Division for Heart Disease and Stroke Prevention be funded at $160 million to explore the intersections between COVID–19 and cardiovascular disease; build or enhance critical data infrastructure;

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[1] Heart Disease Facts; Centers for Disease Control and Prevention. https://www.cdc.gov/heartdisease/facts.htm.

[2] National Coalition for Heart and Stroke Research; American Heart Association. http://www.heart.org/HEARTORG/Advocate/IssuesandCampaigns/Research/National-Coalition-for-Heart-and-Stroke-Research__UCM__428347__Article.jsp#.Wt4h-m4vypo.

[3] Decline in Cardiovascular Mortality; National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5268076/.

[4] HHS/NIH/NHLBI FY2017 Congressional Justification Report; https://www.nhlbi.nih.gov/sites/default/files/media/docs/Final%20NHLBI%202017%20CJ__R508__v1__0.pdf.

[5] https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351.

[6] Heart Valve Disease Awareness Day; https://www.valvediseaseday.org/the-issue/.

and expand current work in priority areas through new partnerships, programs, and projects, all focused on eliminating disparities in health outcomes.

Launched in 2012 and co-led by the CDC and the Centers for Medicare and Medicaid Services, the Million Hearts program coordinates and enhances CVD prevention activities with the objective of preventing 1 million heart attacks and strokes in 5 years. The initiative aims to achieve this goal by encouraging the public to lead a healthy and active lifestyle, as well as improving medication adherence for aspirin and other medications to manage blood pressure, cholesterol, and smoking cessation. New funding would frontload the success of Million Hearts by facilitating extensive partner input into the design of the next five-year phase; integration of insights gleaned from the pandemic, including and especially the inequities further exposed by COVID–19; and analysis of the individual, community, and healthcare actions with the greatest impact on cardiovascular health for all. We recommend that Million Hearts be funded at $10 million to enhance efforts preventing heart attacks and strokes.

CDC's WISEWOMAN initiative provides more than 165,000 under-insured, low-income women ages 40–64 with services to help reduce heart disease and stroke risk factors. Heart disease ranks as the leading cause of death for women. Only 1 in 5[7] women believes heart disease is her greatest health threat, and 11 percent[8] of women remain uninsured. We recommend that $46.7 million be allocated for WISEWOMAN to provide preventive health services, referrals to local health care providers, lifestyle programs, and counseling in all 50 states.

Congenital heart disease (CHD), a life-long consequence of a structural abnormality of the heart present at birth, is the number one birth defect in the U.S. While the diagnosis and treatment of CHD has greatly improved over the years, most patients with complex heart defects need special care throughout their lives, and only by expanding research opportunities can we fully understand the effects of CHD across the lifespan. As authorized by the Congenital Heart Futures Reauthorization Act of 2017, we recommend that the CDC National Center for Birth Defects and Developmental Disabilities be funded at $10 million for enhanced CHD surveillance and public health research.

Programs within CDC's Office on Smoking and Health (OSH) work to prevent smoking among young adults and eliminate tobacco-related health disparities in different population groups. From 2012–2018, the CDC estimates that more than 16.4 million people who smoke have attempted to quit and about 1 million have successfully quit because of the OSH Tips from Former Smokers campaign.[9] While these programs have proven effective in tobacco cessation and prevention, more than 480,000 people still die every year from causes attributable to smoking, and 33 percent of those deaths stem from heart disease[10] We recommend that OSH be funded at $310 million to continue leading the nation's efforts in preventing chronic diseases caused by tobacco use.

On behalf of our members who work to prevent and treat CVD, ACC would like to thank members of Congress for supporting medical innovation as we continue the fight against heart disease and understand the cardiovascular consequences of COVID–19. Stable funding for medical research and healthy lifestyle promotion will save lives and health care costs in the long term by creating jobs and new technologies, which will produce billions of dollars in Medicare and Medicaid savings over the next decade. Please help us secure robust funding for NIH and CDC funding to protect the health of future generations.

[This statement was submitted by Dipti Itchhaporia, MD, FACC, President, American College of Cardiology.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), representing more than 60,000 physicians and partners dedicated to advancing women's health, is pleased to offer this statement to the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies.

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[7] WISEWOMAN; Centers for Disease Control and Prevention. https://www.cdc.gov/wisewoman/.

[8] Women's Health Insurance Coverage; The Henry J. Kaiser Family Foundation. http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/.

[9] CDC Office on Smoking and Health; https://www.cdc.gov/chronicdisease/pdf/aag/osh-H.pdf.

[10] FDA Tobacco Products Public Health Information; https://www.fda.gov/tobacco-products/public-health-education/health-information.

We thank Chairwoman Murray, Ranking Member Blunt, and the entire Subcommittee for this opportunity to provide comments on some of the most important programs to support and advance women's health in FY22. ACOG commends Congress for making great strides to support research and data collection that advance the health of women and families. Looking ahead, we urge you to appropriate:

—*Centers for Disease Control & Prevention (CDC):* At least $10 billion for the CDC, including $102.5 million for the Safe Motherhood Initiative, including $30 million for maternal mortality review committees and $30 million for perinatal quality collaboratives; and $250 million for public health surveillance;

—*National Institutes of Health (NIH):* $46.1 billion for the NIH, including at least $1.7 billion for Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and $50 million shared evenly between CDC and NIH, for research into firearm morbidity and mortality prevention;

—*Health Resources & Services Administration (HRSA):* $750 million for the Title V Maternal and Child Health Block Grant, including $15 million for the Alliance for Innovation on Maternal Health (AIM) within the Special Projects of Regional and National Significance (SPRANS); $10 million to expand depression screening and treatment for pregnant and postpartum women; and $5 million to establish, identify, and distribute clinicians in maternity care health professional target areas;

—*Office of Population Affairs (OPA):* $737 million for the Title X Family Planning Program; and

—$500 million for the Agency for Healthcare Research and Quality (AHRQ).

Safe Motherhood Initiative at CDC: The United States has the highest rate of maternal mortality and severe morbidity of any industrialized country. The Safe Motherhood Initiative at CDC works with state health departments to collect information on pregnancy-related deaths, supports maternal mortality review committees (MMRCs), tracks preterm births, and improves maternal outcomes through perinatal quality collaboratives. Important strides have been made as nearly every state either currently has, is in the process of implementing, or is making plans to develop a state MMRC. In addition, the CDC currently supports 13 perinatal quality collaboratives (PQCs), often considered the implementation arm of MMRCs. We must continue to build on this progress and improve maternal health outcomes. ACOG requests that you fund the Safe Motherhood Initiative at $102.5 million, including $30 million to help states expand or establish maternal mortality review committees, and $30 million to support state-based perinatal quality collaboratives in every state.

Women's Health Research at NIH: Women represent half of the US population. As such, conditions and diseases that are specific to women's health, or those that present differently in women than men, must be a priority for federally funded research. Women's health research is a central part of the research mission and portfolio of NICHD, and the Institute has achieved great success in advancing research on women's health throughout the life cycle; maternal, child, and family health; fetal development; reproductive biology; population health; and medical rehabilitation. With sufficient resources, NICHD can build upon existing initiatives to produce new insights and solutions to benefit women and families. ACOG supports an appropriation of $46.1 billion for the NIH in FY22, including at least $1.7 billion for NICHD.

Maternal Therapeutics at NIH: In the United States each year, more than 4 million women give birth and more than 3 million breastfeed. However, little is known about the effects of most drugs on the woman and her child. In 2015 as part of the 21st Century Cures Act (Sec. 2041 of P.L. 114–255), Congress created the Task Force on Research Specific to Pregnant Women and Lactating Women (PRGLAC) to advise the Secretary of HHS on gaps in knowledge and research on safe and effective therapies for pregnant and breastfeeding women. In August 2020, PRGLAC produced an implementation plan for each of the 15 recommendations made in 2018 to facilitate the inclusion of this population in clinical research. ACOG supports the implementation of these recommendations under the oversight of NICHD, working with other relevant NIH Institutes, the CDC, and the Food and Drug Administration, and urges Congress to express its continued support.

Title X Family Planning Program at OPA: Title X is the only federal program dedicated to providing family planning services for people with low incomes. For many individuals, particularly those who are low-income, uninsured, or adolescents, Title X is essential to their ability to affordably and confidentially obtain birth control, cancer screenings, STI tests and other basic care. Title X has been cut or flat-funded every year for the past decade. A significant investment is needed to support robust restoration of the program and ensure demand for services is met. ACOG requests $737 million for Title X in FY22 to ensure individuals in need have access

to evidence-based care. ACOG is pleased that the Biden administration has proposed to eliminate the 2019 Title X regulations that decreased access to health care services and disproportionately imposed barriers to care for Black, Latinx, and Indigenous communities. ACOG urges Congress to show its strong support for transparent, respectful, evidence-based, and comprehensive reproductive health care by funding this critical program.

Title V Maternal and Child Health Block Grant at HRSA: The Title V Maternal and Child Health (MCH) Block Grant at HRSA is the only federal program that exclusively focuses on improving the health of mothers and children. The Block Grant is a cost-effective, accountable, and flexible funding source used to address critical, pressing, and unique needs of maternal and child health populations in each state, territory and jurisdiction. Notably, through the SPRANS discretionary grant, the Block Grant supports the Alliance for Innovation on Maternal Health (AIM) program—a program that works with states and hospital systems to implement evidence-based best practices to improve maternal health outcomes and reduce rates of maternal mortality and severe maternal morbidity. For FY22, ACOG requests at least $750 million to respond to the increased demands placed on the Block Grant, including $15 million within SPRANS to support continued implementation of AIM.

Investing in Data and Quality at AHRQ: AHRQ is the federal agency with the sole purpose of improving health care quality. AHRQ produces data with the mission of making health care safer, higher quality, more accessible, equitable, and affordable. AHRQ works with HHS and other partners to ensure that the evidence improves patient safety. ACOG supports $500 million for AHRQ in FY22, which reflects the FY10 funding level for the agency adjusted for inflation and additional funding to respond to the pandemic.

Public Health Surveillance at CDC: Uniform, accurate, and comprehensive data is essential for addressing the rising rates of maternal mortality and severe maternal morbidity in the US. Unfortunately, the nation's public health data systems are antiquated, lack interoperability and data and reporting standards, and are in dire need of security updates. ACOG urges Congress to include a robust investment in public health surveillance, and requests funding to be used to modernize these systems to improve health. ACOG requests $250 million in FY22 for public health surveillance at CDC to implement advanced technologies and train the next generation of data scientists.

Firearm Morbidity and Mortality Prevention (CDC and NIH): In 2017, there were more than 39,000 U.S. firearm-related fatalities. Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes, smoking, or Sudden Infant Death Syndrome. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, and CDC research will be as critical to that effort as it was to these previous public health achievements. The foundation of a public health approach is rigorous research that can accurately quantify and describe the facets of an issue and identify opportunities for reducing its related morbidity and mortality. For FY22, ACOG requests $50 million, shared evenly between CDC and NIH, to conduct public health research into firearm morbidity and mortality prevention.

Diagnosing and Treating Maternal Depression (HRSA): About 1 in 5 women experience maternal depression, and ACOG recommends that all women be screened, yet barriers to accessing treatment remain. ACOG commends Congress for funding Sec. 10005 of P.L. 114–255 to support the establishment of a program at HRSA to expand depression screening and treatment for pregnant and postpartum individuals. ACOG urges you to fund the program at $10 million for FY22, a $5 million increase over FY21, and increase support for the maternal mental health hotline to $5 million.

Maternity Care Target Areas (HRSA): Major pockets of the U.S. do not have adequate access to needed maternity care, due to both a workforce shortage and maldistribution of clinicians. This disproportionately impacts access to obstetric care in rural communities. Maternity care shortages threaten the ability of pregnant individuals to receive timely prenatal and labor/delivery services. According to the latest available data, more than half of pregnant people living in rural areas reside more than 30-minutes by car from the nearest hospital offering perinatal services. Further, a 2019 study that analyzed severe maternal morbidity and mortality during childbirth hospitalizations among rural and urban residents found that when controlling for sociodemographic factors and clinical conditions, rural residents had a 9 percent greater probability of severe maternal morbidity and mortality, compared with urban residents.

The Improving Access to Maternity Care Act of 2018 (P.L. 115–320) requires HRSA to identify maternity care health professional target areas that are suffering from a shortage of maternity care clinicians, including obstetrician-gynecologists

and certified nurse-midwives, so that those participating in the National Health Service Corps can be placed in the communities most in need of their services. ACOG urges you to fulfill the President's request for $5 million in FY22 to implement the Improving Access to Maternity Care Act. Funding would be used to establish criteria for and identify maternity care health professional target areas, distribute maternity care health professionals to those areas, and collect and publish data on the availability and need for maternity care services within primary care health professional shortage areas.

Thank you again for the opportunity to submit our recommendations to the subcommittee, and for your commitment to improving women's health.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians (ACP) is pleased to submit the following statement for the record on its priorities, as funded under the U.S. Department of Health & Human Services, for Fiscal Year (FY) 2022. ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. As the Subcommittee begins deliberations on appropriations for FY2022, ACP is urging funding for the following proven programs to receive appropriations from the Subcommittee:

—Health Resources Services Administration (HRSA), $9.2 billion;
—Title VII, Section 747, Primary Care Training and Enhancement (PCTE), Health Resources and Services Administration (HRSA), $71 million;
—National Health Service Corps (NHSC), $860 million in total program funding;
—Agency for Healthcare Research and Quality (AHRQ), $500 million;
—Centers for Medicare and Medicaid Services (CMS), Program Operations for Federal Exchanges, $296.5 million;
—Centers for Disease Control and Prevention (CDC), $10 billion, Injury Prevention and Control, Firearm Injury and Mortality Prevention Research, $50 million; National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Social Determinants of Health program, $153 million;
—National Institutes of Health (NIH), $46.1 billion.

The United States is facing a shortage of physicians in key specialties, notably in general internal medicine and family medicine-the specialties that provide primary care to most adult and adolescent patients. Current projections indicate there will be a shortage of 21,400 to 55,200 primary care physicians by 2033. Without critical funding for vital workforce programs, this physician shortage will only grow worse. HRSA is responsible for improving access to health-care services for people who are uninsured, isolated or medically vulnerable. Without critical funding for vital workforce programs, this physician shortage will only grow worse. A strong primary care infrastructure is an essential part of any high-functioning healthcare system. A recent report by the National Academy of Sciences, calls on policymakers to increase our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience. Therefore, we urge the Subcommittee to provide $9.2 billion for HRSA programs for FY2022 to improve the care of medically underserved Americans by strengthening the health workforce.

The health professions' education programs, authorized under Title VII of the Public Health Service Act and administered through HRSA, support the training and education of health care providers to enhance the supply, diversity, and distribution of the health care workforce. Within the Title VII program, we urge the Subcommittee to fund the Section 747 PCTE program at $71 million, in order to maintain and expand the pipeline for individuals training in primary care. While the College appreciates the $10 million increase to the program in FY2018, ACP urges more funding because the Section 747 PCTE program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefitted from PCTE grants for primary care training in rural and underserved areas that have helped prepare physicians for a career in primary care.

The College urges at least $860 million in total program funding for the NHSC in FY2022. In FY2021, the NHSC received $120 million in discretionary funding to

expand and improve access to quality opioid and substance use disorder treatment in underserved areas, in addition to $310 million in mandatory funds which have been extended through FY2023. The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities across the country. In FY2020, with a projected field strength of over 14,000 primary care clinicians, NHSC members are providing culturally competent care to a target of almost 15 million patients at a targeted 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These funds would help maintain NHSC's field strength helping to address the health professionals' workforce shortage and growing maldistribution. There is overwhelming interest and demand for NHSC programs, and with more funding, the NHSC could fill more primary care clinician needs. In FY2016, there were 2,275 applications for the scholarship program, yet only 205 new awards were made. There were only 150 scholarship awards in FY2020. There were 7,203 applications for loan repayment and only 3,079 new awards in FY2016. Accordingly, ACP urges the subcommittee to double the NHSC's overall program funding to $860 million to meet this need and to sustain the American Rescue Plan Act's $800 million for the NHSC for when the pandemic subsides.

AHRQ is the leading public health service agency focused on health care quality. AHRQ's research provides the evidence-based information needed by consumers, clinicians, health plans, purchasers, and policymakers to make informed health care decisions. The College is dedicated to ensuring AHRQ's vital role in improving the quality of our nation's health and recommends a budget of $500 million, restoring the agency to its FY2010 enacted level adjusted for inflation. This amount will allow AHRQ to help providers help patients by making evidence-informed decisions, to fund research that serves as the evidence engine for much of the private sector's work to keep patients safe, and to make the healthcare more efficient by providing quality measures to health professionals.

ACP supports at least $296.5 million in discretionary funding for federal exchanges within CMS' Program Operations, which has been funded at $2.8 billion in FY2020. This funding would allow the federal government to continue administering the insurance marketplaces, as authorized by the Affordable Care Act, if a state has declined to establish an exchange that meets federal requirements. CMS now manages and operates some or all marketplace activities in over 30 states. Without these funds it will be much more difficult for the federal government to operate and manage a federally-facilitated exchange in those states, raising questions about where and how their residents would obtain and maintain coverage, especially with increased need for health coverage due to the COVID–19 pandemic.

The Center for Disease Control and Prevention's mission is to collaborate to create the expertise, information, and tools needed to protect their health-through health promotion, prevention of disease, injury, and disability, and preparedness for new health threats. ACP supports $10 billion overall for this mission, especially in light of the ongoing COVID–19 public health emergency (PHE). The College also supports $50 million for the CDC's Injury and Prevention Control to fund research on firearm Injury and mortality prevention research and support 10 to 20 multi-year studies to continue to continue to rebuild lost research capacity in this area. ACP greatly appreciates funding for this research in FY2020 and FY2021 after many years of no federal resources for researching the prevention of firearms-related injuries and deaths. The College also supports the administration's budget request of $153 million for the NCCDPHP to fund its Social Determinants of Health program. The PHE caused by the COVID–19 has highlighted the urgent need to collect racial, ethnic, and language preference demographic data on testing, infection, hospitalization, and mortality during a pandemic. These data should be shared with local, state, territorial, and tribal governments. Frequent, granular, and high-quality disaggregated demographic data are needed to fully understand the impact on racial and ethnic minority communities and better offer targeted care not only for COVID–19, but for health care overall.

Lastly, the College strongly supports $46.1 billion for NIH in FY2022 so the nation's medical research agency continues making important discoveries that treat and cure disease to improve health and save lives and that maintain the United States' standing as the world leader in medical and biomedical research.

The College greatly appreciates the support of the Subcommittee on these issues and looks forward to working with Congress on the FY2022 appropriations process.

[This statement was submitted by Jared Frost, Senior Associate, Legislative Affairs, American College of Physicians.]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee, on behalf of the more than 82,000 members of the American College of Surgeons (ACS), thank you for the opportunity to submit written testimony addressing fiscal year (FY) 2022 appropriations. The ACS is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and improve the quality of care for all surgical patients. ACS is dedicated to the ethical and competent practice of surgery. Its achievements have significantly influenced the course of scientific surgery in America and have established it as an important advocate for all surgical patients.

The ACS respectfully requests your consideration of the following priorities as the Subcommittee works through the annual appropriations process for FY 2022:

Military and Civilian Partnership for the Trauma Readiness Grant Program (MISSION ZERO)

In 2016, the National Academies of Science, Engineering, and Medicine (NASEM) released a report titled, "A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury." This report suggests that one in four military trauma deaths and one in five civilian trauma deaths could be prevented if advances in trauma care reach all injured patients. The report concludes that military and civilian integration is critical to saving lives both on the battlefield and at home, maintaining the nation's readiness and homeland security.

The MISSION ZERO Act was signed into law on June 24th, 2019 as part of S. 1279, the Pandemic and All Hazards Preparedness and Advancing Innovation (PAHPAI) Act (Public Law No:116–22). MISSION ZERO takes the recommendations of the NASEM report to create a grant program, within the U.S. Department of Health and Human Services (HHS), to cover the administrative costs of embedding military trauma professionals in civilian trauma centers. These military-civilian trauma care partnerships will allow military trauma care teams and providers to gain exposure to treating critically injured patients and increase readiness for when these units are deployed, further advancing trauma care and providing greater patient access.

By facilitating the implementation of military-civilian trauma partnerships, this program will preserve lessons learned from the battlefield, translate those lessons to civilian care, and ensure that service members maintain their readiness to deploy in the future. The ACS strongly supports the funding of MISSION ZERO at the authorized amount of $11.5 million for FY 2022.

Funding for Cancer Research and Prevention

The ACS Cancer Programs, including the Commission on Cancer (CoC), is dedicated to improving survival and quality of life for cancer patients through advocacy on issues pertaining to prevention and research. To continue the progress that has led to medical breakthroughs for treatment therapies for millions of cancer patients, the ACS supports the following funding increases for FY 2022.

To ensure a robust, long-term commitment to cancer research and prevention, Congress should increase the overall budget of the National Institutes of Health (NIH) to at least $46.111 billion including $7.609 billion for the National Cancer Institute (NCI). The ACS also urges the inclusion of $559 million for cancer programs at the Centers for Disease Control and Prevention (CDC), including $50 million for the National Comprehensive Cancer Control Program, and $70 million for the National Program of Cancer Registries (NPCR).

Firearm Morbidity and Mortality Prevention Research

According to the Centers for Disease Control and Prevention (CDC), there were more than 39,000 firearm-related fatalities in 2019, a measured increase over previous years. ACS believes this number can be reduced through federally funded firearms research. As with other injury prevention related efforts, public health research can play a role in reducing the number of firearm-related injuries and deaths.

Federally funded research from the perspective of public health has contributed to reductions in motor vehicle crashes, smoking, and Sudden Infant Death Syndrome (SIDS). ACS believes that a similar approach can provide necessary data to inform efforts to reduce firearm-related injuries and deaths. The ACS supports $50 million specifically for public health research into firearm morbidity and mortality prevention through the CDC for FY 2022.

Removal of Language in Section 510

Serious patient safety concerns arise if a patient's health record is mismatched or includes inaccurate or incomplete information, potentially resulting in missed allergies, medication interactions, or duplicate tests ordered. Unfortunately, there is no accurate or consistent way for surgeons to link patients to their health information across the continuum of care, due to long-standing federal statutory language. The language, located in Section 510 of the LHHS Appropriations bill, has prohibited HHS from spending any federal dollars to promulgate or adopt a Unique Patient Identifier, thereby hampering public-private sector collaborative efforts to advance a nationwide patient identification strategy that is cost-effective, scalable, secure, and prioritizes patient privacy.

Removing the language in Section 510 will provide HHS with the ability to evaluate a range of patient identification solutions and enable the agency to work with the private sector to explore potential challenges. ACS supports removal of Section 510 from the Labor-HHS appropriations bill that prohibits HHS from spending any federal dollars to promulgate or adopt patient identification strategies.

Thank you for your consideration of our requests. Please contact Amelia Suermann, ACS Congressional Lobbyist, at asuermann@facs.org if you have any questions or would like additional information.

PREPARED STATEMENT OF THE AMERICAN EDUCATIONAL RESEARCH ASSOCIATION

Chair Murray, Ranking Member Blunt, and Members of the Subcommittee, thank you for the opportunity to submit written testimony on behalf of the American Educational Research Association (AERA). AERA recommends that the Institute of Education Sciences (IES) within the Department of Education receive $737.47 million for FY 2022, aligned with the top line included in the president's budget request. This recommendation is also consistent with the request from the Friends of IES coalition, for which we are a leading member. In addition, AERA recommends the base funding level of $46.1 billion for the National Institutes of Health (NIH) in fiscal year 2022, in support of important research in the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the Office of Behavioral and Social Science Research (OBSSR).

AERA is the major national scientific association of 25,000 faculty, researchers, graduate students, and other distinguished professionals dedicated to advancing knowledge about education, encouraging scholarly inquiry related to education, and promoting the use of research to improve education and serve the public good. Our members, as well as state and federal policymakers and practitioners, rely on IES to provide and support reliable education statistics, data, research, and evaluations.

IES is the independent and nonpartisan statistics, research, and evaluation arm of the U.S. Department of Education charged with supporting and disseminating rigorous scientific evidence on which to ground education policy and practice. Located within the Department of Education to provide essential education data, statistics, and science to the Department, the federal government, and the nation, the mission of IES is analogous to other prominent federal research agencies such as the National Science Foundation and the National Institutes of Health.

We appreciate the increase to IES appropriations over the past few fiscal years and the funding provided in the American Rescue Plan Act, the latter of which will go toward needed resources in data and special education research to understand how schools will work to address learning gaps due to lost instructional time. Throughout the pandemic, IES has served as an important resource in providing information about distance learning; pursuing interventions to address socioemotional needs; and collecting salient data on schools offering remote, hybrid, and in-person learning. The increased demand for evidence-based programs since the onset of COVID–19 and the need to address potential learning recovery only further speaks to the priority importance of support for education research and statistics at IES to inform policy and practice.

We see numerous examples of bipartisan support for scientific research and evidence-based decision making. The Department of Education is implementing the provisions of the bipartisan Foundations of Evidence-Based Policymaking Act, which directs federal agencies to leverage data and evaluations to inform policy decisions. A bipartisan bill that has been introduced to inform the forthcoming reauthorization of the Workforce Investment and Opportunity Act (WIOA) would call for investment in research in adult education. The data and research infrastructure to build evidence for improving educational outcomes require additional funding necessitating action by your committee.

Since IES was created in 2002, it has made visible scientifically-based contributions to the progress of education that are used in classrooms across the country. For example, IES has funded research on multi-tiered systems of support, including positive behavior interventions and supports, that have been highlighted in the Department of Education's COVID–19 handbook to guide school reopening. Several webinars and resources produced by the Regional Educational Laboratories highlighting evidence-based practices for educators, school support staff, and school leaders are incorporated in the Safer Schools and Campuses Best Practices Clearinghouse. As the nation continues to emerge from the pandemic, this is a critical time to invest in education research to produce essential knowledge about teaching and learning across all levels of education as well as to identify lessons learned that can foster educational innovations.

States are increasingly seeking ways to determine the long-term impact of state policies, including in education, and they turn to information in their Statewide Longitudinal Data Systems (SLDS). Initially developed to help states measure accountability, data has transformed from a hammer to a flashlight, increasing understanding about student performance and teacher effectiveness. To date, IES has been unable to meet the state demand for SLDS grants. For the FY 2019 competition, 28 of 44 states that submitted applications received grants, although the average amount of grants was reduced by half compared with those awarded in FY 2015. Growing interest in using data from these systems, including an IES research competition encouraging the research use of these data for examining longitudinal impacts of state policies, show the importance of continuing investment in these data systems.

AERA also is concerned with the reduced staff capacity at IES, and I would like to draw particular attention to the decades-long staff attrition at the National Center for Education Statistics (NCES). As the second-oldest principal federal statistical agency in the United States, NCES provides objective, nonbiased data on a wide range of education indicators, including information on teacher salaries, the amount of loans taken out by undergraduate students, and the participation of students in English language learner programs. NCES staff are also responsible for the development and administration of the National Assessment of Educational Progress, detailing longitudinal trends in student achievement. In recognizing the need for NCES to produce accurate, reliable, and trustworthy data, we encourage the subcommittee to ensure that NCES and IES have the appropriate level of staff in order to effectively carry out their missions in the Program Management line.

In addition to IES, AERA recommends $46.1 billion for the National Institutes of Health (NIH) in fiscal year 2022 with proportional increases for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the Office of Behavioral and Social Science Research (OBSSR). NICHD supports research at the intersection of health and education, including ways to foster health literacy, potential influencers of family environments on child well-being and cognitive development, and interventions for students with learning disabilities who struggle with reading. Investment in NICHD will allow the institute to continue research to both increase understanding how best to support executive functioning, and to bolster the professional development of early career researchers. OBSSR plays an important role in coordinating and co-funding behavioral and social science research across NIH that contribute to the understanding of influences on health and interventions to improve health outcomes. OBSSR has long recognized the interdependence of education and health and in terms of prevention, intervention, and the health-risk consequences of a lack of or limited educational exposure.

Thank you for the opportunity to submit written testimony in support of $737 million for IES and $46.1 billion in base level funding for NIH in fiscal year 2022. AERA welcomes working with you and your subcommittee on strengthening investments in essential research, data, and statistics related to education and learning.

[This statement was submitted by Felice J. Levine, PhD, Executive Director, American Educational Research Association.]

PREPARED STATEMENT OF THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION

The American Foundation for Suicide Prevention (AFSP), the nation's largest nonprofit dedicated to saving lives and bringing hope to those effected by suicide is submitting testimony on behalf of our over 30 thousand volunteer Field Advocates nationwide. AFSP has Chapters in all 50 states and sponsors a variety of community-based programming across the country each year.

The following testimony outlines suicide in the United States and AFSP's recommendations to the Subcommittee for Fiscal Year 2022.

SUICIDE: A NATIONAL PUBLIC HEALTH CRISIS

Suicide is the second leading cause of death for ages 10–34 in the United States and in 2019 was the 10th leading cause of death.[1] Provisional 2020 suicide death data from the CDC show that deaths by suicide in the U.S. declined from 47,511 to 44,834 (5.6%) between 2019 and 2020.[2] Suicide reportedly moved from the tenth to the eleventh leading cause of death as COVID–19 became the third leading cause of death in 2020.[3] While the decreases in suicide deaths are promising and the curve may be beginning to shift downward, efforts must continue to be expanded and built upon to ensure there are mental health resources as the pandemic continues to shift and impact different populations disproportionately. Historically, suicide rates have initially gone down during some periods of wartime and other disasters and have shown mixed results during or after previous epidemics. Provisional 2020 data appear consistent with this trend. It is possible, though not pre-determined, that we could experience an increase in suicide risk as the immediate COVID–19 threat lessens and in the aftermath period if community cohesion diminishes and if less attention is paid to intentional social connections, proactive resilience and mental health self-care, and the importance at key times of engaging in mental health treatment and crisis care. Helping those who are struggling with basic needs can also mitigate suicide risk.

While provisional 2020 mortality data show a declining rate of suicide for the overall U.S. population, we do not yet have the full picture as to how this translates to geographic areas within states or specific populations. The pandemic has had a disproportionate impact on certain populations; there are concerning signals of increasing suicide rates in some non-White populations during the pandemic, e.g., in Maryland and Connecticut.[4] It may be a year or longer until data and research are available to understand the entire impact of COVID–19 on suicide.

Furthermore, during the COVID–19 pandemic, data show 50–70% of the population report elevations in experiences of depression, anxiety, loneliness, trauma, loss, grief and increased substance use.[5] Numerous studies have kept abreast of the nation's mental health experiences and suffering during the pandemic through various mechanisms such as the CDC Household Pulse Survey during COVID which has been surveying 60–90,000 Americans adults every 3–5 weeks during the pandemic. The portion of the American public experiencing anxiety, isolation, symptoms of depression, insomnia and increased substance use has been rising.

As the pandemic progressed during 2020, the proportion of respondents who reported detrimental effects on their mental health continued to rise—39% in May 2020 and 53% in July 2020. It was only until just recently, in March 2021, that we are seeing the first decreases in distress—8–10 percentage points—for depression and anxiety across age and demographic groups.[6] However, the CDC reported on June 18, 2021 there was a 51 percent rise in suspected suicide attempts among girls ages 12–17 from February 2021 to March 2021 compared to the same time period in 2019, prior to the pandemic.[7] While this does not mean that there was necessarily an uptick in suicide deaths, the statistic is certainly alarming, and we do not yet have race and ethnicity data for when this study was conducted.

RECOMMENDATIONS

As instances of suicidal ideation and attempts increase, funding and resources must meet the needs of those most at risk. Therefore, AFSP is advocating for Fiscal Year 2022 funding increases to ensure that communities are adequately prepared to respond to crisis, implement community-based programming for those most at risk, collect data to improve prevention, and to invest in research to meet patients where they are, in healthcare settings. We thank Chairwoman Murray and Ranking Member Blunt for the opportunity to share our below priorities.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The National Suicide Prevention Lifeline coordinates a network of over 180 crisis centers across the United States by providing 24/7 free and confidential suicide prevention and crisis intervention services for people in distress, their loved ones, and best practices for professionals. The Lifeline routes calls from anywhere in the coun-

[1] https://www.cdc.gov/injury/wisqars/index.html.
[2] https://jamanetwork.com/journals/jama/fullarticle/2778234?utm__source=newsletter&utm__medium=email&utm__campaign=newsletter__axiosvitals&stream=top.
[3] Ibid.
[4] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2774107.
[5] https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm.
[6] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.
[7] https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s__cid=mm7024e1__w.

try to a network of certified local crisis centers that can then link callers to local emergency, mental health, and social services resources. Last year, over 2.5 million calls were made to the Lifeline, resulting in longer wait times and a strain on local crisis centers. Additional funding is needed to ensure that the Lifeline is adequately equipped to handle increasing call and outreach volume.

We request at least $102 million for the National Suicide Prevention Lifeline, as included in the President's Fiscal Year 2022 Budget Request. Following passage of the National Suicide Hotline Designation Act in September 2020, the easily accessible 9–8–8 dialing code was designated to replace the Lifeline's current 1–800 number. 9–8–8 will be the new easy to remember and universal phone number for suicide prevention and mental health crisis by July 2022. This presents an urgent need to ensure that local crisis call centers and the national infrastructure for the Lifeline are prepared for the anticipated increase in calls and strain on an already overburdened system. Additional funding to the Lifeline would facilitate the development of a unified call center platform and data analytics, telecom costs for each contact and routing to local crisis centers, provision of specialized services at national back up centers for calls, chat, and text, targeted funding for call centers and national backup centers, multi-lingual assistance, quality assurance and training standards, and supporting partnership outreach. Based on an initial analysis from Vibrant Emotional Health, the current administrator of the Lifeline, year one implementation estimates for 988 could grow to as much as $240 million. It is expected that SAMHSA and the Department of Veterans Affairs (VA) will jointly release a final cost estimate report to Congress regarding Lifeline funding needs later in the summer of 2021 which will help better inform the critical resource needs that are urgently needed. We hope the Appropriations Committee will work with us to adequately address this critical resource, in Fiscal Year 2022 and beyond.

The Centers for Disease Control (CDC)

As the nation's leading health protection agency, it is a natural fit that the CDC expand their suicide prevention efforts. Through investing further in the CDC's new suicide prevention line, there is a more holistic approach to suicide prevention programming beyond the work that SAMHSA and the National Institutes of Health (NIH) are implementing, evaluating, and researching. There is a need to make strategic investments that will help save lives and reduce the suicide rate. Therefore, AFSP advocates for $36 million for Suicide Prevention initiatives at CDC's Center for Injury Prevention and Control. Created in Fiscal Year 2020, the Congress has generously provided $22 million for the program over the last two fiscal years. Enhanced funding in Fiscal Year 2022 will help expand these community-based grants into approximately 25 states. The grants are used to implement and evaluate a comprehensive public health approach to suicide prevention, with attention to vulnerable populations, such as Veterans, tribal and rural communities, LGBTQ, or homeless citizens. These groups account for a significant proportion of the suicide burden and have suicide rates greater than the general population. A key outcome of this funding is a 10% reduction in suicide and suicide attempts among vulnerable populations. Through these cooperative agreements, CDC aims to build a national program that will help reverse increasing suicide trends across our nation and contribute to the national goal of reducing suicide by 20% by 2025.

Data collection as it relates to suicide deaths is an important piece of preventing future deaths and implementing prevention strategies within our communities. AFSP advocates for a $10 million increase for the National Violent Death Reporting System (NVDRS) as included in the President's Fiscal Year 2022 Budget Request. NVDRS is the most comprehensive database on circumstances surrounding violent deaths in the U.S., including suicide. Since the program's inception in 2002, NVDRS has grown to a nationwide program with funding to support implementation in all 50 states and select territories. Yet, the current funding is not sufficient for long-term program success. States are clamoring for additional resources to address various implementation challenges and support investments in program infrastructure, as well as program growth and innovation. NVDRS stakeholder organizations support a funding level of $50 million by FY 2027 to strengthen the program.

National Institute of Mental Health

As the largest private funder of suicide prevention research in the US, AFSP continues to advocate for increased federal funding and prioritization of suicide prevention research. The National Institutes for Health and more specifically the National Institute of Mental Health (NIMH) play a key role in advancing the Nation's suicide prevention research priorities. AFSP encourages the continued implementation of the Prioritized Research Agenda for Suicide Prevention released by the National Action Alliance for Suicide Prevention, that is meant to advance the National Strategy

for Suicide Prevention. To note, more recently, in January 2021, there was a Surgeon Generals Call to Action to Implement the National Strategy for Suicide Prevention, which further outlines the six actions and associated strategies that will move the U.S. further towards implementation of the National Strategy. Overall imparting the need for increased federal investment in suicide prevention research and programmatic needs.

As the COVID–19 pandemic shifts, there is a need to ensure that when individuals are visiting the Emergency Department or their primary care physician that screening tools and resources meet them, so if they are in need of mental health and crisis services, they are able to receive comprehensive care. This is an especially prominent area for necessary research as, up to 45 percent of people who die by suicide visit their primary care physician in the month prior to their death.[8] AFSP recommends the following report language for Fiscal Year 2022, to place a special emphasis on the primary care setting, given the great number of Americans seeking mental health care from their primary care physician.

PROPOSED FISCAL YEAR 2022 REPORT LANGUAGE: SUICIDE PREVENTION

The Committee is encouraged that 2019 was the first year in two decades in which the suicide rate decreased. But death by suicide remains the tenth leading cause of death in the United States, and the Committee remains committed to providing the resources necessary to address this alarming crisis. The Committee commends NIMH for consistently expanding resources for suicide screening and prevention research over the last four fiscal years and strongly encourages the Institute to provide additional increases for this purpose in fiscal year 2022, with special emphasis on producing models that are interpretable, scalable, and practical for clinical implementation, including utilization of healthcare, education and criminal justice systems that serve populations at risk. In addition, the Committee encourages NIMH to prioritize research efforts related to primary care settings to evaluate suicide prevention interventions, strategies, and programs, including assessments of the effects of the COVID–19 epidemic. The Committee requests that NIMH provide an update on these efforts in the fiscal year 2023 Congressional Justification.

The American Foundation for Suicide Prevention is grateful for the Subcommittee's continued support of suicide prevention efforts and looks forward to additional conversations about the vital resources needed to help save lives and prevent suicide. Please do not hesitate to contact Natalie Tietjen, Manager of Federal Policy (ntietjen@afsp.org) on my staff with additional questions or clarifications.

[This statement was submitted by Laurel Stine, JD, MA, Senior Vice President, Public Policy, American Foundation for Suicide Prevention.]

PREPARED STATEMENT OF THE AMERICAN GASTROENTEROLOGICAL ASSOCIATION

NATIONAL CANCER INSTITUTE

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, I would like to start by thanking you for the opportunity to submit testimony on the U.S. Department of Health and Human Services (HHS) fiscal year (FY) 2022 appropriations bill. I am Dr. Fola May, and I am an associate professor of medicine at the University of California, Los Angeles, and researcher at the UCLA Center for Cancer Prevention Control Research (CPCR) and UCLA Kaiser Permanente Center for Health Equity. I am submitting testimony on behalf of the American Gastroenterological Association (AGA). The AGA was founded in 1897, and today, it has expanded its membership to include more than 16,000 professionals who are dedicated to the advancement of science, practice, and research in the field of gastroenterology. We want to first thank you for your ongoing bipartisan investment in the National Institutes of Health (NIH). We respectfully request the subcommittee to support our FY 2022 NIH funding recommendation of at least $46.111 billion, a $3.177 billion increase over the comparable FY 2021 funding level for the NIH, which would allow for the NIH's base budget to keep pace with the biomedical research and development price index of 2.3 % and allow meaningful growth of 5%. Additionally, we request report language to support research to better understand the impact of COVID–19 on colorectal cancer disparities.

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[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146379/#:~:text=A%20review%20of%20studies%20analyzing,the%20month%20before%20their%20death.&text=Only%2020%25%20saw%20a%20mental,10%20in%20the%20preceding%20month.

Colorectal Cancer Incidence

Colorectal cancer (CRC) remains the second leading cause of cancer deaths in the United States. The American Cancer Society (ACS)[1] estimates 149,500 new cases of CRC and 52,980 CRC-related deaths in the U.S. in 2021. The ACS 2021 cancer report also shows an emerging trend of CRC in a younger demographic; The data shows a 2% increase in CRC in individuals under 50 years.

CRC has a higher impact on communities of color. Specifically, Black, and Native American individuals have the highest incidence of CRC; Black Americans have the highest rate of CRC-related death, and Latinos have CRC screening rates far below White and Black Americans.[2]

COVID–19's Impact on CRC Screenings

Screening can prevent colorectal cancer deaths by detecting precancerous polyps early, allowing for early treatment and full recovery. Unfortunately, as with other health care services, the COVID–19 pandemic significantly reduced the volume of preventive screenings. According to a report,[3] CRC screenings were estimated to have dropped by 86% in the first few months of the pandemic and have not yet fully recovered.

With the drop in screenings, delay in diagnosis, lack of access to care, abandonment of care, interruption or alteration in treatment and job loss resulting in lapsed health insurance coverage etc., cancer mortality rates across numerous cancers have increased. The National Cancer Institute (NCI) estimates a 1% increase in deaths from breast and colon cancer over the next 10 years, which equates to an additional 10,000 deaths due to the pandemic's impact on screening and treatment.[4]

As communities across the U.S. fight the pandemic locally, community-based health care facilities that typically would offer cancer screenings and other preventative health services have reallocated their limited resources and shifted workforce deployment to address the pandemic. This reduction in cancer screening resources has heightened the ongoing health care access issues that impact vulnerable populations, and their worsening clinical outcomes. Specifically, racial, and ethnic minority communities, who, including before the pandemic, have lower rates of CRC screening and higher rates of incidence and mortality from CRC.

Health disparities and CRC

Colorectal cancer (CRC) during the pandemic places a spotlight on the health disparities and inequities stemming from social determinants of health that continue to plague medically underserved populations. COVID–19 cases, hospitalizations and deaths were highest among communities of color, especially those with comorbidities like obesity, diabetes, and asthma. Although screening rates are resuming, the rates in minority communities likely still lag due to access, financial, transportation and other socioeconomic factors exacerbated by the pandemic.

The NIH resources spent on COVID–19 and health disparities have been essential to better understand the long-term impact of the pandemic on the medically underserved population in the U.S. To improve CRC screening, prevention and treatment, AGA recognizes the continued need to collect systemic data on the short and long-term outcomes of COVID–19 and CRC disparities. Therefore, AGA urges the subcommittee to include the following report language that would allow NIH to continue its support of studies focused on CRC disparities heightened by the COVID–19 pandemic.

COVID–19 Pandemic Impact on Colorectal Cancer Disparities.—Given the impact that screening can have on reducing mortality and morbidity in colorectal cancer (CRC), the Committee encourages the NIH to study the impact of the COVID–19 pandemic on the incidence of CRC in minority communities. The committee is hopeful that such information will provide policymakers with a better understanding of the effects on minority communities and help develop strategies to address barriers to screening and reduce health inequities and cancer deaths.

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[1] American Cancer Society. Cancer Facts & Figures 2021. Atlanta: American Cancer Society; 2021. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf.

[2] Balzora, S., Issaka, R. B., Anyane-Yeboa, A., Gray, D. M., 2nd, & May, F. P. (2020). Impact of COVID–19 on colorectal cancer disparities and the way forward. Gastrointestinal endoscopy, 92(4), 946–950. https://doi.org/10.1016/j.gie.2020.06.042.

[3] EPIC Health Research Network. Delayed Cancer Screenings-A Second Look. Available at: https://ehrn.org/articles/delayed-cancer-screenings-a-second-look/. pdf. Accessed May 17, 2021.

[4] Sharpless, N. E. (2020). COVID–19 and cancer. https://tcjl.com/wp-content/uploads/2020/06/Science-COVID-19-and-Cancer-editorial-copy.pdf.

On behalf of AGA, its members, and the GI community, I would like to thank you for your consideration of this request. If you have any questions, please contact Kathleen Teixeira, Vice President of Government Affairs, at kteixeira@gastro.org.

[This statement was submitted by Dr. Fola May, MD, PhD, MPhil, Associate Professor of Medicine, University of California, Los Angeles.]

PREPARED STATEMENT OF THE AMERICAN GEOPHYSICAL UNION

The American Geophysical Union (AGU), a non-profit, non-partisan scientific society, appreciates the opportunity to submit testimony regarding the fiscal year (FY) 2022 appropriation for the National Institute of Environmental Health Sciences (NIEHS). AGU, on behalf of its community of 130,000 Earth and space scientists, respectfully requests that the 117th Congress appropriate $875 million for the NIEHS. AGU's appropriations request takes into consideration any previous budget cuts is driven by the need for significant investment in federal research and development to ensure that the U.S. remains at the forefront of research and innovation.[1]

Under the umbrella of the National Institutes of Health (NIH), the NIEHS conducts essential, innovative research that advances our understanding of the effects of environmental changes or exposures on human health and disease in the U.S. and across the globe. Through NIEHS research, policymakers have access to vital, unbiased science that is necessary for making informed decisions when addressing public health issues. A few examples of the NIEHS's invaluable work are provided below.

Improving Disaster Response, Reducing Health Impacts, & Preventing Future Harm

The NIH Disaster Research Response program, launched by the NIEHS and the National Library of Medicine, helps to address the ongoing need for time-sensitive research in the aftermath of disasters, such as hurricanes, wildfires, oil spills, and public health crises. Such research helps scientists, government agencies, and communities better understand immediate environmental exposures and injury risks, potential short-term and long-term health impacts, the effectiveness of health response efforts and environmental cleanup efforts, as well as factors affecting post-disaster recovery and resiliency to future events. To support timely gathering of the environmental and toxicology data needed, the program has readily available research protocols, data collections tools, and training resources.[2]

Increasing Knowledge of Health Effects Related to PFAS Exposure

The NIEHS continues to be at the forefront of research on perfluoroalkyl and polyfluoroalkyl substances (PFAS). A couple of years ago, at least 610 locations in 43 states were known to be affected by PFAS contamination, which included drinking water systems serving an estimated 19 million people.[3] Research into the possible health impacts of PFAS chemicals exposure has already unmasked many links to adverse health outcomes. For example, research has revealed that PFAS exposure may increase a woman's risk of pregnancy complications.[4] However, there is still much to understand regarding the effects of PFAS exposure, which is why the NIEHS continues to conduct research and award grants to external organizations across the nation.

Growing the Environmental Health Science Workforce

To further expand the world's understanding of environmental impacts on human health and disease and support interdisciplinary scientific research, the NIEHS provides training and educational opportunities for students of all ages-from the high school and undergraduate levels to graduate students and faculty. For example, the NIEHS Medical Student Research Fellowship program provides medical students an opportunity to train in environmental health-related research for a year at the

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[1] This amount of growth is recommended by the Innovation: An American Imperative statement, which was authored by nine large U.S. corporations and endorsed by over 500 leading industry, higher education, science, and engineering organizations from across the 50 states. https://innovation-imperative.herokuapp.com/index.html.

[2] See, NIH Disaster Research Response Program (DR2), https://dr2.nlm.nih.gov/.

[3] Based on data analysis by the Environmental Working Group and Northeastern University. Walker, B., (6 May 2019). Mapping the PFAS contamination crisis: New data show 610 sites in 43 states, EWG News and Analysis, https://www.ewg.org/news-and-analysis/2019/04/mapping-pfas-contamination-crisis-new-data-show-610-sites-43-states.

[4] Broadfoot, M., (February 2020). Replacement chemicals may put pregnancies at risk. Environmental Factor, NIEHS Newsletter, https://factor.niehs.nih.gov/2020/2/science-highlights/replacement/index.htm.

NIEHS.[5] The NIEHS also awards NIH Summer Research Experience Program (R25) grants that give high school and college students and science teachers an opportunity to gain valuable research experience at a higher education institution during the summer.[6]

CONCLUSION

At a time when our nation is recovering and has many pressing priorities that need to be addressed, the future of the U.S. will be strengthened by strong and sustained investments in the full scope of our research enterprise-including new, innovative research regarding the impact of environmental factors on human health generated by the NIEHS. AGU appreciates the Subcommittee's leadership in this area, as well as the opportunity to submit this testimony. Thank you for your thoughtful consideration of our request.

[This statement was submitted by Michael Villafranca, Senior Specialist, Science Policy & Government Relations.]

PREPARED STATEMENT OF THE AMERICAN GERIATRICS SOCIETY

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit this testimony. The AGS is a national non-profit organization of nearly 6,000 geriatrics healthcare professionals and basic and clinical researchers dedicated to improving the health, independence, and quality of life of all older Americans. As the Subcommittee works on its fiscal year (FY) 2021 Labor, Health and Human Services, and Related Agencies Appropriations Bill, we ask that you prioritize funding for the geriatrics education and training programs under Title VII of the Public Health Service (PHS) Act, and for aging research within the National Institutes of Health (NIH) and National Institute on Aging (NIA).

We are appreciative of your ongoing support of the Title VII Geriatrics Health Professions Programs at the Health Resources and Services Agency (HRSA), which includes the Geriatrics Workforce Enhancement Program (GWEP) and Geriatrics Academic Career Award (GACA) program. However, the AGS believes it is urgent that we increase the educational and training opportunities in geriatrics and gerontology and ensure that HRSA receives the funding expansion necessary for these critically important programs for the care and health of older adults.

We ask that the Subcommittee consider the following funding levels for these programs in FY 2022:

—At least $105.7 million to support the GWEP and GACA program (PHS Act Title VII, Sections 750 and 753(a))

—An increase of no less than $3.3 billion over the enacted FY 2021 level in the FY 2022 budget for total spending at NIH for current institutes and operations; a minimum increase of $500 million to invest in biomedical, behavioral, and social sciences aging research efforts across NIH; and a minimum increase of $289 million for research on Alzheimer's disease and related dementias over the enacted FY 2021 level in the FY 2022 budget

Sustained and enhanced federal investment in these initiatives is essential to delivering high-quality, better coordinated, efficient, and cost-effective care to our older Americans whose numbers are projected to increase dramatically in the coming years. According to the U.S. Census Bureau, the number of people age 65 and older is projected to more than double from 54.1 million today[1] to more than 94 million by 2060,[2] while those 85 and older is projected to more than triple from 6.4 million today to 19 million by 2060.[3] As our aging population increases, so too will the prevalence of diseases disproportionately affecting older people—most notably Alzheimer's disease and related dementias (including vascular, Lewy body, and frontotemporal dementia)—and the economic burden associated with these diseases.

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[5] See, NIEHS Medical Student Research Fellowships, https://www.niehs.nih.gov/careers/research/med-students/index.cfm.

[6] See, the NIH Summer Research Experience Programs (R25), https://www.niehs.nih.gov/research/supported/irt/summer_research/index.cfm.

[1] U.S. Census Bureau. 2019 American Community Survey 1–Year Estimates Subject Tables. Available at https://data.census.gov/cedsci/table?q=S0101&tid=ACSST1Y2019.S0101&hidePreview=false.

[2] U.S. Census Bureau. An Aging Nation: Projected Number of Children and Older Adults. Available at https://www.census.gov/library/visualizations/2018/comm/historic-first.html. Published March 13, 2018.

[3] Ibid.

To ensure that our nation is prepared to meet the unique healthcare needs of this rapidly growing population, we request that Congress provide additional investments necessary to expand and enhance the geriatrics workforce, which is an integral component of the primary care workforce, and to foster groundbreaking medical research.

PROGRAMS TO TRAIN GERIATRICS HEALTHCARE PROFESSIONALS

Geriatrics Workforce Enhancement Program and Geriatrics Academic Career Award Program (at least $105.7 million)

Our healthcare workforce receives little, if any, training in geriatric principles,[4] which leaves us ill-prepared to care for older Americans as health needs evolve, especially during the current COVID–19 public health emergency. With our nation continuing to face a severe shortage of geriatrics healthcare providers and academics with the expertise to train these providers, the AGS believes it is urgent that we increase the number of educational and training opportunities in geriatrics and gerontology. The requested increase in funding over FY 2021 levels would help ensure that HRSA receives the funding necessary to expand these critically important programs commensurate with the increasing need.

The GWEP is currently the only federal program designed to increase the number of providers, in a variety of disciplines, with the skills and training to care for older adults. The GWEP awardees educate and engage the broader frontline workforce, including family caregivers, and focus on opportunities to improve the quality of care delivered to older adults, particularly in underserved and rural areas. Due to GWEPs' partnerships with primary care and community-based organizations, GWEPs are uniquely positioned to rapidly address the needs of older adults and their caregivers. The GWEP was launched in 2015 by HRSA with 44 three-year grants provided to awardees in 29 states. In 2019, HRSA funded a second cohort of 48 GWEPs across 35 states and two territories (Guam and Puerto Rico) and provided extension grants to 15 former GWEP awardees.

The GACA program is an essential complement to the GWEP. GACAs ensure we can equip early-career clinician educators to become leaders in geriatrics education and research. It is the only federal program designed to increase the number of faculty with geriatrics expertise in a variety of disciplines. The program was eliminated in 2015 through a consolidation of several training programs. However, the program was reestablished in November 2018 when HRSA released a funding opportunity indicating their intention to fund 26 GACAs for four years starting September 1, 2019. Since 1998, original GACA recipients have trained as many as 65,000 colleagues in geriatrics expertise and have contributed to geriatrics education, research, and leadership across the U.S.

Most recently, the GWEPs and GACAs have been an asset for states as many states and localities grapple with the rollout of the COVID–19 vaccine and address vaccine hesitancy. GWEPs have been staffing call lines to assist older adults to register for the vaccine, advising local authorities on making the sign-up websites age-friendly, and working with health systems to participate in the rollout and outreach to vulnerable and hard-to-reach populations, preventing widening the health disparity gap exacerbated by the pandemic. Looking forward, these programs will be critical in providing assistance for proactive public health planning with their geriatrics expertise and knowledge of long-term care and can help ensure states and local governments have improved plans for older adults in disaster preparedness for future pandemics and natural disasters. Furthermore, as the U.S. population rapidly ages, access to a well-trained workforce and appropriate care for medically complex older adults is imperative to maintaining the health and quality of life for this growing segment of the nation's population.

To address this issue, we ask the Subcommittee to provide a FY 2022 appropriation of at least $105.7 million for the GWEP and GACA program. This increase in funding over FY 2021 levels would help ensure that HRSA receives the funding necessary to carry these critically important programs forward. Additional funding will also allow HRSA to expand the number of GWEPs and GACAs and move towards closing the current geographic and demographic gaps in geriatrics workforce training. As laid out in President Biden's American Jobs Plan, the infrastructure of care

[4] Only 3 percent of medical students take even one class in geriatric medicine and fewer than 1 percent of RNs, pharmacists, physician assistances and physical therapists are certified in geriatrics or gerontology. Yet estimates are that by 2030, 3.5 million additional health care professionals and direct-care workers will be needed to care for older adults. 2018 Issue Brief, Eldercare Workforce Alliance, Available at https://eldercareworkforce.org/wp-content/uploads/2018/03/GWEP__OnePager__v2.pdf.

in the U.S. needs substantial investments so that access to long-term services and supports is expanded while the healthcare workforce is adequately supported and prepared to care for us all as we age.

RESEARCH FUNDING INITIATIVES

National Institutes of Health/National Institute on Aging (additional $500 million for aging research efforts and a minimum increase of $289 million for Alzheimer's disease and related dementias research)

The institutes that make up the NIH, and specifically the NIA, lead the national scientific effort to understand the nature of aging and to extend the healthy, active years of life. As a member of the Friends of the NIA (FoNIA), a broad-based coalition of aging, disease, research, and patient groups committed to the advancement of medical research that affects millions of older Americans—the AGS urges you to include an increase of at least $500 million in the FY 2022 budget for biomedical, behavioral, and social sciences aging research efforts across NIH and a minimum increase of $289 million for research on Alzheimer's disease and related dementias over the enacted FY 2021 level.

The federal government spends a significant and increasing amount of funds on healthcare costs associated with age-related diseases. By 2050, for example, the number of people age 65 and older affected by dementia is estimated to reach 12.7 million cases—nearly double the number in 2021—and is projected to cost $355 billion which does not include the $256.7 billion in unpaid caregiving by family and friends.[5] Further, chronic diseases related to aging, such as diabetes, heart disease, and cancer continue to afflict 80 percent of people age 65 and older[6] and account for more than 75 percent of Medicare and other federal health expenditures.[7] Continued and increased federal investments in scientific research will ensure that the NIH and NIA have the resources to conduct groundbreaking research related to the aging process, foster the development of research and clinical scientists in aging, provide research resources, and communicate information about aging and advances in research on aging.

Additionally, the AGS supports no less than a $3.3 billion increase over the enacted FY 2021 level in the FY 2022 budget for total spending at NIH for current institutes and operations. We believe that a meaningful increase in NIH-wide funding, in combination with aging and increase in prevalence of diseases, will be essential to sustain the research needed to make progress in addressing chronic disease, Alzheimer's disease, and related dementias that disproportionately affect older people.

Strong support such as yours will help ensure that every older American is able to receive high-quality care. We greatly appreciate the Subcommittee for the opportunity to submit this testimony.

PREPARED STATEMENT OF THE AMERICAN HEART ASSOCIATION

Chair Murray, Ranking Member Blunt, and members of the subcommittee, thank you for the opportunity to testify today. My name is Dr. Keith Churchwell, and I am President of Yale New Haven Hospital and a volunteer for the American Heart Association where I Chair the National Advocacy Committee. As a cardiologist for over 25 years, a hospital administrator who has worked in a number of roles across the country to improve and expand care for our patients, along with more than 20 years as a volunteer with the American Heart Association, I understand firsthand the burden of heart disease as the world's leading killer, and the importance of research and prevention.

I'm pleased to testify today on two specific opportunities to improve Americans' health in the fiscal year (FY) 2022 Labor, Health and Human Services, Education and Related Agencies appropriations bill. I respectfully request you work over the next three years to triple the budget of the Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to $3.75 billion. I also respectfully request that, within this increase,

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[5] Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. Alzheimers Dement. 2021; 17(3):327–406. https://doi.org/10.1002/alz.12328.

[6] National Prevention Council. Healthy Aging in Action: Advancing the National Prevention Strategy. Available at https://www.cdc.gov/aging/pdf/healthy-aging-in-action508.pdf. Published November 2016.

[7] Erdem, E, Prada, SI, Haffer, SC. Medicare Payments: How Much Do Chronic Conditions Matter?. Medicare & Medicaid Research Review. 2013;3(2). http://dx.doi.org/10.5600/mmrr.003.02.b02.

you provide $20 million in new funding to expand an existing COVID–19 Cardiovascular Disease (CVD) registry in partnership with NCCDPHP.

FUNDING FOR THE NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Chronic diseases represent 7 of the 10 leading causes of death,[1] and account for 90% of the nation's $3.8 trillion in annual health care costs.[2] Heart disease remains the number one cause of death in the United States, with approximately 655,000 individuals in America dying from heart disease each year. In 2018, stroke accounted for about 1 of every 19 deaths in the United States.[3] Chronic diseases are best managed by consistent access to health care services and treatments, for example, a 10% increase in hypertension treatment could prevent 14,000 deaths each year.[4]

My positions at Yale New Haven Hospital and the American Heart Association have provided me a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions, and I can personally attest to the importance of cardiovascular disease prevention programs specifically supported by the CDC. The burden of chronic disease is growing faster than our ability to ameliorate the growth, putting an increasing strain on the health care system, health care costs, our productivity, educational outcomes, military readiness and well-being.[5] Current funding for CDC NCCDPHP falls far short of what is needed to prevent chronic disease, slow its spread, and protect patients. The COVID–19 pandemic has only exacerbated these challenges, and the underfunding of NCCDPHP has made the nation more vulnerable to the pandemic. For example:

—COVID–19 poses elevated health risks for people with chronic conditions-including severe illness and death-and may lead to heart failure, stroke, kidney failure, chronic lung disease, blood pressure abnormalities, neurological conditions, and other long-term health complications in people who have survived the virus.

—Deaths from ischemic heart disease and hypertensive diseases in the United States increased during the COVID–19 pandemic, while globally, COVID–19 was associated with significant disruptions in cardiovascular disease testing, diagnosis and timely treatment.[6]

After more than a decade of stagnant funding, a congressional commitment to triple CDC NCCDPHP's budget over the next three fiscal years is long overdue to respond to the increasing threat chronic diseases pose to Americans. A robust investment, appropriate to the magnitude of the problem, will allow CDC NCCDPHP to fulfill its mission by expanding the current patchwork of existing programs nationwide and by implementing new programs to address emerging health challenges, including the emerging chronic disease cohort of COVID–19 "long-haulers."

COVID–19 CARDIOVASCULAR DISEASE REGISTRY

Since the start of the pandemic, researchers have made great advances in our knowledge of the disease characteristics, associated health risks, and appropriate mitigation and treatment of COVID–19. We have learned that COVID–19 has a disproportionate impact on patients who face endemic inequities, such as lower paying and hourly wage jobs deemed "essential." Unstable or unsafe housing and decreased availability of health care and insurance coverage also add to that impact. COVID–19 has laid bare the health inequities that have long affected communities of color in the United States as the burden of COVID–19 remains higher among African

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[1] Centers for Disease Control and Prevention. Leading causes of death. Morality in the United States, 2019. Accessed online February 17, 2021.

[2] Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Santa Monica, CA: Rand Corp.; 2017 and Martin AB, Hartman M, Lassman D, Catlin A. National Health Care Spending In 2019: Steady Growth for The Fourth Consecutive Year. Health Aff. 2020;40(1):1–11.

[3] Heart Disease and Stroke Statistics-2021 Update: A Report From the American Heart Association https://www.ahajournals.org/doi/10.1161/CIR.0000000000000950.

[4] Call to Action: Urgent Challenges in Cardiovascular Disease: A Presidential Advisory From the American Heart Association, Mark McClellan, MD, PhD, Nancy Brown, BS, Robert M. Califf, MD, MACC, John J. Warner, MD, FAHA (2019) https://www.ahajournals.org/doi/10.1161/CIR.0000000000000652.

[5] Heidenreich PA, Trogdon JG, Khavjou OA, et al. Forecasting the future of cardiovascular disease in the United States: a policy statement from the American Heart Association. Circulation. 2011;123:933–944.

[6] COVID–19 Pandemic Indirectly Disrupted Health Disease Care. American College of Cardiology. January 11, 2021. Accessed online February 17, 2021.

Americans, American Indians/Alaska Natives, Hispanics/Latinos, and Asian Americans and Pacific Islanders, compared with whites.[7]

In April 2020, the American Heart Association launched the COVID–19 Cardiovascular Disease (CVD) Registry, which captures data on hospitalized COVID–19 patients' clinical characteristics, medications, treatments, biomarkers and outcomes, and focuses on real-time, granular data from acute care hospitals to better help clinicians and researchers understand and provide feedback on how to best treat COVID–19 patients. To date, the COVID–19 CVD Registry includes nearly 170 hospitals and health systems across 35 states, reporting more than 40,000 adult COVID–19 patient records. Approximately 50 percent of the registry patients identify as Black or Hispanic, making the registry representative of communities disproportionately affected by the pandemic.

According to initial research based on the COVID–19 CVD registry data, obese patients experienced some of the worst outcomes of all patients hospitalized with COVID–19, including increased risks for blood clots, the need for breathing assistance and dialysis, and death. Research has already found that patients with COVID–19 who are hospitalized with a stroke have worse outcomes than stroke patients without COVID–19. We are also now beginning to understand the long-term health implications of COVID–19 in the population referred to as "long-haulers." These patients have an increased risk of developing myocarditis, or inflammation of the heart, that can lead to heart failure, thromboembolic disease or blood clots, and other lingering health conditions.

Additional funding is needed to expand the registry infrastructure nationally to enhance geographic representation for both urban and rural hospitals. A more robust, representative registry will provide clinicians and researchers with the tools to advance our understanding of post-COVID syndromes and provide much needed insights into this new chronic disease cohort. Once expanded, this registry also will provide an at-the-ready, adaptable infrastructure to respond to new and emerging public health threats. Therefore, within the new funding provided to the CDC NCCDPHP, the American Heart Association respectfully requests that the Committee provide $20 million to expand the COVID–19 CVD registry nationwide to include hundreds more hospitals-including sole community hospitals, safety net hospitals, and disproportionate share hospitals-and support CDC NCCDPHP in collecting, curating, analyzing, and publishing the registry data.

As the pandemic has demonstrated, chronic diseases and infectious diseases are inextricably linked. Therefore, any efforts to improve pandemic preparedness and prevent the spread of infectious disease must also include efforts to prevent chronic disease, address health disparities, and ultimately, improve underlying health and wellness for all. A significant investment in NCCDPHP is essential to that goal. We must make these investments if we are to preserve health, well-being, productivity, and longevity for all in America. I thank you for the opportunity to offer my perspective today, and for your continued leadership.

Prepared Statement of the American Indian Higher Education Consortium

On behalf of the nation's 37 Tribal Colleges and Universities (TCUs), which collectively are the American Indian Higher Education Consortium (AIHEC), we thank you for the opportunity to share our FY 2022 funding requests. The following is a list of recommendations including Department, program, and funding requests.

Department of Education—Office of Postsecondary Education

—Strengthening Institutions HEA Title III—Part A (Sec. 316): $53,080,000 (discretionary)

—Perkins Career and Technical Education Programs (Sec. 117): $15,000,000

Department of Education—Office of Indian Education

—Indian Education Professional Development Program: $20,000,000

Department of Health and Human Services

—Administration for Children and Families/Office of Head Start
TCU-Head Start Partnership Program: $8,000,000 in existing funds

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[7] Lopez L, Hart LH, Katz MH. Racial and Ethnic Health Disparities Related to COVID–19. JAMA. 2021;325(8):719–720. https://jamanetwork.com/journals/jama/fullarticle/2775687.

Tribal Colleges and Universities: Serving Students Across Indian Country and Rural America

Currently, 37 TCUs operate more than 75 campuses and sites in 16 states. TCU geographic boundaries encompass 80 percent of American Indian reservations and federal Indian trust lands. American Indian and Alaska Native (AI/AN) TCU students represent more than 230 federally recognized Tribes and hail from more than 30 states. Nearly 80 percent of these students receive federal financial aid, and nearly half are first generation students. In total, TCUs serve over 160,000 American Indians, Alaska Natives, and other rural residents each year through a wide variety of academic and community-based programs. Funding cuts of any amount to even one TCU program would force TCUs to scale back vital programs and services that students rely on to complete degree and certificate programs needed to succeed in their chosen career paths. Any reduction in funding will threaten TCU accreditation status and will further stretch overtaxed faculty and staff or result in cuts to faculty and staff. The following are justifications for TCU FY 2022 funding requests.

U.S. DEPARTMENT OF EDUCATION

Strengthening Tribal Colleges (HEA Title III—Part A—Section 316): TCUs urge the Subcommittee to provide $53,080,0000 for the Strengthening Tribal Colleges program (HEA Title III-Part A). The Strengthening Institutions HEA Title III program for TCUs (Section 316) is specifically designed to address the critical, unmet needs of AI/AN students and their communities. Through this program, TCUs are able to provide student support services, Native language preservation, basic upkeep of campus buildings and infrastructure, critical campus expansion, enterprise management systems, faculty for core courses, and other necessary elements for a quality educational experience. The Strengthening Institutions program provides formula-based aid to 35 TCUs through two funding sources: Part A discretionary funding (FY 2021, $38.08 million) and Part F mandatory funding (FY 2020, $28.2 million). In 2019, TCUs feared losing nearly half of Title III funding with the anticipated expiration of Part F funding. Fortunately, the "Fostering Undergraduate Talent by Unlocking Resources to Education Act (P.L. 116–91) was signed into law on December 20, 2019, permanently authorizing Part F mandatory funding at $30 million for TCUs. Part A and Part F of the Title III program are essential in supporting institutional development and student services. AIHEC strongly supports the President Budget Request for FY 2022, and we urge the Subcommittee to fund these programs at the President's requested levels: HEA Title III Part A (discretionary funding) at $53,080,000 and HEA Title III Part F (mandatory funding) at $89,000,000.

Carl D. Perkins Career and Technical Education Programs

Tribally Controlled Postsecondary Career and Technical Institutions: AIHEC requests $15,000,000 to fund grants under Sec. 117 of the Perkins Act. Carl D. Perkins Career and Technical Education Act provides a competitively awarded grant opportunity for Tribally chartered career and technical institutions (Sec.117), which provide critical workforce development and job creation, education, and training programs to AI/ANs from Tribes and communities with some of the highest unemployment rates in the nation.

Native American Career and Technical Education Program (NACTEP): NACTEP (Sec. 116) reserves 1.25 percent of appropriated funding to support AI/AN career and technical programs. The TCUs strongly urge the Subcommittee to continue to support NACTEP, which is vital to the continuation of career and technical education programs offered at TCUs that provide job training and certifications to remote reservation communities.

Office of Indian Education

Indian Education Professional Development Program: AIHEC requests $20,000,000 for grants to TCUs and other institutions of higher education. The Indian Education Professional Development Program, administered by the Office of Indian Education at the U.S. Department of Education, provides grants to institutions of higher education to prepare and train AI/ANs to serve as teachers and school administrators at elementary and secondary schools. There is a growing teacher shortage across the country, especially in urban and rural communities with high AI/AN populations, where teacher recruitment and retention pose unique challenges. In communities with teacher shortages, existing obstacles to student success such as inadequate facilities and limited broadband are further compounded by overcrowded classrooms. Targeted resources like the Indian Education Professional Development Program help address this shortage and ensure that AI/AN students receive high-quality elementary and secondary education.

Report Language Needed: Funding for two distinct activities is provided under the "Special Programs for Indian Children" account: the Indian Education Professional Develop Program and Native Youth Community Projects. Despite increased funding in 2016 to the overall account, increases were only provided to Native Youth Community Projects; the Indian Education Professional Development Program did not receive increased funding. In FY 2020, the Special Programs for Indian Children account received $67,993,000, of which $13,668,000 was allocated for the Indian Education Professional Development Program. AIHEC requests specific report language in order to increase funding for the Indian Education Professional Development Program, at a minimum of $20,000,000 in FY 2022.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS

Administration for Children and Families—Office of Head Start: Tribal Colleges and Universities Head Start Partnership Program: AIHEC requests $8,000,000 for the TCU-Head Start Partnership program. The TCU-Head Start Partnership program was re-established with the designation of $4,000,000 within the FY 2020 LHHS appropriations bill and continued with $4,000,000 within the FY 2021 LHHS appropriations bill. TCUs have had marked success in training early childhood educators and Head Start teachers who are urgently needed across Indian Country. In 2017, 74.5 percent of Head Start teachers nationwide held a bachelor's degree as required by federal law; but less than 42 percent of Head Start teachers met the requirement in Indian Country (Head Start Region 11); only 70 percent of workers in Region 11 met the associate-level requirements or were enrolled in associate's degree programs, compared to 90 percent nationally. TCUs are the most cost-effective way for filling this gap. From 2000 to 2007, the U.S. Department of Health and Human Services provided modest funding for the TCU-Head Start Program (42 U.S.C. 9843g), which helped TCUs build capacity in early childhood education by providing scholarships and stipends for Indian Head Start teachers and teacher aides to enroll in TCU early childhood/elementary education programs. Before the program ended in 2007 (ironically, the same year that Congress specifically authorized the program in the reauthorization of the Head Start Act), TCUs had trained more than 400 Head Start workers and teachers, many of whom have since left for higher paying jobs in elementary schools. Today, TCUs such as Salish Kootenai College (Pablo, MT) are providing culturally based early childhood education free of charge to local Head Start professionals. In Michigan, Bay Mills Community College provides online education programming for $50/credit to Head Start staff nationwide. However, many Head Start programs in Indian Country are paying far more for other sources to provide training. With the restoration and continuation of this modestly funded program, TCUs can aid in building an early childhood education workforce to better serve the education needs of AI/AN children.

Substance Abuse and Mental Health Services Administration (SAMHSA)

NEW Tribal College and University Centers for Excellence in Behavioral Health/Substance Abuse Prevention: AIHEC requests $10,000,000 to establish this program. The goal of the TCU Centers of Excellence program, similar to an existing SAMHSA program for HBCUs, is to grow a highly skilled and culturally competent AI/AN behavioral health workforce by developing an apprenticeship-based network of TCUs and partners from the health industry and local, Tribal, state, and regional providers. The TCU Centers of Excellence would share best practices in curriculum development, program implementation, and apprenticeships; recruit students to careers in behavioral health fields to address mental and substance use disorders; provide job training in behavioral health fields; and prepare students to earn credentials in behavioral health fields. The TCU Centers of Excellence would emphasize education, awareness, workforce training, and preparation for careers in mental and substance use treatment, prevention, and research, including addressing opioid abuse prevention, opioid use disorder treatment, serious mental illness, and suicide prevention.

CONCLUSION

Tribal Colleges and Universities provide thousands of AI/AN students with access to high-quality, culturally appropriate, postsecondary education opportunities, including critical early childhood education and behavioral health programs. The modest federal investment in TCUs has paid great dividends in terms of employment, education, and economic development. We ask you to renew your commitment to help move our students and communities toward self-sufficiency and request your full consideration of our FY 2022 appropriations requests. Thank you.

PREPARED STATEMENT OF THE AMERICAN LIVER FOUNDATION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—Provide the National Institutes of Health (NIH) with at least $46.1 billion and provide individual NIH Institutes and Centers, such as NIDDK, NIMHD, and NCI with proportional discretionary increases.
  —Please support establishment and adequate funding for the new Advanced Research Projects Agency for Health (ARPA–H) at NIH as proposed in the Administration's Budget Request to Congress to facilitate robust scientific progress on cancers and other conditions.
—Provide the Centers for Disease Control and Prevention (CDC) with at least $10 billion to facilitate timely public health efforts along with proportional increases for CDC Centers and Divisions, such as NCCDPHP and NCHHSTP.
  —Please provide $134 million for the Division of Viral Hepatitis at CDC.
  —Please provide $120 million for the Opioid and Infectious Diseases Program at CDC.
  —Please provide $5 million for the new Chronic Disease Education and Awareness Program at CDC.
—Provide the Health Resources and Services Administration (HRSA) with a funding level of at least $9.2 billion and ensure that the agency has sufficient resources to enhance organ donation through awareness activities and partnerships.
—Please support timely committee recommendations on liver diseases and health disparities, NASH/NAFLD, organ donation, and related areas.

Thank you for the opportunity to submit testimony on behalf of the American Liver Foundation (ALF) and the liver disease community. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, we extend our thanks for the significant investments in HHS, particularly NIH, provided over recent years. Please maintain this commitment and further enhances support for public health programs as you work on appropriations for Fiscal Year (FY) 2022. Thank you again.

ABOUT THE FOUNDATION

Founded in 1976, the American Liver Foundation (ALF) is the nation's largest patient advocacy organization for people with liver disease. ALF reaches more than?4?million individuals each year with health information, education and support services via its national office and an active online presence. Recognized as a trusted voice for liver disease patients, ALF also operates a national toll-free helpline (800–GO–LIVER), educates patients, policymakers and the public, and provides grants to early-career researchers to help find a cure for all liver diseases. ALF is celebrating more than 40 years of turning patients into survivors. For more information about ALF, please visit liverfoundation.org.

LIVER FACTS

The liver is one of the body's largest organs, performing hundreds of functions daily including, removal of harmful substances from the blood, digestion of fat, and storing of energy. Non-alcoholic fatty liver disease (NAFLD), hepatitis C, and heavy alcohol consumption are the most common causes of chronic liver disease or cirrhosis (severe liver damage) in the U.S. Approximately 30% of adults and 3–10% of children have excessive fat in the liver or NAFLD which can lead to a severe liver disease called non-alcoholic steatohepatitis (NASH). Approximately 4.4 million Americans are living with Hepatitis B or C but most do not know they are infected. More than 2 million Americans are living with alcohol related liver disease. Approximately 5.5 million Americans are living with chronic liver disease or cirrhosis. Vaccinations for hepatitis A and B and treatments for hepatitis C are helping to change the course of this chronic life altering disease for the patient community.

CDC CHRONIC DISEASE EDUCATION & AWARENESS PROGRAM

Thank you for establishing the CDC Chronic Disease Education & Awareness Program in FY 2021 and providing $1.5 million in initial support. Many patient organizations seek valuable collaborations with CDC that can directly impact patients and improve public health. A few contemporary examples include raising awareness of NASH/NAFLD, and sharing public health information that can slow or stop the progression of various liver conditions into liver cancer. This new program provides a

competitive mechanism that allows CDC to award meritorious cooperative agreements on an annual basis. Since there is tremendous demand in this area, and no shortage of quality opportunities for CDC, we ask that funding be systematically increased with $5 million provided for FY 2022.

ORGAN DONATION

Consistently, the number of organs available for transplantation on an annual basis amounts to only a fraction of the number of patients on the transplant list. Compounding this situation is the fact that fatty liver disease affects a large and growing number of individuals and makes livers unavailable for transplantation. Another complicating factor is the fact that the rationing of cures for hepatitis ensures that many patients who could otherwise be healthy end up on the transplant list too and arbitrarily deny available organs to other patients facing a variety of life-threatening illnesses. Please promote organ donation and otherwise work to ensure Medicaid and other patients impacted by hepatitis receive curative therapy when medically appropriate.

THE OPIOID EPIDEMIC

CDC has dubbed opioids and the infectious diseases that arrive in the wake of the opioid crisis a "dual epidemic". This epidemic has been further fueled by the well-documents rise in opioid abuse during the COVID–19 pandemic. Due to the ongoing increase in rates of injection drug use, CDC recently identified a 400% increase in rates of hepatitis C among 20—29 year olds an 300% increase among 30—39 year olds. A few years ago, the elimination initiative was established at CDC, and the current funding level is $13 million. We ask that this allocation be systematically increased along with the annual funding for the Division of Viral Hepatitis to ensure CDC has adequate resources to make progress.

COVID–19 AND LIVER DISEASES

There is a growing body of work focused on COVID–19's impact on the liver and persistent impacts for COVID "long haulers". We appreciate that a well-resourced NIH and public health response can continue to advance research in this critical area. Moreover, in regards to vaccination, please note that the American Association for the Study of Liver Diseases (AASLD) recommends that providers advocate for prioritizing patients with compensated or decompensated cirrhosis or liver cancer, patients receiving immunosuppression such as SOT recipients, and living liver donors for COVID–19 vaccination based upon local health policies, protocols, and vaccine availability.

NASH BILL OF RIGHTS

Nonalcoholic steatohepatitis or NASH is liver inflammation and damage caused by a buildup of fat in the liver. The prevalence of NASH has been rising and innovative treatment options have been coming to market along with improved healthcare. To better serve patients, ALF crafted a NASH Patient Bill of Rights that provides critical information on non-invasive testing options and coordinating multidisciplinary healthcare. The Foundation looks forward to working with the U.S. Public Health Services to disseminate critical information about NASH to patients and providers.

PATIENT PERSPECTIVES

(Alison).—Alison is now a healthy 25-year-old from Trumbull, Connecticut, only five years ago she was near death. Alison had been suffering for most of her life with primary sclerosing cholangitis (PSC), a condition that left her in need of a life-saving liver transplant. On October 19th, 2009, Alison began her new life when her transplant was successfully performed at Yale-New Haven Hospital. Further complications ensued. Alison needed three additional surgeries to ensure her health and that of her new liver. Today, she is healthy.

(Kevin).—In May 2007, a medical team at New York Columbia Presbyterian Hospital conducted its first living donor liver transplant surgery on a bile duct cancer patient. The patient was Kevin, my younger brother. I was the living donor. The transplant worked, but Kevin had to endure multiple follow-up surgeries to address a bile leakage that would not stop. But now, over ten years later, he has long since healed and doing great. We were lucky. And we know it. Despite advances in medical and surgical science, the demand for organs continues to vastly exceed the number of donors. Here, in New York, only 27% of people age 18 and over have enrolled in the New York State Donate Life Registry. But every ten minutes another person

is added to the national transplant waiting list. We need to encourage more people to sign up to donate organs.

(David).—In October 2014 my mother Geraldine passed away after a very brief and completely unexpected battle with late-stage NASH. They call NASH the "silent killer" and in Mom's case it was certainly true; she was never diagnosed with any form of liver disease at all before NASH. We had noticed some yellowing of her eyes and convinced her to go to the doctor about a month earlier, but it took time to get an appointment with a specialist, who checked her into a hospital upon the visit. I founded NASHAWARE.com to help raise awareness and educate others. If I can help even a few people it will all be worth it. But I still want to do much more.

[This statement was submitted by Lorraine Stiehl, Chief Executive Officer, American Liver Foundation.]

PREPARED STATEMENT OF THE AMERICAN LUNG ASSOCIATION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

$10 billion for the Centers for Disease Control and Prevention (CDC)

—National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)
Provide $3.75 billion for NCCDPHP
—Provide $310 million for CDC's Office of Smoking and Health (OSH)
—Provide $5 million for CDC's Chronic Disease Education and Awareness Program

—National Immunization Program at CDC's National Center for Immunization and Respiratory Diseases (NCIRD)
Provide $1.13 billion for NCIRD

—National Center for Environmental Health (NCEH)
Provide $322 million for NCEH
—Provide $110 million for CDC's Climate and Health Program
—Provide $35 million for CDC's National Asthma Control Program (NACP)

$46.1 billion for the National Institutes of Health (NIH)

—Provide $3.94 billion for the National Heart, Lung, and Blood Institute
—Support establishment of, and adequate funding for, the new Advanced Research Projects Agency for Health (ARPA–H) at NIH

The American Lung Association is the leading public health organization working to save lives by improving lung health and preventing lung disease through education, advocacy and research. Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the subcommittee, we extend our thanks for the significant investments in the Department of Health and Human Service (HHS), including the robust response to the COVID–19 pandemic. Please maintain this commitment and further enhance support for public health programs as you work on appropriations for Fiscal Year (FY) 2022. The American Lung Association also asks for your leadership in opposing all policy riders that would weaken key lung health protections.

The COVID–19 pandemic has underscored the need for significant and sustained investments in our nation's public health infrastructure, especially at CDC. For years, the Lung Association has requested for robust CDC funding. Unfortunately, funding for CDC has remained stagnant, and the failure to adequately invest has become evident during the public health emergency that has taken the lives of over a half a million people in the US. We ask that CDC funding be increased to at least $10 billion for fiscal year 2022. This funding must be in addition to, not in lieu of, emergency funds to respond to the current pandemic.

The COVID–19 pandemic has also highlighted the importance of preventing and managing chronic lung conditions. Individuals living with certain lung diseases and people who smoke are among the most at risk for severe illness from COVID–19. Research also shows that long-term exposure to air pollution leads to worse COVID–19 outcomes. The Lung Association recognizes the tremendous challenges Congress has faced in responding to the pandemic and appreciates all that it has done thus far. Continued investment in CDC programs that help smokers quit; promote asthma control; support prevention and treatment of lung and other chronic diseases,

including chronic obstructive pulmonary disorder (COPD) and lung cancer; and prepare for and respond to the health impacts created by a warming climate is vital.

The American Lung Association strongly supports substantial federal investments in key public health and biomedical research activities, especially at CDC and NIH, respectively. For FY22, the Lung Association encourages Congress to take a balanced approach in its increases for these vital agencies and urges Congress to make significant investments in public health programs at CDC.

Provide $10 billion for the Centers for Disease Control and Prevention (CDC): The nation is relying on CDC more than ever before. CDC is faced with unprecedented challenges and responsibilities, especially in the respiratory space. Consequently, the American Lung Association strongly supports the CDC Coalition's request of $10 billion for CDC for FY22 and sustained, robust and predictable funding moving forward annually.

Provide $3.75 billion for National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP): In 2019, COPD was one of seven chronic diseases included in the top 10 causes of death in the United States. Chronic diseases can be prevented and/or managed through supportive public health interventions including tobacco prevention and cessation; however, they continue to be a major problem in the United States. Over 90% of the nation's $3.8 trillion in annual health care costs result from chronic diseases. The American Lung Association strongly supports tripling the NCCDPHP budget over three years (FY22–FY24). Such funding will allow NCCDPHP to fulfill its mission by expanding the current patchwork of existing programs to all jurisdictions nationwide and by implementing new efforts to address health challenges currently without programs, including the chronic disease cohort of COVID–19 "long-haulers." It will also enable a significant investment in CDC's Social Determinants of Health (SDOH) program, which seeks to work with communities to identify and remedy SDOH.

Provide $310 million for CDC's Office of Smoking and Health (OSH): One in four high school students continues to use at least one tobacco product. OSH is the lead federal agency for tobacco prevention and control. The American Lung Association is appreciative of the $7.5 million increase in funding for OSH in FY21 and asks for an additional $72.5 million for FY22. The additional funding will be used to continue to address the e-cigarette pandemic, to enhance the "Tips from Former Smokers" campaign so that it can be run year-round, to invest in youth prevention efforts and to work to eliminate health inequities among racial, ethnic, sexual, rural and socio-economic groups.

Provide $5 million for CDC's Chronic Disease Education and Awareness Program: Far too many individuals in the United States have or are at risk of potentially devastating chronic diseases without knowing. COPD is one of the leading causes of death and disability in the United States. Approximately 16 million people in the United States have COPD, and millions more remain undiagnosed. Given this significant gap in knowledge, the Lung Association greatly appreciates the creation and funding of the Chronic Disease Education and Awareness competitive grant program at CDC in FY21. In FY22, the Lung Association asks for this program to be increased to $5 million to continue the momentum and allow CDC to expand its work with stakeholders to respond to chronic diseases, such as COPD, that do not have standalone programs.

Provide $110 million for CDC's Climate and Health Program: CDC's Climate and Health Program is the only HHS program devoted to identifying the risks and developing effective responses to the health impacts of climate change (which include worsening air pollution; diseases that emerge in new areas; stronger and longer heat waves; and more frequent and severe droughts and wildfires) and provides guidance to states in adaptation. Currently, projects in 16 states and two city health departments develop and implement health adaptation plans and address gaps in critical public health functions and services. Unfortunately, the level of investment thus far has been insufficient for this program to reach its full, possibly lifesaving, potential. The President's budget requests $110 million, which would allow CDC to implement a 50-state climate and health program.

Provide $35 million for CDC's National Asthma Control Program (NACP): It is estimated that 24.8 million Americans currently have asthma, of whom 5.5 million are children. The NACP tracks asthma prevalence promotes asthma control and prevention and builds capacity in states. This program has been highly effective: asthma mortality rates have decreased despite the rate of asthma increasing. Additional funding would allow approximately four to five additional states beyond the current 25 states and localities to be funded to implement these lifesaving programs.

Provide $1.13 billion for the National Immunization Program at CDC's National Center for Immunization and Respiratory Diseases (NCIRD): The success of the nation's vaccination programs has enabled many individuals to forget about the impact

of many vaccine preventable diseases, such as polio, that once wreaked havoc. The COVID–19 pandemic, however, has provided a stark reminder of the need and significance of vaccines and a robust national vaccination program. The National Immunization Program must receive strong and sustained funding. The Lung Association asks for $1.13 billion for NCIRD to enhance COVID19 vaccinations, bolster the nation's immunization infrastructure and address any gaps in routine immunizations that may have emerged as a result of the pandemic.

Provide $46.1 billion for the National Institutes of Health (NIH): The Lung Association supports increased funding for NIH research on the prevention, diagnosis, treatment and cures for tobacco use and all lung diseases including lung cancer, asthma, COPD, pulmonary fibrosis, influenza and tuberculosis. The Lung Association also supports robust funding increases for the individual institutes within NIH, recognizing the need for research funding increases to ensure the pace of research is maintained across NIH. Lastly, the Lung Association urges increased funding for lung cancer research in addition to the Cancer Moonshot and the All of Us Program.

Thank you for your consideration of our recommendations. Below please find a vignette demonstrating the importance of CDC programs.

SHARON L. FROM OKLAHOMA: LUNG CANCER & COVID–19 SURVIVOR

"I now live with cancer. I am not a cancer patient; I am a patient who has cancer."

Sharon was diagnosed with Stage 4 lung cancer in October 2015. After six rounds of aggressive chemotherapy, followed by another two rounds shortly thereafter, Sharon is currently six years out from her diagnosis and living without the need for additional treatment. This past year, Sharon became one of the over 32 million individuals in the United States diagnosed with COVID–19.

"I can't emphasize how important funding for the CDC is. Having had COVID, it is even more important, but it has always been important to me."

Sharon and husband tenaciously fought to quit smoking, her husband with the help of a CDC-funded quitline, and they were ultimately successful in doing so. From her experiences, Sharon believes that public health programs are critical to raising awareness about lung cancer prevention and increasing tobacco cessation.

"What the CDC does with smoking cessation is vitally important, so people don't end up like me, thinking they have 14 months to live and watching every plan they have for growing old with their husband flash before their eyes. It is vitally important. Public health is important for everybody. You either pay for it now, or you pay for it at the end. And it always costs more at the back end than now."

MICHIGAN ASTHMA PREVENTION AND CONTROL PROGRAM (MIAPCP)

Michigan is one of the 23 states that receive funding through the National Asthma Control Program (NACP). Through funding from CDC, Michigan was able to create the Asthma Initiative of Michigan website, www.GetAsthmaHelp.org, which enables access to a plethora of resources for those struggling with asthma. The MiAPCP has also worked to facilitate and support Managing Asthma Through Case-Management in Homes (MATCH) throughout parts of Michigan with the highest burden of asthma. Through MATCH programs, individuals can benefit from home visits, an environmental assessment, access to a certified asthma educator, and a physician care conference. As a result, Michigan saw a 60% decrease in asthma-related emergency room visits, 82% decrease in hospitalizations and a 58% decrease in the number of children who missed one or more school days due to asthma.

"Interventions and policy efforts by our program that impact asthma care and environments cannot be sustained without CDC's support."

—John Dowling, Lead Asthma Coordinator of the MiAPCP

Most recently, MiAPCP launched a cohesive effort to improve asthma surveillance and data collection.

[This statement was submitted by Harold P. Wimmer, National President and CEO, American Lung Association.]

PREPARED STATEMENT OF THE AMERICAN MASSAGE THERAPY ASSOCIATION

The American Massage Therapy Association (AMTA) appreciates the opportunity to submit written testimony for the record to the Senate Subcommittee on Labor, Health and Human Services, and Education Subcommittee in support of continued robust funding in FY 2022 for the National Center for Complementary and Integrative Health (NCCIH) within the National Institutes of Health (NIH) as well as for

suggested report language for both NCCIH as well as the Centers for Disease Control (CDC).

Established in 1943 and numbering over 95,00 members, AMTA works to advance the massage therapy profession through the promotion of fair and consistent licensing of massage therapists in all states, public education on the benefits of massage therapy, and support of research to advance knowledge about massage therapy. Massage therapists are currently licensed in 46 states and the District of Columbia.

We appreciate and acknowledge the Committee's ongoing support for massage therapy, including past report language urging the adoption of recommendations from the groundbreaking and widely supported 2019 HHS final report from the Pain Management Best Practices Task Force (Task Force). Unfortunately, most recommendations from that task force—including those that support inclusion of massage therapy and other integrative and complementary health treatments for pain—have still not been adopted.

COVID–19 has exacerbated the already existing public health crisis of acute and chronic pain from delayed access to health care, as well as a rise in substance abuse and overreliance on opioids. We encourage the Committee to include report language in the FY 2022 bill that focuses on the need for greater public awareness on treatment options for pain that include complementary and integrative approaches such as massage therapy. We request the Committee to direct NIH to coordinate with the DoD and VA to launch a much-needed public awareness campaign about these non-opioid treatment options and to widely disseminate the Task Force recommendations to health care providers and public health stakeholders. Last, we request the Committee's continued support to direct all relevant HHS agencies to update their pain management practices to reflect the Task Force recommendations, including those that support massage therapy.

We also support the inclusion of report language accompanying the FY 2022 bill that would direct the CDC to collect and publish population research data that provides a comprehensive assessment of the nature of pain management, who is affected by pain, and direct and indirect costs to society related to pain.

Over recent years, research continues to increase support for massage therapy, which has thus increased policymakers' awareness of the benefits of massage therapy as a non-pharmacologic alternative to opioid use to manage pain. As noted above, massage is specifically addressed throughout the 2019 Task Force report and is even included in the Task Force "Pain Management Toolbox" as an example of a treatment modality that should be considered as part of an overall integrative and collaborative care model to ensure optimal patient outcomes. https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. NCCIH notes the value of massage therapy for a wide variety of health conditions involving both acute and chronic pain, including low back pain, neck and shoulder pain, symptoms and side effects associated with certain cancers, fibromyalgia, HIV/AIDS, among others.

In addition to NIH, massage therapy is supported by the American College of Physicians and The Joint Commission. Massage is currently utilized in many nationally renowned hospitals and other institutions, such as the Mayo Clinic, M.D. Anderson Cancer Center, Duke Integrative Medicine, the Cleveland Clinic, and Memorial Sloan Kettering Cancer Center. Finally, CMS includes massage therapy provided by a state licensed massage therapist as a supplemental benefit for pain management in Medicare Advantage plans, and massage is also a covered benefit for our nation's veterans and active-duty military personnel.

Despite the demonstrated value and efficacy of massage therapy through research, we know that more needs to be done. As recently as last August, a national survey of 1,581 people with pain indicated that massage therapy is the most desired treatment for pain (at 48.4%, followed by pain physician at 32.9% and acupuncture at 29%), but unfortunately a majority of those surveyed indicated that cost prevented them accessing massage therapy. This underscores the disconnect between the best practices that already exist in pain management and those that are realistically available to patients, due to cost and lack of 3rd party insurance coverage, as well as insufficient provider awareness of the benefits of massage and other complementary therapies.

For over 30 years, the Massage Therapy Foundation (MTF) a 501(c) (3) organization, working with AMTA, has provided over $1 million in research grants studying the science behind therapeutic massage. This seed money has funded needed research on a wide range of topics including: the benefits of massage therapy for pediatric populations, patients with heart failure, and those with muscle atrophy, among others. Many of these efforts have been specifically designed to include racially diverse and underserved populations.

We know that massage therapy can improve health outcomes and is also among the most cost-effective therapies that can save health care expenditures in the long

run. Massage therapy demonstrably reduces or mitigates reliance on opioids to address pain. Massage therapy can serve as a 'portal' to increase patient involvement in other important health activities, e.g. research shows that patients who obtain massage are more likely to be able to move better, and thus engage in other physician-prescribed activities such as corrective exercise programs.

We encourage a sustained and robust finding stream for NIH and NCCIH that supports the role of integrative therapies to help mitigate opioid abuse and misuse, and which will enable continued advancements in the use of non-pharmacologic therapies such as massage.

Thank you for your consideration, and AMTA would be happy to provide more information as needed.

Sincerely,

James Specker, AMTA Director, Industry and Government Relations at jspecker@amtamassage.org.

PREPARED STATEMENT OF THE AMERICAN NATIONAL RED CROSS AND THE UNITED NATIONS FOUNDATION

Chairwoman Patty Murray, Ranking Member Roy Blunt, and Members of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, the American Red Cross and the United Nations Foundation appreciate the opportunity to submit testimony. We are writing to request that Congress invest $60 million for CDC's global measles and rubella elimination efforts for fiscal year 2022.

The American Red Cross and United Nations Foundation recognize the leadership that Congress has shown in funding CDC in prior years and urge Congress to protect the CDC's funding necessary for their global measles elimination activities for FY2022 at $60 million, which is part of the overall Global Immunization Division line.

COVID–19 ENVIRONMENT

COVID–19 has had an unprecedented impact on global immunization programs. As of June 1st twenty-three measles and rubella vaccination campaigns that were scheduled for 2020 continue to be postponed as a result of the COVID–19 pandemic, leaving an estimated one hundred and thirty-five million children unvaccinated and vulnerable to the diseases. This growing immunity gap is creating a looming cliff in global public health, as social distancing measures are lowered, the measles virus will quickly spread amongst unvaccinated individuals and communities. Because the measles virus is one of the most transmissible human viruses—with each infectious person capable of infecting as many as 18 unvaccinated individuals—a drastic increase in measles outbreaks around the world is anticipated. Failing to close these immunity gaps will leave millions of children at risk and will compromise U.S. global health security by disrupting economies, trade, and country stability, and increasing the likelihood of the virus infecting U.S. communities. Investments that will quickly close these global immunity gaps will help to ensure that gains made in reducing maternal and child mortality and morbidity are maintained, and that the global health infrastructure established through these investments is preserved and strengthened. Among other benefits, this global health architecture is vital to protecting global health security. Measles investments have established networks of laboratories around the world capable of processing diagnostics, and has bolstered the global public health workforce of trained professionals and volunteers who are often the first responders during health crises. During the pandemic, for instance, these assets and infrastructure investments were pivoted to detect and test cases of COVID–19, giving vulnerable countries a head start in their pandemic response. With this context in mind, we respectfully provide the following justification for continued robust investment in CDC's global measles and rubella elimination efforts.

WHY MEASLES AND RUBELLA?

U.S. leadership has saved the lives of 25.5 million children between 2000 and 2019, with the Measles & Rubella Initiative driving measles deaths down by 62%.

Measles is a highly contagious disease that can cause blindness, swelling of the brain, and death. Nine out of ten people who are not immune to measles will contract the disease if they come into contact with a contagious person, and there are long-term damages to the immune system for those who contract the virus. The rubella virus is a leading infectious cause of birth defects in the world despite availability of an affordable, effective vaccine since 1969. Every day, roughly 567 children still die of measles-related complications. When rubella occurs early in a pregnancy,

it can cause miscarriages, stillbirths, or a constellation of severe birth defects as part of congenital rubella syndrome (CRS) that can impact vision, hearing, heart health, overall development. Each year roughly 100,000 babies are born with CRS despite the preventable nature of the disease.

Since 2000, measles vaccines have been the single greatest contribution in reducing preventable child deaths globally. We have had safe and effective vaccines against both rubella and measles for over 50 years, but unfortunately vaccination rates globally have stagnated for over a decade.

DOMESTIC IMPLICATIONS

In the U.S., measles control measures have been strengthened, and endemic transmission of measles cases has been eliminated since 2000 and rubella in 2002. However, importations of measles cases into this country continue to occur each year. In 2019, for example, the U.S. reported 1,282 cases of measles in 32 states, the largest number of cases since 1992. Major outbreaks in New York and Washington state have been linked to importation of the disease by unvaccinated U.S. residents returning from trips to Israel and Ukraine. Controlling measles and rubella around the world reduces the likelihood of similar disease importations in the future.

Responding to measles outbreaks is resource intensive and costly for health systems, including in the U.S. In a literature review that included 10 studies on measles outbreaks from 2001 to 2018 in the U.S., researchers estimated the cost per case to range from about $7,000 to $76,000 and the total cost per outbreak ranged from $10,000 to $1 million. A recent study of a 72-case outbreak in the U.S. cost local public health and government authorities an estimated $3.4 million for response activities, medical costs, and productivity losses.

THE MEASLES & RUBELLA INITIATIVE

The Measles & Rubella Initiative (M&RI)—which includes the American Red Cross, CDC, UNICEF, the United Nations Foundation, and WHO, all working in collaboration with Gavi, the Vaccine Alliance as well as the Bill & Melinda Gates Foundation—supports countries to prevent, identify, and respond to measles outbreaks through key interventions like surveillance, supplementary vaccination campaigns, and emergency response.

M&RI has achieved outstanding results by helping to vaccinate nearly 3 billion individuals in over 90 countries since 2001, saving the lives of more than 25.5 million children. In part due to M&RI, global measles mortality has dropped 62%, from an estimated 545,000 deaths in 2000 to an approximately 207,000 in 2019 (the latest year for which data is available), mostly children under the age of five. During this same period, measles deaths in Africa fell by 57%.

Despite these gains, we continue to see unfortunate and preventable deaths and complications due to both measles and rubella. In 2019, every day approximately 567 children died of measles-related complications. These deaths could have been prevented with a safe, effective, and inexpensive vaccine that is typically available for less than $2 USD in lower income countries, which protects against both measles and rubella.

Thanks to M&RI leadership, most measles vaccination campaigns have been able to reach more than 90% of their target populations. Countries recognize the opportunity that measles vaccination campaigns provide in reaching mothers and young children and integrating the campaigns with other life-saving health interventions. These include administering vitamin A, which is crucial for preventing blindness in under nourished children; de-worming medicine to reduce malnutrition; doses of oral polio vaccines; distributing insecticide treated bed nets to help prevent malaria and screening for malnutrition. The provision of multiple child health interventions during a single campaign is far less expensive than delivering the interventions separately and has a far greater impact on a child's health.

In addition to the lifesaving benefits of the measles-rubella vaccine, immunization makes sound economic sense. A 2016 Johns Hopkins University study compared the costs for vaccinating against 10 disease antigens in 94 low- and middle-income countries between 2011–2020 versus the costs for estimated treatments of unimmunized individuals during the same period. Their findings show, on average, every $1 invested in these 10 immunizations produces $44 in savings in healthcare costs, lost wages, and economic productivity. The return on investment for measles immunization was found to be the greatest with $58 saved for every $1 invested.

Securing sufficient funding for measles and rubella-elimination activities both globally and nationally is critical. The decrease in donor funds available at a global level to support measles and rubella elimination activities makes increased political

commitment and country ownership of the activities critical for achieving and sustaining the goal of increasing measles vaccination coverage to 95%. Implementation of timely measles and rubella vaccination campaigns is increasingly dependent upon countries funding these activities locally, which can be challenging under such downward financial pressure.

If such challenges are not addressed, the remarkable gains made since 2000 will be lost and a major resurgence in measles death and disability will occur. The combined factors of a highly contagious disease, growing immunity gaps exacerbated by COVID–19 disruptions, and our highly interconnected world means measles is poised to spread quickly, with devastating results that could even threaten countries that have already eliminated the disease. The threat of importation of measles was one of the reasons that the Global Health Security Agenda has selected measles as an important indicator of whether a country's routine immunization system is able to effectively reach and vaccinate all its children.

THE ROLE OF CDC IN GLOBAL MEASLES MORTALITY REDUCTION

Since FY 2001, Congress has generously provided funding to protect children and their families from the threat of measles and rubella in developing countries, thereby also protecting the U.S. population from the threat of measles importations. Funding for measles and rubella globally has remained level since FY 2010 at $50 million dollars. The COVID–19 pandemic has gravely disrupted immunization systems around the world, leaving millions of children vulnerable to measles and other vaccine-preventable diseases. We must quickly "catch up" vaccination coverage rates to reach unvaccinated populations and prevent devastating measles outbreaks. The CDC plays an essential role within this space by providing support for vaccination programs and surveillance to detect outbreaks early and stop them at their source. An increase in resources for these and other critical activities provided by the CDC are needed to prevent needless childhood deaths around the globe.

In 2019, thanks in part to U.S. funding, M&RI supported 62 immunization campaigns in 53 countries, resulting in the vaccination of nearly 203 million children. Funding for CDC permitted the provision of technical support to Ministries of Health that included: 1) planning, monitoring, and evaluating large-scale measles vaccination campaigns; 2) conducting epidemiological investigations and laboratory surveillance of measles outbreaks; 3) CDC's Global Measles Reference Laboratory serving as the leading worldwide reference laboratory for measles and rubella; and 4) conducting operations research to guide cost-effective and high-quality measles and rubella elimination programs.

Since FY10, the CDC's measles and rubella elimination program has been funded at approximately $50 million. In FY 2022, the American Red Cross and United Nations Foundation respectfully request an increase of $10 million to raise funding to $60 million. This investment will allow CDC to help countries to close the immunization gap created by COVID–19, safeguard the progress made over the last decade and protect Americans by preventing measles cases and deaths in the U.S. The CDC Global Immunization Division, through which the Measles & Rubella Initiative is funded, has been highly effective and we strongly support fully funding this work. All the programs funded through the Global Immunization Division budget line also help to build stronger health systems. We respectfully request $60 million for CDC's measles elimination activities, as part of the overall funding for the entire Global Immunization Division account in FY2022.

Thank you for the opportunity to submit testimony, and for your continued commitment to ending preventable death and disability from measles and rubella.

[This statement was submitted by Koby J. Langley, Senior Vice President, International Services and Service to the Armed Forces, American National Red Cross and Peter Yeo, Senior Vice President, United Nations Foundation.]

PREPARED STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA), representing the interests of the nation's 4.2 million registered nurses, thanks Chair Murray, Ranking Member Blunt, and the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies for the opportunity to provide written testimony for Fiscal Year (FY) 2022.

ANA is committed to advancing the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect

nurses and the public. ANA is at the forefront of improving quality of health for all.

NURSING WORKFORCE AND HEALTH EQUITY

Investments in the Title VIII Nursing Workforce Development Programs are essential to ensuring nurses and nursing students have the resources to tackle our nation's health care needs, remain on the frontlines of the COVID–19 pandemic, and be prepared for the public health challenges of the future. Funding for Title VIII has become even more crucial during the pandemic, as these programs connect patients with high-quality nursing care in community health centers, hospitals, long-term care facilities, local and state health departments, schools, workplaces, and patients' homes.

ANA believes there are multiple policy levers to eliminate or reduce health disparities. Our Principles for Health System Transformation [1] call for expanded access to care through universal coverage and other steps to improve the quality and affordability of health care. We also believe policymakers must consider and account for an adequate health care workforce of the future. The nursing workforce, in particular, can play a tremendous role in efforts to create a more equitable health care system. Nurses provide the type of care and coordination that can help people manage their chronic conditions, including links to community resources they need to be healthy. Registered nurses and advanced practice registered nurses are often the backbone of health care delivery in rural and underserved areas, providing access to primary care, maternity care, and prevention. These roles should be strengthened through meaningful reforms.

Expanding the minority health care workforce would be one of the most meaningful steps we could take to improve access and health care in African American population groups. We know that positive patient experience and trust in health care providers can be powerful drivers of health outcomes. The National Sample Survey of Registered Nurses recently reported an increase in the minority nursing workforce between 2008 and 2018.[2] This is encouraging, but there is a long way to go. An increased funding in minority nursing education, to develop a workforce that is more reflective of the patient population would be a first step in the right direction.

ANA is a member of the Nursing Community Coalition which is comprised of 63 national nursing organizations who collectively represent the cross section of education, research, practice, and regulation within the nursing profession. Together, we respectfully request supporting at least $530 million for the Nursing Workforce Development Programs (authorized under Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] and administered by HRSA) in FY 2022.

PUBLIC HEALTH INFRASTRUCTURE

The nation's public health infrastructure and workforce have been underfunded for decades, and we have witnessed the highlighted impacts of this chronic underfunding throughout the COVID–19 public health emergency. Federal funds for state, local, and tribal public health preparedness shrunk from $940 million in 2002 to $675 million in 2019.[3] During the same time period, hospital emergency preparedness was cut by nearly fifty percent, from $515 million in 2004 to $265 million in 2019. This has resulted in a loss of 55,000 public health workers since 2008. The current COVID–19 public health emergency has underscored that our nation must be better equipped with preparedness and response personnel, measures and processes. A robust public health infrastructure and workforce is not only important during the time of crisis, but generally to address the overall health and well-being of our population.

The public health nursing workforce touches every aspect of health care and community well-being. Unfortunately, we can only imagine how different the coronavirus response would have been had greater federal public health infrastructure investment afforded availability of sufficient numbers of nurses and other public health personnel in areas of the greatest need. Nurses could have played an enhanced role in encouraging and administering COVID–19 tests in high-risk populations, conducting contact tracing at an effective pace, educating the public about vaccine safety and all facets of COVID–19 prevention and mitigation, informing

[1] https://www.nursingworld.org/4afd6b/globalassets/practiceandpolicy/health-policy/principles-healthsystemtransformation.pdf.

[2] https://bhw.hrsa.gov/data-research/access-data-tools/national-sample-survey-registered-nurses.

[3] https://www.tfah.org/wp-content/uploads/2020/04/TFAH2020PublicHealthFunding.pdf.

school opening protocols, and collecting data for feedback to pandemic response efforts.

MENTAL HEALTH

Nurses, particularly those early in their career, continue to feel exhausted and overwhelmed. According to the findings of an American Nurses Foundation survey of nearly 13,000 nurses, 51 percent of nurses surveyed continue to feel exhausted and 43 percent report feeling overwhelmed. A breakdown of findings demonstrates that the mental health of early-career nurses, 34 and under, is impacted most, with 81 percent reporting they are exhausted, 71 percent saying they are overwhelmed, and 65 percent who report being anxious or unable to relax. Nurses who are 55 and older reported some strain on their mental health, with 47 percent reporting feeling exhausted and 31 percent reporting they had a desire to quit.[4]

ANA is a member of the Mental Health Liaison Group. We count the American Psychiatric Nurses Association as a premier Organizational Affiliate and many psychiatric nurses as members. We request that the Committee approve the appropriations request put forward by the Mental Health Liaison Group for FY 2022 for mental health and addiction policies and programs.[5]

MINORITY FELLOWSHIP PROGRAM

ANA supports funding and expanding the Minority Fellowship Program (MFP), which is currently administered by the Substance Abuse and Mental Health Services Administration (SAMHSA).[6] The program provides scholarships to minority mental health and addiction professionals in nursing, but also in the fields of psychiatry, psychology, social work, marriage and family therapy, counseling and addictions. The program's mission is to increase the number of culturally competent behavioral health professionals who provide mental health and substance use disorders services to underserved populations.

The MFP was created in 1974 to provide fellowships to minority mental health professionals, and, since then, more than 4,400 fellowships have been issued to nurses, psychiatrists, psychologists, social workers, marriage and family therapists, counselors, and addiction specialists. According to HHS, minorities are less likely to receive diagnosis and treatment for their mental illness, have less access to and availability of mental health services, and often receive a poorer quality of mental health care. The MFP is the only federal program financing culturally competent mental health and substance use disorders professionals.

ANA, along with the MFP Coalition, urges Congress to increase funding for the MFP to $20,200,000 in FY 2022 in order to expand access to nurses and other mental health professionals who provide culturally competent mental health and substance abuse services to ethnic minority populations.

Thank you for the opportunity to provide written testimony as the Subcommittee continues its important work. If you have any questions, please contact Ingrida Lusis, Vice President of Policy and Government Affairs, at Ingrid.Lusis@ana.org.

[This statement was submitted by Debbie D. Hatmaker, PhD, RN, FAAN, Chief Nursing Officer/EVP.]

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the United States, with more than 122,000 researchers, educators, clinicians, consultants, and students as its members. Our mission is to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives.

Many programs in the Labor-HHS-Education Appropriations bill are critical to strengthening the mental health workforce, supporting psychology-based research and education, and improving access to needed mental and behavioral health services, particularly for underserved communities. As the COVID–19 pandemic continues to present broad challenges for our nation in both the short and long term, federal investments are needed to bolster research, expand equitable access to pri-

[4] https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/mental-health-and-wellness-survey-2/.

[5] https://www.mhlg.org/wordpress/wp-content/uploads/2021/04/MHLG-FY2022-Approps-Request-Final-4.7.21.pdf.

[6] https://www.samhsa.gov/minority-fellowship-program/about.

mary and mental health services, and support data-informed approaches to education and public welfare at all levels. To boost critical research funding, support the psychology workforce, improve access to mental and behavioral health services across the lifespan, and address social determinants of health, APA requests the following funding levels for FY22 within the U.S. Department of Health and Human Services, U.S. Department of Education, and U.S. Department of Labor.

Boosting Critical Research Funding: APA requests at least $46.111 billion for NIH in FY22, including $48.9 million for the NIH Office of Behavioral and Social Sciences Research (OBSSR). This funding would allow OBSSR to continue leading the coordination and support of research designed to address the social, behavioral, and economic effects of COVID–19 and its associated containment and mitigation efforts. Understanding these impacts will help policymakers improve their long-term response to the pandemic and prepare more effectively and efficiently for the country's next public health emergency. APA encourages the Committee to resist calls to limit the availability or use of non-human animal models in research, and to ensure this research continues to be conducted appropriately and ethically.

APA recommends at least $700 million for the Institute of Education Sciences (IES), which supports and disseminates scientific evidence on which to base education policy and practice and funds innovative research into many aspects of teaching and learning, including research on pandemic-related learning loss. Finally, APA urges the Committee to provide $50 million in funding shared evenly between the CDC and NIH to conduct public health research into firearm morbidity and mortality prevention. This research is fundamental to helping our nation better understand and address our gun violence public health crisis.

Supporting the Psychology Workforce: The nation's mental and behavioral health workforce must be expanded to adequately respond to the long-term mental health and substance use disorder ramifications of the COVID–19 pandemic, particularly the needs of long-underserved communities like communities of color and older adults. This includes foundational investments in higher education, as well as workforce training programs that support the integration of behavioral healthcare. To address this, APA supports increased funding for the following programs within the Department of Education and HHS' Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA).

Given the heavy burden of student loan debt, APA supports added investments in grant programs for graduate study within the Department of Education, including $35 million for the Graduate Assistance in Areas of National Need (GAANN) Program. The most recent funding cycle marked the first time in nearly a decade where psychology was among the designated areas of national need under this program. As the mental health impact of the pandemic continues to unfold, APA requests that the committee again direct the Secretary to include academic areas that fall under the Classification of Instructional Programs (CIP) 51.15 Mental Health Services in the next grant competition.

Within HRSA, APA joins the Mental Health Liaison Group (MHLG) in urging the Committee to provide $23 million for the Graduate Psychology Education Program; $90 million for the Behavioral Health Workforce Education and Training (BHWET) Grant Program; and $37 million for the Mental and Substance Use Disorder Workforce Training Demonstration. These essential programs increase work to increase our nation's supply of health service psychologists trained to provide integrated services to high-need, underserved populations in rural and urban communities. To expand access to non-pharmacological pain management to improve pain care and reduce the incidence of opioid use disorders, APA recommends $10 million for a program for education and training in pain care, as authorized by the SUPPORT Act under Section 759 of the Public Health Service Act (42 U.S.C. 294i).

Within SAMHSA, APA requests $20.2 million for the Minority Fellowship Program (MFP). This increase will support the program's dual mission to both increase the diversity of the mental and behavioral health workforce while improving access to mental health and substance use disorder services in underserved communities.

Improving Access to Mental and Behavioral Health Care Across the Lifespan: Given the rise in COVID-related mental health concerns, APA joins MHLG in requesting $833 million for SAMHSA's Community Mental Health Block Grant (MHBG) and $1.9 billion for the Substance Abuse Prevention and Treatment (SAPT) Block Grant in FY22. To address rising suicide rates, we urge the Committee to provide $240 million for the National Suicide Prevention Lifeline; $5 million for 988 implementation, $37 million for the State/Tribal Youth Suicide Prevention Program; $6.7 million for the Campus Mental and Behavioral Health Program; and $9.3 million for the Suicide Prevention Resource Center.

To ensure that our K–12 students receive a well-rounded education, and access to school-based mental health services and programs that foster safe and healthy

schools, APA requests $2 billion for Title IV–A, the Student Support and Academic Enrichment (SSAE) block grant. Additionally, to increase the number of mental health providers working in school settings, APA requests $606 million for the Safe Schools National Activities Program in order to support new competitions for the School Based Mental Health Services Professional Demonstration Grant and the School-Based Mental Health Services Grant Program. APA also urges the Committee to include $15.5 billion for Part B (Grants to States) of the Individuals with Disabilities Education Act (IDEA) to help provide an equitable education for students with disabilities.

Given that maternal mental health conditions are the most common complication of pregnancy and childbirth, APA joins the Maternal Mental Health Leadership Alliance and more than 100 other organizations in requesting $5 million for HRSA's Maternal Mental Health Hotline, and $10 million for the Screening and Treatment of Maternal Depression and Related Behavioral Disorders Program. APA urges to Committee to provide $750 million for Title V Maternal and Child Health Services Block Grant Program, which supported 92% of all pregnant women in the U.S. in FY19.

Finally, APA urges the Committee to provide much-needed funding to support Mental Health Parity and Addiction Equity Act (MHPAEA) enforcement. Within the DOL's Employee Benefits Security Administration, APA requests $25 million for MHPAEA enforcement, with 10% allocated to Office of Solicitor for parity litigation. To support MHPAEA enforcement within HHS, APA requests $10 million for CMS' Center for Medicaid and CHIP Services (CMCS).

Addressing Social Determinants of Health & Social Safety Net: Within HHS' Administration for Children and Families, APA supports $1.7 billion for the Social Services Block Grant, which provides vital social services, such as protective services agencies and special services to people with disabilities. In addition, APA urges the Committee to provide $10.7 billion for the Head Start Program, $5.9 billion for Preschool Development Grants, and $500 million for CAPTA Title I to support state child abuse prevention and treatment.

To expand the reach out various federal HIV programs, APA requests $100 million for the CDC Division of Adolescent and School Health (DASH), to increase access to health services, implement evidence-based sexual health education, and foster supportive environments for young people to learn. APA also supports $160 million for the SAMHSA Minority AIDS Initiative to expand efforts at preventing domestic HIV transmission and to increase treatment options for those living with comorbid conditions. APA urges the Committee to provide $120 million for the infectious diseases and opioid program at CDC. Currently funded at a level well below its actual need, this program increases prevention, testing, and linkages to provide a strong ground-level response to the intersecting crises of opioid addiction, HIV, and hepatitis. Finally, to strengthen public health surveillance activities, APA requests $250 million for the CDC's Data Modernization Initiative (DMI).

[This statement was submitted by Katherine B. McGuire, Chief Advocacy Officer, American Psychological Association Services, Inc.]

PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

APHA is a diverse community of public health professionals that champions the health of all people and communities. We are pleased to submit our request of at least $10 billion for the Centers for Disease Control and Prevention and at least $9.2 billion for the Health Resources and Services Administration in FY 2022. Robust funding for CDC and HRSA programs that promote public health and prevention, support surveillance of infectious disease and bolster America's public health workforce will be critical in addressing both the short-term and long-term health impacts of COVID–19 and the many other health challenges we face as a nation. We are thankful for the emergency supplemental funding provided to CDC and HRSA to support the nation's response to COVID–19 and we urge the committee to ensure that all CDC and HRSA programs are adequately funded in FY 2022.

Centers for Disease Control and Prevention: CDC provides the foundation for our state and local public health departments, supporting a trained workforce, laboratory capacity and public health education communications systems. It is notable that more than 70% of CDC's budget supports public health and prevention activities by state and local health organizations and agencies, national public health partners and academic institutions. We urge a funding level of at least $10 billion in FY 2022. We are grateful for the important increases provided for CDC programs in FY 2021 and for the critical emergency funding provided to the agency to address COVID–19. We urge Congress to build upon these investments to strengthen all of

CDC's programs, many of which remain woefully underfunded. We also urge your continued support for the Prevention and Public Health Fund which currently makes up approximately 11% of CDC's budget.

CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. From aiding in the surveillance, detection and prevention of the current COVID–19 outbreak globally and in the U.S. to playing a lead role in the control of Ebola in West Africa and the Democratic Republic of the Congo, to monitoring and investigating disease outbreaks in the U.S., to pandemic flu preparedness to combating antimicrobial resistance, CDC is the nation's—and the world's—expert resource and response center, coordinating communications and action and serving as the laboratory reference center for identifying, testing and characterizing potential agents of biological, chemical and radiological terrorism, emerging infectious diseases and other public health emergencies.

We strongly support the president's budget request for $400 million in new funding to bolster core public health infrastructure and capacity at the federal, state, territorial and local levels. This flexible funding is critical to addressing the gaps in core public health infrastructure and capacity at all levels as well as ensuring our nation's health departments are able to attract and retain experienced leaders and respond to future public health emergencies and disease outbreaks. Sustained, flexible funding is critical to rebuilding and strengthening the nation's public health system.

CDC serves as the lead agency for bioterrorism and other public health emergency preparedness and response programs. We urge you to provide adequate funding for the Public Health Emergency Preparedness grants which provide resources to our state and local health departments to help them protect communities during public health emergencies. We also urge you to provide adequate funding for CDC's infectious disease, laboratory and disease detection capabilities to ensure we are prepared to tackle both ongoing COVID–19 pandemic and other public health challenges and emergencies that will likely arise during the coming fiscal year. Your continued support for CDC's public health Data Modernization Initiative is critical to ensuring we have both the world-class data workforce and data systems that are ready for the next public health emergency.

We thank Congress for providing CDC with dedicated funding for firearm morbidity and mortality prevention research in FY 2020 and FY 2021 and we strongly urge you to increase this funding in FY 2022 to $50 million for CDC and NIH, as requested in President Biden's FY 2022 discretionary budget proposal. This will allow CDC to conduct research into important issues including the best ways to prevent unintended firearm injuries and fatalities among women and children; the most effective methods to prevent firearm-related suicides; and the measures that can best prevent the next shooting at a school or public place.

CDC's National Center for Environmental Health works to control asthma, protect against threats associated with natural disasters and climate change, reduce and monitor exposure to lead and other environmental health hazards and ensure access to safe and clean water. We urge you to provide at least $322 million for NCEH in FY 2022, including $110 million for CDC's Climate and Health program, as requested in President Biden's FY 2022 discretionary budget request. Climate change is threating our health in many ways through the increased spread of vector-borne diseases, degraded air quality from ozone pollution and wildfire smoke, hotter temperatures and more extreme weather events. Increased funding will allow CDC to provide funding to all 50 states and to support additional, cities, counties and tribes to help them prepare for and respond to the health impacts of climate change in their communities.

Programs under the National Center for Chronic Disease Prevention and Health Promotion address heart disease, stroke, cancer, diabetes and tobacco use that are the leading causes of death and disability in the U.S. and are also among the costliest to our health system. CDC provides funding for state programs to prevent disease, conduct surveillance to collect data on disease prevalence, monitor intervention efforts and translate scientific findings into public health practice in our communities. We strongly urge increased investments in these critical programs that are essential to reducing death, disability and health care costs. In particular, we urge your support for the president's request of $153 million for CDC's Social Determinants of Health Program. This increased funding would allow CDC to provide public health departments, academic institutions and nonprofit organizations funding and tools to support cross sector efforts to address the impact that social determinants of health such as unsafe and unstable housing, income insecurity, lack of transportation, and underlying health inequities have on the health of their communities.

Health Resources and Services Administration: HRSA is the primary federal agency dedicated to improving health outcomes and achieving health equity. HRSA's 90-plus programs and more than 3,000 grantees support tens of millions of geographically isolated, economically or medically vulnerable people, in every U.S. state and territory, to achieve improved health outcomes by increasing access to quality health care and services; fostering a health care workforce able to address current and emerging needs; enhance population health and address health disparities through community partnerships; and promote transparency and accountability within the health care system.

We are grateful for the increases provided for HRSA programs in FY 2021 and for the emergency supplemental funding to battle the COVID–19 pandemic, but HRSA's discretionary budget authority is far too low to effectively address the nation's current public health and health care needs. We recommend Congress build upon the important increases they provided HRSA in FY21 and provide at least $9.2 billion for the Health Resources and Services Administration in FY 2022

HRSA programs and grantees are providing innovative and successful solutions to some of the nation's greatest health care challenges including the rise in maternal mortality, the severe shortage of health professionals, the high cost of health care and behavioral health issues related to substance use disorders-including opioid misuse. Additional funding will allow HRSA build upon these successes and pave the way for new achievements by supporting critical HRSA programs, including:

Primary Health Care that supports nearly 13,000 health center sites in medically underserved communities across the U.S., providing access to high-quality preventive and primary care to nearly 30 million people including 1 in 3 people living in poverty.

Health Workforce supports the health workforce across the training continuum and offers scholarship and loan repayment programs to ensure a well-prepared, well-distributed and diverse workforce that is ready to meet the current and evolving health care needs of the nation.

Maternal and Child Health supports initiatives that reduce infant mortality, minimize disparities, prevent chronic conditions and improve access to quality health care for vulnerable women, infants and children; and serves 60 million people through the MCH block grant.

HIV/AIDS programs deliver a comprehensive system of care to more than 519,000 individuals impacted by HIV/AIDS, improving health outcomes for people with HIV and reducing the chance of others becoming infected, and provides training for HIV/AIDS health professionals. HRSA's Ryan White HIV/AIDS Program effectively engages clients in comprehensive care and treatment, including increasing access to HIV medication, which has resulted in 88.1% of clients achieving viral suppression, compared to just 64.7% of all people living with HIV nationwide.

Family Planning Title X services ensure access to comprehensive family planning and preventive health services for over 3.1 million people, reducing unintended pregnancy rates, limiting sexually transmitted infection transmission and increasing early detection of cancers.

Rural Health supports community solutions to improve efficiencies in delivering rural health services and expand access, including supporting activities that aim to increase access to opioid treatment in rural areas and promote the use of health information technology and telehealth.

HRSA has also been active in the COVID–19 pandemic response, awarding billions of dollars to health centers to administer COVID–19 tests and reimbursing providers who offer COVID–19 care to uninsured individuals.

In closing, we emphasize that the public health system requires stronger financial investments at every stage. It is critical that Congress increase its investments in CDC and HRSA programs to enable the nation to meet the mounting health challenges we currently face and to become a healthier nation.

[This statement was submitted by Georges C. Benjamin, MD, Executive Director, American Public Health Association.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR ENGINEERING EDUCATION

This written testimony is submitted on behalf of the American Society for Engineering Education (ASEE) to the Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies for the official record. ASEE appreciates the Committee's support for the Department of Education (ED) in fiscal year (FY) 2021 and asks you to robustly fund student aid, teacher preparation, and STEM programs in FY 2022. Additionally, ASEE requests federal funding to support initiatives aimed at increasing the diversity of the STEM pipeline and support

for Minority-Serving Institutions (MSIs). The strong support of the National Institutes of Health (NIH) in FY 2021 was greatly appreciated and ASEE requests continued support of NIH.

The American Society for Engineering Education (ASEE) advances innovation, excellence, and access at all levels of education for the engineering profession and is the only society representing the country's schools and colleges of engineering and engineering technology. Membership includes over 12,000 individuals hailing from all disciplines of engineering and engineering technology including educators, researchers, and students as well as industry and government representatives. As the pre-eminent authority on the education of engineering professionals, ASEE seeks to advance the development of innovative approaches and solutions to engineering education and advocates for equal access to engineering educational opportunities for all.

Student Aid

Student aid programs like Pell Grants, Federal Work-Study (FWS), TRIO, and others make higher education accessible and affordable for millions of students. We appreciate the commitment the Biden Administration has made to affordable education through its preliminary Presidential Budget Request and the American Families Plan. ASEE joins the higher education community in requesting funding to support doubling the maximum Pell Grant award to $12,990. Pell Grants are essential to low-income students being able to afford higher education. These awards are vital in helping students access the significant life and career benefits that higher education provides. These benefits are especially prevalent for engineering education, which provides a proven pathway to the middle class, especially for students from low-income backgrounds. ASEE requests funding for Federal Work Study (FWS) at $1.480 billion and $1.061 billion for Supplemental Educational Opportunity Grant (SEOG). These programs are need-based, and often this aid provides the resources a student needs to complete their education. ASEE asks the Committee to consider ways to support work-based learning, such as co-operative education and apprenticeships, within the FWS program. ASEE firmly believes in ensuring access to engineering and engineering technology education for all students, not just those who can afford it, which is why ensuring student aid programs for graduate students is also very important. ASEE requests funding for the Graduate Assistance in Areas of National Need (GAANN) program, which provides fellowships, through academic departments and programs of institutions of higher education, to assist graduate students with excellent records who demonstrate financial need. ASEE requests $35 million for GAANN.

Teacher Preparation

The need for well-prepared and content-confident teachers in early childhood, elementary, and secondary education is high, particularly in STEM subjects. The lack of teacher training focused on STEM, and engineering in particular, is an important issue facing K–12 education. Problem-based learning that incorporates engineering design and analysis skills are often absent from teacher preparation and professional development programs. ASEE supports vigorous funding for Title II of the Elementary and Secondary Education Act (ESEA), which supports the preparation and professional development of school personnel, and Title II of the Higher Education Act, which supports teacher preparation programs at institutions of higher education. ASEE also supports President Biden's proposal to invest $9 billion in training and diversifying the teaching workforce presented in the American Families Plan. Efforts to support teaching skills for STEM postsecondary faculty should also be considered and could include partnerships between STEM disciplines and Schools of Education to support STEM faculty and support for teaching and learning centers at postsecondary institutions. Support of postsecondary faculty and their promotion of STEM learning should utilize research-based methods. Our future is dependent on today's students finding solutions to tomorrow's problems. This can only be accomplished if those students have teachers who are prepared to guide them in developing the knowledge and skills needed to solve those problems.

STEM

Support for science, technology, engineering, and mathematics (STEM) continues to grow and ASEE appreciates the support many STEM programs received in FY 2021. ASEE supports funding for Title IV of the Elementary and Secondary Education Act (ESEA) at its authorized amount of $1.6 billion, which will allow states and school districts additional resources to pursue STEM programs. ASEE supports robust funding for STEM programs for higher education students including the Hispanic-Serving Institutions (HSI) STEM and Minority Science and Engineering Improvement (MSEIP) programs. The STEM workforce is a driving force behind inno-

vation and our economic development. These and other programs targeted towards increasing the representation of historically underrepresented populations, including women, will ensure a healthy STEM workforce pipeline.

Career and Technical Education (CTE)

ASEE knows that high-quality Career and Technical Education (CTE) prepares students for careers and further postsecondary education while fulfilling employer needs in high-demand sectors of the economy.[1] ASEE supports CTE and wants to ensure best practices and high-quality programs are embedded in its programs, for example through faculty professional development and connections to the National Science Foundation -supported Advanced Technological Education (ATE) programs. ASEE also wants to strengthen pathways between CTE at the associate degree level to 4-year engineering technology and engineering degrees. ASEE believes that students should have lifelong options for continuing study and career advancement and that CTE programs can help students achieve their goals. In order for states and their CTE educators to provide high-quality CTE opportunities for students and strengthen pathways between two- and four-year institutions of higher education, ASEE urges Congress to robustly fund the Perkins Basic State Grant funding program in FY 2022 and encourage the program to build connections with NSF's ATE program.

National Institutes of Health—National Institute of Biomedical Imaging and Bioengineering (NIBIB)

NIBIB is the major NIH Institute focused on engineering applications to human health and training the next generation of biomedical engineers. ASEE is grateful to the committee for its strong bipartisan support of the NIH in FY 2021. NIBIB funding is critical for the development of devices and tools that can improve the detection, treatment, and prevention of disease, and also plays a critical role in assessing the effectiveness of new drugs and treatment procedures. NIBIB also supports training programs to enhance and expand education and training for the next generation biomedical engineering workforce. Through grant programs like the Enhancing Science, Technology, and Math Education Diversity Research Education Experiences, and Team-Based Design in Biomedical Engineering Education, NIBIB is committed to supporting all stages of the biomedical engineering career pathway and increasing the participation of traditionally underrepresented groups in engineering. ASEE urges the Committee to provide NIH with $46.1 billion in FY 2022 so that NIBIB can continue to support critical biomedical engineering research and training.

CONCLUSION

Engineering and engineering technology academic programs play critical roles in the STEM ecosystem. The requests made here support the development of a skilled technical workforce, broadening participation, and transdisciplinary study. Thank you for the opportunity to submit this testimony.

[This statement was submitted by Sheryl Sorby, Ph.D., President, and Norman Fortenberry, Sc.D., Executive Director, American Society for Engineering Education.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is the one of the largest life science societies, composed of more than 30,000 scientists and health professionals. Our mission is to promote and advance the microbial sciences. ASM respectfully requests that Congress provide at least $46.1 billion for the National Institutes of Health (NIH) and at least $10 billion for the Centers for Disease Control and Prevention (CDC) in fiscal year (FY) 2022. Within the CDC budget, we request $60 million for the Advanced Molecular Detection (AMD) program in the National Center for Emerging and Zoonotic Infectious Diseases.

Achieving Remarkable Outcomes Through a Strong Investment in the NIH

We thank Congress for its longstanding, bipartisan support for the NIH and for its commitment to basic, translational, and clinical microbial research funded through multiple Institutes and Centers, particularly through the National Institute of Allergy and Infectious Diseases (NIAID). We especially thank Chairman Leahy,

[1] https://www.acteonline.org/wp-content/uploads/2021/04/2021__ACTE__Legislative__Priorities__April.pdf.

Vice Chairman Shelby, Chair Murray and Ranking Member Blunt and members of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies for their unwavering support for the NIH and leadership over the past six years, during which they and their Senate counterparts have worked in a bipartisan manner to place the NIH budget back on the path of meaningful growth above inflation.

Thanks to a renewed commitment to NIH, researchers were able to pivot when SARS–CoV–2 emerged and the race to develop tests, vaccines and therapeutics commenced. Researchers built on decades of federally-funded basic science and technological advances to develop safe and effective vaccines at record speed. This remarkable achievement has reenergized existing and aspiring scientists worldwide, allowed our country to begin moving past the pandemic, and demonstrated the power of public-private partnerships. Continuing to provide robust, sustained and predictable funding for the NIH is the only way we will seize the unparalleled scientific opportunities in microbial research that lie before us, and the only way we will be equipped to address the demands that future infectious disease outbreaks will place on our society.

NIH Funding has Transformed the Microbial Sciences

Even before the COVID–19 pandemic, investments in microbial research at NIH led to great strides in protecting and improving human health as illustrated by the following advances:

—A young person diagnosed with Human Immunodeficiency Virus (HIV) today who receives treatment will have a near normal life expectancy. The AIDS death rate has dropped 80% from its peak in 1995.

—Routine childhood vaccinations prevent millions of cases of illness. For children vaccinated in 2009, an estimated $82 billion in costs will be saved and 20 million cases, including 42,000 early deaths, will be prevented.

—The first preventive vaccine and experimental treatments were recently deployed in Africa against the Ebola virus, marking a significant public health achievement. The Ebola virus, which ravaged West Africa in 2013 and continues to cost lives in the Democratic Republic of the Congo, has killed more than 10,000 people and severely strained regional socioeconomic stability.

—Since 2007, the NIH has been on the forefront of supporting microbiome research with the Common Fund's Human Microbiome Project (HMP), which was formed to develop research resources to study of microbial communities and how they impact human health and disease. Microbiome research has increased over 40 times since the inception of the HMP, and the work engages over 20 NIH Institutes and Centers. This important research has had implications for our understanding of microbiome interactions in pregnancy and preterm birth, inflammatory bowel disease, and diabetes, among other topics.

Continued Progress Requires Sustained Funding and Support for Investigators

Even in the face of the promise and progress highlighted above, well known pathogens and pathogen resistance threaten our nation's health with serious economic and social ramifications. Seasonal flu continues to cost the U.S. billions annually in direct medical costs and lost productivity due to illness, and claims the lives of thousands of Americans each year. Through sustained funding to NIAID, scientists continue the quest for a universal flu vaccine. Antimicrobial resistance (AMR) is a daunting public health challenge and considered a global crisis by the World Health Organization, the G20 and the United Nations. Continued investment in research to better understand how microbes become resistant, and develop more precise clinical diagnostics, novel therapeutics and vaccines is greatly needed.

The COVID–19 pandemic has exacted a toll on the broader research enterprise, especially early career investigators and those who were unable to pivot to work on SARS–CoV–2. Pandemic-related laboratory closures disrupted ongoing research, resulted in loss of animal colonies and cell lines, and loss of laboratory positions. Experiments will need to be restarted, animal colonies repopulated and fieldwork rescheduled for an indeterminate later time. While our nation's research capacity has demonstrated it can absorb shocks, the scale of this one is still growing and unprecedented in duration and impact. Congress should consider additional "research relief" funding to NIH to assist in the recovery of our research workforce and projects negatively affected by the pandemic.

CDC's Indispensable Role in Preventing and Controlling Infectious Disease

The programs and activities supported by CDC are essential to protect the health of the American people. ASM appreciates the extraordinary emergency funding provided to the agency in FY 2021 to meet the needs presented by the pandemic. However, had Congress provided necessary support for CDC and public health infra-

structure over time, our country would have been in a better position to address the public health crisis more effectively from the start. With this in mind, we urge Congress to build on emergency investments in FY 2022, including robust funding for the Data Modernization Initiative and the Prevention and Public Health Fund. CDC aids in surveillance, detection and prevention of global and domestic outbreaks from novel Coronavirus, to Ebola, to the measles, to seasonal flu. CDC is the nation's expert resource and response center, coordinating communications and action, and serving as the laboratory reference center. As we have seen over the course of the pandemic, states, communities, and international partners rely on CDC for accurate information, direction, and resources to ensure they continue to be prepared in a crisis or outbreak.

Three areas that ASM would like to highlight under CDC are: (1) advanced molecular detection technology; (2) antimicrobial resistance; and, (3) laboratory capacity.

—The Advanced Molecular Detection (AMD) program brings cutting edge genomic sequencing technology to the front lines of public health by harnessing the power of next-generation sequencing and high performance computing with bioinformatics and epidemiology expertise to study pathogens. The program has played an indispensable role by leading genomic surveillance efforts and sequencing of SARS-CoV–2 samples, especially aimed at getting in front of emerging variants. We thank Congress for providing transformational funding for AMD in the American Rescue Plan Act, and with increased base funding, the AMD program can continue to promote innovation, expand workforce development, and enter into productive partnerships with academic research institutions and state/local public health agencies. ASM requests $60 million for AMD in FY 2022.

—Multiple programs support antimicrobial resistance, one of the most daunting health challenges we face today. ASM requests funding for the Antibiotic Resistance Solutions Initiative at $672 million, the National Healthcare Safety Network at $100 million, and the Division of Global Health Protection at $465.4 million, which will ensure that we have the resources across multiple programs to address this urgent public health challenge.

—Support for laboratory capacity is paramount, and the Emerging and Zoonotic Infectious Disease labs are the world's reference labs. But maintaining labs costs more each year, from quality and safety initiatives, to the cost of shipments and supplies, to recruiting and retaining specialized and highly trained staff. We urge you to consider additional funding for resources to this area, particularly as we consider ways to bolster lab capacity in times of public health emergency.

ASM looks forward to working with you to ensure that researchers and public health professionals have the resources they need to apply fundamental microbial science research to meet 21st Century challenges in public health promotion, the prevention, detection and treatment of infectious diseases, and the prevention of outbreaks.

[This statement was submitted by Allen Segal, Public Policy and Advocacy Director, American Society for Microbiology.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

Dear Chairman Murray and Ranking Member Blunt:

Thank you for the opportunity to provide testimony regarding Fiscal Year (FY) 2022 appropriations. The American Society for Nutrition (ASN) respectfully requests at least $46.1 billion dollars for the National Institutes of Health (NIH) and $200 million dollars for the Centers for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS) in Fiscal Year 2022. ASN is dedicated to bringing together the world's top researchers to advance our knowledge and application of nutrition, and has more than 8,000 members working throughout academia, clinical practice, government, and industry.

National Institutes of Health (NIH)

The NIH is the nation's premier sponsor of biomedical research and is the agency responsible for conducting and supporting the largest percentage of federally funded basic and clinical nutrition research with $3.2 billion estimated for nutrition and obesity research in 2020. Although nutrition and obesity research make up just five percent of the NIH budget, some of the most promising nutrition-related research discoveries have been made possible by NIH support. NIH nutrition-related discoveries have impacted the way clinicians prevent and treat heart disease, cancer, diabetes and other chronic diseases. For example, from 1990 to 2019, U.S. diet-related

death rates decreased from 154 to 101 deaths per 100,000 population, although the proportion of deaths attributable to dietary risks was largely stable.[1] However, the burden and risk factors remain high. With additional support for NIH, additional breakthroughs and discoveries to improve the health of all Americans will be made possible.

Investment in biomedical research generates new knowledge, improved health, and leads to innovation and long-term economic growth. ASN recommends at least $46.1 billion dollars for NIH in Fiscal Year 2022 to support NIH nutrition-related research that will lead to important disease prevention and cures. A budget of $46.1 billion will allow NIH to provide support to the new NIH Common Fund's Nutrition for Precision Health, powered by the All of Us Research Program, while still providing much needed increases to other parts of the portfolio. NIH needs sustainable and predictable budget growth to fulfill the full potential of biomedical research, including nutrition research, that is aimed at improving the health and wellbeing of all Americans, as well as global populations.

Centers for Disease Control and Prevention National Center for Health Statistics (CDC NCHS)

The National Center for Health Statistics, housed within the Centers for Disease Control and Prevention, is the nation's principal health statistics agency. ASN recommends a Fiscal Year 2022 funding level of $200 million dollars for NCHS to help ensure uninterrupted collection of vital health and nutrition statistics and help cover the costs needed for technology and information security maintenance and upgrades that are necessary to replace aging survey infrastructure. The U.S. is a leader in this area and a decade of flat funding has taken a significant toll on NCHS's ability to keep pace.

The NCHS provides critical data on all aspects of our health care system, and it is responsible for monitoring the nation's health and nutrition status through surveys such as the National Health and Nutrition Examination Survey (NHANES), that serve as a gold standard for data collection around the world. Nutrition and health data, largely collected through NHANES, are essential for tracking the nutrition, health and well-being of the American population, and are especially important for observing nutritional and health trends in our nation's children. This is an invaluable source of data that has been and can continue to be used to address major health issues as they arise.

Nutrition monitoring conducted by the Department of Health and Human Services in partnership with the U.S. Department of Agriculture/Agricultural Research Service is a unique and critically important surveillance function in which dietary intake, nutritional status, and health status are evaluated in a rigorous and standardized manner. Nutrition monitoring is an inherently governmental function and findings are essential for multiple government agencies, as well as the public and private sector. Nutrition monitoring is essential to track what Americans are eating, inform nutrition and dietary guidance policy, evaluate the effectiveness and efficiency of nutrition assistance programs, and study nutrition-related disease outcomes. Funds are needed to ensure the continuation of this critical surveillance of the nation's nutritional status and the many benefits it provides.

Through learning both what Americans eat and how their diets directly affect their health, the NCHS is able to monitor the prevalence of obesity and other chronic diseases in the U.S. and track the performance of preventive interventions, as well as assess 'nutrients of concern' such as calcium, iron, folate, iodine, vitamin D, and other micronutrients which are consumed in inadequate amounts by many subsets of our population. Data such as these are critical to guide policy development in health and nutrition, including food safety, food labeling, food assistance, military rations and dietary guidance. For example, NHANES data are used to determine funding levels for programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Women, Infants, and Children (WIC) clinics, which provide nourishment to low-income women and children. Additional support would enable collection of more data on under-represented groups, such as pregnant and lactating women, and assessment of nutritional status indicators for nutrients on which we have no, or inadequate, information.

Thank you for the opportunity to submit testimony regarding FY 2022 appropriations for the National Institutes of Health and the CDC/National Center for Health Statistics. Please contact John E. Courtney, Ph.D., ASN Executive Officer, at 9211 Corporate Boulevard, Suite 300, Rockville, Maryland 20850, jcourtney@nutrition.org, if ASN may provide further assistance.

Sincerely.

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[1] https://www.ahajournals.org/doi/10.1161/CIR.0000000000000950.

[This statement was submitted by Lindsay H. Allen, Ph.D., 2020–2021 President, American Society for Nutrition.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF HEMATOLOGY

The American Society of Hematology (ASH) represents more than 17,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases, including malignant disorders such as leukemia, lymphoma, and myeloma; conditions including thrombosis and bleeding disorders; and congenital diseases such as sickle cell disease, thalassemia, and hemophilia.

FY 2022 Request: National Institutes of Health (NIH)

American biomedical research has led to new medical treatments, saved innumerable lives, reduced human suffering, and spawned entire new industries, none of which would have been possible without support from the NIH. Hematology research, funded by many institutes at the NIH, including the National Heart, Lung and Blood Institute (NHLBI), the National Cancer Institute (NCI), the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK), the National Institute on Aging (NIA), and the National Institute of Allergy and Infectious Diseases (NIAID), has been an important component of this investment in the nation's health.

NIH-funded research has led to tremendous advances in treatments for children and adults with blood cancers and other hematologic diseases and disorders. Hematology advances also help patients with other types of cancers, heart disease, and stroke. Basic research on blood has aided physicians who treat patients with heart disease, strokes, end-stage renal disease, cancer, and AIDS. The Society recently updated the ASH Agenda for Hematology Research, which serves as a roadmap to prioritize research within the hematology field and includes recommendations for areas of additional federal investment that will equip researchers to make truly practice-changing discoveries in hematology and other fields of medicine for years to come.

Additionally, the extraordinary research that has occurred to identify and develop potential COVID–19 vaccines, antivirals, and other medical countermeasures is all built on the scientific foundation enabled by the federal investment in NIH. In response to the emergence of hematologic complications from COVID–19 infection, ASH developed the COVID–19 Research Agenda in Hematology, which highlights fundamental questions that experts in hematology and blood research deem of critical importance to researchers, physicians, and patients.

ASH thanks Congress for the robust bipartisan support that has resulted in several consecutive years of welcome and much needed funding increases for NIH. For FY 2022, ASH joins nearly 400 organizations and institutions across the NIH stakeholder community to strongly support the Ad Hoc Group for Medical Research recommendation that NIH receive a program level of at least $46.1 billion. This funding level would allow for meaningful growth above inflation in the base budget that would expand NIH's capacity to support promising science in all disciplines.

While we are grateful for Congress's ongoing commitment to NIH as a top national priority through the regular appropriations process, we also urge the inclusion of emergency supplemental investments for the NIH as Congress considers future legislation to promote the nation's physical, health, and economic resilience to the COVID–19 pandemic.

The pandemic's impact on biomedical research has been serious and far-reaching. Researchers in every state were forced to suspend many laboratory activities for their own personal safety and to comply with physical distancing guidelines. The closure of many research facilities impacted trainees, technicians, early-stage investigators, and established investigators alike, preventing the research workforce from maintaining momentum toward better prevention, treatments, diagnostics, and cures for diseases such as blood cancers, sickle cell disease, and other hematologic diseases and conditions. While many institutions have been implementing plans to ramp this work back up again as safely as possible, challenges associated with the disruptions continue to linger. For example, certain types of research—such as clinical trials and other research projects with human participants—have been slower to recover. Additionally, as a result of the lags, we risk undoing progress we have made in recent years in strengthening the research workforce, including among women, underrepresented minorities, and early-career investigators and others at a pivotal point in their career trajectories.

To enable NIH to mitigate the pandemic-related disruptions without foregoing promising new science, ASH strongly supports emergency funding for federal re-

search agencies as outlined in the bipartisan Research Investment to Spark the Economy (RISE) Act (H.R. 869/S. 289), including $10 billion for NIH.

FY 2022 Request: Centers for Disease Control and Prevention (CDC)

The Society also recognizes the important role of the CDC in preventing and controlling clotting, bleeding, and other hematologic disorders. This is especially important for improving the care and treatment of individuals with sickle cell disease (SCD).

Sickle cell disease is an inherited, lifelong disorder affecting approximately 100,000 Americans. Individuals with the disease produce abnormal hemoglobin which results in their red blood cells becoming rigid and sickle-shaped, causing them to get stuck in blood vessels and block blood and oxygen flow to the body, which can cause severe pain, stroke, organ damage, and in some cases premature death. Though new approaches to managing SCD have led to improvements in diagnosis and supportive care, many people living with the disease are unable to access quality care and are limited by a lack of effective treatment options.

The Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Treatment Act of 2018 (P.L. 115–327) authorized CDC, through its Sickle Cell Data Collection program, to award grants to states, academic institutions, and non-profit organizations to gather information on the prevalence of SCD and health outcomes, complications, and treatment that people with SCD experience. Currently eleven states participate in the data collection program. Funding through the CDC Foundation has allowed Georgia and California to collect data since 2015; seven additional states (Alabama, Indiana, Michigan, Minnesota, North Carolina, Tennessee, and Wisconsin) were able to begin their programs in FY 2021 with the $2 million in funding provided by Congress in the FY 2021 Consolidated Appropriations Act. In early March 2021, the program expanded to Colorado and Virginia with additional funding from the CDC Foundation. These eleven states are estimated to include just over 35% of the U.S. SCD population.

ASH thanks Congress for the $2 million provided for the data collection program in FY 2021 and for the Administration's request for $2 million in funding for the program in FY 2022. The Society strongly supports providing CDC with at least $5 million in FY 2022 to continue to phase in the data collection program in the currently participating states and to allow for an expansion to additional states with the goal of covering the majority of the U.S. SCD population over the next five years.

FY 2021 Request: Health Resources and Services Administration (HRSA)

Finally, ASH supports the Administration's funding requests for the SCD programs within HRSA's Maternal and Child Health Bureau, including $7.205 million for the SCD Treatment Demonstration Program (SCDTDP) and $5 million for the SCD Newborn Screening Program, which is part of HRSA's Special Projects of Regional and National Significance (SPRANS) program. The grantees funded by these programs work to improve access to quality care for individuals living with SCD and sickle cell trait. The SCDTDP funds five geographically distributed regional SCD grants that support SCD providers to increase access to high quality, coordinated, comprehensive care for people with SCD, while the SCD Newborn Screening Program provides grants to support the comprehensive care for newborns diagnosed with SCD. ASH also supports the inclusion of language in the report accompanying the FY 2022 appropriations bill asking HRSA to provide Congress with a report detailing how the Sickle Cell Disease Treatment Demonstration Program is supporting the growth of comprehensive sickle cell disease centers.

Thank you again for the opportunity to submit testimony. Please contact ASH Senior Manager, Legislative Advocacy, Tracy Roades at troades@hematology.org, if you have any questions or need further information concerning hematology research or ASH's FY 2022 requests.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF HUMAN GENETICS

The American Society of Human Genetics (ASHG) thanks the Subcommittee for its continued strong support and leadership in funding the National Institutes of Health (NIH). The $1.25 billion increase provided for Fiscal Year (FY) 2021 reinforces our nation's commitment to the health and well-being of all Americans—at a time when investing in biomedical research and scientific innovation is most needed to defeat the COVID–19 pandemic. ASHG urges the Subcommittee to appropriate $46.1 billion for NIH in FY 2022.

ASHG was delighted to see President Biden propose a major increase to NIH's budget in FY 2022. We note that President Biden proposes a significant investment

for the creation of a new Advanced Research Projects Agency for Health (ARPA–H). We look forward to learning more about ARPA–H and how research on human genetics and genomics might play a role in its mission.

SAVING LIVES: GENETICS RESEARCH IN THE FIGHT AGAINST COVID–19

Less than a year after the first case of COVID–19 was reported, the U.S. Food and Drug Administration (FDA) authorized the use of two COVID–19 vaccines.[1] This record speed in vaccine development was built on decades of research and scientific knowledge, including NIH-funded basic research and private investments that have led to rapid and inexpensive DNA sequencing technologies.[2] Our ability to quickly and inexpensively analyze the genome of the SARS—CoV–2 virus has been crucial for developing diagnostics and vaccines, testing, tracking variants, and trying to understand the range of responses to infection. NIH Director Dr. Francis Collins noted that the ability to rapidly sequence the new coronavirus "...made it possible within 24 hours for the first vaccine design to get started!"[3]

Human geneticists across the world mobilized quickly to try to understand why some individuals were asymptomatic while others suffered from severe disease, including so-called "Long COVID." Early data supports that genetic differences between individuals play a part in determining susceptibility to the disease. The COVID–19 Host Genetics Initiative and the COVID–19 Human Genetics Effort brought together researchers from dozens of countries to share resources and data to understand how human genetics affects COVID–19 susceptibility, severity, and outcomes.[4,5]

RETURN ON INVESTMENT: GENETICS RESEARCH BENEFITS THE ECONOMY

The pandemic has demonstrated that federally funded research is critical for us to return to normalcy and recover economically. In addition, investments in research and development continue to be a strong driver of economic activity overall. A new study commissioned by ASHG and conducted by TEConomy Partners highlights the growth of a dynamic ecosystem derived from human genetics research, and that the development and manufacturing of genomic technologies, diagnostics and therapeutics, and the associated healthcare services, "generate substantial U.S. economic activity and support a large volume of jobs across the nation."[6] The report estimates that the human genetics and genomics sector supports 850,000 jobs and generates $265 billion in total economic activity annually,[7] demonstrating that this sector has grown around five-fold in the last decade. Beyond the economic impact, the study also catalogues the many ways in which human genetics and genomics is being integrated into routine clinical care across a broad range of diseases.[8] Key data from the report are shown below.

GENETICS & GENOMICS: STRIVING FOR EQUITY

The COVID–19 pandemic has disproportionately affected racial and ethnic minorities in the U.S., reinforcing that there are social factors in this country that cause major health disparities.[9] It is imperative that the application of genetic science in healthcare does not worsen existing health disparities, but instead advances health to benefit all Americans. Indeed, NIH-funded research has demonstrated how genetics and genomics research can be a tool for health equity through deliberate inclusion and participation of individuals from diverse groups. As genetics research is foundational to our understanding of human biology, gleaning the full scope of genetic variation will improve both healthcare and health equity. Inclusion of populations from diverse ancestries in studies is revealing novel insights about drug responses, diagnostic accuracy, and disease risk, demonstrating the need for increased

[1] https://covid19.nih.gov/research-highlights/vaccine-development.
[2] Ibid.
[3] https://www.forbes.com/sites/billfrist/2021/01/20/nih-director-dr-francis-collins-connecting-the-dots-from-the-human-genome-project-to-the-covid-19-vaccine/?sh=36f948a27543.
[4] https://www.covid19hg.org/partners/.
[5] https://www.covidhge.com/.
[6] Tripp, S., and Grueber, M. 2021. The Economic Impact and Functional Applications of Human Genetics and Genomics. https://www.ashg.org/wp-content/uploads/2021/05/ASHG-TEConomy-Impact-Report-Final.pdf.
[7] Ibid.
[8] Ibid.
[9] https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html.

diversity in research studies and clinical trials.[10] In ensuring broad cohort diversity in biomedical research, we need to consider all types of diversity, including engagement with both urban and rural communities, and taking into account social demographics such as gender, age, and economic status.

The Society commends NIH's efforts to advance diversity and equity in research, which are made possible by the strong support of this Subcommittee in providing robust funding for the NIH. The great strides made by the All of Us Research Program in having its research cohort reflect the diversity of the United States is one such example.[11] Furthermore, UNITE, NIH's new initiative to address "racial equity in the biomedical research workforce" and "long-standing health disparities and issues related to minority health inequities in the United States"[12] comes at a crucial time for our nation.

America's greatest asset is its people—all of its people. From the research workforce to research participants, increasing diversity is essential if we are to realize the full promise of genomics research and the equitable application of genetic discoveries in healthcare and society. Sustained budget increases for NIH are necessary to fund programs that emphasize diversity and equity in the workforce and that broaden participation by the public in research.

NIH FUNDING FOR THE FUTURE

The COVID–19 pandemic caused unprecedented disruptions to the biomedical research enterprise in 2021. This was especially true in the human genetics and genomics community, where researchers either closed laboratories or repurposed their genome sequencing machines for performing SARS–CoV–2 testing, tracking and tracing. Strong funding is needed in FY2022 to help the workforce recover.

ASHG joins its fellow members of the Federation of American Societies for Experimental Biology (FASEB) and the Ad Hoc Group for Medical Research in recommending a $46.1 billion base budget for NIH for FY 2022. This funding level would allow NIH's base budget to keep pace with inflation, specifically the biomedical research and development price index, and support crucial research on human genetics and genomics across all of the NIH's 27 Institutes and Centers.

The American Society of Human Genetics (ASHG), founded in 1948, is the primary professional membership organization for human genetics specialists worldwide. The Society's nearly 8,000 members include researchers, clinicians, genetic counselors, nurses and others who have a special interest in the field of human genetics.

[This statement was submitted by Gail Jarvik, MD, PhD, President, American Society of Human Genetics.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF NEPHROLOGY

On behalf of the more than 37 million Americans living with kidney diseases, the American Society of Nephrology respectfully requests that in the Office of the Secretary of Health and Human Services (IOS), General Department Management, $25 million be included for KidneyX, a public-private partnership to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases, in the Fiscal Year (FY) 2022 Labor, Health and Human Services, Education and Related Agencies Appropriations bill.

More than 37 million people in the United States are living with kidney diseases, and nearly 800,000 have kidney failure, for which there is no cure. This under-recognized epidemic disproportionately affects communities of color. For instance, Black Americans comprise 13 percent of the U.S. population but represent 33 percent of Americans receiving dialysis, the most common therapy for kidney failure.

The COVID–19 pandemic is especially deadly for kidney patients. Americans with kidney diseases are among the most at risk among Medicare beneficiaries for severe outcomes from COVID–19—including hospitalization and death,i,ii,iii,iv and COVID–19 damages the kidneys of as many as 40–50% of all hospitalized COVID–19 patients, even those without a prior history of kidney diseases.v,vi

The status quo for treating and managing kidney diseases is far too costly to taxpayers to continue without intervention. Before the COVID–19 pandemic, Medicare dedicated $130 billion, or 25 percent of all traditional Medicare fee-for-service

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[10] Collins, F., Doudna, J.A., Lander, E., and Rotimi, C.N. Human Molecular Genetics and Genomics—Important Advances and Exciting Possibilities. N.Engl.J.Med 2021. 384:1–4.

[11] https://allofus.nih.gov/.

[12] https://www.nih.gov/ending-structural-racism/unite.

spending, to the care of all kidney diseases, including $50 billion, or 7 percent of Medicare fee-for-service spending, to manage kidney failure alone. Relative to other chronic diseases with comparable federal spending and disease burden, people with kidney diseases have had a lack of innovation in the prevention, diagnosis, and treatment of kidney diseases, but hope is on the horizon: KidneyX is attracting a new generation of innovators and investors and transforming kidney care.

KidneyX is incentivizing innovators to fill unmet patient needs through a series of prize competitions, de-risking the commercialization process by fostering coordination among federal agencies and creating a sense of urgency on behalf of patients and families. To date, KidneyX has provided funding to more than 50 innovators across 4 prize competitions for solutions ranging from patient-generated solutions that improve quality of life while living with kidney diseases to steps toward paradigm-shifting technologies such as a wearable or implantable artificial kidney. In 2020, KidneyX awarded the COVID–19 Kidney Care Challenge to identify solutions that will reduce the risk of COVID–19 to kidney patients and launched the Artificial Kidney Prize to accelerate the development of an artificial kidney. Winners of Phase 1 of the Artificial Kidney Prize will be announced in September 2021. FY 22 funding will support continued development of an artificial kidney through Phase 2 and 3 of the Artificial Kidney Prize and other innovations to catalyze further private investment in meeting the long unmet needs of this underserved population.

Winning innovations awarded KidneyX prizes have supported innovators in 22 states, including those highlighted below:

—Applying advances in science and technology to improve current kidney failure therapies, such as nanomaterials to reduce infections in dialysis grafts and an innovative catheter which might exponentially reduce infections in the provision of dialysis, both seeded through the Redesign Dialysis Phase 1 and Redesign Dialysis Phase 2 prize competitions

—Patient generated solutions to better manage their care, such as clothing which provides health care staff easy access to dialysis ports without having to remove or scrunch up clothing, seeded through the Patient Innovator Challenge

—Novel methods for maintaining kidney health during the pandemic such as a "Good Humoral Immunity Truck" to deliver vaccines to patients in hard-to-reach communities, and a new reusable N–95 respirator to aid in the high-touch care setting of a dialysis unit, seeded through the COVID–19 Kidney Care Challenge

—New technologies as innovative treatment options, such as an implantable silicon filter cartridge that mitigates the need for dialysis needles or a method to grow human kidney cells on animal kidney scaffolds that could increase the number of transplantable organs, both seeded through the Redesign Dialysis Phase 1 and Redesign Dialysis Phase 2 prize competitions

A bipartisan achievement, KidneyX was first unveiled as a concept at the 2016 Obama White House Organ Summit and was a central pillar of Former President Donald J. Trump's July 2019 Executive Order on Advancing American Kidney Health. KidneyX is a true public-private partnership: the private sector has already committed $25 million to KidneyX and is committed to matching federal funding to achieve a total $250 million in the first 5 years. KidneyX has received $10 million since FY 20 in enacted appropriations. Since its inception, KidneyX has demonstrated the success of its public-private prize funding model, delivering on its mission of accelerating innovation in kidney care, attracting new innovators and investors to the kidney space, and broadening the availability of novel ideas and capital to improve the lives of the 37 million Americans with kidney disease.

In light of this strong track record, we respectfully request that the Labor-HHS Subcommittee continue its commitment by appropriating $25 million in FY 2022 for KidneyX, catalyzing private sector investment in kidney health including to develop the world's first artificial kidney. In addition, we also ask that you include the following language in the report accompanying your Committee's appropriations bill:

The Committee is aware that more than 37 million people in the United States are living with kidney diseases, and for nearly 800,000 of those individuals, the diseases progress to kidney failure, requiring access to dialysis or kidney transplantation to live. The Committee notes that kidney failure alone accounted for more than 7% of Medicare spending (approximately $50 billion) in CY 2018, yet therapeutics for kidney failure remain limited and 50% of patients starting dialysis, the most common therapy for kidney failure, will die within 5 years.

Given the high cost of kidney disease in terms of health consequences and federal spending, the Committee recommends that a total of $25,000,000 be added to the funds for the Office of the Secretary in FY 2022 and that those funds be made available to support KidneyX. These funds will accelerate the development and adoption

of the artificial kidney and other novel therapies and technologies that improve the diagnosis and treatment of people with kidney diseases.

Thank you for your consideration of this important request. Should you have questions or need additional information, do not hesitate to contact Zach Kribs, Senior Government Affairs Specialist of the American Society of Nephrology, at (202) 618–6991 or zkribs@asn-online.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

The American Society of Nephrology is a 501(c)(3) non-profit, tax-exempt organization that leads the fight against kidney disease by educating the society's more than 21,000 nephrologists, scientists, and other healthcare professionals, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. For more information, visit www.asn-online.org.

v Birkelo, B C. et al. Comparison of COVID–19 versus influenza on the incidence, features, and recovery from acute kidney injury in hospitalized United States Veterans. Kidney Int. 2020;0(0). doi.org/10.1016/j.kint.2021.05.029

vi Chan L, et al. AKI in Hospitalized Patients with COVID–19. JASN. 2021;32(1):151–160. doi: 10.1681/ASN.2020050615

[This statement was submitted by Zachary Kribs, Senior Government Affairs Specialist, American Society of Nephrology.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF NEPHROLOGY, THE AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY, AND THE NATIONAL KIDNEY FOUNDATION

On behalf of more than 37 million children, adolescents, and adults living with chronic kidney diseases (CKD) in the United States, the American Society of Nephrology, the American Society of Pediatric Nephrology, and the National Kidney Foundation request $46.11 billion for the National Institutes of Health in FY 2022, an increase of 7.3% that will provide real growth of 5% after accounting for the biomedical research and development price index of 2.3%, and request an increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) that is at least proportional to the increase for NIH. Greater investment in kidney research is needed to advance understanding of the under-recognized public health epidemic of kidney diseases and address the disproportionate impact of COVID–19 and racial disparities experienced by Americans living with kidney diseases.

For nearly 800,000 Americans, kidney diseases progress to kidney failure, a life-threatening condition for which there is no cure. Kidney failure is most commonly managed by in-center hemodialysis, a therapy that has changed little in the 50 years since its development with a survival rate worse than most cancers (and comparable with brain cancers), or a kidney transplant, the optimal therapy for most patients but often inaccessible due to a shortage of organs and inequities in our nation's transplant health system. Both therapies involve suppression of the immune system and put patients at increased risk of communicable diseases—especially COVID–19—and significant racial and ethnic disparities exist in terms of therapy access and patient outcomes.

Almost 50 years ago, Congress made a commitment to treat all Americans with irreversible kidney failure through the Medicare End-Stage Renal Disease (ESRD) Program regardless of age. Medicare spends $130 billion on the care of people with kidney diseases, or 22% percent of all Medicare fee-for-service spending. Of this amount, $49 billion is spent managing the care of people with kidney failure. Individuals with kidney failure represent only 1% of Medicare beneficiaries but comprise 7.2% of Medicare fee-for-service expenditures. Despite this enormous societal cost, kidney disease research supported by NIH is equivalent to one-half of one percent of Medicare fee for service expenditures for beneficiaries with kidney diseases and kidney failure.

People with kidney diseases face stark racial and socioeconomic disparities in disease burden and access to care. Black Americans (17%) and Hispanic Americans (15%) are more likely to have kidney diseases than white Americans (14%) and these disparities increase as kidney diseases progress to kidney failure: Black Americans are 3.5 times more likely than white Americans to have kidney failure and Hispanic Americans are 1.5 times more likely to have kidney failure than white Americans. Disparities in prevalence and outcomes are due to multiple factors including lack of access to care, social determinates of health, and systemic racism. Greater investment in research is needed to increase understanding about the underlying causes of disparities and generate interventions to address them.

Kidney disease patients also are at an increased risk of severe outcomes from COVID–19, such as hospitalization and death, due to their vulnerable physical conditions, multiple chronic conditions, weakened immune systems, and for those on dialysis, the need to leave home three times a week to receive care in a facility with other vulnerable patients. Further, COVID–19 has been shown to cause kidney damage in as many as 50% of hospitalized COVID–19 patients, even those without a previous history of kidney disease, often requiring emergency dialysis. While the long-term effects of COVID–19 on kidney health and function are under investigation, it is likely that COVID–19 will lead to an influx of new patients with kidney diseases, and that some of these patients will require ongoing care. Despite the severe impact of COVID–19 on people with kidney diseases and kidney health, no dedicated COVID–19 funding has been provided to NIDDK to-date, forcing research of the impact of COVID–19 on kidney health to come at the expense of existing research projects.

Many kidney disease patients also experience comorbidities such as cardiovascular disease (including heart attack and stroke), anemia, bone disease, hypertension, and diabetes. Pediatric kidney disease patients often have rare medical conditions with different needs associated with them than typical adult patients, which must be better understood. Greater investment in kidney research should be an urgent priority to slow disease progression, improve treatment, reduce morbidities, and improve patients' quality of life. NIDDK-funded scientists have produced several major breakthroughs in the past several years that require further investment to stimulate therapeutic advancements. For example, NIDDK launched the Kidney Precision Medicine Project that will pinpoint targets for novel therapies-setting the stage for personalized medicine in kidney care. However, additional funding is needed to accelerate these and other novel opportunities to improve the care of patients with kidney disease. Better understanding of the natural history of kidney disease and its progression in adults and children could lead to earlier detection and better treatments to slow disease progression and perhaps prevent irreversible kidney failure.

Thank you again for your leadership, and for your consideration of our request. Should you have any questions or wish to discuss kidney disease research in more detail, please contact Erika Miller with the American Society of Pediatric Nephrology at emiller@dc-crd.com; Rachel Meyer with the American Society of Nephrology at rmeyer@asn-online.org; or Lauren Drew with the National Kidney Foundation (NKF) at lauren.drew@kidney.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

The American Society of Nephrology is a 501(c)(3) non-profit, tax-exempt organization that leads the fight against kidney disease by educating the society's more than 21,000 nephrologists, scientists, and other healthcare professionals, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. For more information, visit www.asn-online.org.

ABOUT THE AMERICAN SOCIETY OF PEDIATRIC NEPHROLOGY

Founded in 1969, the American Society of Pediatric Nephrology is a professional society composed of pediatric nephrologists whose goal is to promote optimal care for children with kidney disease and to disseminate advances in the clinical practice and basic science of pediatric nephrology. ASPN currently has over 600 members, making it the primary representative of the Pediatric Nephrology community in North America.

ABOUT THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation is the largest, most comprehensive, and longstanding patient-centric organization dedicated to the awareness, prevention, and treatment of kidney disease in the U.S. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the National Kidney Foundation Kidney Disease Outcomes Quality Initiative (KDOQI). For more information about NKF, visit www.kidney.org

[This statement was submitted by Sharon Pearce, Senior Vice President, Government Relations, National Kidney Foundation, American Society of Nephrology, American Society of Pediatric Nephrology, and National Kidney Foundation.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF PLANT BIOLOGISTS

On behalf of the American Society of Plant Biologists (ASPB), we would like to thank the Subcommittee for its support for the National Institutes of Health (NIH). ASPB and its members strongly believe that sustained investments in scientific research are a critical component of economic growth, job creation, and innovation for our nation. ASPB supports continued robust funding for NIH in fiscal year (FY) 2022 and asks that the Subcommittee encourage increased support for plant-related research with relevance to health within the agency.

ASPB, founded in 1924 as the American Society of Plant Physiologists, was established to promote the growth and development of plant biology, to encourage and publish research in plant biology, and to promote the interests and professional advancement of plant scientists in general. ASPB members educate, mentor, advise, and nurture future generations of plant biologists; they work to enhance understanding of plant biology and its impacts on public health and wellbeing, as well as science in general, in K–16 schools and among the general public; they advocate in support of plant biology research; work to convey the relevance and importance of plant biology; and they provide expertise in policy decisions world-wide. Overall, ASPB members, as representatives of the society, work to disseminate information and to excite future generations about plant sciences, especially through ASPB's advocacy, outreach activities, conferences, and publications.

PLANT BIOLOGY RESEARCH AND AMERICA'S FUTURE

Among many other functions, plants are the building blocks at the base of the food chain upon which all life depends. Importantly, plant research is also helping make many fundamental contributions to the study of human health, including that of a sustainable supply and discovery of plant-derived pharmaceuticals, nutriceuticals, and alternative medicines. One example is the antimalarial compound artemisinin, purified from sweet wormwood plants, whose biosynthetic pathway was defined and transplanted into yeast to create a low-cost source of this pharmaceutical for the developing world. Plants are potential resources to produce vaccines against infectious diseases such as Ebola, hepatitis B, cholera, and coronavirus. At least one plant-derived COVID–19 vaccine candidate, developed by GlaxoSmithKline and Medicago, is already in phase III clinical trials and could be a valuable asset in ending the COVID–19 pandemic.[1] Nearly 120 pure compounds extracted from plants are used globally in medicine, hinting at the significant possibilities for future discoveries applicable to human health, agriculture, and manufacturing.[2] Plant research also contributes to the continued, sustainable, development of better and more nutritious foods and the understanding of basic biological principles that underpin improvements in public health and human nutrition.

PLANT BIOLOGY AND THE NATIONAL INSTITUTES OF HEALTH

Plant science and many of our ASPB member research activities have enormous positive impacts on the NIH mission to pursue "fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability." In general, plant research aims to improve the overall human condition-be it food, nutrition, medicine, clean air, or agriculture-and the benefits of plant science research readily extend across disciplines. In fact, plants are often the ideal model systems to advance our "fundamental knowledge about the nature and behavior of living systems" as they provide complexity of multi-cellular organisms including humans while affording ease of genetic manipulation, a lesser regulatory burden, and maintenance requirements that are less expensive than those required for the use of animal systems.

Fundamental Biological Research.—Many fundamental biological components and mechanisms are shared by plants and animals. Examples include but are not limited to genetic principles, cell division, host-pathogen interactions, organism-environment interactions, polar growth, DNA methylation and repair, innate immunity signaling, and circadian (biological) rhythms. Fundamental hereditary laws were derived from the study of garden peas. The phenomenon of RNA interference, which has application in gene therapies for human disease, was first discovered in plants. Contributions of plant genetics to advancing human health were exemplified when

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[1] https://www.medicago.com/en/media-room/medicago-and-gsk-start-phase-3-trial-of-adjuvanted-covid-19-vaccine-candidate/.

[2] Page 19, Decadal Vision, https://plantsummit.files.wordpress.com/2013/07/plantsciencedecadalvision10-18-13.pdf.

Barbara McClintock, an American scientist and cytogeneticist, was awarded the Nobel Prize in Physiology for the discovery of "jumping genes" or transposable elements in maize, which function as mobile DNA sequences within a genome. Similar elements constitute ~40% or more of the human genome. More recently, plants are among organisms that have been used to develop revolutionary technologies such as gene editing (CRISPR), capable of precisely editing genomes to potentially correct mutations that lead to disease. These technologies will benefit plant biology and agriculture to produce healthy food and feed the world. Furthermore, many treatments and therapies are based on metabolites derived from plants, which exemplifies the application of plant biology research to improving human health. These important discoveries, among many others in science and technology, reflect the fact that some of the most important biological discoveries applicable to human physiology and medicine can find their origins in plant-related research endeavors.

Health and Nutrition.—Plant biology research is also central to the application of basic knowledge to "extend healthy life and reduce the burdens of illness and disability." Without good nutrition, there cannot be good health. Indeed, a World Health Organization study on childhood nutrition in developing countries concluded that over 50% of child deaths under the age of five could be attributed to malnutrition's effects on weakening the immune system and exacerbating common illnesses such as respiratory infections and diarrhea;[3] this is expected to worsen as global populations increase. One example of how advances in plant biology have been applied to tackling nutritional deficiencies is golden rice, designed to address vitamin A deficiency and reduce blindness risk in vulnerable children. Golden rice was engineered to include additional genes that switch on production of beta-carotene, and a bowl of this golden rice can provide 60% of a child's daily requirement of vitamin A to prevent blindness. Significant advances have also been made in the production of value-added and resilient crops capable of withstanding drought, natural disasters, and extreme temperature shifts. DroughtGard Hybrid corn, engineered to maximize water storage, usage, and crop yield in unfavorable drought conditions, is just one example of the progress being made towards health, nutrient, and food security through innovations made in plant science.

Obesity, cardiac disease, and cancer also take a striking toll globally. Research to improve and optimize concentrations of plant compounds known to have, for example, anti-cancer properties, will help in reducing disease incidence rates. Ongoing development of crop varieties with value-added nutraceutical content is an important contribution that plant biologists are making toward realizing a common goal of personalized, preventative medicine.

Drug Discovery.—Plants are fundamentally important as sources of both extant drugs and drug discovery leads. In fact, 60% of anti-cancer drugs in use within the last decade are of natural product origin-plants being a significant source. An excellent example is the anti-cancer drug Taxol, which was discovered as an anti-carcinogenic compound from the bark of the Pacific yew tree through collaborative work involving scientists at the NIH National Cancer Institute and plant natural product chemists. While the pharmaceutical industry has invested some efforts on natural products-based drug discovery, research support from NIH remains a crucial component of the drug development pipeline. Multidisciplinary teams of plant biologists, bioinformaticians, and synthetic biologists are being assembled to develop new tools and methods for natural products discovery and creation of new pharmaceuticals. We appreciate NIH's current investment into understanding the biosynthesis of natural products through transcriptomics and metabolomics of medicinal plants and support more funding opportunities similar to the "Genomes to Natural Products" which will enhance new plant-related medicinal research.

CONCLUSION

Plants play unique and pivotal roles in nutrient and health, agriculture, and food supply, as well as basic science discoveries directly or indirectly relevant to public health. Plant biology research integrates seamlessly and synergistically with many different disciplines and core missions at NIH. As such, ASPB asks the Subcommittee to provide continued robust funding for NIH and direct the agency to support additional plant research in order to continue to pioneer new discoveries and new methods with applicability and relevance in biomedical research. Thank you for your consideration of ASPB's testimony. For more information about ASPB, please see www.aspb.org.

[This statement was submitted by Crispin Taylor, Ph.D., Chief Executive Officer, American Society of Plant Biologists.]

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[3] https://www.who.int/bulletin/archives/78(10)1207.pdf.

PREPARED STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Chairwoman Murray and Ranking Member Blunt: The American Speech-Language-Hearing Association (ASHA) thanks you for the opportunity to submit testimony on the fiscal year (FY) 2022 Labor-HHS-Education funding bill. My name is A. Lynn Williams, PhD, CCC–SLP, ASHA's President for 2021. As the Subcommittee begins its work on this critical legislation, I offer support for the following funding requests:

—$15.5 billion for Individuals with Disabilities Education Act (IDEA) Part B State Grants, $598 million for IDEA's Part B Section 619 Preschool Grants, and $732 million for IDEA Part C Infants and Toddlers with Disabilities within the Department of Education.

—$11,851,488 for the Centers for Disease Control and Prevention (CDC) and $19,522,758 for the Health Resources and Services Administration (HRSA) for the Early Hearing Detection and Intervention programs within the Department of Health and Human Services. In addition, ASHA urges the Subcommittee to include report language to address hearing health care disparities in medically underserved communities.

—$15.5 million increase in funding for the National Institute on Deafness and Other Communications Disorders (NIDCD) at the National Institutes of Health (NIH), while ensuring that NIDCD receives an equitable funding share from any increases to NIH funding in FY 2022.

—$122,970,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) at the Administration for Community Living (ACL) within the Department of Health and Human Services.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

ASHA thanks members of the Subcommittee for increasing funding for the Individuals with Disabilities Education Act (IDEA) last year. Children and youth (ages 3–21) receive special education services and related services under IDEA Part B, and infants and toddlers (birth-2 years old) with disabilities and their families receive early intervention services under IDEA Part C. Congress must continue to make appropriate investments in IDEA to ensure children with disabilities receive the free appropriate public education (FAPE), which they are entitled to under law. A substantial increase in funding for IDEA is a step toward fulfilling the promise that Congress made to fund 40% of the average per-pupil expenditure in public elementary and secondary schools. This critical program serves more than 6.5 million children in our nation's schools, including students with communication disorders.[1] ASHA appreciates the Administration's budget request for IDEA, which would provide substantial increases for IDEA Part B State Grants, Section 619 Preschool Grants, and Part C Infants and Toddlers early intervention services, and that is a significant investment toward fully funding this program.

These resources are essential to support states and local education agencies in providing FAPE to all students with disabilities. However, schools and districts continue to grapple with costs associated with the Coronavirus Disease 2019 (COVID–19) pandemic and require additional resources to address challenges associated with ensuring continued education and delivering the services and supports for children with disabilities. ASHA supports robust funding for IDEA as identified to ensure students with disabilities can continue to access the services to which they are entitled.

EARLY HEARING DETECTION AND INTERVENTION PROGRAM

The Early Hearing Detection and Intervention (EHDI) Act is one of the nation's most important public health programs, offering early hearing screening and intervention to all newborns, infants, and young children in every state and territory. EHDI provides state grants to develop and support infant hearing screening and intervention programs through HRSA and requires the CDC to provide surveillance of screenings, referral to treatment and diagnosis, technical assistance, and applied research. When the Children's Health Act of 2000 was passed-which established the state-based universal newborn hearing screening programs-only 46.5% of newborns were screened.[2] However, today approximately 98% of newborns receive an

[1] U.S. Department of Education. (n.d.). About IDEA. https://sites.ed.gov/idea/about-idea/.

[2] Centers for Disease Control and Prevention (CDC). (2010). Summary of infants screened for hearing loss, diagnosed and enrolled in early intervention, United States, 1999–2008. Atlanta, GA: U.S. Department of Health & Human Services, CDC; 2010. https://www.cdc.gov/ncbddd/hearingloss/2008-data/ehdi__1999__2008.pdf.

audiologic screening totaling 4 million infants and children in 2016 alone.[3] Funding for hearing screenings and early intervention services has proven to be a wise investment for the United States' economy and saves the country approximately $200 million in education costs each year.[4]

Fully funding EHDI at its authorized level is critical to ensure all newborns are screened for hearing loss and receive follow-up services. Hearing loss is a serious health condition that impacts more than 34 million Americans, and two to three out of every 1,000 children in the United States are born with a detectable level of hearing loss in one or both ears.[5] Underfunding EHDI may leave thousands of children with undiagnosed hearing loss and deprive children who are deaf or hard of hearing from receiving follow-up services that improve language skills and development as many health care appointments and treatments have been delayed or canceled due to the COVID–19 pandemic. When hearing loss is detected late, the critical time for stimulating the auditory pathways to hearing centers of the brain is lost. Late hearing loss detection also delays speech and language development affecting social and emotional growth, academic achievement, and employment options.

Children with hearing loss also face significant barriers in accessing hearing health care services. Variables including socioeconomic factors, geographic location, medical infrastructure, and access to social support contribute to delays in diagnosis and treatment of hearing loss. These disparities particularly impact members of racial and ethnic minority communities. According to a 2017 study, African American infants are 92% more likely to experience loss to follow-up than infants from other ethnic groups.[6] Rural Hispanic children whose caregivers have low English fluency encounter greater difficulty accessing these health care services.[7] According to CDC data, American Indian and Alaskan Native children enroll in early intervention services at a rate 26.4% less than their White counterparts.[8] The CDC must expand its work to improve surveillance, ensure access to timely identification of congenital and acquired hearing loss, and enhance the connection to follow-up services, particularly among racial and ethnic minority populations. ASHA supports fully funding EHDI at its authorized level and encourages the Subcommittee to include the following language in the report on its FY 2022 bill:

The Committee recognizes the importance of access to pediatric hearing health care. The Committee is aware of the significant racial and ethnic disparities in care facing children with hearing loss, and the effect unaddressed congenital hearing loss has on communication skills, psychosocial development, educational progress, and language development. The Committee encourages the CDC to expand their work to improve surveillance of state and territorial-based EHDI systems to ensure access to timely identification of congenital and acquired hearing loss and develop materials to enhance connection to follow up services among racial and ethnic minorities, and other medically underserved populations.

National Institute on Deafness and Other Communication Disorders, and the National Institute on Disabilities, Independent Living and Rehabilitation Research

ASHA applauds the Subcommittee's continued efforts to increase funding for health care research. ASHA strongly supports continued increases in funding for the National Institute on Deafness and Other Communications Disorders (NIDCD) at the National Institutes of Health (NIH), and the National Institute on Disabilities, Independent Living and Rehabilitation Research (NIDILRR) at the Administration for Community Living (ACL). NIDCD investments are needed to ensure groundbreaking research on communication sciences as rehabilitation continues to evolve and expand. Approximately 46 million Americans have a communication disorder.[9] These disorders impact the economy through costs related to lost produc-

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[3] Centers for Disease Control and Prevention (CDC). (2018). Summary of 2016 National CDC EHDI Data. https://www.cdc.gov/ncbddd/hearingloss/2016-data/01-2016-HSFS-Data-Summary-h.pdf.

[4] Gross, S.D. (2007). Education cost savings from early detection of hearing loss: New findings. Volta Voices, 14(6),38–40.

[5] National Institute on Deafness and Other Communication Disorders (NIDCD). (2017). Researchers help uncover a root cause of childhood deafness in the inner ear using animal model. https://www.nidcd.nih.gov/news/2017/childhood-deafness-research.

[6] Bush, M. L., Kaufman, M. R., & McNulty, B. N. (2017). Disparities in access to pediatric hearing health care. Current opinion in otolaryngology & head and neck surgery, 25(5), 359–364. https://doi.org/10.1097/MOO.0000000000000388.

[7] Ibid.

[8] Centers for Disease Control and Prevention (CDC). (2020). Hearing Loss in Children. https://www.cdc.gov/ncbddd/hearingloss/2018-data/15-screening-demographics.html.

[9] National Institute on Deafness and Other Communication Disorders (NIDCD). (2019). Mission. https://www.nidcd.nih.gov/about/mission.

tivity, special education services, rehabilitation needs, health care expenditures, and lost revenue. Increases in NIDILRR's funding would allow the Institute to support the wide range of applied research and expand into new areas of emerging science to support individuals with disabilities. ASHA urges the Subcommittee to provide necessary funding for NIDCD and NIDILRR to ensure this research continues and evolves to address the needs of individuals with communication disorders.

CONCLUSION

Thank you for the opportunity to provide this testimony for the record. ASHA appreciates the Subcommittee's past investments in these important health and education programs and urges continued support at the recommended funding levels. These investments are crucial to ensuring audiologists and speech-language pathologists can meet the hearing, balance, speech, language, swallowing, and cognition-related needs of their patients, clients, and especially students who are receiving special education services in schools.

If you or your staff have any questions, please contact ASHA's associate director of federal affairs: Erik Lazdins, elazdins@asha.org, 444 North Capitol St NE, Washington, DC 20001.

PREPARED STATEMENT OF THE AMERICAN THORACIC SOCIETY

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—ATS urges Congress to provide at least $46.1 billion for the National Institutes of Health (NIH) for Fiscal Year (FY) 2022, an increase of $3.2 billion over FY2021.
  —$3.94 billion for the National Heart, Lung, and Blood Institute (NHLBI) at NIH.
  —$6.52 billion for the National Institute of Allergy & Infectious Diseases at NIH.
  —$419.9 million for the National Institute on Minority Health and Health Disparities at NIH.
  —$187.9 million for the National Institute of Nursing Research at NIH.
  —$875 million for the National Institute of Environmental Health Sciences (NIEHS).
—ATS urges Congress to provide $10 billion in funding for the Centers for Disease Control and Prevention (CDC) for FY 2022. After decades of under-investment, the COVID–19 pandemic has revealed that we must strengthen our national, state and local public health systems and reinvest in the CDC.
  —$5 million in funding for the Chronic Disease Education and Awareness Program
  —$225 million in FY 2022 for the CDC's domestic Division of TB Elimination program and $21 million for the Global TB program
  —$35 million in funding for the National Asthma Control Program at CDC
  —ATS requests $50 million in FY2022 for CDC's Climate and Health Program
  —ATS requests $262.5 million in FY2022 for the Office on Smoking and Health
  —$354.8 million in funding for the National Institute of Occupational Safety and Health

ABOUT THE AMERICAN THORACIC SOCIETY

The ATS is a multi-disciplinary society of 16,000 physicians, scientists, respiratory therapists and nurses dedicated to the prevention, detection, treatment and cure of pulmonary disease, critical illness and sleep disordered breathing. Our members treat a wide range of lung disorders and have been on the frontlines of the COVID–19 pandemic treating individuals and conducting vital scientific research to develop diagnostics, treatments, and prevention interventions for COVID, even as we continue our efforts on other pulmonary, critical illness and sleep disorders.

ATS urges Congress to provide at least $46.1 billion for NIH for FY 2022

ATS thanks Congress for providing funding for NIH's COVID–19-related research which helped develop life-saving vaccines and other important advances. But the evolving pandemic requires the continued mobilization of research resources to improve our understanding of the SARS–CoV2 virus and develop new diagnostics, therapeutics, and updated vaccines to combat new virus variants. African Ameri-

cans, Native Americans and other racial and ethnic minorities continue to become infected and die from COVID–19 at high rates—we must accelerate efforts to address these disparities and develop prevention and therapeutic interventions for these and other high-risk populations. In addition, thousands of Americans who recovered from COVID–19 are now suffering chronic long-term complications. Studies into the causes, treatment, and prevention of long-term complications, such as pulmonary fibrosis, are urgently needed.

Respiratory disease in America is on the rise. Even before the COVID pandemic, lung disease was the fourth leading cause of death in the US, driven primarily by chronic obstructive lung disease (COPD). Despite the rising lung disease burden, lung disease research is underfunded. Although COPD is the fourth leading cause of death in the U.S., research funding for the disease is a small fraction of what is invested for the other leading causes of death, such as heart disease, cancer, and stroke, as outlined below. Funding for implementation of the COPD National Action Plan would address this disparity.

ATS urges Congress to provide $3.94 billion for NHLBI

Since 1948, the NHLBI has made important progress in the treatment and prevention of cardiovascular disease, respiratory diseases, and blood and sleep disorders. Even with this progress, challenges remain as these conditions continue to account for more than 1 million American deaths each year and cost our nation an estimated $479 billion in medical expenses and lost productivity.

To continue important advances in research, the NHLBI is investing in prevention programs and developing novel therapies for lung diseases such as chronic obstructive pulmonary disease (COPD), asthma, cystic and pulmonary fibrosis and driving precision medicine that is tailored to individual patient needs through data science.

ATS urges Congress to provide $875 million for NIEHS

NIEHS is the leading institute conducting research to prevent human illness and disability by understanding how the environment influences the development and progression of human diseases and illnesses such as cancer, autism, asthma and autoimmune diseases. Researchers funded by NIEHS have highly relevant expertise that will aid our response to COVID–19 and future pandemics through study of mechanisms to protect health care workers facing occupational exposure to SARS-CoV–2 and COVID–19, and how environmental exposures such as air pollution impact individual susceptibility to infection and development and severity of COVID–19 disease.

ATS urges Congress to provide $10 billion for CDC for FY 2022

In order to halt the COVID–19 pandemic and ensure our preparedness for future infectious disease outbreaks, it is critical that the CDC receives sustained annual funding increases. In FY2022, increased CDC funding is needed to ensure resources for COVID–19 vaccine distribution, administration and public education, testing, contact tracing, disease surveillance and targeted community assistance, including to communities that have been disproportionately impacted by COVID–19 and remain at high-risk, such as minority populations. More than 70 percent of CDC's budget goes directly to state public and local health organizations and academic institutions for programs that protect public health. CDC programs in chronic disease prevention, tuberculosis control, asthma, tobacco control and occupational safety and health are essential to protecting the health of millions of Americans.

ATS urges Congress to provide $225 million for the Division of TB Elimination and $21 million for CDC's Global TB program through the Center for Global Health.

Prior to the COVID–19 pandemic, TB was the leading global infectious disease killer, killing 1.4 million annually. Every state in the U.S. reports cases of TB each year. Further, in its 2019 report on antibiotic resistance, the CDC identified drug resistant TB as a serious health threat to the nation. CDC estimates that up to 13 million Americans have latent TB infection. These cases, which can be preventively treated, are the reservoir of future active TB cases. CDC's domestic TB program has been flat funded since FY2014, leaving states ill-equipped to manage drug resistant TB and unable to do LTBI testing and preventive treatment. In addition, we urge NIH to expand research to develop new tools to address TB.

ATS urges Congress to provide $35 million in funding for the National Asthma Control Program

An estimated 25 million people in the U.S. have asthma, including 6 million children. Asthma is the most common cause of missed school days—about 14 million per year. As recently as 2016, 3,274 Americans died of asthma. About 63% of these deaths were among women.

CDC's asthma program includes the following core functions, 1) provides state grants for asthma control activities including asthma tracking and public health interventions, 2) Improves asthma education and management through coordinated school health programs, and 3) Conducts public health research to help target and inform asthma control efforts.

ATS urges Congress to provide $5 million in funding for the Chronic Disease Education and Awareness Program

In response to advocacy by ATS and disease advocates, in FY2021 Congress created CDC's new Chronic Disease Education and Awareness program to address chronic diseases such as COPD and sleep disorders. The program will fund competitive grants focused on public health initiatives to increase awareness and educate communities on how to prevent chronic diseases. Program grants can be used to support national and local implementation of the COPD National Action Plan, by raising awareness and improving access to COPD care and management and prevention. The program is funded at $1.5 million in FY2021, and additional resources are needed to support new cooperative agreements in meritorious areas. We also urge CDC to include COPD-based questions to future CDC health surveys, including the National Health and Nutrition Evaluation Survey (NHANES), the Behavioral Risk Factor Surveillance System (BRFSS) and the National Health Information Survey (NHIS).

SLEEP

Research studies demonstrate that sleep-disordered breathing and sleep-related illnesses affect an estimated 50–70 million Americans. The public health impact of sleep illnesses and sleep disordered breathing is known to include increased mortality, traffic accidents, cardiovascular disease, and other comorbidities. The ATS recommends a funding level of $1 million in FY2022 to support activities related to sleep and sleep disorders at the CDC. The ATS also recommends an increase in funding for research on sleep disorders at the NHLBI's Nation Center for Sleep Disordered Research (NCSDR). Thank you for your consideration of these requests.

[This statement was submitted by Lynn Schnapp, MD, ATSF, President, American Thoracic Society.]

PREPARED STATEMENT OF THE AMERICAN UROGYNECOLOGIC SOCIETY

The American Urogynecologic Society (AUGS) thanks the Subcommittee for the opportunity to submit comments for the record regarding our Fiscal Year 2022 report language recommendations for prioritizing research on Overactive Bladder and medications commonly prescribed to treat this condition at the NIH National Institute on Aging and the National Institute of Diabetes, Digestive and Kidney Diseases. AUGS is a national medical society whose mission is to promote the highest quality of care in female pelvic medicine and reconstructive surgery through excellence in education, research, and advocacy.

Overactive Bladder is a sudden, intense urgency to urinate often followed by an involuntary loss of urine. It can cause the need to urinate frequently, and often throughout the night, because of altered bladder nerve signaling. Overactive Bladder occurs in the absence of a urinary tract infection or other pathology.

Overactive Bladder affects more than 38 million Americans, and 1 in every 3 older adults. It is more common with aging and in women. Overactive Bladder has a significant impact on quality of life and on the healthcare system. Adults with Overactive Bladder are more likely to report anxiety and depression, falls, decreased quality of life, and have 20% higher health care utilization than matched counterparts without this condition. The Centers for Disease Control and Prevention estimated in the U.S., the direct and indirect costs of Overactive Bladder would be approximately $76 billion in 2015 and projected these costs would account for $82.6 billion of U.S. healthcare costs by 2020.

Anticholinergic medications are commonly prescribed to treat Overactive Bladder. These therapies are the most studied, most frequently used, and most often covered by insurance companies as a treatment for Overactive Bladder. However, there is increasing clinical evidence suggesting an association between long-term use of anticholinergic medications and the risk of developing cognitive impairment and Alzheimer's disease and related dementias (ADRD) in some patients with Overactive Bladder. In fact, the evidence is compelling enough that the American Urogynecologic Society's "Choosing Wisely" campaign recommends the avoidance of anticholinergic medications to treat Overactive Bladder in women older than 70.

It is well documented that the prevalence of Overactive Bladder increases with age. Therefore, as the American population continues to age over the next few decades, the personal and public health burden of Overactive Bladder will become more acute. Despite compelling data suggesting the negative impact of Overactive Bladder medications on cognitive function, more robust evidence is needed to guide evidence-based treatment approaches. Thus, current Overactive Bladder medications must undergo additional study to definitively determine their impact on cognition and Alzheimer's disease and related dementias (ADRD) development and to determine if the risks substantially outweigh the benefits of these therapies.

For these reasons, the American Urogynecologic Society urges the Subcommittee to adopt the following report language in the report accompanying the Fiscal Year 2022 Labor-HHS-Education appropriations bill that directs the National Institutes of Health National Institute on Aging (NIA) and the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) to study the association between current medications for Overactive Bladder and Alzheimer's disease and related dementias (ADRD) in certain patient populations, in order to advance research resulting in safe and effective treatment initiatives for all patients with Overactive Bladder.

NATIONAL INSTITUTES OF HEALTH

National Institute on Aging and National Institute of Diabetes, Digestive and Kidney Diseases

Overactive Bladder.—The Committee is concerned that anticholinergic medications commonly prescribed to treat Overactive Bladder, a condition that affects one in three older Americans, have been shown in recent studies to increase the risk of developing Alzheimer's disease and related dementias (ADRD). The Committee believes that further research of anticholinergic medications as well as on alternatives to these treatments is urgently needed to establish certainty regarding the safety of these medications as a treatment option for Overactive Bladder in older adults. The Committee urges that the National Institute on Aging (NIA) and the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK) prioritize research grants and contracts that study the long-term use of anticholinergic medications and the risk of cognitive impairment and ADRD. The Committee requests an update on this issue and on research activities to advance safe and effective alternative treatments for Overactive Bladder in the fiscal year 2023 Congressional Budget Justification.

Thank you in advance for your favorable consideration of this report language request and for your support for prioritizing research to ensure there are safe and effective treatments for the millions of Americans in this country that suffer from Overactive Bladder.

PREPARED STATEMENT OF THE ANTI-DEFAMATION LEAGUE

On behalf of the Anti-Defamation League (ADL), I write to urge Members of the Subcommittee to adopt legislative and report language that condemns proposals that would effectively curtail anti-bias programming in public schools. During 2021 sessions, a number of state legislatures have considered and adopted proposals that purport to block the teaching of material that is vaguely characterized as "divisive concepts," or as assigning blame or responsibility or creating guilt based on race, ethnicity, or sex. We are deeply concerned that these policies would drastically curb the use and further development of an essential tool in the effort to eliminate hate incidents: lessons and programs that teach young people about the history and institutionalization of hateful ideologies, awareness of biases, and importance of each person vocally opposing expressions of prejudice.

Founded in 1913 in response to an escalating climate of anti-Semitism and bigotry, ADL is a leading anti-hate organization with the mission of protecting the Jewish people and securing justice and fair treatment for all. Today, we continue to fight all forms of hate with the same vigor and passion. A global leader in exposing extremism, delivering anti-bias education, and fighting hate online, ADL's ultimate goal is a world in which no group or individual suffers from bias, discrimination, or hate. To that end, ADL is an advocate for Holocaust education. We strongly believe that learning about the Holocaust, and the unchecked anti-Semitism and racism that set the stage for and sustained it, is one of the best ways to fight prejudice and discrimination, and to help ensure that genocide and other atrocities never happen again.

ADL has actively opposed anti-″divisive concepts" bills and policies including Texas HB 3979, Arizona SB 1532, Louisiana HB 564, and New Hampshire HB 544; similar proposals that have advanced or been enacted in 2021 also include Iowa HF

802, which applies not only to K–12 schools but also to government agencies and public universities and was enacted by the legislature in early May 2021; West Virginia HB 2595, which proposes to end state funding for any agencies that promote "divisive" concepts or acts; and Oklahoma SB 803, which authorizes dismissal of teachers for instructing students in disapproved-of ideas and beliefs about, for example, the fundamentally racist and sexist nature of American society.

Although these bills vary in their details, their common features include vagueness, subjectivity, and the singling out of particular ideas for a prohibition on speech, which constitutes unconstitutional viewpoint discrimination. In fact, a federal judge has already determined that plaintiffs were likely to succeed in a First Amendment-based challenge to a similar federal prohibition adopted by a subsequently-revoked Executive Order. ADL is acutely dismayed that these proposals will have, and already have had, the effect of prompting cautious administrators to cancel or postpone critically important efforts to expand students' knowledge, experience, and sensitivity to systemic biases. The Iowa Department of Education, for example, postponed a conference on social justice and equity in education originally planned for April 2021, noting publicly that, "We are mindful of pending legislation that may impact the delivery and content of certain topics related to diversity, equity and inclusion."

Another common feature of recent legislation billed as taking aim at the spread of "divisive concepts" is language that prohibits teaching that makes an individual "feel discomfort, guilt, anguish or any other form of psychological distress because of the individual's race, ethnicity or sex." We are particularly alarmed that this measure would effectively create a "heckler's veto" of critical education in our public schools. Legitimate Holocaust curricula or educational programs must necessarily condemn the antisemitic and racist ideology of the Nazis, as well as Holocaust denial. As a leading authority on extremism, terrorism, and hate, both foreign and domestic, we also note that today's white supremacists and neo-Nazis are virulently antisemitic, racist, xenophobic, misogynistic, homophobic, and do not consider light-skinned Jews to be "white people." We foresee that under the rules set forth in these bills, any student or employee who is white and holds these odious beliefs, whether or not affiliated with an extremist group, could claim that a Holocaust education program impermissibly makes them feel discomfort, guilt, anguish, or other psychological distress because of their white race. The same could be true for someone holding these beliefs who claims that discussion of the Holocaust and historical antisemitism constitutes discrimination based on their German ethnicity or national origin. This concern is not hypothetical. Only two years ago there was a disturbing issue at a South Florida public high school involving parents who did not believe the Holocaust occurred, who succeeded in impacting the school's delivery of state-mandated Holocaust education.

At a time of rising hate crimes and anti-Semitic incidents, the need to teach young people who are still forming their beliefs and principles the universal lessons of the Holocaust, and the devastating consequences of all forms of bigotry and hate, is acute and urgent. Anti-bias education and the imparting of honest information about the historical and social reasons for persistent disparities among people of different races, ethnicities, religions, genders, sexual orientations, and abilities are essential elements to the deconstruction of stratified, discriminatory systems: we simply cannot create a more just future without examining and confronting our unjust past and its modern-day footprints. Curricula that identify the hallmarks of bigotry and bring unconscious prejudices to light not only bend the moral arc of the universe toward justice, but also teach youth valuable leadership and problem-solving skills, and ensure that classroom environments are conducive to every student's progress. Positive communities that proactively welcome and celebrate inclusion foster academic and life success.

ADL urges Members of the Subcommittee to protect students' access to essential education about discrimination, biases, and the consequences of government and institutional embrace of prejudice by adopting legislative language that withdraws and withholds federal funding for public educational agencies and institutions that implement prohibitions on the teaching of so-called "divisive concepts," to include histories and present-day indicators of endemic hate and discrimination against groups of people based on race, ethnicity, national origin, religion, gender, gender identity, sexual orientation, and disability. In addition, we urge Members to adopt report language that notes the need for and benefits of anti-bias education in schools and that condemns attempts to limit or prohibit anti-bias programming in schools and other government institutions.

Thank you for your consideration.

[This statement was submitted by Erin Hustings, Director of Govt. Relations, Civil Rights Anti-Defamation League.]

PREPARED STATEMENT OF THE ASSOCIATION FOR CAREER AND TECHNICAL EDUCATION AND ADVANCE CTE

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, on behalf of the Association for Career and Technical Education (ACTE), the nation's largest not-for-profit association committed to the advancement of education that prepares youth and adults for career success, and Advance CTE, the nation's longest-standing not-for-profit that represents State Directors and leaders responsible for secondary, postsecondary and adult Career Technical Education (CTE) across all 50 states and U.S. territories, we respectfully request that the subcommittee increase funding for the Carl D. Perkins Career and Technical Education Act (Perkins V) Basic State Grant program, administered by U.S. Department of Education's Office of Career, Technical, and Adult Education, to $2.5 billion in the Fiscal Year (FY) 2022 Labor, Health and Human Services, Education, and Related Agencies appropriations bill. It is vital that Congress continues to build upon the recent increases to Perkins V in order to fully support the implementation of the law and the over 11 million learners it serves across the nation.[1]

In the Administration's recent budget proposal, the FY 2022 discretionary request proposes only a disappointing 1.5%, or $20 million, increase for the Perkins V Basic State Grant. This is inadequate given the growing need for skilled workers facing employers and learner demand for CTE. The additional $1 billion annually for middle and high school career pathways included in the President's budget request but through the American Jobs Plan would actually have a greater impact if this increase was authorized and appropriated through the Basic State Grant, and thus is included in our request.

CTE at the secondary and postsecondary levels is an integral part of achieving an equitable and efficient economic recovery. COVID–19 (the coronavirus) has affected the most foundational aspects of our society. With millions of Americans unemployed, or underemployed, and some industry sectors shuttered or undergoing rapid transformation, Black and Latinx workers, workers with a high school education or less and female workers have been disproportionately impacted. Now, more than ever, CTE is vital to our nation's learners, employers and economic recovery. Consider:

—The unemployment rate reached 14.8 percent in April 2020, the highest unemployment rate since data collection started in 1948. As of May 2021 unemployment remained higher than it had been in February 2020, before the pandemic came to the forefront (5.8 percent compared to 3.5 percent).[2]

—The unemployment rate for teenagers aged 16–19 hit 31.9 percent in April 2020, the highest it has even been in over 70 years. The only other time the unemployment rate for this population reached over 25 percent was during the Great Recession.[3]

—As of May 2021, 7.9 million workers reported that they were not able to find a job because their original employer either closed or was not hiring because of the pandemic.[4]

—The unemployment rates are also much worse for non-White young adults—35.5 percent and 31.1 percent for Black and Latino teenagers respectively, compared to 29 percent for White teenagers.[5]

For those individuals just at the beginning of their careers, losing opportunities to gain experience and a foothold in the labor market can have major, long-term impacts. For example, the millennial generation, who entered the workforce during the

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[1] Perkins Collaborative Resource Network, State Profiles. Retrieved from https://cte.ed.gov/profiles/national-summary.

[2] Congressional Research Service, Unemployment Rates During the COVID–19 Pandemic, June 2021. Retrieved from https://fas.org/sgp/crs/misc/R46554.pdf.

[3] U.S. Department of Labor, Bureau of Labor Statistics. Retrieved from https://www.bls.gov/opub/ted/2020/unemployment-rate-rises-to-record-high-14-point-7-percent-in-april-2020.htm.

[4] U.S. Department of Labor, Bureau of Labor Statistics, The Employment Situation—May 2021, June 2021. Retrieved from https://www.bls.gov/news.release/pdf/empsit.pdf.

[5] U.S Department of Labor, Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey. Retrieved from https://www.bls.gov/web/empsit/cpsee__e16.htm, based on quarterly averages.

height of the Great Recession, is estimated to have relatively low levels of home ownership, net worth and real income compared to previous generations.[6]

Unemployment trends during the pandemic have shown that upskilling and reskilling needs have already increased, and we can expect that will continue. CTE programs are instrumental in delivering high-quality education programs aligned with in-demand careers. It is projected that some—but not all—of the jobs lost during the pandemic will come back in one form or another. One study estimates approximately 60 percent of job loss will be temporary, while other studies predict about a quarter of job losses will be permanent. What is not in question is that the economy will look different on the other side of the recovery, with marginalized communities the most likely to be impacted, given Latinx Americans have been the most likely to have hours or shifts reduced and Black Americans have been the most likely to have been laid off during this crisis.[7]

CTE serves a critical role in supporting learners in their reskilling or upskilling as they look to either re-enter the economy or grow into new opportunities. Looking at data from the last recession, the vast majority of new and replacement jobs went to individuals with more than a high school diploma, including 3.1 million jobs that went to those with associate degree or postsecondary certificates. There is growing data that suggest that those who lost their jobs due to the coronavirus will pursue CTE-focused programs and degrees. About a third of adults report that, if they lose their jobs, they would need more education to replace them. Consider:

—A third of adults report they would potentially change careers.

—Two-thirds of adults interested in enrolling in postsecondary education and training in the next six months would do so to upskill or reskill.

—A majority of American workers say they prefer non-degree and skill-based education and training programs in today's economy.

This all aligns with outcomes from the last recession, with over 50 percent of displaced workers changing industries when they re-entered the workforce.[8]

Just as all education programs have been hit hard by the pandemic, so have CTE programs. This has been exacerbated by the lack of CTE-designated funding in stimulus bills. What sets CTE apart from other educational pathways is its focus on real-world skills and applied learning. High-quality CTE programs provide opportunities for direct engagement between industry and learners and instructors, often include work-based learning experiences, and enable learners to earn credentials of value. Yet what sets CTE apart is also what has presented unique challenges during the coronavirus era. CTE programs are facing many of the same dire needs as the entire education system, particularly those related to broadband and technology access, digital curriculum, and teacher professional development. However, many needs in CTE are exacerbated by the applied and lab-based nature of many courses, the need for learners to meet certification requirements, and the benefits of work-based learning and other experiential programs. CTE programs stand ready to provide employers a talent pipeline, and prepare students for careers in high-skill, high-wage, or in-demand industry sectors and occupations, but need additional support. Jobs that require more than a high school diploma but less than a baccalaureate degree were growing before the pandemic, and will continue to do so now. Further, automation coupled with the unemployment rate requires nimble, proactive, and responsive CTE and workforce programs that provide specific technical as well as transferable skills. As jobseekers and employers have looked to recover from the economic impacts of the pandemic, additional funding will ensure that the CTE system is primed to support their needs.

Despite this, no stimulus package during the pandemic has included CTE-designated funding. Although Perkins V has been named as an authorized use of some of the funding under the Education Stabilization Fund in each package, there is no guarantee that money will be allocated to CTE programs.

High-quality CTE programs are delivering real results. Across the country, CTE programs are preparing learners for promising career paths and giving employers and our economy a competitive edge. CTE programs provide unique opportunities for learners to engage with employers and participate in internships, apprenticeships and other meaningful on-the-job experiences. In addition, these programs produce strong outcomes for the learners they serve. The average high school grad-

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[6] Federal Reserve Bank of St. Louis, The Demographics of Wealth, How Education, Race and Birth Year Shape Financial Outcomes, 2018. Retrieved from https://www.stlouisfed.org/~/media/files/pdfs/hfs/essays/hfs__essay__2__2018.pdf?la=en.

[7] https://www.stradaeducation.org/wp-content/uploads/2020/04/Public-Viewpoint-Report-Week-4.pdf.

[8] The White House, Addressing America's Reskilling Challenge, 2018. Retrieved from https://www.whitehouse.gov/wp-content/uploads/2018/07/Addressing-Americas-Reskilling-Challenge.pdf.

uation rate for students concentrating in CTE is 95 percent, compared to a national adjusted cohort graduation rate of 85 percent.[9] Additionally, students involved in CTE are far less likely to drop out of high school than other students, a difference estimated to save the economy $168 billion each year.[10] Furthermore, those students are highly likely to continue their education-91 percent of high school graduates who earned two to three CTE credits enrolled in college.[11]

The outcomes for adult learners are also significant: 84 percent of adults concentrating in CTE programs either continued their education or were employed within six months of completing their program.[12] In fact, 90 percent of Americans agree that apprenticeships and skills training programs prepare individuals for a good standard of living.[13]

Expanding funding for CTE programs will create a brighter future for communities—leading to more career options for learners, better results for employers, and increased growth for our economy. Investing in CTE programs provides substantial benefits for not just the students enrolled, but for states and communities across the country. Every dollar spent on secondary CTE students in Washington state leads to $26 in lifetime earnings and employee benefits,[14] while individuals who receive a certificate or degree from California Community Colleges almost double their earnings within three years.[15] In Wisconsin, taxpayers receive $12.20 in return for every dollar invested in the technical college system.[16] Oklahoma's economy reaps a net benefit of $3.5 billion annually from graduates of the CareerTech System.[17] If we are serious about providing learners with the real-world skills, hands-on opportunities and real options for college and rewarding careers that come with CTE and making progress toward closing the skills gap, then there is no better time than now to invest $2.5 billion in Perkins CTE State Grants.

CTE programs are also preparing individuals with the skills that employers seek. A 2020 survey found that employers believe CTE is good for business, the economy, and public education, and the majority of those surveyed reported that those from a CTE program are better prepared with workplace, technical and real-world skills. Employers who recruit from CTE programs are also more likely to report industry growth. CTE programs have long provided unique opportunities for learners to engage with employers and participate in internships, apprenticeships, and other meaningful on-the-job experiences. Now more than ever, CTE serves a critical role in supporting learners in their reskilling or upskilling as they look to either re-enter the economy or grow into new opportunities.

CTE programs prepare students for careers in in-demand fields and provide an affordable pathway to both a family-sustaining career and financial independence. Health care occupations, many of which require an associate degree or industry credential, are projected to grow 14 percent by 2028-adding almost 2 million new jobs.[18] Half of all STEM occupations, which offer students high-skilled, high-wage

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[9] Perkins Collaborative Resource Network, Perkins Data Explorer, customized Consolidated Annual Report data. https://perkins.ed.gov/pims/DataExplorer; U.S. Department of Education, Office of Elementary Secondary Education, Consolidated State Performance Report, 2010–11 through 2016–17.

[10] Kotamraju, P. Measuring the return on investment for CTE. Techniques: 28–31, 2011. Retrieved from https://files.eric.ed.gov/fulltext/EJ943149.pdf.

[11] U.S. Department of Education, National Center for Education Statistics, Data Point: Career and Technical Education Coursetaking and Postsecondary Enrollment and Attainment: High School Classes of 1992 and 2004, 2016. Retrieved from https://nces.ed.gov/pubs2016/2016109.pdf.

[12] Includes only states that report data on adult CTE learners to the U.S. Department of Education. Perkins Collaborative Resource Network, Perkins Data Explorer, customized Consolidated Annual Report data. Retrieved from https://perkins.ed.gov/pims/DataExplorer/Performance.

[13] New America, Varying Degrees 2018: Executive Summary. Retrieved from https://www.newamerica.org/education-policy/reports/varying-degrees-2018/executive-summary/.

[14] Workforce Training and Education Coordinating Board, Workforce Training Results 2020. Retrieved from https://www.wtb.wa.gov/wp-content/uploads/2020/01/2020-Dashboard.pdf.

[15] Foundation for California Community Colleges, California Community Colleges, n.d. Retrieved from https://foundationccc.org/Portals/0/Documents/NewsRoom/FactSheets/ccc-facts-figures.pdf.

[16] Wisconsin Technical College System, The Technical College Effect, 2016. Retrieved from https://www.wistechcolleges.org/sites/default/files/POSTER8.5x11-2016update2__0.pdf.

[17] Snead, M. C., The Economic Contribution of CareerTech to the Oklahoma Economy: Cost-Benefit Analysis of Career Majors (FY11), 2013. Retrieved from https://www.okcareertech.org/about/costbenefit-analysis-of-career-majors/cost-benefit-analysis-of-career-majorsfy-11-pdf.

[18] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Healthcare Occupations. Retrieved from https://www.bls.gov/ooh/healthcare/home.htm.

career opportunities, require less than a bachelor's degree.[19] There are currently about 30 million "good jobs"-jobs that pay a median income of $55,000 or more and require education below a bachelor's degree.[20]

Additionally, the demand for workforce credentials is growing. The number of individuals earning certificates or associate degrees in CTE fields, such as manufacturing, health care, and STEM, rose 71 percent from 2002 to 2012.[21] Students can pursue these valuable credentials at community and technical colleges for a fraction of the cost of tuition at other institutions: $3,730, on average for the 2019–2020 academic year.[22] Highly-skilled workers deliver direct benefits to American employers through enhanced productivity and innovation; however, the increased demands on the workforce pipeline are a persistent barrier to economic growth. A projected three million workers are needed to fill infrastructure jobs in the next few years, including careers in construction, transportation and telecommunications.[23] Meanwhile, 89 percent of executives agree there is a talent shortage in the U.S. manufacturing sector, 5 percent higher than 2015 results.[24] These industries still need talent, even in the current economic climate.

Funding Perkins V at adequate levels will ensure that educators can equip students with the skills they will need for in-demand fields. This will become increasingly pressing as the country continues to recover from the current health pandemic and economic crisis. Already, healthcare jobs are projected to have the largest increase of any occupational sector.[25] Filling these and other positions created, as well as ensuring that each individual is able to access the training needed for employment, is critical.

CTE programs can serve even more learners and employers—but only if they receive more resources. According to The Bureau of Labor Statistics Job Openings and Labor Turnover Survey (JOLTS) Highlights for May 2021, the ratio of unemployed workers to job openings is 1.2, meaning that for 9.8 million unemployed workers there are only 9.1 million jobs available.[26] As more jobs lost during the pandemic become permanent, CTE remains a critical component to the workforce pipeline for key industries that are needed to sustain a long-term economic recovery, such as healthcare, STEM, manufacturing, construction and transportation distribution and logistics. But, learner demand for CTE programs, especially programs in in-demand sectors is greater than supply. With current and anticipated demand growing, more resources are needed to build, expand and support high-quality CTE programs. It is vital that Congress continues to build upon the recent increases to Perkins V to ensure we have the talent pipeline needed to fully recover from the jobs crisis caused by the pandemic.

And there's widespread support for CTE: 94 percent of parents approve of expanding access to CTE.[27] However, a survey of school districts offering CTE found that the top barrier to offering CTE in high school was a lack of funding or the high cost

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[19] Rothwell, J. The Hidden STEM Economy, Brookings Institution, 2013. Retrieved from https://www.brookings.edu/research/the-hidden-stem-economy/.

[20] Georgetown University Center on Education and the Workforce, Good Jobs that Pay Without a BA, 2017. Retrieved from https://goodjobsdata.org/wp-content/uploads/Good-Jobs-wo-BA-final.pdf.

[21] U.S. Department of Education, Office of Planning, Evaluation and Policy Development, Policy and Program Studies Service, National Assessment of Career and Technical Education: Final Report to Congress, 2014. Retrieved from https://www2.ed.gov/rschstat/eval/sectech/nacte/career-technical-education/final-report.pdf.

[22] College Board, Average published charges, 2018–19 and 2019–20. Retrieved from https://research.collegeboard.org/trends/college-pricing/figures-tables/average-published-charges-2018-19-and-2019-20.

[23] Kane, J. W., and Tomer, A. Infrastructure skills: Knowledge, tools, and training to increase opportunity, Brookings Institution, 2016. Retrieved from https://www.brookings.edu/research/infrastructure-skills-knowledge-tools-and-training-to-increase-opportunity/.

[24] Deloitte and the Manufacturing Institute, Skills Gap and the Future of Work Study, 2018. Retrieved from http://www.themanufacturinginstitute.org/~/media/E323C4D8F75A470E8C96D7A07F0A14FB/DI__2018__Deloitte__MFI__skills__gap__FoW__study.pdf; Deloitte and the Manufacturing Institute, The skills gap in U.S. manufacturing 2015 and beyond, 2015. Retrieved from http://www.themanufacturinginstitute.org/~/media/827DBC76533942679A15EF7067A704CD.ashx.

[25] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Healthcare Occupations. Retrieved from https://www.bls.gov/ooh/healthcare/home.htm.

[26] U.S. Department of Labor, Bureau of Labor Statistics, Job Openings and Labor Turnover Survey (JOLTS) Highlights; January 2020. Retrieved from https://www.bls.gov/web/jolts/jlt__labstatgraphs.pdf.

[27] Hart Research Associates, Public School Parents on the Value of Public Education: Findings from a National Survey of Public School parents conducted for the AFT, September 2017. Retrieved from https://www.aft.org/sites/default/files/parentpoll2017__memo.pdf.

of the programs.[28] As the chart below demonstrates, between FY2004 and FY2020, funding for CTE State Grants declined by over $77 million dollars, the equivalent of $427 million inflation-adjusted dollars (i.e., 28 percent in inflation-adjusted dollars).

Taking a longer view, before FY18, the investment in CTE State Grants had been relatively flat since 1991 without being tied to inflation, and the program's buying power had fallen by approximately $933 million in inflation-adjusted dollars—a 45 percent reduction over a quarter century.[29] Congress recognized the need to begin to reverse this trend and from FY18 to FY21 provided an additional $217 million for CTE State Grants, bringing the total investment to $1.342 billion. While the past four budgets represented initial down payments to meet increased need, a significant, robust investment in CTE programs is still imperative to account for persistent underfunding, the lack of inflation-adjusted increases, and most importantly, the overwhelming growth in demand for these programs from both learners and the American economy. Congress should build on the momentum from recent years and continue to strengthen the investment in CTE State Grants in FY2022. And, Americans agree: 93 percent of voters support increasing the investment in skills training.[30]

Now more than ever, individuals need access to upskilling and reskilling opportunities to be part of the evolving workforce, and CTE programs will be adapting, as always, to the needs of business and industry in the current economy. CTE is both a proactive and responsive strategy for attending to the economic downturn—CTE programs prepare learners for lifelong success while also offering targeted skilled training for others. We applaud the commitment to growing our investment in Perkins V, and we urge the subcommittee to make CTE a top priority in the FY 2022 Labor, Health and Human Services, Education, and Related Agencies appropriations bill. Now is not the time to back away from our commitment to advancing high-quality CTE, but rather the time to double down and ensure CTE programs are available for every learner who seeks to better their own lives and opportunities

Thank you for your thoughtful consideration of our request. For more information or if you wish to discuss our request, please contact ACTE's Government Relations Manager Michael Matthews (mmatthews@acteonline.org) or Advance CTE's Senior Associate for Federal Policy Associate Meredith Hills (mhills@careertech.org).

PREPARED STATEMENT OF THE ASSOCIATION FOR CLINICAL ONCOLOGY

The Association for Clinical Oncology (ASCO), the world's leading professional organization representing nearly 45,000 physicians and other professionals who treat people with cancer, thanks this subcommittee for its long-standing commitment to support federally funded research at the National Institute of Health (NIH) and National Cancer Institute (NCI). ASCO is extremely grateful for the $1.25 billion increase for the NIH in fiscal year (FY) 2021. This strong commitment to scientific discovery will help the research community continue current momentum and sustain our nation's position as the world leader in biomedical research. ASCO appreciates this opportunity to provide the following recommendations for FY2022 funding to build on our nation's investment in biomedical research:

—National Institutes of Health (NIH): $46.111 billion
  —National Cancer Institute (NCI): $7.609 billion
    —Beau Biden Cancer Moonshot Initiative: $194 million
—Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC): $559 million
  —Cancer Registries Program: $70 million

THE NIH: A GOOD INVESTMENT

In FY2020, the NIH provided over $34 billion in extramural research to scientists in all 50 states and the District of Columbia.[1] NIH research funding also supported

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[28] U.S. Department of Education, National Center for Education Statistics, Career and Technical Education Programs in Public School Districts: 2016–17. Retrieved from https://nces.ed.gov/pubs2018/2018028.pdf.

[29] U.S. Bureau of Labor Statistics, CPI Inflation Calculator. Retrieved from https://data.bls.gov/cgi-bin/cpicalc.pl.

[30] ALG Research, Poll Finds Overwhelming Support for More Funding for Skills Training, 2019. Retrieved from https://www.nationalskillscoalition.org/news/press-releases/body/Poll-Finds-Overwhelming-Support-for-More-Funding-for-Skills-Training.pdf.

[1] National Institutes of Health; https://www.nih.gov/about-nih/what-we-do/impact-nih-research.

more than 536,000 jobs and generated over $91 billion in economic activity last year.[2]

The importance of federally funded biomedical research has been on display over the last year as scientists from all corners of the country worked to quickly develop effective COVID–19 vaccines. Researchers working towards a vaccine were not starting from scratch; years of federally funded research progress led to the discovery and identification of practical uses for messenger RNA, or mRNA, as used in the Pfizer and Moderna vaccines. Prior to COVID–19 cancer researchers were using mRNA to trigger the immune system to target specific cancer cells. Building on previous scientific advancements, coupled with collaboration across federal agencies, academic institutions, and the private sector, unprecedented flexibility, and reduction in regulatory red tape, the resulting vaccines came to market at a record pace. This remarkable achievement—a result of years of research and scientific discovery—is a testament to the need for continued investment.

Despite recent funding increases, the COVID–19 pandemic has resulted in stagnant research progress and low clinical trial accrual rates, stifling the progress of our biomedical research enterprise and weakening our clinical trials networks. The funding levels we are requesting for FY2022 would aid in recovery from these setbacks and allow meaningful growth above biomedical inflation for the first time in over a decade. They would also allow the extraordinary progress seen pre-pandemic to continue. Failure to sustain investment in research places health outcomes and the scientific leadership and economic growth of the country at risk.

THE NCI: THE NEED FOR A RENEWED COMMITMENT

This year marks the 50th anniversary of the passage of the National Cancer Act of 1971, which established the NCI in its current form. Over the last 30 years alone, the cancer death rate has fallen 31%. This includes a 2.4% decline from 2017 to 2018—a record for the largest one-year drop in the cancer death rate. However, even during a global pandemic, cancer remains the second most common cause of death in the United States. In 2021, almost 1.9 million new cancer cases will be diagnosed, and more than 600,000 people will die from cancer.[3]

The time is ripe for a renewed commitment for robust NCI funding. ASCO is grateful for funding provided to the Beau Biden Cancer Moonshot Initiative and its focus on modernizing clinical trials, establishing a direct patient engagement network, developing a national cancer data ecosystem, continuing advances in precision oncology, and developing effective immunotherapies for a broader array of cancers. However, funding for the Initiative peaked FY2019, and dropped to $195 million in FY2021; FY2023 will mark the last year of authorized Moonshot funding. ASCO urges Congress to bolster NCI funding in anticipation of the end of the Cancer Moonshot Initiative.

The NCI is the largest funder of cancer research in the world, with most of its funding directly supporting research at NCI and at cancer centers, hospitals, community clinics, and universities across the country. While the NCI has received modest funding increases over the last few years, funding has not kept up with the growth of research grant applications as compared to other NIH Institutes or Centers. In fact, over the last five years R01 grant applications submitted to the NCI rose by 50%, while funding only grew by 20%. This means NCI is funding a smaller proportion of grant applications compared to previous years. Only 10% of viable applications received funding in 2020 compared to 28% in 1997. Even after accounting for Cancer Moonshot funding, NCI's budget has not kept up with scientific opportunity. ASCO supports the NCI's 15 by 25 initiative, in which the Institute aims to fund 15% of grant applications by 2025. Unfortunately, the President's FY2022 budget proposal of $6.733 billion for the NCI would not allow for an increase in funded applications for 2022. ASCO's request of $7.609 billion for FY2022 would allow NCI to fund 12% of grants submitted, a modest increase, but a step closer to their own goal.[4]

BRINGING THE RESEARCH TO THE PATIENT

NIH-funded translational research and clinical trials have significantly improved the standard of care in many diseases. Clinical trials and translational research

[2] United for Medical Research; https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf.

[3] American Cancer Society; https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf.

[4] National Cancer Institute; https://www.cancer.gov/research/annual-plan/2022-annual-plan-budget-proposal-aag.pdf.

yield insight critical to the development of targeted therapies, which identify patients most likely to benefit from treatments and help patients who will not benefit avoid the cost and pain of treatment unlikely to help them. This is where science becomes practice-changing for patients in America.

ASCO has developed the Targeted Agent and Profiling Utilization Registry (TAPUR(tm)) Study, which provides access to targeted therapies for patients aged twelve and older and who have been identified as candidates for benefitting from those treatments because of a promising tumor biomarker target identified in their cancer. TAPUR evaluates use of these molecularly targeted anti-cancer drugs and collects data on clinical outcomes. As of May 2021, there are over 2,130 participants enrolled in the TAPUR Study at 128 sites in 24 states. Without federal investment spurring the pipeline of new cancer treatments, studies such as TAPUR would not be possible.

To maintain access to research for cancer patients, ASCO urges a substantial increase in funding for the National Clinical Trials Network (NCTN) and NCI Community Oncology Research Program (NCORP). Just last year, the NCI awarded 53 grants to researchers at 46 NCORP sites, which have assembled more than 1,000 affiliates across the country to conduct research. The NCORP network now covers 44 states and the District of Columbia.[5] An increase in NCI's budget would enable the Institute to maintain or increase the number of accruals to trials and cover the cost of conducting research.

CANCER REGISTRIES & CLINICAL TRIALS: HARNESSING DATA & REDUCING DISPARITIES

We have seen tremendous progress in cancer research. Even so, with more targeted and patient-specific therapies in development, certain populations are still missing out on potentially life-threatening treatment options. ASCO was encouraged to see the CLINICAL TREATMENT Act become law at the end of 2020. This legislation will require Medicaid to cover routine care costs for clinical trials for patients with life-threatening conditions. A step forward, but barriers remain; diversity and generalizability of clinical trials is crucial for making trial results applicable more broadly and to ensure positive clinical outcomes for all patients. We hope to continue our work with Congress, NCI, and the Centers for Medicare and Medicaid Services (CMS) to improve access to clinical trials for underrepresented patient populations.

As a compliment to inclusive trials, cancer providers and researchers also need accessible data to understand cancer at a broader level. This data can prove especially crucial for rare and pediatric cancers, where trials are limited due to smaller patient populations. To that end, ASCO joins the cancer community in requesting $559 million for the CDC's Division of Cancer Prevention and Control (DCPC), and $70 million for the CDC's Cancer Registries Program. Cancer registries are a critical tool for providers and researchers, providing cancer surveillance, identifying trends amongst different patient cohorts, illustrating the impact of early detection, and showing the impact of treatment advances on cancer outcomes. Registries allow providers to collect data in real time and improve cancer research, public health interventions and treatment protocols. While we work towards greater trial inclusion, registries help ensure we have data from underrepresented patient cohorts such as racial and ethnic minorities, women, children, and rural populations.

WORKING TOWARDS CURES: A NEW APPROACH

Modern cancer research delivers new treatments to patients faster than ever, thanks to continuing innovation in research and regulatory infrastructure. The continued investment Congress has made in cancer research helps make progress possible. ASCO is committed to partnering with Congress and the Administration to spur innovation and expediently get treatments to patients.

As Congress and the Administration evaluate ways to improve our national biomedical research enterprise through such efforts as the proposed Advanced Research Projects Agency-Health (ARPA–H), we urge lawmakers to leverage collaboration between the private market, biotech, health care companies, academic institutions, and government and regulatory agencies. Fostering public-private partnerships and standardization to accelerate discovery to clinically impactful products that help patients is vital. Additionally, any efforts to establish a new agency or reform the biomedical research enterprise and health innovation, should ensure sustained and dedicated funding to achieve impactful translational research with demonstration of patient benefit. It should not impact the current or future resources of existing research enterprises.

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[5] National Cancer Institute; https://ncorp.cancer.gov/news/2019-08-19.html.

Any new agency should be transparent about its selection criteria and decision-making process for its broad strategic goals and selection of individual research projects, including clear metrics to ensure the funds are being used to advance public health meeting established deliverables. Furthermore, innovation should come from peer-reviewed science that provides evidence-based decision making for care, and the findings should be published in peer-reviewed publications. Finally, as previously discussed, all patients should have access to the clinical trials and the resulting treatments conducted with investment by the agency; insurance coverage and cost should not be a barrier to clinical trial participation and equitable care; and should implement strategies to encourage decentralization of trials and ensure diversity and equity in research.

MITIGATING THE EFFECTS OF COVID–19 AND CONTINUING THE WORK TOWARDS CURES

As with nearly every sector of society, individuals in the research community have faced loss of employment, lab closures, and loss of momentum in pre-pandemic research. Younger investigators and support staff have been especially vulnerable during the last year. Our clinical trials network has also been impacted; one study showed that clinical trial enrollment in May 2020 was 73% lower than accrual in May 2019.[6] Another study found the COVID–19 pandemic was associated with a 60% decrease in the number of launches of oncology clinical trials of drugs and biologic therapies.[7] In May 2021, NCI Director Ned Sharpless, M.D. speculated that clinical trial accrual was still just 50% of what it had been pre-pandemic.

To regain the momentum over the last few years, lawmakers and researchers will need to work together to mitigate COVID–19 related disruptions to research and restore momentum across the nation's medical research network. Therefore, I urge you to prioritize the important role NIH and NCI play in medical innovation and economic growth by protecting and strengthening federally funded research in FY2022.

ASCO again thanks the subcommittee for its continued support of cancer patients in the U.S. through funding for the NIH, NCI, and CDC. We look forward to working with all members of the subcommittee on an FY2022 budget that continues to advance U.S. cancer research. Please contact Kristin Stuart at Kristin.Stuart@asco.org with any questions.

[This statement was submitted by Howard Burris, MD, FASCO, Chair of the Board, Association for Clinical Oncology.]

PREPARED STATEMENT OF THE ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

APS RECOMMENDATIONS FOR FISCAL YEAR 2021 APPROPRIATIONS

—APS strongly supports the Administration's request for $51 billion for NIH in FY 2022. We are eager to see the details of the President's request. We appreciate the Administration's commitment to meaningful growth in the base budget and expanding NIH's capacity to support promising research in all scientific fields that contribute to improved health.

—APS is pleased that an NIH working group has been established to review how to integrate and realize the benefits of overall health from behavioral research at NIH, but we request Congress include report language urging that this review also address the necessary funding, authority, and organizational changes needed for the Office of Behavioral and Social Sciences Research (OBSSR) to better meet its mission. OBSSR has the mission to enhance NIH's behavioral science research enterprise across all institutes and centers. Its direct authorities to achieve its mission, however, are limited. OBSSR does not report directly to the NIH Director and has no grantmaking authority. Importantly, with a small budget of less than 1/1000 of NIH's overall budget, it has limited capacity to leverage institutes' research priorities. APS urges that these limitations be addressed in the NIH review.

—Finally, APS asks the Committee to favorably consider the requests of the Psychological Clinical Science Accreditation System (PCSAS) to urge the modification of HRSA and National Health Service Corps regulations to permit the

[6] U.S. National Institutes of Health's National Library of Medicine; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7538012/#ref5.

[7] The Journal of the American Medical Association https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775637.

graduates of PCSAS-accredited schools to be eligible for employment in these programs. APS believes that the strong emphasis on science in PCSAS accreditation offers promise of improved prevention and treatment interventions which will strengthen HRSA and the National Health Service Corps programs.

STATEMENT OF APS EXECUTIVE DIRECTOR

Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee, thank you for the opportunity to provide testimony as you consider funding priorities for Fiscal Year (FY) 2022. I am Robert Gropp, Executive Director of the Association for Psychological Science (APS). APS is a nonprofit scientific organization dedicated to advancing the science of psychology for the benefit of science and society. APS recognizes and appreciates the Subcommittee's efforts to strengthen public health research in the United States.

FUNDING FOR THE NATIONAL INSTITUTES OF HEALTH AND POLICY ISSUES

As previously noted, APS recommends an FY 2022 funding level of $51 billion for NIH, which would enable real growth over health research inflation as an important step to ensuring stability in the Nation's research capacity over the long term. In addition to funding priorities, APS is concerned about several policy issues at HHS.

1. Inclusion of Psychologists in the Pandemic Response: Nearly 600,000 Americans have died from COVID–19. This is a tragedy that is based in human behavior, both in the human response necessary to stop the spread of the disease as well as the disproportionate impact of the disease on health disparity and racial and ethnic minority populations. Research from psychological science must be one of the inputs informing an effective public health emergency response. Psychology research teaches us how to encourage individuals to practice safe behaviors and receive vaccines, for example. But psychological scientists investigate fundamental science questions, too. For instance, improved scientific understanding of risk assessment, social motivations, and interpersonal relationships can powerfully influence the spread of infectious diseases. Psychological science helps us address consequences of social distancing such as loneliness and emerging threats to mental health. Researchers in our field have proven essential to improving our understanding and addressing COVID–19's impact. APS urges that the following report language be included in the FY 2022 Labor-HHS Report:

> *Behavioral Science and the COVID–19 National Strategy*.—The Committee applauds the Administration's robust National Strategy for the COVID–19 Response and Pandemic Preparedness and appreciates that the strategy reflects the best advice of scientists and public health experts. However, even with effective and safe vaccinations, we must continue and expand mask-wearing, testing, and social distancing; all citizens, organizations, and communities must rally together in that common purpose. As our success in these areas depends on our scientific understanding of human behavior, the Committee urges that the Department include psychological scientists at every level of the Department's response to COVID–19 and future public health emergencies to best and most effectively meet these common goals.

2. Behavioral Science at NIH: The NIH mission is to "seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability." APS is concerned by the continued low level of funding support for behavioral science research and training at NIH despite the central importance of this research to all dimensions of human health. APS is pleased that the NIH Council of Councils created a new Behavioral Sciences Working Group on Integration and Realization of the Benefits to Health from Behavioral Research at NIH to complete an assessment providing recommendations on how NIH-funded behavioral research can be better integrated with the NIH research programs to improve health. There is concern, however, that this working group may not look beyond current structures and practices. We request that the following report language be included in the FY 2022 Labor-HHS Report to direct NIH to ensure that appropriate OBSSR funding levels, authority, and organizational structure be included in this review.

> *Enhancements for the Office of Behavioral and Social Sciences Research*.—The Committee notes that the Office of Behavioral and Social Sciences Research (OBSSR) has the mission to enhance NIH's behavioral science research enterprise across all institutes and centers. As multiple Surgeons General and the National Academy of Medicine have declared that most health problems facing the nation have significant behavioral components, the Committee strongly supports the continued strengthening of the behavioral science enterprise at NIH

and urges OBSSR funding and authorities be increased to accomplish this mission. In this regard, the Committee is pleased that an NIH working group has been established to review how better to integrate and realize the benefits of overall health from behavioral research at NIH, and directs that appropriate OBSSR funding levels, authority, and organizational structure be included in this review.

UPDATING HRSA AND NATIONAL HEALTH SERVICE REGULATIONS

APS requests the Committee favorably consider the requests of the Psychological Clinical Science Accreditation System (PCSAS) to urge the modification of HRSA and National Health Service Corps regulations to permit the graduates of PCSAS-accredited schools to be eligible for employment in these programs. The strong emphasis on science in PCSAS accreditation offers promise of improved prevention and treatment interventions that will strengthen HRSA and the National Health Service Corps.

PCSAS was recognized by the Council for Higher Education Accreditation (CHEA) in 2012 and now accredits 45 of the Nation's doctoral clinical science programs. CHEA is the largest higher education membership organization in the United States. It is a national body formed by 3,000 universities which reviews and screens applications from organizations to serve as accrediting bodies for the professions. CHEA is widely recognized as a primary national voice for accreditation and quality assurance. After a thorough review, CHEA approved the Psychological Clinical Science Accreditation System (PCSAS) in September 2012 to accredit schools of clinical psychology.

Prior to 2012, the American Psychological Association (APA) was the only accrediting body for clinical psychology programs. Many agency regulations are outdated and refer to the need for applicants for employment to have graduated from APA accredited programs. This historical artifact needs to be updated for HRSA and the National Health Service Corps. Doing so will help to ensure the federal government is able to recruit and hire top quality psychologists, regardless of whether they are from an APA or PCSAS accredited graduate program.

1. Updating Two HRSA Health Professions Programs Regulations is Necessary: HRSA's two psychology education training programs, called the Behavioral Health Workforce Education and Training Program (BHWET) and the Graduate Psychology Education Program (GPE), support programs that produce graduates who work in clinical psychology practice upon completion of their program. The authorizing statute in the Public Health Service Act at 756(a)(2) specifically says the Secretary may make grants for the "...training of psychology graduate students for providing behavioral and mental health services..."; however, the authorizing legislation limits eligibility to the graduates of APA-accredited programs. This excludes the graduates of PCSAS-accredited programs. FY 2021 report language is requested to open program eligibility to the graduates of PCSAS accredited programs. The language follows:

Health Workforce Eligibility Requirements.—The Committee is concerned that HRSA has not complied with the language in the Joint Explanatory Statement for Public Law 216–260 which urged HRSA to update eligibility requirements for the BHWET program and the GPE program to account for accreditation changes that have occurred since the eligibility requirements were established. The Committee notes the Council for Higher Education Accreditation, as well as the Department of Veterans Affairs, recognizes the Psychological Clinical Science Accreditation System [PCSAS]. HRSA is directed to make the necessary administrative updates to ensure that HRSA's health workforce programs continue to have access to the best qualified applicants, including those who graduate from PCSAS programs.

2. Updating National Health Service Corps Regulations is Necessary: The regulations of the National Health Service Corps also need to be updated. While this change has been agreed to, it remains pending for final approval. The language needed to urge this change follows:

Public Health Service Corps Eligibility Requirements.—The Committee is concerned that the Office of the Surgeon General has not complied with the language in the Joint Explanatory Statement for Public Law 216–260 which encouraged the Secretary to update accreditation and eligibility requirements for the Public Health Service Corps to allow access to the best qualified applicants, including those who graduate from Psychological Clinical Science Accreditation System programs. The Committee directs the Department to make these necessary the necessary changes to its eligibility requirements.

SUMMARY AND CONCLUSION

We thank the Subcommittee for its ongoing commitment to supporting scientific research that improves the human condition in the United States and around the world. Reducing barriers to research and training in behavioral science is warranted by the central role of behavior in many of our most pressing health problems and by the enormous potential of psychological science and other behavioral science disciplines to reduce the suffering experienced by the millions of people with behavior-based conditions. APS shares your commitment to addressing the health needs of the Nation and appreciates the opportunity to provide this testimony.

[This statement was submitted by Robert Gropp, Executive Director, Association for Psychological Science.]

PREPARED STATEMENT OF THE ASSOCIATION FOR RESEARCH IN VISION AND OPHTHALMOLOGY

EXECUTIVE SUMMARY

The Association for Research in Vision and Ophthalmology (ARVO), on behalf of the eye and vision research community, thanks Congress, especially the House and Senate LHHS Appropriations Subcommittees, for the strong bipartisan support for the National Institutes of Health (NIH) funding increases from Fiscal Year (FY) 2016 through FY2021.

This past investment in NIH has improved our understanding of fundamental life and health sciences and prepared the nation to combat unprecedented health threats, including COVID–19. To maintain this momentum in FY2022, ARVO strongly supports $51.95 billion in NIH funding as proposed by President Biden, including no less than $46.1 billion for NIH's base program level budget (absent proposed funding for the Advanced Research Projects Agency—Health [ARPA–H]), an increase of at least $3.177 billion or 7.4%, which would allow NIH's base budget to keep pace with the Biomedical Research and Development Price Index (BRDPI) and allow for 5% growth. This increase will support promising science across all Institutes and Centers (ICs), ensure continued Innovation Account funding established through the 21st Century Cures Act for special initiatives, and support early-stage investigators.

Along with our partners and other scientific societies, ARVO also urges one-time emergency funding for federal agency "research recovery" investment to enable NIH to mitigate pandemic-related disruptions without foregoing promising new science. ARVO supports the bipartisan Research Investment to Spark the Economy (RISE) Act (H.R. 869/S. 289) which includes $10 billion for NIH.

ARVO also urges Congress to fund the NEI at $900 million, a $64.3 million or 7.7% increase over FY2021 that reflects both biomedical inflation and growth, compared to the Administration's suggested $858.4 million funding level-a $22.83 million or 2.7% increase. Despite NEI's total $160 million funding increases in the FY2016–2021 timeframe, its enacted FY2021 budget of $835.7 million is just 19% greater than the pre-sequester FY2012 funding of $702 million. Averaged over those nine fiscal years, the 2.1% annual growth rate is still less than the average annual biomedical inflation rate of 2.7%, thereby eroding purchasing power. In fact, NEI's FY2021 purchasing power is less than that of FY2012.

The NEI currently faces an increasing burden of vision impairment and eye disease due to an aging population, the disproportionate risk/incidence of eye disease in minority populations, and the impact on vision from numerous chronic diseases, such as diabetes. NEI also faces additional challenges with the COVID–19 pandemic, as both the working-age population and students have relied almost exclusively on electronic devices and e-learning platforms, which research has shown correlates to increased rates of myopia, dry eye and eye strain.

Maintaining the momentum of eye and vision research is vital to vision health and to overall health and quality of life and would secure the U.S. as the world leader in eye and vision research and training the next generation of eye and vision scientists.

NEI-FUNDED RESEARCH SAVES SIGHT AND RESTORES VISION

Historical federal investment has led to landmark advances in the prevention of vision loss as well as the restoration of vision, including:

—*Audacious Goals Initiative:* The NEI has been at the forefront of regenerative medicine with its Audacious Goals Initiative (AGI), launched in 2013 with the goal of restoring vision. AGI-funded consortia have developed innovative ways

to image the visual system such that researchers can now look at individual nerve cells in the eyes of patients to learn directly whether new treatments are successful. Another consortium has identified biological factors that allow neurons to regenerate in the retina, and current AGI proposals may result in clinical trials for therapies within the next decade.

—*Retinal Diseases:* The NEI has been at the forefront of research into retinal diseases. NEI-funded researchers helped to show that the Vascular Endothelial Growth Factor (VEGF) protein stimulates abnormal blood vessel growth that occurs in the advanced stages of the "wet" form of age-related macular degeneration (AMD) and diabetic retinopathy. Food and Drug Administration (FDA)-approved anti-VEGF drug therapies that slow the development of blood vessels in the eye delay vision loss and may improve vision for patients. NEI has funded comparison trials of anti-VEGF drugs to provide clinicians and patients with information they need to choose the best treatment options. With respect to the "dry" form of AMD, also known as geographic atrophy and is the leading cause of vision loss among individuals age 65+, since 2019 NEI has been performing a first-in-human clinical trial that tests a stem cell-based therapy from induced pluripotent stem cells (iPSC) to treat geographic atrophy. This trial converts a patient's own blood cells to iPS cells which are then programmed to become retinal pigment epithelial (RPE) cells, which nurture the photoreceptors necessary for vision and which die in geographic atrophy. Bolstering remaining photoreceptors, the therapy replaces dying RPE with iPSC-derived RPE.

—*Genetics/Genomics:* The NEI has been at the forefront of genetics/genomics and gene therapy approaches to various eye and vision disorders-both common and rare. The causes of AMD and glaucoma remain elusive, although most cases are not inherited, genetics does play a role. While NEI-funded researchers have identified many genetic risk factors for AMD and glaucoma, further study of these genes is helping to understand disease biology and the promise for improved therapies. NEI-funded research has also made discoveries of dozens of rare eye disease genes possible, including the discovery of RPE65, which causes congenital blindness known as Leber congenital amaurosis (LCA). As of late 2017, NEI's initial efforts led to a commercialized FDA-approved gene therapy for this condition. These gene-based discoveries form the basis of new therapies that treat and may prevent the disease.

—*Front-of-Eye Research:* The NEI has launched an Anterior Segment Initiative (ASI) studying clinically significant, front-of-eye problems such as ocular pain and Dry Eye Disease (DED), especially in terms of pain and discomfort sensations and disruptions in the tearing process. Using multi-disciplinary approaches, the ASI plans to elucidate relevant anterior segment innervation pathways that contribute to normal or abnormal functioning of the neural circuits related to the ocular surface.

NEI FUNDING DEMONSTRATES SIGNIFIGANT RETURN ON INVESTMENT

Optical coherence tomography (OCT) is a technology developed with federal research funding through the NIH, which has led to significant cost savings by helping to diagnose conditions that lead to vision loss among patients more efficiently. In 2017, ARVO shared the story of OCT, including the significant associated cost savings:

—$9 billion: Medicare savings from clinicians using OCT to optimize the injection schedule of anti-VEGF drugs for patients with wet-AMD

—$2.2 billion: Wet-AMD patient savings from reduced spending on drug copays

—$0.4 billion: Total investment over 20 years made by NIH and NSF to invent and develop the technology

—2,100%: Return on taxpayer investment

[http://www.ajo.com/article/S00029394(17)30419-1/fulltext]

NEI RESEARCH ADDRESSES INCREASING BURDEN OF EYE DISEASE

NEI's FY2021 enacted budget of $835.7 million is less than 0.5% of the $177 billion annual cost (inclusive of direct and indirect costs) of vision impairment and eye disease, which was projected in a 2014 Prevent Blindness study to grow to $317 billion—or $717 billion in inflation-adjusted dollars—by year 2050. Of the $717 billion annual cost of vison impairment by year 2050, 41% will be borne by the federal government as the "Baby Boomer" generation ages into the Medicare program. A 2013 Prevent Blindness study reported that direct medical costs associated with vision disorders are the fifth highest—only less than heart disease, cancers, emotional disorders, and pulmonary conditions. The U.S. is spending only $2.53 per person, per

year for eye and vision research, while the cost of treating low vision and blindness is at least $6,680 per person, per year. [http://costofvision.preventblindness.org/]

Investing in vison health is an investment in overall health. In summary, ARVO requests FY2022 NIH funding of at least $51.95 billion, but urges the Subcommittee to appropriate no less that $46.1 billion for the NIH's base program level. Further, we request NEI funding of $900 million. ARVO also supports one-time emergency "research recovery" investment to mitigate the pandemic-related disruptions without foregoing promising new science.

The Association for Research in Vision and Ophthalmology (ARVO) is the largest eye and vision research organization in the world. Members include approximately 10,000 eye and vision researchers from over 75 countries.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI), representing 102 premier academic and freestanding cancer centers across the United States and Canada, appreciates the opportunity to submit this statement for consideration by the subcommittee. AACI submits this request for the Department of Health and Human Services budget for the National Institutes of Health (NIH) as the subcommittee considers Fiscal Year (FY) 2022 funding. AACI requests a $3.177 billion increase for the NIH for FY 2022, bringing the recommended funding level for the NIH to $46.111 billion. This proposed level of NIH funding would ensure that academic cancer centers conducting lifesaving research can continue to discover and deliver new therapies for patients with cancer. AACI also requests at least $7.609 billion in FY 2022 for the National Cancer Institute (NCI).

Additionally, we look forward to seeing what comes of the $6.5 billion proposal for an Advanced Research Projects Agency-Health (ARPA–H) that was laid out in President Biden's Fiscal Year 2022 (FY22) budget. We appreciate the proposal outlining cancer as a primary initial focus of ARPA–H. We are pleased with any expenditures that include more funding for cancer research; however, our hope is that the APRA–H proposal will not be diverting any funding from base funding for the NIH or the NCI. As Congress moves into the Fiscal Year 2022 (FY22) budget process and consideration of an infrastructure package, we wanted to share our priorities related to the budget.

AACI CANCER CENTERS

AACI cancer centers are beacons of discovery, largely funded by the NIH and NCI. In order to ensure continued progress, these agencies rely on stable, predictable federal funding to invest in groundbreaking cancer research.

Cancer centers develop and deliver state-of-the-art therapies and provide comprehensive care, from prevention to survivorship, to patients. These centers are at the forefront of the national effort to eradicate cancer, yet progress in cancer research is complex and time-intensive. The pace of discovery and translation of novel basic research to new therapies can be accelerated if researchers are able to count on an appropriate and predictable investment in federal cancer funding.

COVID–19 CHALLENGES

The COVID–19 pandemic has taken a significant toll on medical research, making increased funding more critical than ever. Clinical trials were brought to a halt and trial sites experienced challenges with safely facilitating care for enrolled patients and freezing the process of enrolling new patients.

As noted in last year's testimony, American Cancer Society data show that the mortality rate from cancer in the United States has declined 29 percent since its peak in 1991. This translates to more than 2.9 million deaths avoided between 1991 and 2016—progress tied to the commitment of Congress to fund the NIH and NCI.[1] Dr. Norman E. Sharpless, NCI director, has stated that the COVID–19 pandemic will influence cancer mortality for at least the next decade, with an estimated 10,000 additional breast and colorectal cancer deaths during this time.[2] Further, the NCI reports that an increase in overall cancer mortality rates for the first time in almost 30 years is likely due to the impact of COVID–19. But the pandemic has taught us important lessons about the benefits of scientific progress to public health.

The future of cancer research relies on robust funding to the NIH and NCI. The broad portfolio of science supported by these agencies is essential for improving our

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[1] https://www.cancer.org/latest-news/facts-and-figures-2020.html.

[2] https://cancerletter.com/nci-director-report/20200619__1/.

basic understanding of cancer and has contributed to the health and well-being of Americans. We cannot let the challenges of the last year slow this meaningful progress.

PAYLINE

Uncertainty surrounding research project grants (R01s) from year to year and a decline in cancer center resources often drives promising scientists to explore opportunities abroad or outside of the biomedical research community. For most academic cancer centers, the majority of NCI grant funds are used to sustain shared core resources that are essential to basic, translational, clinical, and population cancer research, or to provide matching dollars that allow departments to recruit new cancer researchers to a university and support them until they receive their first grants. It is imperative that we enable America's scientists to master their craft.

We noted last year that in FY 2020, R01 grants for established and new investigators are being funded to the 10th percentile, up from the 8th percentile in FY 2019. In FY 2021, the grants were funded to the 11th percentile.[3] We request that Congress build on progress with a FY 2022 funding increase to meet the goal of raising the NCI payline to the 15th percentile by FY 2025. AACI supports the NCI Director's Professional Judgment Budget Proposal for FY 2022 of $7.609 billion for the NCI, which will increase funding to the 12th percentile.[4]

CONCLUSION

Now is the time for Congress to invest in biomedical research—and cancer research in particular. According to the American Cancer Society, there will be an estimated 1.9 million new cancer cases diagnosed in the United States in 2021.[5] Fortunately, improvements in early detection, cancer staging, and surgical techniques, as well as the development of innovative therapies, have contributed to better outcomes for patients with cancer. We join our colleagues in the biomedical research community in recommending that the subcommittee recognize the NIH as a national priority by enacting a final FY 2022 spending package that includes $46.111 billion for the NIH and $7.609 billion for the NCI.

A robust federal investment in NCI-Designated Cancer Centers and academic cancer centers will allow the cancer research community to accelerate progress against cancer, despite challenges such as the COVID–19 pandemic.

[This statement was submitted by Jennifer W. Pegher, Executive Director, Association of American Cancer Institutes.]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN EDUCATORS FELLOWS

My name is Jessica Saum and I am a special education teacher at Stagecoach Elementary School in Cabot, Arkansas. I am the current Stagecoach Elementary School and Cabot Public School Distict's Teacher of the year. I teach a self-contained classroom of students grades kindergarten through fourth grade where my students spend less than 40% of the school day out of my classroom with their typically developing peers. This time includes lunch, recess, activity classes, and for certain students instructional times such as phonics, social studies, and science.

Students with diverse needs, especially those in early childhood special education, need more time in the general education classroom learning prosocial behaviors and having more exposure to grade level curriculum. In order to provide this, schools need additional funding to ensure staffing of trained paraprofessional support for students with moderate to severe learning disabilities as well as to fund inclusion co-taught classroom supporting those with specific learning disabilities and deficits in specific content areas.

When learning happens in an inclusive classroom, general education teachers and special education teachers work together and are able to meet the needs of all students. Carl A. Cohn, EdD, the executive director of the California Collaborative for Educational Excellence, said, "It's important ... to realize that special education students are first and foremost general education students." This is often not how students with special needs are treated.

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[3] https://www.cancer.gov/grants-training/nci-bottom-line-blog/2021/funding-from-congress-allows-nci-to-raise-grants-payline.

[4] https://www.cancer.gov/research/annual-plan/budget-proposal.

[5] https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2021.html.

Inclusive classes look different in how they are arranged and how they operate. Some use co-teaching with a collaborative team model having is a special education teacher in the room all day. In other inclusive classrooms, there is a special education teacher that "pushes in" to the class during specific times during the day to teach. This allows students to minimize transitions that can be very overwhelming, and is used in place of pulling kids out of class to a separate room. In both of these situations, teachers are available to teach and help all students.

This type of learning is beneficial for all students, not just for those who are receiving special education services, having both positive short-term and long-term effects. Studies have shown that students with special education needs who are in inclusive classes are absent less often and develop stronger skills in reading and math. Additionally they also more likely to have jobs and pursue education after high school. The same research shows that their peers benefit, too. The typically developing students are more comfortable with and more tolerant of differences. I have seen this in my own children as they have formed meaningful relationships with students I teach and are advocates even at a young age and friends to exceptional learners.

Most students than ever with special needs are expected to take the same high stakes assessments as students without special needs. Eleven of the thirteen students in my special class setting took the same district and state assessments as their grade level peers in the 2020–2021 school year. They deserve the opportunity to learn alongside typical peers, having access to the same curriculum, with the support from special educators to navigate appropriate prosocial behaviors and receive modifications and accommodations to ensure success.

What we must directly address is how we can spend this much-needed federal money. It is important to determine whom it goes to when investing more into this often overlooked population, where the needed training comes from, and for whom is it used for. General education teachers need additional training provided at the state level through professional development at their district or coop, specifically on High Leverage Practices for Inclusion to support this data proven practice being implement in their classrooms. There needs to be increased funding, specifically designated for districts to hire additional paraprofessionals and special education teachers to work with students in the general education classroom, ensuring students are being educated in their least restrictive environment as required through the Individuals with Disabilities Act (IDEA). Furthermore, there needs to be an increased emphasis nationally at the collegiate level in teacher preparation programs on educating diverse learners in the general education setting. Teachers are not adequately prepared to meet the needs of exceptional learners when they enter the teaching profession and the lack of training to ensure this has led to many students being educated in settings more restrictive than necessary.

Teachers can and will do more when supported appropriately and when they are properly trained. I have witnessed this first hand as a special education teacher. When my students have general education teachers trained to support them and confident in their abilities to meet their unique needs, they have more growth academically, are more socially competent, and lead happier and more successful lives at home and in their communities. It is critical to note that lasting effects of inclusive practices in schools extend far beyond the school setting making children a part of their community, helping them develop a sense of belonging and becoming better prepared for life.

Providing children with the resources to attend schools which are committed to and prepared for inclusive practices, demonstrates the shared commitment to having all children feel appreciated and accepted throughout life. All children deserve to attend age appropriate regular classrooms to the maximum extent possible receiving curriculum relevant to their needs that will provide for their educational success. All children benefit from cooperation, collaboration among home, among school, among community.

Thank you for your time and consideration.

[This statement was submitted by Jessica Saum, Special Education Teacher, Association of American Educators Advocacy Fellow.]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is a not-for-profit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and

more than 70 academic societies. Through these institutions and organizations, the AAMC?leads and serves America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The COVID–19 pandemic has illustrated how sustained support for the research, education, and patient care missions of medical schools and teaching hospitals, with a strong commitment to community collaborations, is essential to ensure a resilient health care infrastructure prepared to respond to both novel and existing threats. For FY 2022, the AAMC recommends the following for federal priorities essential in assisting medical schools and teaching hospitals to fulfill their missions that benefit patients, communities and the nation: at least $46.1 billion for the National Institutes of Health (NIH); $500 million for the Agency for Healthcare Research and Quality (AHRQ); $1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs, and $485 million for the Children's Hospitals Graduate Medical Education (CHGME) program; and at least $10 billion for the Centers for Disease Control and Prevention (CDC). The AAMC appreciates the Subcommittee's longstanding, bipartisan efforts to strengthen these programs. Additionally, to enable the necessary support for the broad range of critical federal priorities, the AAMC urges Congress to approve a funding allocation for the Labor-HHS subcommittee that enables full investment in the priorities outlined below.

National Institutes of Health. Congress's longstanding bipartisan support for medical research has contributed greatly to improving the health and well-being of all Americans, highlighted by the central role medical research has played in combatting COVID–19. As illustrated over the last year, the foundation of scientific knowledge built through NIH-funded research drives medical innovation that improves health through new and better diagnostics, improved prevention strategies, and more effective treatments. Over half of the life-saving research supported by the NIH takes place at medical schools and teaching hospitals, where scientists, clinicians, fellows, residents, medical students, and trainees work together to improve the lives of Americans through research. This partnership is a unique and highly productive relationship that lays the foundation for improved health and quality of life and strengthens the nation's long-term economy.

The AAMC thanks Congress for the bipartisan support that resulted in the inclusion of $42.9 billion for medical research conducted and supported by the NIH in the FY 2021 omnibus spending bill. Additionally, the AAMC thanks the Subcommittee for recognizing the importance of retaining the salary cap at Executive Level II of the federal pay scale in FY 2021, and for the emergency resources that have advanced COVID–19 research.

In FY 2022, the AAMC joins nearly 400 partners in supporting the Ad Hoc Group for Medical Research recommendation that Congress provide at least $46.1 billion in program level funding for the NIH, including funds provided through the 21st Century Cures Act for targeted initiatives. This funding level for the foundational work at the core of NIH's mission would continue the momentum of recent years by enabling meaningful growth of 5% in the NIH's base budget over biomedical inflation to help ensure stability in the nation's research capacity long term. Securing a reliable, robust budget trajectory is key in positioning the agency—and the patients who rely on the research it funds—to capitalize on the full range of research in the biomedical, behavioral, social, and population-based sciences. We must continue to strengthen our nation's research capacity, solidify our global leadership in medical research, ensure a research workforce that reflects the racial and gender diversity of our citizenry, and inspire a passion for science in current and future generations of researchers.

In addition to our strong support for a robust increase in NIH's base funding, we look forward to working with lawmakers and the administration to fulfill the goals of the proposed Advanced Research Projects Agency for Health (ARPA–H) within NIH as part of the administration's $52 billion request for the NIH to "drive transformational health research innovation and speed medical breakthroughs by tackling ambitious challenges requiring large-scale, sustained, and cross-sector coordination." The nation's medical schools and teaching hospitals are hubs of innovation in research and care delivery, and the AAMC looks forward to engaging with lawmakers and the administration on opportunities to advance a bold and productive medical research agenda in harnessing our shared commitment to innovation and scientific discovery.

We also wish to highlight the challenges that the pandemic has imposed on the medical research workforce and the broader research enterprise. We continue to be concerned that, without supplemental resources, the disruptions imposed by

COVID–19 will undermine NIH's ability to support previous investments in the existing research workforce and new investments in life-saving research. In his recent testimony before the subcommittee, NIH Director Francis Collins, MD, PhD, cited the $16 billion impact of the coronavirus pandemic on medical research progress in all disease areas, and especially on the research workforce. We urge support for emergency funding for NIH as outlined in the bipartisan Research Investment to Spark the Economy (RISE) Act (H.R. 869/S.289).

Agency for Healthcare Research and Quality. Complementing the medical research supported by NIH, AHRQ sponsors health services research designed to improve the quality of health care, decrease health care costs, and provide access to essential health care services by translating research into measurable improvements in the health care system. The AAMC joins the Friends of AHRQ in recommending $500 million in funding for AHRQ in FY 2022.

Health Professions Funding. The Health Resources and Services Administration (HRSA) Title VII and Title VIII programs have helped the country combat COVID–19, despite the challenges the pandemic posed for grantees. Many grantees adapted their curricula to educate our health workforce during this public health challenge. They also dealt with the unexpected costs of providing personal protective equipment for in-person clinical training and switching from in-person to virtual learning. The pandemic has underscored the need to increase and continuously reshape our health workforce. The programs have proven successful in recruiting, training, and supporting public health practitioners, nurses, geriatricians, mental health providers, and other front-line health care workers critical to addressing COVID–19. Additionally, in coordination with HRSA, grantees have used innovative models of care, such as telehealth, to improve patients' access to care during the pandemic.

The COVID–19 pandemic has also highlighted the pervasive health inequities facing minority communities and gaps in care for our most vulnerable patients, including an aging population that requires more health care services. The HRSA Title VII and Title VIII programs educate current and future providers to serve these ever-growing needs, while preparing providers for the health care demands of tomorrow. A diverse health care workforce improves access to care, patient satisfaction, and health professionals' learning environments. Studies show that HRSA Title VII and Title VIII programs increase the number of underrepresented students enrolled in health professions schools, heighten awareness of factors contributing to health disparities, and attract health professionals more likely to treat underserved patients. The AAMC joins the Health Professions and Nursing Education Coalition (HPNEC) in recommending $1.51 million for these critical workforce programs in FY 2022.

In addition to Title VII and Title VIII, HRSA's Bureau of Health Workforce also supports the CHGME program, which provides critical federal graduate medical education support for children's hospitals to train the future primary care and specialty care workforce for our nation's children. We support $485 million for the CHGME program in FY 2022. We also encourage Congress to provide robust funding to HRSA's Rural Residency Programs, which provides funding to develop new rural residency programs or separately accredited rural training track programs, to expand training opportunities in rural areas.

The AAMC encourages Congress to provide long-term sustained funding for the National Health Service Corps (NHSC), through its mandatory and discretionary mechanisms. We were appreciative of the $800 million in supplemental funding for the NHSC in the American Rescue Plan (H.R. 117–2), and we support an appropriation for the NHSC that would fulfill the needs for current Health Professions Shortage Areas.

Centers for Disease Control and Prevention. The AAMC joins the CDC Coalition in a recommendation of at least $10 billion for the CDC in FY 2022. In addition to ensuring a strong public health infrastructure and protecting Americans from public health threats and emergencies, CDC programs are crucial to reducing health care costs and improving health. Within the CDC total, the AAMC supports $102.5 million for the Racial and Ethnic Approaches to Community Health (REACH) program and $25 million to support gun safety research.

Additional Programs. The AAMC also supports at least $474 million for the Hospital Preparedness Program within the Office of the Assistant Secretary for Preparedness and Response (ASPR), in addition to $40 million to continue the regional preparedness programs created to address Ebola and other special pathogens, including funding for regional treatment centers, frontline providers, and the National Emerging Pathogen Training and Education Center (NETEC).

Once again, the AAMC appreciates the opportunity to submit this statement for the record and looks forward to working with the subcommittee as it prepares its FY 2022 spending bill.

PREPARED STATEMENT OF THE ASSOCIATION OF FARMWORKER OPPORTUNITY PROGRAMS

Chair Murray and Ranking Minority Member Blunt:

Thank you for the opportunity to present to you and your subcommittee the testimony of the Association of Farmworker Opportunity Programs (AFOP) in support of the nation's more than 50-year commitment to providing eligible agricultural workers the opportunity to achieve the American Dream for themselves and their families. As you begin work on your fiscal year 2022 Labor-Health and Human Services-Education appropriations bill, AFOP encourages you to build on the foundations laid by the highly successful programs described below by adequately funding them in the coming fiscal year: National Farmworker Jobs Program (NFJP), United States Department of Labor (DOL) Employment and Training Administration ($98,896,000); and Susan Harwood Training Grants, DOL Occupational Safety and Health Administration ($10,537,000). Not only do these programs maximize the Federal government's investment in them, they also generate for employers the qualified and healthy workers essential to their growth. These programs also dramatically change peoples' lives for the better, often in rural areas, allowing them to enjoy economic success and participate more fully in our great nation. Thank you for supporting these very effective programs and the excellent results they bring for society's most vulnerable.

NATIONAL FARMWORKER JOBS PROGRAM

NFJP is the bedrock of the nation's commitment to helping agricultural workers upgrade their skills in and outside agriculture, providing employers with what they increasingly say they need: hardworking, well-trained, skilled workers. Administered by DOL, NFJP provides funding through a competitive grant process to 54 community-based organizations and public agencies nationwide that assist workers and their families to attain greater economic stability. One of DOL's most successful employment training programs, NFJP helps agricultural workers acquire the new skills they need to start careers that offer higher wages and a more stable employment outlook. In addition to employment and training services, the program provides supportive services that help agricultural workers retain and stabilize their current agriculture jobs, as well as enable them to participate in up-training and enter new careers. NFJP housing assistance helps meet a critical need for the availability and quality of agricultural worker housing and supports better economic outcomes for workers and their families. NFJP also facilitates the coordination of services through the American Job Center network for agricultural workers so they may access other services of the public workforce system.

The agricultural workers who come to NFJP seek training to secure and excel in the in-demand jobs employers say they find challenging to fill. In doing so, the workers establish the financial foundation that allows them and their families to escape the chronic unemployment and underemployment they face each year. Many NFJP participants enter construction, welding, healthcare, and commercial truck-driving. Others train for the solar/wind energy sector, culinary arts, and for positions such as machinists, electrical linemen, and a variety of careers in and outside of agriculture. To be eligible for NFJP, workers must be low-income, depend primarily on agricultural employment, and provide proof of American citizenship or work authorization. Additionally, male applicants must have registered with the Selective Service.

Agricultural workers are some of the hardest working individuals in this country, enduring tremendous physical and financial hardships in providing produce Americans eat every day. Yet, agricultural workers remain among the nation's most vulnerable employees and job seekers, facing significant barriers to work advancement, including:

—The average agricultural worker family of four earns just $20,000 per year, well below the national poverty line.

—English-language fluency is a substantial challenge for many.

—More than half the children of migratory agricultural workers drop out of school, and, among all agricultural workers, the median highest grade completed is 9th grade (National Agricultural Workers Survey).

—Due to poverty and their rural locations, most agricultural workers have extremely limited access to transportation.

Despite these barriers, NFJP continues to be one of the most successful Federal job training programs, exceeding all DOL's goals. In 2019 alone, NFJP service organizations provided more than 17,300 agricultural workers with services, according to DOL. These NFJP providers have served more than an estimated 170,000 agricultural workers and their family members over the last 10 years. Funding program

this year at $98,896,000 would allow NFJP to train even more dependable, capable workers to take on the nation's most challenging jobs, such as those needed to rebuild the nation's infrastructure. Also, consistent appropriations for youth agricultural workers (ages 14- to 24-years) will allow this cohort, so often overlooked and ignored by anti-poverty programs, to stay in school, and, if not in school, to avail themselves of crucial training to get a good job and establish themselves as productive and successful members of society.

AGRICULTURAL WORKER HEALTH & SAFETY

AFOP also supports appropriations for OSHA's Susan Harwood grant program, through which AFOP has augmented pesticide safety training with curricula to help workers recognize and avoid the dangers of heat stress so common in the fields. In supporting this funding, you can arm the nation's agricultural workers with the knowledge they need to keep themselves safe on the job. The NFJP network of some 220 trainers in 30 states trains agricultural workers on how to protect against pesticide poisoning. Trainers then follow up with agricultural workers to assess knowledge gained and retained, and changes in labor practice. Since 1995, more than 492,000 agricultural workers have become certified as trained in safety precautions, and hundreds of thousands of family members, children, and community agencies have also received safety training. The network collaborates with universities, community organizations, local governments, and businesses to maximize its unparalleled access to agricultural workers and their families. By reaching agricultural workers with pesticide safety training, the network's trainers offer access to other services and create a ripple effect of positive impact—improving the quality of life for agricultural workers and their families—which is what NFJP organizations do best.

Thank you for supporting these worthy programs. AFOP stands ready to assist you in any way as you proceed with your very important work.

[This statement was submitted by Daniel J. Sheehan, Executive Director, Association of Farmworker Opportunity Programs.]

PREPARED STATEMENT OF THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

The Association of Independent Research Institutes (AIRI) thanks the Subcommittee for its long-standing and bipartisan leadership in support of the National Institutes of Health (NIH). We continue to believe that science and innovation are essential if we are to improve our nation's health, sustain our leadership in medical research, and remain competitive in today's global information and innovation-based economy. AIRI urges the Subcommittee to provide NIH with at least $46.1 billion in fiscal year (FY) 2022. AIRI also commends Congress for continuing to reject harmful policies such as reducing support for facilities and administrative (F&A) costs or investigator salary support on NIH grants. In addition, AIRI looks forward to working with the Subcommittee and the Biden Administration to explore how the proposed Advanced Research Project Agency for Health (ARPA–H) can support high-risk, high-reward research to quickly develop new cures. AIRI urges the Subcommittee to ensure that this proposed effort complements, and does not negatively impact, NIH's funding for fundamental biomedical research that is critical for understanding and addressing the public health challenges facing the United States.

AIRI is a national organization of more than 90 independent, non-profit research institutes that perform basic and clinical research in the biological and behavioral sciences. AIRI institutes vary in size, with budgets ranging from a few million to hundreds of millions of dollars. In addition, each AIRI member institution is governed by its own independent Board of Directors, which allows our members to focus on discovery-based research while remaining structurally nimble and capable of adjusting their research programs to emerging areas of inquiry. Investigators at independent research institutes consistently exceed the success rates of the overall NIH grantee pool, and they receive about ten percent of NIH's peer-reviewed, competitively awarded extramural grants.

AIRI thanks the Subcommittee for providing an increase of $1.25 billion for NIH in the FY 2021 Consolidated Appropriations Act. The Subcommittee's support of NIH is strongly demonstrated by these much-needed funds for life-saving biomedical research. However, there is still much more to do. NIH is tackling vast, interdisciplinary problems such as cancer, Alzheimer's Disease, emerging infectious diseases, and the opioid crisis, among others. In addition, NIH's instrumental role in developing new vaccines to combat the COVID–19 pandemic reminds us that now is not the time to pull back on needed investments in the nation's biomedical re-

search ecosystem. Continued budget certainty is needed for the agency to predictably fund new and ongoing grants and consider new initiatives necessary to improving human health and ensuring that we are prepared for the next public health crisis. To ensure cutting-edge research at independent research institutes is not disrupted, AIRI strongly supports a topline of $46.1 billion for NIH in FY 2021.

AIRI thanks the Subcommittee and Congress for providing critically needed supplemental funding in 2020 to combat the COVID–19 pandemic. NIH investments were critical in the record-breaking development of multiple vaccines and improved treatments and therapeutics for COVID–19. Independent research institutions are, by design, structurally nimble and responsive to emerging research issues. In part because of this, AIRI members have made significant contributions to COVID–19 research. Selected examples include:

—The Fred Hutchison Cancer Research Center's and RTI International's role in the Accelerating COVID–19 Therapeutic Interventions and Vaccines (ACTIV) program essential for the development of treatments and vaccines.

—Fred Hutch's work in modeling the spread and evolution of COVID–19 and as the coordination center for the NIH-funded COVID–19 Prevention Network.

—La Jolla Institute of Immunology's pioneering work to understand T cell responses to the infection.

—Jackson Lab's work in developing a line of ACE2 mice for preclinical studies.

Not only is NIH research essential to advancing health, it also plays a key economic role in communities nationwide. In FY 2020, NIH invested $34.65 billion, or almost 80 percent of its budget, in the biomedical research community. This investment supported more than 536,338 jobs nationwide and generated nearly $91.35 billion in economic activity across the U.S.[1] AIRI member institutes are particularly relevant in this regard, as they are located across the country, including in many smaller or less-populated states that do not have major academic research institutions. In many of these regions, independent research institutes are major employers and local economic engines, and they exemplify the positive impact of investing in research and science.

The NIH model for conducting biomedical research, which involves supporting scientists at independent research institutes, medical centers, and universities provides an effective approach to making fundamental discoveries in the laboratory that can be translated into medical advances that save lives. AIRI member institutions are private, stand-alone research centers that set their sights on the vast frontiers of medical science. However, AIRI member institutes are especially vulnerable to reductions in the NIH budget, as they do not have other reliable sources of revenue to make up the shortfall.

AIRI member institutes' flexibility and research-only missions provide an environment particularly conducive to creativity and innovation. Independent research institutes possess a unique versatility and culture that encourages them to share expertise, information, and equipment across research institutions, as well as neighboring universities. These collaborative activities help minimize bureaucracy and increase efficiency, allowing for fruitful partnerships in a variety of disciplines and industries. Also, unlike institutes of higher education, AIRI member institutes focus primarily on scientific inquiry and discovery, allowing them to respond quickly to the research needs of the nation.

AIRI looks forward to working with Congress and the Biden Administration to examine how the proposed establishment of an ARPA–H can push the research enterprise to take on high-risk, high-reward research efforts. If successful, an ARPA–H has the potential to convene researchers to take on grand challenges in public health that were previously thought to be impossible to solve. However, we still do not fully understand many of the basic mechanisms underlying diseases and public health challenges facing the nation today, such as cancer, Alzheimer's, and addiction, among others. Funding for fundamental research is still crucial to address these issues, and AIRI urges the Subcommittee to ensure that new proposals do not negatively impact these important ongoing efforts.

The U.S. has the most robust medical research enterprise in the world, but our leadership in biomedical research is being challenged by the investments being made in the research capacity of other nations, such as China. While the most recent funding increases to the NIH budget will greatly help sustain biomedical research in the U.S., it is important to continue providing stable funding to uphold our biomedical excellence.

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[1] NIH's funding information and economic impact data comes from United for Medical Research's 2021 State-By-State Update, https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf.

AIRI deeply thanks the Subcommittee for its important work dedicated to ensuring the health of the nation, and we appreciate this opportunity to urge the Subcommittee to continue the success of NIH by providing $46.1 billion in FY 2021 and reaffirming support for NIH's current F&A and investigator salary policies to strengthen our nation's investment in life-saving medical research.

PREPARED STATEMENT OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

SUMMARY OF FISCAL YEAR 2022 RECOMMENDATIONS

Health Resources and Services Administration:

—$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
—$47.42 million for HRSA's Minority Centers of Excellence
—$47.95 million for HRSA's Health Careers Opportunity Program.
—$2 million for HRSA's Minority Faculty Loan Repayment Program.
—$67 million for HRSA's Scholarships for Disadvantaged Students (SDS).
—$67 million for HRSA's Area Health Education Center (AHEC) Program

Centers for Disease Control and Prevention:

—$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

National Institutes of Health:

—$46.1 billion for the National Institutes of Health
—1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
—$300 million for the Research Centers at Minority Institutions (RCMI)
—$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
—$100 million for NIH's Extramural Research Facilities program
—$100 million to reinvigorate the NIMHD's Research Endowment Program (REP)

Office of the Secretary:

—$72 million for the Office of Minority Health at the Department of Health and Human Services.
—$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

Department of Education:

—$100 million for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony and thank you for your leadership in addressing challenges facing the health workforce, health disparities, and medically underserved communities. I am Dr. Kathleen Kennedy, Malcolm Ellington Professor of Health Disparities Research and Dean, College of Pharmacy Xavier University of Louisiana and the Chair of the Association of Minority Health Professions Schools (AMHPS), which was established in 1976 to promote a national minority health agenda by addressing the needs of the health workforce and improving health status in medically-underserved communities. Speaking to you today against the backdrop of the continued COVID–19 pandemic with hope on the horizon, we have learned valuable lessons over the past year and a half, but we know that there is more work to be done. The pandemic has pulled back the curtain on what many of AMHPS institutions know and work towards everyday: the pitfalls and shortcomings of minority health. Given the recent deluge of media coverage surrounding this disheartening topic, the country is primed and ready to act in a meaningful way. Our funding recommendations are robust and we realize ambitious, however there have rightfully been discussion concerning the devastating effect of the pandemic on people of color and the need to address this effect for any future pandemic. To be as clear we can be, there must be more robust investment on mi-

nority health and disparities. To achieve this we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

AMHPS is comprised of the twelve historically black medical, dental, pharmacy, and veterinary schools in the United States. The members are two schools of dentistry at Howard University and Meharry Medical College; four schools of medicine, at Charles R. Drew University, Howard University, Meharry Medical College, and Morehouse School of Medicine; five schools of pharmacy, at Florida A&M University, Howard University, Texas Southern University, Hampton University, and Xavier University; and one school of veterinary medicine, at Tuskegee University. Today, the association assists its member institutions in the expansion and enhancement of educational opportunities in the health professions for minorities and disadvantaged students and disadvantaged people. AMHPS continuously adheres to is founding call and honors its threefold mission to improve the health status of blacks and other minorities; improve the representation of blacks and other minorities in the health professions; strengthen our institutions and programs and to strengthen other programs throughout the nation, which in turn will improve the role of minorities in the provision of health care.

Health disparities across racial and ethnic groups in the U. S. have been well documented over the last several decades and have remained remarkably persistent in spite of the changes in many facets of the society over that period. Moreover, the benefits of increasing diversity in the health professions to reduce such disparities have been studied at length, are based on empirical data, and are well understood by the medical community. Examples of these benefits include:

—Minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay.

—Minority physicians are more likely to choose primary care practices.

—Evidence suggests that improving cross-cultural communication between doctors and patients and providing patients with access to a diverse group of doctors improve adherence, satisfaction and health outcomes.

—There is evidence that the intellectual, cultural sensitivity, competency, and civic development of students is enhanced by learning in a diverse educational environment.

—A diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities.

There is little left to discover or dispute with respect to the benefits of achieving greater racial and ethnic diversity of the nation's health professionals—the attention has once again shifted to identifying the most effective and sustainable methods to do so. While there are many national campaigns underway to increase diversity in all medical and health professions schools particularly during this period of enrollment growth, it is imperative that we further recognize and leverage the public value of Historically Black Health Professions Schools.

The daunting news that Blacks Americans in the US are disproportionately suffering and dying from the novel coronavirus (COVID–19) unfortunately was not a tremendous surprise to those of us who regularly monitor and understand health status disparities in this nation. There are well-known health status challenges faced daily by Black Americans and minority health care providers, it also represents a surrogate for the glaring lack of health infrastructure in medically underserved communities. At AMHPS institutions, we have long been and remain committed to addressing these very same disparities in whatever way that we can, with an eye first and foremost towards the communities with the greatest need across our country.

Ironically, as a result of their mission focus the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions—with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors—these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability. Consequently, they are disproportionately dependent on the various federal programs that support their core purpose.

Specifically, these programs include: the Title VII Health Professions Training Programs administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS); the Research Centers at Minority Institutions (RCMI), the Extramural Research Facilities; the Research Endowment; and Centers of Excellence programs administered the National Institutes of Health's National Institute on Minority Health and Health Disparities; and the Historically Black Graduate Institution (HBGI) program administered by the Office of Postsecondary Education of the U.S. Department of Education (DOE).

Madam Chair, unfortunately, over the past several years funding for diversity-focused programs has deteriorated in varying degrees. Absent a monumental overall investment the financial position and academic viability of historically black health professions schools will deteriorate rapidly. The front loaded investment in health professions training programs, graduate programs in biomedical sciences and public, and safety net providers is more cost effective than absorbing uncompensated care originating from minority and underserved communities. Now is the time for targeted investments in historically black health professions schools to ensure a steady pipeline of minority healthcare providers, biomedical scientists, and other health practitioners prepared to support and advance the delivery of high quality, culturally appropriate, evidence based health care. Thank you all again for the opportunity to share the priorities of the Association of Minority Health Professions Schools.

[This statement was submitted by Kathleen B. Kennedy, Pharm.D., Chair, Association of Minority Health Professions Schools, Inc. and Malcolm Ellington, Professor, Health Disparities Research and Dean, College of Pharmacy Xavier University of Louisiana.]

PREPARED STATEMENT OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

On behalf of the Association of State and Territorial Health Officials (ASTHO), I respectfully submit this testimony on FY22 appropriations for the U.S. Department of Health and Human Services (HHS). ASTHO is requesting $10 billion for the Centers for Disease Control and Prevention (CDC), $824 million for the Public Health Emergency Preparedness Cooperative Agreement (PHEP), $149 million for the CDC Preparedness and Response, All Other CDC Preparedness line, $170 million for the Preventive Health and Health Services Block Grant (Prevent Block Grant), and $250 million for the data modernization effort at the CDC. Under the Assistant Secretary for Preparedness and Response (ASPR), ASTHO is requesting $474 million for the Hospital Preparedness Program (HPP) and not less than $45.6 million to sustain the Regional Treatment Network for Ebola and Other Special Pathogens (RTNESP) and the National Ebola Training and Education Center (NETEC). Additionally, we are requesting $9.2 billion in discretionary funding for the Health Resources and Services Administration (HRSA).

You are probably wondering, "Why is governmental public health at the table requesting more funding? Didn't Congress just provide billions of dollars in emergency funding for you all?" The answers are yes and thank you. We all must recognize the sheer amount of emergency funding required to boost our public health system and respond to the COVID–19 pandemic. We must also acknowledge that huge sums of this emergency funding could have been avoided with ongoing, predictable funding that meets the needs of state, territorial, and local public health departments. The emergency supplemental funding is narrow, specific, and time limited. All too often, after emergency supplemental funding expires, health officials are forced to shut down programs, allow software licenses to expire, furlough staff, and move on. While there are billions of emergency supplemental dollars in the system right now—that we are immensely grateful for—we anticipate that, without a change of course, there will be an enormous funding cliff in two to three years. Meanwhile, we all know that communities of color are disproportionately impacted by underinvestment on all public health fronts, whether we are discussing maternal morbidity and mortality, infant mortality, the prevalence of chronic diseases, substance use and misuse, behavioral and mental health, the HIV epidemic, and most strikingly, overall life expectancy. We have an opportunity to make things better for the American people, especially for those who need it most. This committee and Congress can ensure we have sustained, predictable, and increased funding for all of public health, which translates into better lives for those we serve.

ASTHO is the national nonprofit organization representing the public health agencies of the United States, the U.S. territories and freely associated states, and the District of Columbia. ASTHO members, the chief health officials of these jurisdictions, are dedicated to ensuring excellence in public health practice. The mission of our nation's governmental health agencies is to protect and improve the health of the population, everywhere, every day. Our members' mission is to provide the leadership, expertise, information, and tools to assure conditions in which all residents can be healthy. In short: Keeping people safe.

America's state and territorial public health departments work in strong partnership with CDC toward this goal. For this essential task, we request $10 billion in overall funding for CDC. CDC plays a vital role in supporting communities to ex-

pand the capacity of our nation's front line of public health defense: Our country's state, tribal, territorial, and local public health departments. Through this partnership with CDC, state and territorial health agencies work across the country to prevent avoidable diseases, promote healthy communities, protect the public's health, and ensure the vibrance and security of our economy. These resources also support disease-neutral infrastructure such as data and information technology systems, workforce development, community partnership building, and administrative preparedness. We continue to learn how far behind we are as a country when it comes to our ability to accurately track diseases or even transmit data efficiently and accurately to a central location. ASTHO is thankful for the current investment in our public health systems, but dependable and appropriate financing is essential to keep our country ahead of the curve.

Public health preparedness requires support at the federal level and implementation by state, territorial, and local jurisdictions. Recognizing this, ASTHO requests $824 million for PHEP at CDC. America's public health preparedness outlays have operated in a punctuated equilibrium. We make leaps forward after emergencies such as September 11, Ebola, Zika, and measles outbreaks, and then are lulled into periods of stasis for far too long. PHEP requires ongoing and increased funding to ensure that lessons and improvements from the COVID–19 response are not lost. In close partnership with the PHEP is the Hospital Preparedness Program (HPP) at ASPR, for which ASTHO requests $474 million. As the only source of federal funding that supports regional healthcare system preparedness, HPP promotes a sustained national focus to improve patient outcomes, minimizes the need for supplemental state and federal resources during emergencies, and enables rapid recovery. Now more than ever, we clearly understand the importance of public health and healthcare preparedness programs working collaboratively and with proper resources. We are also requesting that Congress provide no less than $49.5 million to sustain the National Emerging Special Pathogen Training and Education Center and the 10 existing regional Ebola and other special pathogen treatment centers under ASPR. The investment made in this system over five years ago has proven its importance in providing specialty treatment, training, and national-level expertise during the COVID–19 response. This network is a valuable front-line tool in protecting our country.

Preventing disease in the first place is the most economical use of our public funds when it comes to health spending. ASTHO's members strive to implement locally tailored, innovative programs that not only prevent disease and disability but support wellness as we work toward national health priorities. For this, ASTHO requests $170 million for the Prevent Block Grant. Programs funded by the Prevent Block Grant cannot be adequately supported or expanded through other funding mechanisms. The success of the Prevent Block Grant is achieved by using evidence-based methods and interventions, reducing risk factors, leveraging other funds, and continuing to monitor and reevaluate funded programs.

ASTHO appreciates this committee's ongoing support of CDC's data modernization initiative. Public health is singlehandedly keeping the fax industry alive, and we must leap forward. We applaud Congress's investment and down payment to date ($600 million through FY21 and FY21 funding and the CARES Act) and the inclusion of language authorizing activities to improve the public health data systems at CDC in the Consolidated Appropriations Act for FY21. We respectfully request the Subcommittee continue to provide sustained annual funding of at least $250 million for the public health Data Modernization Initiative at CDC.

ASTHO is also encouraged by the Administration's plan to end the HIV epidemic and address social determinants of health in America. State and territorial health officials look forward to working with federal and local partners across the country to bring effective strategies to scale. State, territorial, local, and tribal jurisdictions, community-based organizations, and healthcare partners must have the resources necessary to enhance and deliver these evidence-based public health interventions.

While the pandemic is at the forefront of our minds, we have never fully addressed the ongoing crisis in our country caused by substance misuse, addiction, and drug overdoses. ASTHO is appreciative of previous investments in public health to address this crisis. We respectfully request Congress to sustain activities and continue the response to the opioid epidemic and substance abuse and misuse disorders more broadly.

CDC is not the only federal agency that strives to improve the public's health in states and territories. ASTHO is requesting $9.2 billion for discretionary funding for HRSA. HRSA administers programs that focus on improving care for tens of millions of Americans who are medically underserved or face barriers to needed care by strengthening the health workforce.

As you look to the FY22 discretionary appropriations bills, we strongly urge you to build a base funding for public health—through CDC, ASPR, and HRSA—that is sustainable and predictable. Thank you so much for your time and consideration of our request. We stand ready to continue working toward optimal health for all.

[This statement was submitted by Michael Fraser, PhD, MS, CAE, FCPP, Chief Executive Officer, Association of State and Territorial Health Officials.]

PREPARED STATEMENT OF THE ASSOCIATION OF UNIVERSITY PROGRAMS IN OCCUPATIONAL HEALTH AND SAFETY

On behalf of the Association of University Programs in Occupational Health and Safety (AUPOHS), we respectfully request that the Fiscal Year 2022 Labor, Health, and Human Services Appropriations bill include no less than $375,300,000 for the National Institute for Occupational Safety and Health (NIOSH), including no less than $34,000,000 for the Education and Research Centers (ERCs), $30,500,000 for the Agriculture, Forestry, and Fishing (AgFF) Program, and a $4,000,000 increase over the FY21 level for the Total Worker Health(r) (TWH) Program.

As you have no doubt heard from other testimonies, far too many Americans still lose their lives on the job. In 2019, a worker died every 99 minutes from injuries they got on the job (BLS 2020). This includes our first responders, who can be struck and killed by drivers while helping victims of a roadside traffic accident; our construction workers, who may fall from an inadequately marked or guarded roof edge; and our shop owners and employees who may be asked to work late nights without proper security and become victims of violence. Although it is harder to measure, we also estimate that an additional 145 people die every day in America from work-related disease—developing cancers from hazardous chemicals that we encounter at work, or heart disease from our chronically stressful work environments. In addition to work-related deaths, we also have a high burden of non-fatal workplace injury and illness. Leading up to the pandemic, 2.8 million workers were seriously injured on the job every year and one-third of those injured workers required time off to recover before they could return to work. This not only costs the nation's businesses more than $1.1 billion a week on serious, nonfatal workplace injuries (Liberty Mutual 2020) but also causes great harm to workers and their families if their workers' compensation systems fail to provide adequate care or wage replacement.

The pandemic has amplified all of these issues for the American workforce. More than 3,600 of our health care workers died from COVID–19 in the first year of the pandemic, and we know that many of these deaths are attributable to the extreme shortage of protective gear encountered in medical settings (Lost on the Frontline 2021). That is to say, these deaths were preventable. In just the first months of the pandemic, 16,233 workers in meat and poultry processing facilities were infected with COVID–19 (CDC 2020); these were also workers who sacrificed their health and wellbeing in order to keep essential goods and services moving. We owe an immense debt to all of our essential workers, and as such, we have an opportunity to better serve these workers moving forward. By designing safer workplaces that reduce the risk of exposure to future variants, answering workers' questions about vaccines and making them accessible, and by researching, designing, and preparing programs to bolster workers' mental health as we come to terms with what we have experienced this past year, we can serve our essential workers.

NIOSH is the primary federal agency responsible for conducting research that leads to actions and policies that prevent work-related illness and injury by promoting safe work practices and work environments as well as worker health and well-being. NIOSH is also the federal agency charged with certifying and approving Personal Protective Equipment (PPE), including the masks that are necessary to protect U.S. workers from inhalation exposures to chemical and biological agents, including viruses. During this pandemic, NIOSH has accelerated the approval process for establishing the safety and quality of new masks and other PPE. NIOSH continues to fund and promote critical research for a changing workforce and work practices, an important service for employers and employees in the face of the current pandemic and other disasters. NIOSH has, for example, deployed teams across the country in response to industry requests for assistance, including more than 15 meatpacking plants that experienced outbreaks. NIOSH has contributed key leadership and expertise, providing federal guidance and decision tools for industries including construction, manufacturing, food and agriculture, mass transit, transportation and trucking, restaurants and bars, childcare facilities, schools, among others, including recent guidance for businesses to safely return to work and/or expand operations.

The NIOSH-supported extramural Centers, including the Education and Research Centers (ERCs), Centers in the Agriculture, Forestry, and Fishing (AgFF) Program, and the Total Worker Health(r) (TWH) Centers of Excellence, have responded rigorously to the pandemic and supported NIOSH to rapidly respond to the needs and safety of the nation's workforce. These Centers have been proactive in providing resources, employer assistance, over 100,000 hours of outreach training, and research that are helping to drive improvements in our rapid response to emerging occupational safety and health issues. The work the Centers have undertaken during this pandemic underscores the need for increased funding for NIOSH and the Centers. As workplaces rapidly evolve, changes continue to present new health and safety risks to workers, which need to be addressed promptly through occupational health and safety research and training.

The 18 university based ERCs provide local, regional, and national resources for all those in need of occupational health and safety assistance. Collectively, the ERCs provide graduate- and post-graduate level education and research training in the occupational health and safety disciplines. The ERCs prepare a workforce of occupational safety and health professionals to every Federal Region in the U.S who are trained to identify and mitigate vulnerabilities from all sources, including increased readiness to respond to chemical, biological, radiological, or nuclear attacks. Occupational health and safety professionals work with emergency response teams to minimize disaster losses, as exemplified by their lead role in minimizing hazards among workers involved in clean-up and restoration of the extreme devastation caused by Hurricanes Harvey, Irma, and Maria in Texas, Florida, Puerto Rico, and the U.S. Virgin Islands. In 2020, the ERCs responded rapidly to provide employers across the country with accessible, concise information on the workplace implications of COVID–19 and are now providing local and national online and telephonic advising programs for businesses as they seek to reopen safely.

NIOSH also focuses research and outreach efforts on the nation's most dangerous worksites that often impact lives in more rural parts of America. The Centers for AgFF were established by Congress in 1990 (PL 101–517) in response to evidence that agricultural, forestry, and fishing workers suffer substantially higher rates of occupational injury and illness than other nation's workers. Agricultural workers are more than six times more likely to die on the job than the average worker, averaging 540 fatalities per year, and more than 1 in 100 workers incur nonfatal injuries resulting in lost workdays each year. Our food security depends on a healthy and safe agricultural workforce—an essential sector that has been hit particularly hard during the pandemic. Today, the NIOSH AgFF initiative includes ten regional Agricultural Centers and one national Children's Farm Safety and Health Center. The AgFF program is the only substantive federal effort to ensure safe working conditions in these vital production sectors. The program also conducts research and outreach to ensure the safety of our nation's 86,000 workers in forestry and logging, an industry with a fatality rate more than 30 times higher than that of all our nation's workers. The AgFF Centers have had a significant impact on protecting safety and health of agricultural workers. For example, the developed of rollover protective structures (ROPS or roll bars) and seatbelts on tractors were shown to prevent 99% of overturn-related deaths. Partnering with fishing communities, the AgFFs developed comfortable lifejackets to wear at work, which have increased chances of survival in the event of a fall overboard. The lifesaving, cost-effective work of the AgFF program is not replicated by any other agency. USDA's National Institute of Food and Agriculture interacts with experts at NIOSH to learn about cutting-edge research and new directions in this area. In addition, state and federal OSHA personnel rely on NIOSH research to develop evidence-based standards for protecting agricultural workers and would not be able to fulfill their mission without the AgFF program.

NIOSH also supports six TWH Centers of Excellence that conduct multidisciplinary research and test practical solutions to emerging challenges that impact the safety, health, well-being, and productivity of the American workforce. The TWH Centers conduct solutions-focused research in partnership with employers and employees and partner with government, business, labor, and community to improve the health and productivity of the workforce. The TWH Centers' research, education, and outreach activities occur in workplaces, such as hospitals, factories, offices, construction sites, and small businesses, resulting in immediate and measurable improvements in health and safety. These Centers have been heavily relied upon by employers and employees to address the impact of the current pandemic not only from an infectious disease perspective but also to address the impact on mental health, stress, burnout, and resiliency of essential workers, workers abruptly working remotely, and those furloughed or laid off. The TWH Centers are an investment

in the American economy, helping valued employees return home safe and healthy at the end of a productive workday.

We urge you to recognize the critical contribution of NIOSH, including the ERCs, the AgFF Program, and the TWH Program to the health and productivity of our nation's workforce. Thank you for the opportunity to submit testimony.

PREPARED STATEMENT OF KATHERINE BENNETT, MD FACP

As the Assistant Director for Education of the Northwest Geriatrics Workforce Enhancement Center (NW GWEC) at the University of Washington (UW), immediate past president of the National Association for Geriatric Education (NAGE), and a current Geriatrics Academic Career Award recipient, I am pleased to submit this statement for the record on behalf of myself, the NW GWEC, and NAGE recommending appropriations of at least $105.7 million in Fiscal Year 2022 to support geriatrics workforce training under the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA) program. Administered by the Health Resources and Services Administration (HRSA), both programs reach rural and underserved populations and address health inequities. We thank you for your past extensive support of these programs. An appropriation at this level will build upon these programs that are vital to the health and well-being of our nation's older adults and those who provide care for them.

We all know that there are many older people in our homes, communities, and states who need the care of well-trained health professionals. It turns out that we have much of the know-how, expertise, curricula, and teachers to offer this training! What we need from you is the funding to support the dissemination of this expertise to more health care providers and systems who treat older patients. The GWEP and the GACA programs are the only federally funded programs designed to increase the number of health professionals with the skills and training to provide high quality, patient-centered, equitable, cost-saving care for older adults. This training is critical to addressing the suboptimal care that is so frequent and widespread, and something I see the devastating impacts of each day—older adults who are prescribed dozens of medications that are contributing to falls and cognitive impairment; advanced dementia that has gone undiagnosed for years; and life-altering injuries from falls that could have been prevented.

Suboptimal healthcare occurs not because primary care teams do not care but because most providers in practice have received insufficient and more often no training whatsoever in the core principles of high-quality care for older adults. In a just society, we aspire to provide adequate health care at every age and stage of life. The care of older adults is a unique skill set, largely due to age-related changes to the entire body, the simultaneous presence of multiple chronic diseases, and conditions that are unique to older adults—this care really cannot be done well without specific training. The GWEP and the GACA programs seek to change the present reality through quality improvement and education initiatives conducted in partnership with primary care practices and community agencies, and by training future leaders in geriatrics care transformation.

There are currently 48 GWEPs, located in 35 states and 2 territories, that are working to rapidly transform and expand the health care of older adults. The current appropriation level makes it impossible to have at least one GWEP in every state or for current GWEPs to have adequate funds to do an expanding body of work. This increased funding is urgently needed so that these vital programs can equitably reach all areas of the country and effectively respond to the rapid growth in number and increasing health complexity of older adults. These programs are integral to the training, support, and expansion of the eldercare workforce and long-term services and supports infrastructure.

The 48 current GWEPs have tremendous impact on their regions. During 2019–2020, 56,603 health professions trainees participated in GWEP-led education activities, and 290,161 faculty and providers attended 2,069 different continuing education events, which included 906 events focused on Alzheimer's disease and other dementias. GWEPs partner with health systems (including federally qualified health centers and Veteran's Affairs Medical Centers) and community-based organizations to have the greatest impact and optimize the community/health care linkages that are essential to older adults and their caregivers. Every GWEP is focused on meeting the needs of rural and/or underserved populations, and GWEPs play an integral role in reducing health inequities. For example, a GWEP based on the South Side of Chicago addressed health disparities for African Americans with dementia by partnering with faith-based community leaders, and another GWEP partnered with

FQHCs to create and distribute multilingual COVID–19 education materials and increase behavioral health capacity.

Over the past two years, GWEPs have joined forces with the Institute for Healthcare Improvement and The John A. Hartford Foundation to drive spread of the Age-Friendly Health System initiative. This initiative aims to align healthcare with an older adult's goals by eliciting what matters most to them, ensuring that medications regimens minimize the risk of harm, optimizing mood and cognition, and guiding them to move safely and prevent falls. This type of evidence-based care not only improves outcomes but reduces healthcare costs. To date, GWEPs are partnering on this initiative with 302 health care delivery sites, 42% of which are in medically underserved communities and 45% designated as primary care. Nearly 6,000 different activities focused on Age-Friendly Health System transformation have reached 205,322 individuals.

The COVID–19 pandemic highlighted the fragility of the network of supports that help keep older adults healthy and thriving in the community. The GWEPs quickly pivoted to redirect the training of the healthcare workforce in the face of the obstacles resulting from the pandemic while continuing to meet the needs of older adults and their caregivers. For example, our GWEP partnered with Area Agencies on Aging to provide electronic tablets (along with training and support) and telehealth stations to keep older adults connected online to essential primary care services. We also quickly shifted our training to an entirely virtual format and focused on what interprofessional teams need to optimally care for older adults during the pandemic. Training sessions covered COVID–19 in older adults, assessing cognition via telehealth, addressing goals of care during the pandemic, and screening for falls via telehealth.

Around the country, GWEPs have done nothing short of amazing work during COVID–19 by partnering with primary care and community agencies to meet the medical, behavioral health, social, and basic needs of older adults and their caregivers. GWEPs addressed social isolation via virtual connection and phone outreach, trained teams of healthcare providers in age-friendly telehealth, provided virtual trainings on key care principles for older adults, delivered virtual caregiver support, and partnered on rapid vaccine rollout to the most vulnerable in the community, to name just a few examples. Taken together, the GWEPs delivered 400 unique training sessions that addressed COVID–19 related issues and reached over 54,000 individuals. The pandemic demonstrated the tremendous ability of GWEPs to adapt to unforeseen circumstances and remain focused on transforming the care of older adults to be age-friendly and preparing the healthcare workforce to meet the most pressing needs of older adults and their caregivers.

The Northwest Geriatrics Workforce Enhancement Center (NW GWEC), UW's GWEP, was established in 2015 and provides training and programs that enhance the lives of older adults and their caregivers in Washington and throughout the region. Our programs include Project ECHO-Geriatrics, a Primary Care Liaison Program based at the Area Agencies on Aging (AAA), a AAA Practicum for health professions trainees, and the Geriatrics Healthcare Lecture Series. Here are some examples of our reach.

—*Project ECHO-Geriatrics:* NW GWEC's Project ECHO—Geriatrics, or the Extension for Community Healthcare Outcomes, which is based on the evidence-based ECHO model that trains and mentors current and future primary care providers to provide specialty care to their own patients and reduce health disparities. Sessions involve virtual mentoring sessions with teaching and consultations with an interprofessional geriatrics specialist panel. Since 2016, we have held over 60 monthly sessions with over 1,000 unique participants. Sessions focus on key primary care topics such as dementia, fall prevention, and depression. Dr. Braun, a faculty member at the Providence St. Peter Family Medicine Residency Program with sites in Olympia and Chehalis, WA said, "The program not only helps achieve our hours of required geriatrics training but has transformed the care I see provided by our residents in clinic and across healthcare settings."

—*Primary Care Liaison Program:* Our GWEP partnered with several Area Agencies on Aging in WA to create a Primary Care Liaison (PCL) program to connect primary care clinics to AAAs through outreach, engagement, and education as well as facilitating referrals. This program has increased primary care referrals to participating AAAs by over 4-fold.

The GACA program aims to train the next generation of leaders in geriatrics. There are currently 26 GACA awardees across 16 states representing a range of health professions disciplines (e.g., physicians, social workers, dentists, physical therapists). GACA awards support career development of future educators, leaders, and innovators in geriatrics and awardees also train interprofessional teams to pro-

vide age-friendly care. For example, as a current GACA awardee, I partnered with my local Area Agency on Aging (AAA) to create a new Project ECHO specifically to train AAA case managers in age-friendly care. The curriculum covers dementia, fall prevention, depression, and medication safety, and each ECHO session includes consultation on complex patients. GACA awardees throughout the country are reshaping the care of older adults through innovative projects such as redesigning airports to be age-friendly, reducing unsafe opioid prescribing in nursing homes, and integrating (oft neglected) oral health into routine primary care.

Although GWEPs are preparing the healthcare workforce to meet the needs of older adults and their caregivers, not all states are benefiting: Only 35 states and two territories have a GWEP, and only 16 states have a GACA recipient. Moreover, since renewal of the GWEP program in 2019, annual funding per GWEP has been reduced by $100,000 compared to the initial award period (2015–2019). An increase in appropriation is essential to ensure that every state has at least one GWEP and that GWEP sites can expand their work. Additionally, increased appropriations can ensure that there are more GACA awardees to meet the nation's current and future needs for transformative leaders in geriatric medicine.

In summary, GWEPs and GACAs are essential to ensure that the healthcare workforce in this country can meet the needs of older adults. Through our GWEPs, we have developed the knowledge and expertise to train interprofessional health care teams. Through our many partnerships and training activities, we have proved integral to the training and care delivery of the healthcare workforce including those in the long-term services and supports infrastructure as well as eldercare workforce infrastructure. I thank you for your consideration of this request for appropriations and am deeply grateful for your past support of these programs that are revolutionizing healthcare of older adults and their caregivers to be age-friendly, high-quality, equitable, cost-saving, and aligned with their personal goals and preferences.

PREPARED STATEMENT OF THE BEYOND AIDS FOUNDATION

Dear Committee Members,

I am writing in support of a FY 2022 budget request for Department of Health and Human Services (DHHS) to develop a national strategy and implementation plan for the prevention, control and treatment of Herpes Simplex Virus, Types 1 and 2 infections.

It is critical for public health and disease control to address Herpes Simplex Virus (HSV), a lifetime infection that impacts nearly half of Black women in our country, disproportionately impacts LGBTQ populations, and is an important driver of the HIV epidemic. Approximately 40% of new cases of HIV infection have been attributed to chronic HSV infection. HSV also kills approximately 1,000 infants annually as a result of neonatal herpes and injures thousands more. Despite this largely preventable mortality and morbidity, neonatal herpes is currently not even a national reportable condition. Additionally, there is a growing body of research indicating that HSV may be a contributing factor to Alzheimer's Disease, Encephalitis, Bell's palsy, among other neurodegenerative diseases.

There is currently no organized national strategy to address HSV. It is often not tracked nor routinely tested for during clinical and screening visits. And the majority of spread is via asymptomatic carriers who are in most cases unaware of their infection status. It is estimated that over 60 million Americans have genital infections with either HSV–2 or HSV–1, making it among the most prevalent STIs in the US. We can and should be doing more to stop the spread and provide better treatment to the nearly 1 in 3 Americans with this chronic condition.

For the past two decades, I have served as the volunteer Medical Advisor for the largest in-person herpes support (HELP) groups in the country (Los Angeles and Orange Counties, San Diego), and since the COVID–19 pandemic, the online SoCal HELP group. I have been privy to observe the negative outcome of having non-existent federal HSV policies and programs. They include severe genital pain syndromes as well as bouts of depression, anxiety, shame, and loss of self esteem accompanying these infections. As the former Director of the largest domestic STD Program (Los Angeles County) in the US for over a decade, I was and am currently acutely aware of the shortcomings of our HSV policies, planning and services, and the great need to change our approach and address this problem.

If we prioritize women's and maternal health, the health of Black, Hispanic, LGBTQ, indigenous and other at-risk communities, we must prioritize Herpes Simplex Virus treatment and prevention. If we prioritize mental health, biomedical research for incurable diseases such as Alzheimer's or HIV, and dismantling systemic

racism in healthcare, we must also prioritize Herpes Simplex Virus control. Addressing HSV addresses all of these national priorities and can improve the health and quality of life, and reduce the economic burden for millions of Americans.

Sincerely.

[This statement was submitted by Gary A. Richwald, MD, MPH, President, Beyond AIDS Foundation.]

PREPARED STATEMENT OF THE BIG CITIES HEALTH COALITION

On behalf of the Big Cities Health Coalition (BCHC), we respectfully request that the Subcommittee provide the highest possible funding for the U.S. Centers for Disease Control and Prevention (CDC), central to protecting the public's health, for Fiscal Year 2022. Key CDC programmatic priorities of the Coalition and our member health departments include violence prevention, immunization, public health preparedness, epidemiology and laboratory capacity, opioid overdose prevention, and the public health data modernization initiative.

BCHC is comprised of health officials leading 30 of the nation's largest metropolitan health departments, who together serve nearly 62 million—or one in five—Americans. Our members work every day to keep their communities as healthy and safe as possible. We thank you for your continued leadership and support for our nation's public health workforce and systems during the ongoing COVID–19 pandemic.

As the Subcommittee members recognize, federal funding for CDC and the programs that support local and state public health departments have remained largely stagnant. Additional investments through sustained annual funding is necessary to build public health capacity for the next pandemic, as well as the everyday population health programs.

NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

National Immunization Program

We respectfully request $1.1 billion in FY2022 for the National Immunization Program. The CDC Immunization Program funds 50 states, six large, BCHC member cities (Chicago, Houston, New York City, Philadelphia, San Antonio, and Washington, D.C.), and eight territories for vaccine purchase and immunization program operations. In addition to the challenges of the COVID–19 pandemic and continuing disease outbreaks, recent growth of electronic health records and compliance with associated regulations, new vaccines and school requirements have increased the complexity of vaccine management. Additional base funding is needed for each grantee to sustain improvements supported by emergency funding and maintain sound and efficient immunization infrastructure. We also ask that the Committee encourage CDC to be as flexible as possible in coordinating funding and guidance across immunization program streams as we do COVID vaccinations while still also carrying out routine immunizations.

NATIONAL CENTER FOR EMERGING AND ZOONOTIC INFECTIOUS DISEASE

Epidemiology and Lab Capacity

We respectfully request $500 million in FY2022 for the Epidemiology and Lab Capacity (ELC) program, which is a single vehicle for multiple programmatic initiatives that go to 50 state health departments, six large, BCHC member cities (Chicago, Houston, Los Angeles County, New York City, Philadelphia, and Washington, D.C.), Puerto Rico, and the Republic of Palau. ELC grants strengthen local and state capacity to contain infectious disease threats by detecting, tracking and responding in a timely manner, as well as maintaining core capacity as the nation's public health eyes and ears on the ground. Increased funding will help build the epidemiology workforce, allowing state and local health departments to begin to move towards establishing a minimum epidemiology workforce; to promote and offer training for state and local epidemiologists; and to monitor needs in state- and/or local-based epidemiology capacity. ELC dollars sent to the states should be tracked through existing CDC reporting structures and shared publicly to ensure funds are also supporting big city epidemiology activities.

PUBLIC HEALTH SCIENTIFIC SERVICES

Public Health Data Modernization Initiative (DMI)

We respectfully request $250 million in FY2022 for the DMI that is working to create modern, interoperable, and real-time public health data and surveillance sys-

tems at the state, local, Tribal, and territorial levels. These efforts will ensure our public health officials on the ground are prepared to address any emerging threat to public health-whether it be COVID–19, measles, a foodborne outbreak like E. coli, or another crisis. COVID–19 exposed the gaps in our public health data systems and since then Congress has provided funding for DMI through the CARES Act and American Rescue Plan Act. These investments have been critical, but the public health surveillance systems must live beyond COVID–19 and be ready for any and all future threats. This requires long-term, sustained investment that is not just to build capacity at the federal and state level, but also at health departments in cities and counties across the country.

PUBLIC HEALTH WORKFORCE

We respectfully request $160 million in FY2022 for the public health workforce and career development programs as proposed in the President's budget. The public health workforce is the backbone of our nation's governmental public health system at the county, city, state, and tribal levels. Investments must be made to build back the public health workforce, as well as attract and retain diverse candidates with diverse skill sets. These funds support CDC's fellowship and training programs including the Public Health Associate Program and the Epidemic Intelligence Service that extend the capacity of health departments and key partners at all levels of government.

CROSS-CUTTING ACTIVITIES AND PROGRAM SUPPORT

Public Health Infrastructure and Capacity

We respectfully request $400 million in FY2022 for a new Public Health Infrastructure and Capacity investment as proposed in the President's budget request. The pandemic exposed the deadly consequences of chronic underfunding of basic public health capacity. Because public health is largely funded by disease or condition, there has been little investment in cross-cutting capabilities that are critical for effective public health. These capabilities include: public health assessment; preparedness and response; policy development and support; communications; community partnership development; organizational competencies; accountability; and equity. Governmental public health infrastructure requires sustained investments over time and we believe this is an important start. This investment is critical to ensuring that our governmental public health system is prepared for the next pandemic as well as to strengthen the health of our communities every day.

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Opioid Overdose Prevention and Surveillance

We respectfully request $713 million in FY2022 for Opioid Overdose Prevention and Surveillance in line with the President's request. Many health departments were forced to curtail opioid and other substance use disorder services during the pandemic. Unfortunately, overdose numbers are increasing in many communities, erasing progress of recent years. Previously, programs that connected with people in hospital emergency departments after an overdose had seen successful outcomes in steering people toward syringe services programs and treatment programs. However, these programs rely on in person interactions that have been scaled back during the pandemic. Funding is needed in local communities to ensure that substance use disorder prevention continues to stem the tide of overdose and death. We also encourage the Committee to include directive language to insure these dollars reach the local level in those communities that are not directly funded, as well as have CDC and the Office of the Assistant Secretary of Health at the Department of Health and Human Services better track and share publicly state expenditures.

Gun Violence Prevention Research

We respectfully request $25 million in FY2022 for Gun Violence Prevention Research and the same as the President's budget request. Firearm violence is a serious public health problem in the United States that impacts the health and safety of all Americans. Despite initial funding in FY 2021 to research key issues around firearm violence, significant gaps remain in our knowledge about the problem and ways to prevent it; we need to continue and expand the research. Addressing these gaps is an important step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences. The public health approach to violence prevention includes working to define the problem, identifying risk and protective factors, developing and testing prevention strategies, and then, assuring widespread adoption of effective, targeted programs. Additional funds would be used to

provide grants to conduct research into the root causes and prevention of gun violence focusing on those questions with the greatest potential for public health impact. The goal of this research is to stem the continued rise of firearm violence across the country to make our communities safer.

Community Based Violence Intervention Initiative

We respectfully request $100 million in FY2022 for a new Community Violence Intervention initiative as proposed in the President's budget request to implement evidence-based community violence interventions locally. BCHC whole-heartedly supports such an investment. Violence, like many public health challenges, is preventable. Yet, the majority of public investments are used to address the aftermath of violence, too often through systems that can cause further harm. Communities can be made safer when we understand the events that have led to present conditions and act on this knowledge by implementing policies and practices that address the root causes of violence. By making investments in public health strategies within communities that are most impacted by violence, cities can work across sectors to shift from an overreliance on the criminal justice system and move from reimagining to realizing community safety.

CENTER FOR PREPAREDNESS AND RESPONSE

Public Health Emergency Preparedness Cooperative Agreements

We respectfully request $1 billion in FY2022 for the public health emergency preparedness (PHEP) grant program. PHEP provides funding to strengthen local and state public health departments' capacity and capability to effectively respond to public health emergencies, including terrorist threats, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies. PHEP funding has been cut by over 30% in the last decade. Recent events, such as the response to the COVID–19 pandemic, demonstrate the need to invest in these programs to rebuild and bolster our country's public health preparedness and response capabilities. America's public health preparedness systems are stretched to the brink and will need increased and stable base funding for years to rebuild and improve. We also encourage the committee to include directive language to insure these dollars reach the local level in those communities that are not directly funded, as well as have CDC and the Office of the Assistant Secretary of Health at the Department of Health and Human Services better track and share publicly state expenditures.

NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Social Determinants of Health

We respectfully request $153 million in FY2022 for the Social Determinants of Health (SDOH) program in line with the President's request. CDC's SDOH program was initially funded in FY2021 to coordinate CDC's activities and to begin to provide tools and resources to public health departments, academic institutions, and nonprofit organizations to address the social determinants of health in their communities. Local and state health and community agencies lack funding and tools to support these cross-sector efforts and are limited in doing so by disease-specific federal funding. Given appropriate funding and technical assistance, more communities could engage in opportunities to address social determinants of health that contribute to high health care costs and preventable inequities in health outcomes.

Office of Smoking and Health (OSH)

We respectfully request $310 million in FY2022 for the Office of Smoking and Health (OSH). Tobacco use has long been the leading preventable cause of death in the United States. Each year, it kills more than 480,000 Americans and is responsible for approximately $170 billion in health care costs. OSH has a vital role to play in addressing this serious public health problem. It provides grants to states and territories to support tobacco prevention and cessation, runs a highly successful national media campaign, conducts research and surveillance on tobacco use, and develops best practices for reducing it. Additional resources will allow OSH to address the alarmingly high rates of youth e-cigarette in addition to other forms of tobacco.

PREPARED STATEMENT OF THE CAMPAIGN FOR TOBACCO-FREE KIDS

I am Matthew Myers, President of the Campaign for Tobacco-Free Kids. I am submitting this written testimony for the record to urge the subcommittee to increase funding by $72.5 million for the Office on Smoking and Health (OSH) at the Centers

for Disease Control and Prevention (CDC). By providing OSH with a fiscal year 2022 funding level of $310 million, CDC will be able to more effectively address high levels of youth e-cigarette use, expand its highly effective Tips from Former Smokers public education campaign, and aggressively address the role that tobacco use plays in health disparities by increasing its efforts to assist populations and regions of the country with disproportionately high rates of tobacco use and tobacco-related disease and premature death. Helping tobacco users to quit is of particular importance at this time given that cigarette smoking increases the risk of severe illness from COVID–19.[1]

Tobacco use remains the leading cause of preventable disease and death in the United States. More than 480,000 Americans die from tobacco use each year, and over 16 million Americans are currently living with a tobacco-caused disease.[2] Thirty-two percent of heart disease deaths, 30 percent of all cancer deaths, 87 percent of lung cancer deaths, and nearly 80 percent of all chronic obstructive pulmonary disease (COPD) deaths stem from tobacco use.[3] Smoking shortens the life of a smoker by more than a decade.[4]

Funding for CDC's Office on Smoking and Health remains modest when compared to the estimated $226 billion in annual health care costs attributable to tobacco use.[5] Even with the funding increases it has received over the past two years, the Office on Smoking and Health's resources remain stretched too thin. OSH needs additional resources to address an epidemic in youth use of e-cigarettes while continuing to reduce other forms of tobacco use, especially among populations disproportionately harmed by tobacco products.

High levels of youth e-cigarette use is threatening to undermine decades of progress in reducing youth tobacco use. E-cigarettes have been the most popular tobacco product used by kids since 2014.[6] These products come in a wide array of flavors that attract youth and often deliver high levels of nicotine.[7] In 2020, 3.6 million youth were current users of e-cigarettes, including nearly 1 in 5 high school students.[8] Alarmingly, 38.9 percent of all high school e-cigarette users used e-cigarettes for 20 days or more a month, an indicator of addiction.[9] In addition to exposing users to nicotine and other harmful and potentially harmful substances, research shows that e-cigarette use increases the risk of smoking cigarettes.[10]

The CDC's Office on Smoking and Health has a critical role to play in addressing the youth e-cigarette epidemic. The agency has extensive experience working with

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[1] CDC, "People with Certain Medical Conditions," accessed April 28, 2021, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

[2] U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014, http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/.

[3] HHS, The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014; "Centers for Disease Control and Prevention (CDC) Vital Signs, Cancer and Tobacco Use, Tobacco Use Causes Many Cancers," November 2016. https://www.cdc.gov/vitalsigns/pdf/2016-11-vitalsigns.pdf.

[4] HHS, The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014.

[5] Xu, X et al., "Annual Healthcare Spending Attributable to Cigarette Smoking in 2014," American Journal of Preventive Medicine, 2021.

[6] Wang, TW, et al., "E-cigarette Use Among Middle and High School Students—United States, 2020," MMWR, Volume 69, September 9, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6937e1-H.pdf; Gentzke, A., et al., "Vital Signs: Tobacco Product Use Among Middle and High School Students—United States, 2011–2018, MMWR, Vol. 68, No. 6, February 2019. https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6806e1-H.pdf.

[7] Office of the Surgeon General, "Surgeon General's Advisory on E-Cigarette Use Among Youth," December 18, 2018, https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf.

[8] Wang, TW, et al., "E-cigarette Use Among Middle and High School Students—United States, 2020," MMWR, Volume 69, September 9, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6937e1-H.pdf.

[9] Wang, TW, et al., "E-cigarette Use Among Middle and High School Students—United States, 2020," MMWR, Volume 69, September 9, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6937e1-H.pdf.

[10] HHS, E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016; Barrington-Trimis, JL, et al., "E-Cigarettes and Future Cigarette Use," Pediatrics, 138(1), published online July 2016; National Academies of Sciences, Engineering, and Medicine. 2018. Public health consequences of e-cigarettes. Washington, DC: The National Academies Press. http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx. Berry, KM, et al., "Association of Electronic Cigarette Use with Subsequent Initiation of Tobacco Cigarettes in US Youths," JAMA Network Open, 2(2), published online February 1, 2019;.

state and local health departments and the capacity to identify and implement effective prevention strategies designed specifically towards youth. An increase in funds would allow CDC to provide more resources to state and local health departments; educate students, parents and their communities about the risks of youth e-cigarette use; and develop and implement other strategies to protect kids.

In addition to the youth e-cigarette epidemic, there remains a great need to help adult tobacco users who want to quit. The vast majority of adult smokers started as youth, want to quit and wish they had never started.[11] The CDC's national media campaign, Tips from Former Smokers (Tips), has proven to be highly successful at helping smokers quit. The campaign features former smokers discussing the harsh realities of living with a disease caused by smoking and how current smokers can access evidence-based resources to assist them in quitting. Between 2012 and 2018, the campaign motivated over 16.4 million smokers to make a quit attempt and helped over one million smokers to successfully quit for good.[12] A recent cost-effectiveness analysis found that over the same timeframe, Tips helped prevent 129,100 smoking-related deaths and saved an estimated $7.3 billion in smoking-related health care costs.[13]

The Tips campaign has been enormously successful despite being on air for only part of the year. In 2020, the campaign ran for 28 weeks. The 2014 Surgeon General's Report, The Health Consequences of Smoking-50 Years of Progress, said that media campaigns like Tips would ideally run 12 months a year.[14] With additional funding, the CDC could extend the number of weeks the campaign is on the air as well as the frequency with which the ads are run. Research has demonstrated that increased exposure to Tips ads leads to increases in intentions to quit and quit attempts.[15]

Tobacco use plays a significant role in health disparities. Despite the progress that has been made in reducing tobacco use, certain populations and regions of the country face disproportionately high rates of tobacco use and tobacco-related disease and premature death. For example, Americans with lower levels of education and income, American Indians and Alaska Natives, lesbian, gay and bisexual adults, and adults with a mental illness all smoke at significantly higher rates than other Americans.[16] Despite initiating smoking later in life than whites, Black Americans suffer from significantly higher rates of diseases and death caused by smoking.[17]

With additional funding, CDC could provide targeted assistance to groups disproportionately harmed by tobacco use. By collaborating with state and local health departments and community organizations, CDC could implement prevention and cessation programs tailored to resonate with and serve specific groups.

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[11] U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014; Babb, S., et al., "Quitting Smoking Among Adults—United States, 2000–2015," MMWR 65(52), January 6, 2017;Nayak, P., et al., "Regretting Ever Starting to Smoke: Results from a 2014 National Survey," International Journal of Environmental Research and Public Health, 2017; O'Connor, Richard J., et al., "Exploring relationships among experience of regret, delay discounting, and worries about future effects of smoking among current smokers." Substance Use & Misuse 51, no. 9 (2016).

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[13] Shrestha SS, est al., "Cost Effectiveness of the Tips From Former Smokers Campaign—US, 2012–2018. American Journal of Preventive Medicine, December 2020.

[14] U.S. Department of Health and Human Services (HHS), The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014, http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/.

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We urge the subcommittee to increase funding for CDC's Office on Smoking and Health from the $237.5 million it received in fiscal year 2021 to $310 million in fiscal year 2022. An additional $72.5 million would provide CDC with the resources it needs to increase funding to states and take other steps to address the epidemic of youth e-cigarette use, expand the highly successful Tips from Former Smokers media campaign, and provide targeted assistance to groups disproportionately harmed by tobacco use.

We appreciate the opportunity to highlight the important work of CDC's Office on Smoking and Health and the need to increase its funding to $310 million in fiscal year 2022.

[This statement was submitted by Matthew L. Myers, President, Campaign for Tobacco-Free Kids.]

PREPARED STATEMENT OF THE CAREGIVER ACTION NETWORK

On behalf of Caregiver Action Network (CAN), I am testifying in support of the Care Corps program funded through HHS' Administration for Community Living (ACL). We request doubling the appropriation for Care Corps from $4 million in FY 2021 to $8 million in FY 2022.

Care Corps is an innovative Federally funded grant program that was created in FY 2019 with a $5 million appropriation, subsequently receiving $4 million in FY 2021. In August 2019, the U.S. Administration for Community Living (ACL) awarded a five-year cooperative agreement to implement the new Care Corps program to a team of four organizations comprised of Oasis Institute, Caregiver Action Network, the National Association for Area Agencies on Aging, and Altarum. The four organizations named the new program the Community Care Corps.

Community Care Corps fosters innovative local models to provide volunteer nonmedical assistance to family caregivers, older adults, and adults with disabilities. Community Care Corps is an opportunity for community organizations to use volunteers to address some of the gaps in existing basic supports for family caregivers, older adults, and people with disabilities. The program, intended as a demonstration program over 5 years, will also evaluate the effectiveness of local models in different communities nationally.

For tens of millions of Americans who are older, frail, or functionally disabled, timely access to reliable assistance with simple household tasks and meaningful companionship can make an enormous difference in the quality of their lives and their ability to sustain meaningful, ongoing connections to the community in which they live.

Today, 80% of the care for those over age 65 is provided by family caregivers. Yet in the future there will be fewer caregivers. According to AARP, in 2010, there were more than 7 potential caregivers for every person over age 80. By 2030, the caregiver ratio will drop to 4 to 1; and by 2050, the ratio drops to less than 3 to 1. During this same period, the number of individuals over the age of 84 is set to rise by 350%.

Given the rapidly shrinking ratio of family caregivers to the number of older Americans who need assistance, volunteers aged 18 and older can help ameliorate the coming "caregiving cliff" brought on by the nation's demographic changes. In support of the Care Corps program, the Report accompanying the House Labor-HHS Appropriations bill last year "recognize[d] the growing demand for services and supports to help seniors and individuals with disabilities live independently in their homes, and the need to support family caregivers who facilitate that independence."

Interest in the new Community Care Corps program across the country has been tremendous. Community Care Corps issued its first RFP in 2020 and received 183 applications from 45 states plus DC and Puerto Rico. The application process was very competitive, with the 183 applications totaling $23 million in funding requests. Clearly, not all applications received funding (we were only able to fund 10% of the grant requests); and those that did, did not receive the full amount requested.

We selected 23 grantees from 20 states from this competitive pool of applications. The award amounts range in size from $30,000—$250,000. The 23 grantees' local model volunteer programs are community-based and provide a wide range of nonmedical volunteer services. Community Care Corps volunteer programs do not replace the important services that the home care workforce and other paid professionals provide to help individuals live independently in the community.

Our 2020 grantees represent a diverse cross section of the nation, representing urban, rural, Frontier and Tribal communities. The grantees comprise numerous types of organizations including community-based organizations, university-based clinics, area agencies on aging, neighborhood villages, government agencies, coali-

tions, hospitals, and social service organizations. The size of the organizations also varies considerably—from very large such as Maryland's St. Agnes Hospital, a member of Ascension Health, the largest non-profit health care organization in the nation, to North Carolina's Carova Beach Volunteer Fire and Rescue Auxiliary with a volunteer staff of one serving a small ocean front community that can only be accessed by four-wheel-drive. Grantees provide services to individuals of a variety of races and ethnicities including Hispanic, Native American, White, Black, Asian, and Native Alaskan. Two grantees specifically serve new Americans.

We particularly search for local grantees with innovative ways to use volunteers to provide non-medical assistance in their community. For example, in Alaska volunteers assisted the target population with fishing and hunting to supplement food sources. The grantee in Michigan leveraged face-to-face video calls to participants even prior to the COVID crisis. In Connecticut, the grantee exercised flexibility by using their Trusted Ride Transportation program to pivot and provide COVID vaccine appointments and transportation for older adults in need of the vaccine.

In the first six months—even with time needed to adapt their original plans to the then-emerging Covid pandemic that required changes in how they deliver volunteer services—the grantees have already served 2,744 people. That included:

—2,273 older adults

—162 adults with disabilities

—309 family caregivers

Also, during the first six months, more than a thousand volunteers provided non-medical services and 191 training sessions were held for these volunteers.

Over the five years of the Community Care Corps program, local models with the most promising results, most effective and efficient outputs and outcomes, and greatest positive ROI will be assessed as ideal candidates for broader dissemination. Several outcomes and outputs are measured on a quarterly basis.

We are now about to begin the second grant cycle. The Senate Appropriations Labor/HHS Subcommittee included $4 million for Community Care Corps in FY 2021 and that was the level that was enacted for FY 2021. With the $4 million appropriated, we are able to fund additional grants and look forward to getting applications for innovative volunteer models from local communities across the country. The RFP for new applications has just been released and applications will be accepted through July 9. In addition, current grantees can apply for second-year funds. One of the key enhancements to our 2021 RFP is an intensified focus on diversity of volunteers, communities served, and caregivers in both the application and review process.

Caregiver Action Network (CAN) is the nation's leading non-profit family caregiver organization providing education, peer support, and resources to family caregivers across the country free of charge. One of the many things CAN does for Community Care Corps is to provide a wide range of communication and outreach support. CAN works with the grantees to capture videos of the experiences of care recipients, family caregivers, and volunteers to amplify their collective voices through stories. These videos provide a true and authentic voice that increases awareness about the impact of grantee local models on their communities. As of this reporting period, grantees have generated more than 30 videos of volunteers, care recipients, family caregivers, and staff that have been shared on social media, with local media outlets, and with elected officials.

The first grant cycle of the Community Care Corps has been extremely successful. With the tremendous interest in the program and the large number of worthy applications from communities across the country, we request doubling the appropriation for Care Corps to $8 million in FY 2022 from the $4 million level in FY 2021 (and the $5 million level in FY 2019). This will allow the program to fund more local volunteer services and make up for the gap in funding that occurred in FY 2020. Thank you.

[This statement was submitted by John Schall, Chief Executive Officer, Caregiver Action Network.]

PREPARED STATEMENT OF THE CDC COALITION

The CDC Coalition is a nonpartisan coalition of organizations committed to strengthening our nation's prevention programs. We represent millions of public health workers, clinicians, researchers, educators and citizens served by CDC programs. We believe Congress should support CDC as an agency, not just its individual programs. We urge a funding level of at least $10 billion for CDC's programs in FY 2022 to help ensure the agency has adequate resources for its many important programs to improve the public's health. We appreciate the increases provided

for CDC in FY 2021 and we are grateful for the emergency supplemental funding provided for CDC to address COVID–19. We urge Congress to continue efforts to build upon these investments to strengthen all of CDC's programs. We strongly support the increases for important CDC programs outlined in President Biden's FY 2022 budget request and urge the committee to support these and other needed funding increases for CDC programs.

CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. From aiding in the surveillance, detection and prevention of the current COVID–19 outbreak globally and in the U.S. to playing a lead role in the control of Ebola in West Africa and the Democratic Republic of the Congo, to monitoring and investigating disease outbreaks in the U.S., to pandemic flu preparedness to combating antimicrobial resistance, CDC is the nation's—and the world's—expert resource and response center, coordinating communications and action and serving as the laboratory reference center for identifying, testing and characterizing potential agents of biological, chemical and radiological terrorism, emerging infectious diseases and other public health emergencies.

CDC serves as the lead agency for bioterrorism and public health emergency preparedness and response programs and must receive sustained support for these critical programs. We urge you to provide adequate funding for the Public Health Emergency Preparedness grants which provide resources to our state and local health departments to help them protect communities in the face of public health emergencies. We also urge you to provide adequate funding for CDC's infectious disease, laboratory and disease detection capabilities to ensure we are prepared to tackle both ongoing COVID–19 pandemic and other public health challenges and emergencies that will likely arise during the coming fiscal year. Additionally, your continued support for CDC's public health Data Modernization Initiative is critical to ensuring we have both the world-class data workforce and data systems that are ready for the next public health emergency.

We strongly support the president's budget request for $400 million in new funding to bolster core public health infrastructure and capacity at the federal, state, territorial and local levels. This flexible funding is critical to addressing the gaps in core public health infrastructure and capacity at all levels as well as ensuring our nation's health departments are able to attract and retain experienced leaders and respond to future public health emergencies and disease outbreaks. Sustained, flexible funding is critical to rebuilding and strengthening the nation's public health system.

Injuries are the leading causes of death for people ages 1–44. Unintentional and violence-related injuries, such as older adult falls, firearm injury, child maltreatment and sexual violence, account for nearly 27 million emergency department visits each year. In 2013, injury and violence cost the U.S. $671 billion in direct and indirect medical costs. In 2019, opioids killed nearly 50,000 individuals nationwide. CDC provides states with resources for opioid overdose prevention programs and to ensure that health providers to have information to improve opioid prescribing and prevent addiction and abuse. In 2019, there were over 39,707 U.S. firearm-related fatalities. We thank Congress for providing CDC with dedicated funding for firearm morbidity and mortality prevention research and we strongly urge you to support the president's request to double this funding in FY 2022. All programs within the National Center for Injury Prevention and Control must be adequately funded to conduct research, prevent injuries, and help save lives.

In 2019, 659,041 people in the U.S. died from heart disease, the nation's number one cause of death, accounting for about 23% of all U.S. deaths. More males than females died of heart disease in 2019, while more females than males died of stroke that year. Stroke is the fifth leading cause of death and is a leading cause of disability. In 2019, 150,005 people died of stroke, accounting for about one of every 19 deaths. Annually, heart disease and stroke cost the U.S. an estimated $363.4 billion in health care and lost productivity. CDC's Heart Disease and Stroke Prevention Program; WISEWOMAN; and Million Hearts improve cardiovascular health and we urge you to provide adequate funding for these important lifesaving programs.

More than 1.9 million new cancer cases and over 600,000 deaths from cancer are expected in 2021. The amount spent on cancer related healthcare is expected to grow from $183 billion in 2015 to $246 billion in 2030—an increase of 34%. The National Breast and Cervical Cancer Early Detection Program helps millions of low-income, uninsured and medically underserved women gain access to lifesaving breast and cervical cancer screenings and provides a gateway to treatment upon diagnosis. The Colorectal Cancer Control Program improves screening rates among targeted, low-income populations aged 50–75 years in targeted states and territories through evidence-based interventions. CDC funds all 50 states, DC, 7 tribes and tribal organizations and 7 U.S. territories and Pacific Island jurisdictions to develop

comprehensive cancer control plans to address each state's particular needs. We urge Congress to adequately support these critical programs.

Cigarette smoking causes more than 480,000 deaths each year. CDC's Office of Smoking and Health funds important programs and education campaigns such as the Tips From Former Smokers campaign which has already helped more nearly one million individuals quit smoking and millions more to make a serious quit attempt. Congress must continue to support these and other programs to reduce the enormous health and economic costs of tobacco use in the U.S.

Of the more than 34 million Americans living with diabetes, more than 7 million cases are undiagnosed. Diabetes is the leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness among adults in the U.S. and the total direct and indirect costs associated with diabetes were $327 billion in 2017. We urge you to provide adequate resources for CDC's Division of Diabetes Translation and the National Diabetes Prevention Program which fund critical diabetes prevention, surveillance and control programs.

Obesity prevalence in the U.S. remains high. More than 42% of adults are obese and 19.3% of children ages of 2 to 19 are obese. Obesity, diet and inactivity are cross-cutting risk factors that contribute significantly to heart disease, cancer, stroke and diabetes. The Division of Nutrition, Physical Activity and Obesity funds programs to encourage the consumption of fruits and vegetables, encourage sufficient exercise and develop other habits of healthy nutrition and physical activity and must be adequately funded.

CDC provides national leadership in helping control the HIV epidemic by working with community, state, national, and international partners in surveillance, research, prevention and evaluation activities. CDC estimates that about 1.2 million Americans are living with HIV with 14% undiagnosed. Prevention of HIV transmission is the best defense against the AIDS epidemic. Sexually transmitted diseases continue to be a significant public health problem in the U.S. Nearly 26 million new infections occurred in 2018. STDs, including HIV, cost the U.S. healthcare system almost $16 billion annually in direct lifetime medical costs.

The National Center for Health Statistics collects data on chronic disease prevalence, health disparities, emergency room use, teen pregnancy, infant mortality and causes of death. The health data collected through the Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, Youth Tobacco Survey, National Vital Statistics System, and National Health and Nutrition Examination Survey must be adequately funded.

CDC's REACH program helps communities address serious disparities in infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and immunizations by supporting community-based interventions and we urge the committee to provide continued funding for these important activities.

We thank the committee for its initial investment in CDC's Social Determinants of Health program and urge you to build upon this investment by increasing funding for the program to ensure that public health departments, academic institutions and nonprofit organizations are supported to address the social determinants of health in their communities that contribute to high health care costs and preventable inequities in health outcomes. We urge you to support the president's request of $153 million for this important program.

CDC oversees immunization programs for children, adolescents and adults, and is a global partner in the ongoing effort to eradicate polio worldwide. Childhood immunizations provide one of the best returns on investment of any public health program. For every dollar spent on childhood vaccines to prevent thirteen diseases, more than $10 is saved in direct and indirect costs. Over the past 20 years, CDC estimates childhood immunizations have prevented 732,000 deaths and 322 million illnesses. We urge you to provide adequate funding for the Section 317 Immunization program and other efforts to prevent vaccine-preventable disease.

Birth defects affect one in 33 babies and are a leading cause of infant death in the U.S. Children with birth defects that survive often experience lifelong physical and mental disabilities. Approximately one in six U.S. children is living with at least one developmental disability and one in four adults live with a disability. The National Center on Birth Defects and Developmental Disabilities conducts programs to prevent birth defects and developmental disabilities and promote the health of people living with disabilities and blood disorders.

CDC's National Center for Environmental Health funds programs to control asthma, protect from threats associated with natural disasters and climate change and reduce, monitor and track exposure to lead and other environmental health hazards. Increased funding for all NCEH programs is critical to protecting the public from environmental health hazards and reducing illness, disease, injury and even death.

To meet the many ongoing public health challenges facing the nation, including those outlined above, we urge you to provide at least $10 billion for CDC's programs in FY 2022.

[This statement was submitted by Don Hoppert, Director of Government Relations, American Public Health Association.]

PREPARED STATEMENT OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Committee, it is an honor to appear before you today to discuss how investments in the Centers for Disease Control and Prevention (CDC) are protecting American's health, now and in the future. I am grateful for this opportunity to address this committee, as well as for your long-standing and consistent leadership on issues of critical importance to the health of Americans, and the world.

It is my privilege to represent CDC at this hearing. CDC is America's health protection agency. For 75 years, CDC has been trusted to carry out its mission to protect America's safety, health, and security. Even during the unprecedented circumstances of the past year, CDC's scientific expertise, determination, selflessness, and innovation has helped the agency continue to advance its mission. We work 24/7 to prevent illness, save lives, and protect America from threats to our health, safety, and security. Addressing infectious diseases and pandemics, like COVID–19, is central to our mission. CDC's expertise lies in our ability to study emerging pathogens like SARS–CoV–2, to understand how they are transmitted, and to translate that knowledge into timely action to protect the public's health. CDC identifies and mitigates other causes of morbidity and mortality beyond infectious diseases, such as environmental and workplace hazards and intentional and unintentional injuries (such as those from falls, violence, or overdose). CDC promotes healthy behaviors, such as exercise and nutrition, to prevent chronic diseases such as diabetes and heart disease, and to prevent outcomes such as stroke. We promote healthy communities by increasing access to nutritious food and safe walking and green space. By deploying experts on the ground to support our state, Tribal, local, territorial and global partners, we translate science into implementing guidance that protects individuals, communities, and populations. In our work with other Federal agencies we ensure the safe and appropriate use of medical countermeasures, including vaccines, and collaborate with the academic and private sector to further our understanding of new diseases and problems that affect health.

The COVID–19 pandemic threw the United States and the world into a health, economic, and humanitarian crisis. As the crisis unfolded, it put a spotlight on preexisting weaknesses and gaps that threaten the health of Americans. It brought into stark light the great disparities in health outcomes by race and ethnicity. We must acknowledge the long-standing and too often unstated impact that racism has on public health. The pandemic has also highlighted our frail public health infrastructure, and the way that frailty impacted our ability to respond at the necessary scale and speed.

Experts had warned for years that a pandemic of this scale was coming. Today, we know to expect additional novel and currently rare diseases to emerge and gain footing as a result of our changing climate, closer interaction with animals, and globalization. Over the last 12 years, the United States has faced four significant emerging infectious disease threats—the H1N1 influenza pandemic, Ebola, Zika, and COVID–19. These experiences show that public health emergencies and, specifically, infectious disease threats, are here to stay. While urgency demanded rapid and unique responses to each of these threats, none resulted in the sustained improvements needed in our nation's public health infrastructure. This lack of robust public health infrastructure continues to present significant challenges in our ongoing fight against COVID–19. In fact, emergencies have resulted in the rapid build-up of infrastructure needed to address the emergency, then dissolution of that infrastructure, often leaving no sustainable infrastructure in place to address the next threat. This lack of robust public health infrastructure continues to present significant challenges in our ongoing fight to tackle COVID–19.

World-wide, billions of people do not and will not have immediate access to COVID–19 vaccines. Cases will continue to increase, and variant COVID–19 strains are likely to emerge, persist, and cause outbreaks. As this becomes more common, our public health system at home and abroad must be ready with highly sophisticated detection and sequencing, combined with a rapid response at the source. The unprecedented investments provided to CDC through COVID–19 supplemental appropriations have helped our efforts to control COVID–19, and will also go a long way toward addressing deficits in the core components of the public health infra-

structure that has long been ignored. Our ability to respond to the next public health crisis will depend on whether we invest in a public health system that is highly functional on a day-to-day basis and pivots to meet new threats, rather than continue our partial defense, which ramps up in response to an urgent and often short-term event.

A resilient public health system can be realized with careful planning that builds on the gains made with COVID–19 emergency supplementals and incorporates lessons learned as a result of this crisis, including reliable, flexible funding. The FY 2022 Discretionary Budget Request for CDC and ATSDR includes a total funding request of $8.7 billion, an increase of $1.6 billion over FY 2021 Enacted. This is the largest increase in budget authority for CDC in nearly two decades and defends Americans' health in four ways: (1) building public health infrastructure, (2) reducing health disparities, (3) using public health approaches to reduce violence, and (4) defeating other diseases and epidemics.

First, building the public health infrastructure. CDC's FY 2022 request prioritizes foundational funding to rebuild the public health infrastructure needed to safeguard the Nation's health and economic security. Drawing on lessons learned, as well as the latest information and technologies, CDC will begin to address long-standing vulnerabilities in the U.S. public health network by training a larger cadre of experts who can deploy and support public health efforts, and building capacity to detect and respond to emerging global biological threats.

Public health action is driven by data. Earlier improvements in our systems for collecting information after other public health emergencies, including Ebola and EVALI, facilitated exchange of health information, linking local, state, and federal public health systems with healthcare systems and the public. With investments in public health data modernization in the FYs 2020 and 2021 appropriations and the COVID–19 supplementals, CDC increased the scale and speed of these systems during the COVID–19 response to protect people who are at risk for severe illness (such as older Americans), those with chronic medical conditions, and those from racial and ethnic minorities. These advancements must be applied across the public health system and at all levels of government. The funds requested in FY 2022 will be used to continue building a modern disease surveillance system at CDC, which will catalyze a multi-sectoral, comprehensive, and cohesive approach to documenting evidence, using state-of-the-art technology and analytical tools. CDC will continue working diligently to ensure its research and data are of the highest quality and are disseminated nationally to inform decision-making throughout the public health system, while supporting advances in data systems at all levels.

The COVID–19 pandemic made clear the role that CDC labs and public health labs across the nation play in conducting critical surveillance and responding to outbreaks and emerging threats. CDC and state laboratories were required to flex and surge during peak periods of illness, far beyond routine clinical testing. In FY 2019, CDC was only able to meet 50% of state and local health departments' stated needs for epidemiology and laboratory capacity funding, with personnel support being the biggest unfunded need, followed by equipment and supplies. The FY 2022 request will foster innovation, collaboration with the clinical system, and a commitment to quality. Improving technologies at the state and local levels would enable public health labs to quickly utilize and scale up essential laboratory analyses. In a post-COVID–19 world, investments to maintain and improve laboratories will help prevent the failures we experienced while trying to address COVID–19.

The U.S. needs a workforce of qualified public health professionals who will prepare for, respond to, and prevent public health crises. Physicians working for states often earn less than $150,000 per year. This is after having taken on medical school debt of $200,000 on average. The FY 2022 request includes an increase to build a diverse and culturally competent workforce who can rapidly develop innovative approaches in surveillance and detection, risk communications, laboratory science, data systems, and disease containment. With this funding, CDC will support critical training programs for public health professionals that develop strategic and systems thinking, data science, communication, and policy evaluation. Existing cooperative agreement mechanisms will be leveraged to support public health jobs that meet current needs and attract new personnel to work in underserved and rural areas.

Addressing gaps in capacity across levels of government to detect and respond to outbreaks while maintaining and surging in other problem areas requires investments to be disease-agnostic and flexible. With FY 2022 funding, CDC will provide support to health departments to meet national quality standards, conduct performance improvement activities, increase communication and collaboration across the public health system, and reshape health departments to meet changing conditions and needs. Funding will help health departments strengthen their abilities to effec-

tively respond to a range of public health threats, such as COVID–19, and build capacities that do not currently exist.

COVID–19 is a sobering reminder that a disease threat anywhere is a disease threat everywhere. Or as stated by WHO: no one is safe unless everyone is safe. We cannot adequately protect American lives and the U.S. economy without addressing global disease threats wherever they may arise. CDC's strategic investments in global health security are critical to U.S. health security by building sustainable global capacity to prevent, detect, and respond to emerging infectious disease threats. CDC works in more than 60 countries on more than 150 projects and is a key implementing agency for the U.S. Government's leadership role in the Global Health Security Agenda. With additional resources requested in FY 2022, CDC will build on existing partnerships with Ministries of Health, public health agencies, infectious disease research institutions, and international organizations to strengthen global laboratory capacity for early disease detection, enhance disease surveillance for accurate data to drive decision making, and foster effective regional and global coordination.

Next, I'd like to talk about reducing health disparities. The disparities seen over the past year among communities of color were not a result of COVID–19. In fact, the pandemic illuminated inequities that have existed for generations and revealed a known, unaddressed, and serious public health threat: racism. The well-being of our entire nation will be compromised as long as we fail to address this.

Racism is not just discrimination against one group based on the color of their skin or their race or ethnicity, but the structural barriers that impact racial and ethnic groups differently to influence where a person lives, where they work, where their children play, and where they worship and gather in community. The social determinants of health (SDOH)-such as high-quality education, stable and fulfilling employment opportunities, safe and affordable housing, access to healthful foods, commercial tobacco-free policies, and safe green spaces for physical activity-are critical drivers of health inequities in this country. CDC is building the evidence-base for collaborative approaches to SDOH through community accelerator planning and expanding a network of community health workers to develop a sustainable infrastructure to improve health equity. CDC's FY 2022 budget request includes an increase of $150 million to use a social determinants of health approach to improve health equity and health disparities in racial and ethnic minority communities and other disproportionately affected communities around the country.

This budget directly responds to health disparities recorded in our public health data. For example, about 700 women die each year in the U.S. as a result of pregnancy or delivery complications, and American Indian, Alaska Native, and Black women are two to three times more likely to die than White women. Data show that about 2/3 of these deaths may be preventable. Children from lower-income and racial and ethnic minority households experience a disparate, increased risk for lead exposure.

Achieving health equity is central to addressing the HIV epidemic. The U.S. Government spends $20 billion per year in direct health expenditures for HIV care and treatment. An estimated 1.2 million persons have HIV and approximately 15% are unaware they have it. With recent advancements in antiretroviral therapy and biomedical advancements in HIV prevention, such as pre-exposure prophylaxis (PrEP), along with effective care and treatment, we have the tools to end the HIV epidemic. An increased investment requested in FY 2022 for the Ending the HIV Epidemic (EHE) initiative will enable CDC to advance the four key strategies needed to end the epidemic in the 57 EHE focus jurisdictions. In addition, CDC will address health equity in the entire HIV prevention portfolio, test innovation in service delivery models to increase access to prevention services, use syndemic approaches to broaden reach to key populations and create efficiencies, and strengthen engagement of grassroots community-based organizations in implementing EHE initiative.

Third, the budget request also addresses the public health epidemic of violence. We know too well how this epidemic permanently alters the lives of its victims and their families and puts enormous strain on our communities and local economies. Increases in CDC's FY 2022 budget request will help address violence through public health approaches, which include improving reporting systems that provide the data needed to understand and address violent deaths and injuries in the United States.

And fourth, we must defeat other diseases and epidemics. Just as racism underlies a number of public health issues, climate issues underlie a number of infectious diseases and have significant health impacts. Climate changes are associated with changes in the geographical range of mosquitos, ticks, and other disease vectors. Climate-related events impact a wide range of health outcomes. Some of the most significant climate-related events-such as heat waves, floods, droughts, and ex-

treme storms-affect everyone. These climate events compromise our access to clean air, clean water, and a reliable food supply. In addition, climate events can impact the presence of allergens and vectors, like ticks and mosquitoes, and the subsequent health outcomes that can result from these changes in exposures. We know that a changing climate can intensify existing public health threats, and that new health threats will emerge: unequally distributed risks (age, economic resources, location), increased respiratory and cardiovascular disease, injuries and premature deaths related to extreme weather events, changing prevalence and geography of foodborne and waterborne illnesses and other infectious diseases, and threats to mental health as people feel less safe.

CDC works with states, cities, and tribes to apply the best climate science available, predicting health impacts, and preparing public health programs to protect their communities. To do this, CDC developed the Building Resilience Against Climate Effects (BRACE) framework to help communities prepare for the health effects of climate change by anticipating climate impacts, assessing vulnerabilities, projecting disease burden, assessing public health interventions, developing adaptation plans, and evaluating the impact and quality of activities. With the requested increase in FY 2022, we can further expand the Climate and Health Program by providing a larger number of health departments with technical assistance and funding and finding innovative ways to protect health via climate adaptations. As with every other public health threat, we will inform our effort by building and examining systems that collect data on conditions related to climate, including asthma and vector-borne diseases, and coordinate programs and communication that improve health outcomes.

The opioid epidemic has shattered families, claimed lives, and ravaged communities across the Nation-and the COVID–19 pandemic has only deepened this crisis. Addressing the current overdose epidemic remains a priority for CDC. The Administration's strategy brings together surveillance, prevention, treatment, recovery, law enforcement, interdiction, and source-country efforts to address the continuum of challenges facing this country due to drug use. CDC's role is to prevent drug-related harms and overdose deaths.

The additional funding requested in FY 2022 to address the opioid epidemic will enable CDC to provide more funding to all States, Territories, and select cities/counties. CDC will prioritize support to collect and report real-time, robust overdose mortality data and to move from data to action, building upon the work of the Overdose Data to Action (OD2A) program. To do so, CDC will partner with funded jurisdictions to implement surveillance strategies that include contextual information alongside data, as well as increase surveillance capabilities for polysubstance use and emerging substance threats such as stimulants. The additional resources requested will enable CDC to support investments in prevention efforts for people put at highest risk, for example, supporting risk reduction and access to medications for opioid use disorder for people transitioning from alternate residence (jail/prison, treatment facility, homeless shelter). CDC will also address infectious disease consequences, such as viral hepatitis, of the opioid epidemic.

I look forward to working together to address both the immediate challenges ahead in our fight against COVID–19, as well as the weaknesses in the public health infrastructure that left our country vulnerable to this pandemic. We at CDC are grateful for your support. We will continue to work tirelessly to ensure the health of this nation and the world. Together, we can build a sustainable and resilient public health system that can respond effectively to emerging threats and also to ongoing public health needs of every American.

[This statement was submitted by Rochelle P. Walensky, M.D., M.P.H., Director, and Anne Schuchat, M.D.,Principal Deputy Director, Centers for Disease Control and Prevention.]

PREPARED STATEMENT OF THE CHRISTOPHER & DANA REEVE FOUNDATION

Thank you for this opportunity to submit testimony in support of an appropriation of $9,700,000 for the Paralysis Resource Center (PRC) within the Administration for Community Living (ACL) at the Department of Health and Human Services (HHS).

I am proud to speak on behalf of the 1 in 50 individuals living with paralysis in the United States, who rely on programs like the Paralysis Resource Center to live independent and empowered lives. The Reeve Foundation has operated the Paralysis Resource Center for 19 years, competing in a rigorous, competitive bidding process every three years for renewal of this grant. For fiscal year 2022, we request funding of $9.7 million for the Paralysis Resource Center. Of this total, we request that the Committee direct no less than $8.7 million to the National Paralysis Re-

source Center. These requests are in line with the final appropriation for FY21. The Reeve Foundation was also pleased to see that the President's Budget for FY22 requests a 5% increase for the Paralysis Resource Center.

When Christopher Reeve was paralyzed from the neck down due to a spinal cord injury in 1995, his family found themselves in total darkness as to what to do next. There was no phone number to call for guidance or help. There were no experts reaching out to connect them to the right rehabilitation facilities, or to discuss how they could support his return home and ongoing well-being. There was certainly no promise that an individual living with that level of spinal cord injury could lead a full and active life as a father and husband. Yet, instead of accepting that life with paralysis would be full of limitations, he dreamed of a brighter future.

That was the genesis of the Christopher & Dana Reeve Foundation: Christopher's dream to elevate the needs and rights of the 5.4 million Americans living with paralysis. But he was far from alone. The real drive behind the Paralysis Resource Center came from his wife, Dana. As a caregiver herself, she knew that paralyzed individuals and caregivers around the country needed a centralized place to call for resources and expertise.

Since the PRC opened its doors in 2002, it has served as a free, comprehensive, national source of informational support for people living with paralysis and their caregivers. Our work is deeply aligned with ACL's mission to empower people living with disabilities and older adults to live independently and participate in their communities throughout their lives. The PRC is the only program of its kind that directly serves individuals living with spinal cord injury, MS, ALS, stroke, spina bifida, cerebral palsy and other forms of paralysis. The services and programs described below would not be possible without the ongoing support of this Subcommittee.

A. The PRC's Core Programs

(1) *Information Specialists.* One of the PRC's most essential functions is the team of certified, trained Information Specialists (IS) who provide personalized support to individuals, families, and caregivers on how to navigate the challenges of life with paralysis. This team of experts, many living with paralysis themselves, are often the first port of call for individuals who are newly injured or diagnosed. Just twenty-four hours after my daughter, Ellie, sustained a spinal cord injury, I contacted the Paralysis Resource Center. The same day I was told my daughter would probably never walk again; I was offered a lifeline. I believe that call turned the nose of the Titanic away from the iceberg before it hit us. It altered the course of desperation and isolation of what we were dealing with and gave us real hope. I was assured that Ellie would drive again, work again, and enjoy her life—and that the Foundation and the PRC team would hold my hand the entire way. It is also important to note how critically their services have been educating and supporting the paralysis community during the pandemic.

To date, the PRC Information Specialists have provided direct counseling to over 106,000 people. We have distributed 220,000 copies of our Paralysis Resource Guide, which is a staple in hospitals and rehabilitation facilities across the country.

(2) *Peer & Family Support Program.* A second pillar of the PRC is our Peer & Family Support Program. This program is born of the idea that the best source of knowledge is experience: and that peer-to-peer connections empower not only the newly paralyzed individual, but also the mentor. Through the PRC, more than 450 peer mentors have been trained and certified in 43 states and Washington, DC. These individuals have mentored over 17,000 peers.

(3) *Quality of Life Grants Program.* Our third pillar, the Quality of Life Grants Program, operates at the community level to fund nonprofit initiatives in all 50 states, the District of Columbia and the U.S. territories. Since 1999, the Quality-of-Life Grants Program has directed over $33 million dollars to assist over 3,300 projects. This program has increased employment trainings and accessible transportation; established adaptive sports programs and camps for children; improved access to buildings, playgrounds, and universities; helped individuals learn how to manage their financial well-being and provided support services for veterans. In 2020, the PRC created a new Quality of Life (QOL) grants program specifically aimed at addressing social isolation during the COVID–19 pandemic, with the goal of enhancing connectedness of people living with paralysis and their caregivers to their communities and preventing adverse health outcomes.

(4) *Military & Veterans Program; Multicultural Outreach Program.* The PRC has a comprehensive Military and Veterans Program, which provides dedicated resources to help individuals navigate military and civilian benefits and programs as they reintegrate into their communities. The PRC also facilitates a Multicultural Outreach Program that is designed to engage and support underserved populations

like racial and ethnic minorities, older adults, low-income earners, and LGBTQ individuals.

(5) *ChristopherReeve.org*. One of the most challenging aspects about living with paralysis is combating feelings of isolation and exclusion, especially for those who are unable to leave their homes due to physical and societal barriers. The Reeve Foundation's website, ChristopherReeve.org, provides a vibrant online community and resource hub as part of the PRC, which attracts close to three million visitors per year, and Reeve Connect, our online forum, has allowed over 8,000 individuals to connect with experts, chat with one another and share the experiences that matter to them in a secure, private space.

B. The Importance of Federal Funding.

I would like to close my remarks by emphasizing why federal funding for this program is so important. Simply put neither the Reeve Foundation, nor any organization competing to run the PRC, could provide this type of centralized resource alone. Because many individuals, including my daughter, are required to attend rehabilitation clinics and/or draw on other resources from out of state, nationwide expertise is required. To get the benefit of investing in a centralized hub of information, we need to promote and deliver these services at scale. Federal funds are essential for this valuable, life-changing resource to work.

Christopher Reeve once said, "Hope is like a lighthouse," helping individuals who are lost in the darkness find their way. But like a lighthouse, hope must be built on solid foundations. The resources, support and community created by the PRC are the foundation for hope for millions of individuals affected by paralysis around the country. I thank you for your ongoing support and urge you to protect the Paralysis Resource Center so that individuals nationwide can achieve greater quality of life, health, and independence. Thank you.

PREPARED STATEMENT OF THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—CCTS joins the broader medical research community in asking Congress to provide the National Institutes of Health (NIH) with at least a $3.2 billion funding increase for FY22, to bring total agency funding up to a minimum of $46.1billion annually.

—Please provide the Clinical and Translational Science Awards (CTSA) program at the National Center for Advancing Translational Sciences (NCATS) with at least a $32 million increase in dedicated line-item funding for FY22 to bring annual support for the program up to a minimum of $620 million.

—Please provide the Cures Acceleration Network (CAN) at NCATS with $100 million in dedicated funding for FY22.

—Please provide the Institutional Development Awards (IDeA) program and the Research Centers in Minority Institutions (RCMI) program at NIH with meaningful proportional funding increases for FY22.

—CCTS joins the broader public health community in requesting $500 million for the Agency for Healthcare Research and Quality (AHRQ).

—CCTS joins the broader public health community in requesting $10 billion for the Centers for Disease Control and Prevention (CDC).

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, thank you for considering the views of the clinical and translational research community as work on FY 2022 appropriations. The community deeply appreciates the ongoing investment in medical research, including FY21 NIH funding and overall support for the COVID–19 response. Moreover, CCTS commends you for continuing to protect line-item funding for the CTSA program, which provides critical research infrastructure support to meritorious institutions across the country and serves as a major catalyst for advancing the full spectrum of medical research at NIH. The value, importance, and impact of the CTSA program as well as full-spectrum research at NIH was best highlighted by our ability to quickly develop treatments, vaccines, diagnostic tools, and health information to quickly respond to the ongoing COVID–19 pandemic. As you consider FY 2022 funding, CCTS and the broader community would like to highlight recent progress, emerging opportunities, and the importance of sustained investment.

ABOUT THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

The Association for Clinical and Translational Science, Clinical Research Forum, the CTSA PIs, and the related stakeholder community work together through the Coalition for Clinical and Translational Science (CCTS) to speak out with a unified voice on behalf of the clinical and translational research community. CCTS is a nationwide, grassroots network of dedicated individuals who seek to educate Congress and the administration about the value and importance of clinical and translational research, and research training and career development activities. Our goals are to ensure that the full spectrum of medical research is adequately funded, the next generation of researchers is well-prepared, and the regulatory and public policy environment facilitates ongoing expansion and advancement of the field of clinical and translational science.

ABOUT THE CTSA PROGRAM AND THE FULL SPECTRUM OF MEDICAL RESEARCH

The CTSA Program was established to disseminate medical and population health interventions to patients and populations more quickly, and to enable research teams, including scientists, patient advocacy organizations and community members, to tackle system-wide scientific and operational problems in clinical and translational research that no one team can overcome in isolation. The CTSA program honors the promise of the Cures Act by improving research infrastructure and accelerating the rate at which breakthroughs in basic science are translated to innovations with a tangible benefit to patients.

The goals of the CTSA program include; (1) train and cultivate the translational science workforce, (2) engage patients and communities in every phase of the translational process, (3) promote the integration of special and underserved populations in translational research across the human lifespan, (4) innovate processes to increase the quality and efficiency of translational research, particularly of multisite trials, (5) advance the use of cutting-edge informatics.

The CTSA Program supports a national network of "hubs" at academic research centers across the country that work collaboratively to improve the translational research process to get more treatments to more patients more quickly. The hubs collaborate locally and regionally to catalyze innovation in research training, tools, and processes. Approximately 60 medical research institutions across the nation currently receive CTSA program funding, and these hubs work together to speed the translation of research discovery into improved patient care and public health. Resources appropriated to these hubs allow the network to expand to include additional sites, advance science, and directly invest in the health workforce of the communities where they are located.

The full spectrum of translational science takes the fruits of basic and pre-clinical research and translates them into effective clinical care and public health measures, with a focus on having impact on health. In order to maximize efficiency and patient-centeredness, this research must be done collaboratively and in a systematic way. This team-science approach focuses on outcomes and patient/health system benefits, rather than the advancement of science for the sake of science.

Most crucially, the appropriations committees have included detailed committee recommendations in the past that have facilitated meaningful advancements for the full spectrum of medical research, the CTSA program, and career development for early stage investigators and we hope similar recommendations advancing full spectrum research and team science as well as maintaining the integrity of the CTSA line-item will be provided for FY 2022.

RECENT CTSA ACTIVITY

Yale Center for Clinical Investigation (YCCI)

YCCI initiated double-blind randomized outpatient covid treatment trials involving the experimental drug apilimod dimesylate (LAM–002A), a first in class, highly selective PIKfyve kinase inhibitor from Connecticut Biotech firm AI therapeutics, which prevents SARS–CoV–2 viral entry into cells. Similarly, a randomized, double blind outpatient repurposing trial of camostat mesylate, which inhibits SARS–CoV–2 infection by blocking the virus-activating host cell protease TMPRSS2, was simultaneously initiated. YCCI also supported participation in multi-institutional randomized placebo controlled trials including Pfizer-sponsored vaccine trials and a randomized, placebo controlled cooperative inpatient trial of convalescent plasma by a consortium of CTSA institutions. Innovative pandemic monitoring approaches were developed including the measuring of SARS–CoV–2 RNA concentrations in primary municipal sewage sludgeas a leading indicator of COVID–19 outbreak dynamics.

The YCCI's Cultural Ambassador program, initiated eleven years ago, has been a critical component in the response to the pandemic. This bi-directional partnership influences Yale research priorities and drives research that meets the needs of the surrounding community. The Cultural Ambassadors, appointed by the community, collaborate with Yale researchers on trial design, recruitment, and reducing access barriers for the community and engage in advocacy and education efforts in the community, driving awareness of the importance of clinical research. The program builds trust-based relationships, increases health system engagement and contributes to improved overall health. This has been the lynchpin for community-based clinical trials that has resulted in participation in clinical trials by underrepresented minorities of 31% in the last academic year.

University of Washington

Limiting Opioid Abuse.—Over the last several years, our CTSA has organized dozens of rural clinics into a network. This network initiated an observational study of best practices in the management of patients who are on long-term opioid therapy for chronic pain, which evolved into a prescribing program. Rigorous testing of the developed intervention at 20 rural practice sites demonstrated a 19% reduction in high dose opioid prescribing.

COVID Clinical Trials in Rural Communities.—The UW CTSA, through the development of the rural clinic network, was able to push clinical trials from the UW to rural Washington rapidly. Providence Health in Spokane, WA, one of our Network partners, was 1 of the first 10 US sites to open the ACTIV–1 trial and enrolled their first participant 5 days after receiving the protocol. Inclusion of rural serving clinical sites was critical to our regional communities as COVID–19 infections were increasing dramatically in migrant farm worker populations.

Vanderbilt

The Vanderbilt Institute for Clinical and Translational research was well positioned to respond to the pandemic in large part because of the CTSA-supported infrastructure. First, the local ecosystem was mobilized to organize and coordinate the local response. From this, we identified the need to harmonize various trial activities across the country, and NCATS supported initiatives for harmonizing COVID–19 trial oversight and data pooling. At the same time, we were positioned to conduct clinical trials with efficient contracting and regulatory approvals, launching PassItOn—a trial of convalescent plasma—with seed funding from Dolly Parton. NCATS supported the rest of the trial, which has almost reached its enrollment target of 1000 patients. We were also identified as the science unit for NHLBI's network of networks, providing guidance to the agent selection, design, and analysis of trials of the host-tissue response to SARS-CoV–2 infection, building on the success of our drug repurposing program and biostatistics programs. Continuing to springboard of these foundations, we are now leading ACTIV4D–RAAS and serving as the DCC for ACTIV6, this latter with funding through NCATS. Lastly, our CTSA-supported learning health system has completed the only known large, randomized controlled of prone positioning in moderately sick inpatients, with results in the process of being disseminated.

University of Texas Health Science Center at San Antonio

Resources, facilities, and personnel from the Institute for Integration of Medicine & Science, home to the UTHSCSA CTSA grant, enabled a rapid, collaborative, and comprehensive response to the COVID–19 crisis. Within weeks of the pandemic onset, UTHSCA established a unique virtual clinic for newly diagnosed patients. Research teams are characterizing health disparities and COVID–19 symptoms in this majority (84%) Hispanic population. As part of the NIH Community Engagement Alliance Against COVID–19 Disparities, CTSA specialists partner with regional health professionals and local organizations in underserved regions across South Texas to provide expert community engagement, community based-participatory research, and dissemination of best practices for COVID–19 care. As a result of the extensive preparation of CTSA hub and network research infrastructure, UTHSCA was among the top enrolling sites for major national studies including the NIH Accelerating COVID–19 Therapeutic Interventions and Vaccines (ACTIV) trials. CTSA support was also instrumental in launching a pioneering study of immunological resilience in 522 Veterans with COVID–19, which has yielded new biomarkers and new insights into the relative vulnerability of males to serious illness.

[This statement was submitted by Harry P. Selker, MD, MSPH, Chairman, Clinical Research Forum.]

PREPARED STATEMENT OF THE COALITION FOR HEALTH FUNDING

The Coalition for Health Funding—an alliance of 81 national health organizations representing more than 100 million patients and consumers, health providers, professionals and researchers—appreciates the opportunity to submit testimony for the record about the importance of health funding. Together, our members speak with one voice in support of federally funded health programs with a shared goal of improved health and well-being for all. While each member organization has its own funding priorities within the Department of Health and Human Services (HHS), our coalition is united in support of increased and sustained funding for all federal agencies and programs across the public health continuum—from bench to bedside—to ensure that all Americans lead long, healthy, productive lives.

Today, we have an unprecedented opportunity to shape the future of this country's public health infrastructure. The COVID–19 pandemic critically strained health, social, and economic systems around the world, and highlighted the importance of sustained and predictable health funding. Supplemental funding to address the urgent needs of the pandemic was, and continues to be, essential, but it alone is not the solution to respond to future pandemics. For too long, Congress neglected critical pieces of our public health infrastructure and health research pipeline, which hindered our ability to respond quickly and effectively when disaster struck. Now is the time to take corrective action and make sustained investment in public health. We learned many lessons during the pandemic, including that biomedical research and a robust public health workforce are indispensable and require sustained investment. A significant fiscal year (FY) 2022 allocation for public health funding will allow our health systems to emerge stronger and better equipped to improve health outcomes.

The Coalition urges Congress to seize the opportunity FY 2022 presents as the first appropriations cycle in a decade not governed by the spending caps of the Budget Control Act of 2011 (BCA). Without the BCA imposed budget caps, Congress should provide funding increases across the HHS accounts commensurate with the need for non-defense discretionary programs that support public health, medical and scientific research, infrastructure, education, public safety, and more. Congress should follow the increase set forth in President Biden's FY 2022 Discretionary Budget request and increase the HHS budget by at least 23.5 percent or $25 billion above FY 2021 levels. Increased funding will not only support future economic growth, but will strengthen the health, safety, and security of all Americans.

HHS agencies play a key role in addressing our nation's public health needs and work in partnership with state and local governments to protect and promote health in our communities. While each agency within HHS has a unique mission to respond to our nation's health demands, they are all interconnected. For example, the COVID–19 pandemic has shown that investment in medical research at the National Institutes of Health (NIH) is important, but on its own will not improve health. You need the Food and Drug Administration to approve new treatments. You need the Centers for Disease Control and Prevention, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and Indian Health Service to ensure we have qualified health professionals who can translate research into health care and public health delivery, support Americans while they're awaiting new cures, and prevent them from getting sick in the first place. You also need the Agency for Healthcare Research and Quality to provide clinical evidence on what treatments work best, for whom, and in what circumstances. And you need the Administration for Community Living to support those who are aging and those who have disabilities—as well as their caregivers—so that they can live their best life, every day. Without robust funding for all agencies and programs of the interdependent public health continuum, we're falling short on the promise to protect and improve the health and well-being of all Americans. Shortchanging public health and health research programs—or cutting health programs—leaves Americans vulnerable to health threats and will not prevent public health crises from arising in the first place as we witnessed over the last year.

As COVID–19 cases begin to decline and life starts to look more like it did before the pandemic, it is important to recognize that the pandemic's effects go far beyond the virus itself and will have long-lasting impacts on Americans. Research is just one of the many areas impacted by the pandemic that requires additional investment to get back on track. Every agency within HHS conducts research that is important to strengthening our public health system. Congress has a responsibility to ensure that all agencies within HHS receive equitable funding for efforts to regain some of the ground that has been lost due to necessary pauses in and increased costs of research as well as ensure the pandemic does not wipe out a whole genera-

tion of investigators who were forced to choose other career paths because of the disruption.

Another well-established impact of the pandemic has been the toll it has taken on mental health and substance abuse. Four in ten adults report symptoms of anxiety or a depressive disorder, up from one in ten adults in June 2019. Substance abuse and misuse, including alcohol, has increased by 12 percent.[1] Gains made in the fight against the opioid epidemic-another dire public health crisis-were diminished as an estimated 87,000 Americans lost their lives due to overdose from September 2019 to September 2020, a 29 percent increase over the previous year.[2] Adequate funding for preventive, supportive, and rehabilitative services will be critical to address and reduce these concerning trends.

The detection and management of chronic diseases is another area of public health that was set back as a result of the pandemic. An estimated six in ten American adults have a chronic disease, with four in ten having two or more.[3] Restrictions on elective procedures and non-urgent health care visits, coupled with concerns about the virus and obstacles to connecting virtually with providers during the pandemic caused many Americans to postpone routine care and skip necessary screenings, which in some cases has negatively impacted patients' ability to manage their disease.[4] Additionally, the millions of Americans now living with post-acute sequelae of COVID–19-often referred to as "long-haulers" because they experience lingering symptoms that last from weeks to months-could further increase the number of people in the U.S. living with a chronic disease, like diabetes or heart disease, and adds new complexities to our chronic disease management efforts. As a result, there is a significant need for increased funding for public health programs that reduce barriers to care and help patients detect and manage their conditions.

Research, mental health, substance use disorders, and chronic disease are just some of the areas of public health that have been impacted by the pandemic and require increased investments. Despite the funding included in the emergency appropriations packages, we have seen setbacks in most, if not all, areas of public health. The only way to remedy this situation is through robust and sustained funding. As the country continues to work to build back, Congress has a responsibility to make robust, sustained, investments in our public health system. Health security is national security; Congress would not hesitate, rightfully so, to make increased investments in defense or national security after a crisis. Now is our chance to act boldly and make investments in public health that will benefit all Americans. The goal for our nation's public health system should not be to return to normal, but rather to build a paradigm that makes the U.S. a healthier country by addressing health disparities and ensures that when the next public health crisis comes, we are prepared.

The Coalition for Health Funding strongly supports at least a 23.5 percent increase for the Department of Health and Human Services above FY 2021 levels. We look forward to working with Congress to support the health of all Americans and we hope that you will view us and our member organizations as a resource.

[This statement was submitted by Erin Morton, MA, Executive Director, Coalition for Health Funding.]

PREPARED STATEMENT OF THE COALITION FOR SERVICE LEARNING

On behalf of the Coalition for Service Learning and the 160+ organizations we represent, we respectfully request that you include a $250 million annual appropriation for the Learn and Serve America program and related National Service Trust payments authorized by Subtitle B of the Edward M. Kennedy Serve America Act in the FY22 Labor, Health and Human Services, Education and Related Agencies

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[1] Nirmita Panchal, R. K., & 2021, F. (2021, April 14). The Implications of COVID–19 for Mental Health and Substance Use. KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[2] Centers for Disease Control and Prevention. (2021, May 12). Products—Vital Statistics Rapid Release—Provisional Drug Overdose Data. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[3] Centers for Disease Control and Prevention. (2021, January 12). Chronic Diseases in America. Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm.

[4] Kendzerska, T., Zhu, D. T., Gershon, A. S., Edwards, J. D., Peixoto, C., Robillard, R., & Kendall, C. E. (2021, February 15). The Effects of the Health System Response to the COVID–19 Pandemic on Chronic Disease Management: A Narrative Review. Risk management and healthcare policy. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7894869/#:~:text=Obese%20patients%20with%20chronic%20diseases,during%20in%2Dperson%20medical%20visits.

Appropriations bill for the Corporation for National and Community Service (CNCS) dba AmeriCorps.

Additionally, we request that accompanying report language include the following:

"Within the total, the Committee provides funds for Summer of Service programs, Semester of Service programs, and Innovative and Community-Based Service-Learning programs in public schools and institutions of higher education. Additionally, fifty-percent of the funds are to be directed to economically disadvantaged communities and at least five-percent to be set aside for payments to Indian tribes and territories. Grants to disadvantaged communities are exempt from match requirements. There shall be a two-percent set-aside of the total appropriation for training and technical assistance contracts and program evaluation."

Lastly, since the AmeriCorps agency will need to increase their capacity in order to administer these new programs, we request that such sums as may be necessary shall be appropriated for agency salaries and expenses under Subtitle K of the Serve America Act and such sums as may be necessary for education awards for Summer of Service participants in the National Service Trust.

The COVID–19 pandemic has amplified existing inequities in education, isolated individuals, and put students' educational outcomes at risk. Students are struggling academically but also socially and emotionally, especially those in underserved areas. Engaging students through service-learning is a proven way to instill a sense of community, belonging, and responsibility and is a proven strategy to help address the academic and emotional learning loss that has occurred.

The congressionally-appointed bipartisan National Commission on Military, National, and Public Service completed a report in March of 2020 in which it set a goal of all K–12 students receiving service-learning experiences by 2031. It highlighted the opportunity to give young people the problem-solving and academic achievement skills they will need to be successful in school, work, and life. In the Commission's vision, every American would be exposed to service opportunities throughout their lifetime, beginning with young people experiencing robust civic education and service-learning during elementary, middle, and high school.

In order to achieve this vision, the Commission recommended that Congress provide a $250 million annual appropriation to CNCS to award competitive grants to SEAs, LEAs, IHEs, State Service Commissions, and nonprofits to develop and implement service-learning programs for K–12 and postsecondary students across the country, including:

—$100 million for Summer of Service programs for students who will be enrolled in grades 6–12 at the end of the summer;

—$100 million for Semester of Service programs for students in grades 9–12; and

—$50 million for service-learning programs in public schools and institutions of higher education.

Dedicated resources for educators and districts are essential for the success of service-learning programs. Funding would enable school districts to provide teachers with the training and support needed to develop their service-learning skills and to build service-learning activities into their curricula. Funding for Learn and Serve America would help lower financial barriers and incentivize schools and educators to actively promote and incorporate service-learning into classrooms across the nation.

Service-learning is a critical program strategy at the intersection of education, national service, and civic health, with positive impacts on increasing academic engagement and 21st Century skill development, meeting community needs while building a recruitment pipeline for AmeriCorps programs, and improving civic education and participation.

We are hopeful that Congress recognizes the importance of reestablishing a program that will help address academic and emotional learning loss, re-engage students through service-learning activities, and instill a sense of community. We urge Congress to provide $250 million for Learn and Serve America and are grateful for your consideration of this request.

Best regards,

- Amy Cohen, Executive Director, The George Washington University Honey W. Nashman Center for Civic Engagement and Public Service, and Former Director of Learn and Serve America
- Susan Stroud, Senior Fellow, The George Washington University Honey W. Nashman Center for Civic Engagement and Public Service, and Founding Director of Learn and Serve America
- Emily Samose, Founder, ECS Consulting, and Former Staff, Learn and Serve America
- Brad Lewis, Former Staff, Learn and Serve America

- Amy Meuers, CEO, National Youth Leadership Council
- Aaron Dworkin, CEO, National Summer Learning Association
- Ally Talcott, Step Up Advocacy for the National Summer Learning Association
- Kate Cumbo, Executive Director, PeaceJam Foundation
- Kaira Esgate, CEO, States for Service and America's Service Commissions
- Susan Abravanel, President, Susan Abravanel Consulting
- Michael Minks, Vice President of Operations, Youth Service America
- Steven A. Culbertson, President & CEO, Youth Service America

Coalition Members—National Organizations

- Erik Peterson, Senior Vice President of Policy, Afterschool Alliance
- Gary Kosman, CEO, America Learns
- Dr. Ariel King, President, Ariel Foundation International
- Abby Robinson, Acting CEO, Atlas Corps
- Sage Learn, National Director of Government Relations, Boys & Girls Clubs of America
- Shawna Rosenzweig, Chief Strategy Officer, Camp Fire National Headquarters
- Andrew Seligsohn, President, Campus Compact
- Kei Kawashima-Ginsberg, Director, The Center for Information & Research on Civic Learning & Engagement, Jonathan M. Tisch College at Tufts University
- John Bridgeland, Founder &CEO, Civic
- Robert Hackett, President, Corella & Bertram F. Bonner Foundation
- Sanjli Gidwaney, Director, Design for Change USA
- Marly Leighton, Chief of Staff, DoSomething.org
- Vince Meldrum, President/CEO, Earth Force
- Tamara Roske, Executive Director, Earth Guardians
- Donna Ritter, Executive Director, Educators Consortium for Service Learning
- Adam Fletcher, Director, Freechild Institute
- Amanda Antico, Founder, EvolvED Global
- Stefonie Sebastian, Senior Service Engagement Specialist, National FFA Organization
- Donna Butts, Executive Director, Generations United
- Linda Staheli, Founding Director, Global Collaboration Lab Network
- Rick Lathrop, Founder/Executive Director, Global Service Corps
- Sam Fankuchen, Founder & CEO, Golden
- Patricia Hall, Founder, H2O for Life
- Nichole Cirillo, Executive Director, IAVE
- Serita Cox, CEO, iFoster
- Doug Bolton, CEO, Cincinnati Cares, Inspiring Service
- Bradley Hill, Director of Growth and Strategic Partnership, Junior State of America
- Betsy Peterson, Executive Director, Learning to Give
- Robert Jackson, Sr. Director of Development, Martin Luther King Jr. Center for Nonviolent Social Change
- Abbie Evans, Senior Director, Government Relations, MENTOR
- Sarah Fanslau, VP, Youth Programs, Multiplying Good
- Gina Warner, President & CEO, National Afterschool Association
- Kuna Tavalin, Consultant, National Center for Families Learning
- Lawrence Paska, Executive Director, National Council for the Social Studies
- McClellan Hall, Founder, CEO, National Indian Youth Leadership Project
- Stephanie Grove, President, National Senior Corps Association (NSCA)
- Fish Stark, Global Director of Programs, Peace First
- Moran Banai, Managing Director, Policy and Government Relations, Service Year Alliance
- Lee Arbetman, Executive Director, Street Law
- Derek Summerville, Director of Youth Engagement, YMCA of the USA
- Adam Fletcher, Vice-President, Youth and Educators Succeeding
- David Battey, President and Founder, Youth Volunteer Corps

Coalition Members—State & Local Organizations (listed alphabetically by State)

- Kids 1st Awareness Community Center (AL)
- Blue Crew (CA)
- California Campus Compact (CA)
- CBK Associates (CA)
- Cooline Team of East Palo Alto (CA)
- Norte Vista High School (CA)
- Playable Agency (CA)
- S.C.R.A.P. Gallery (CA)
- 1 Sacred Place (CO)
- Billig Consulting (CO)
- Goldey (DE)

- American University Center for Community Engagement & Service (DC)
- Center for Social Justice Research Teaching & Service (DC)
- Griffin Legacy & Associates (DC)
- LearnServe International (DC)
- Raising A Village Foundation (DC)
- Beyond Before Community Development Corporation (FL)
- Florida Atlantic University (FL)
- FSU Center for Leadership and Social Change (FL)
- Jacksonville University (FL)
- Chautauqua Learn and Serve Charter School (FL)
- Intentional Icon Inc (FL)
- Miami Dade College Institute for Civic Engagement and Democracy (FL)
- AFRD Georgia (GA)
- Favor House (GA)
- John & JeJuan Stewart Jr. Foundation (GA)
- KIPP South Fulton Academy Beta Club (GA)
- The Bridge Foundation (GA)
- Making Dreams Come True Valley of Rainbows (HI)
- Hawaii Pacific Islands Campus Compact (HI)
- University of Hawaii Office of Civic and Community Engagement (HI)
- Serve Illinois Commission (IL)
- ProAct Indy (IN)
- Serve Indiana Commission (IN)
- Volunteer Center of Story County (IA)
- Bluebird Experience (KY)
- Kentucky Campus Compact (KY)
- LSU AgCenter 4 (LA)
- 3Levels.org (ME)
- Bates College (ME)
- Harkins Consulting (ME)
- Maine Campus Compact (ME)
- Saint Joseph's College of Maine (ME)
- Loyola University Maryland Center for Community (MD)
- The Giving Square (MD)
- University of Maryland College Park (MD)
- Campus Compact Mid (MD)
- No Struggle No Success (MD)
- Notre Dame of Maryland University (MD)
- The WordSmith (MD)
- UMBC The Shriver Center (MD)
- Wicomico County Public Schools MD (MD)
- Jonathan M. Tisch College of Civic Life at Tufts University (MA)
- Action 2 Achieve (MA)
- Brandeis Center for Youth and Communities University (MA)
- LEAP Arlington (MA)
- Michigan Community Service Commission (MI)
- West Michigan Consulting Services (MI)
- Peacebunny Islands Inc/Peacebunny Foundation (MN)
- Youthprise (MN)
- Black Girls Rock of MS (MS)
- CryOut Teen Organization (MS)
- Missouri Community Service Commission (MO)
- Center of Effort LLC (MO)
- Montana Education Partnership (MT)
- Boulder Elementary School (MT)
- New Generation for a New World (NJ)
- New Jersey Campus Compact (NJ)
- Operation Grow Inc. (NJ)
- Rider University (NJ)
- Campus Compact of NY & PA (NY)
- Grandma's Love Inc. (NY)
- Hobart and William Smith Colleges/ Geneva 2030 (NY)
- Wagner College (NY)
- GenerationNation (NC)
- Ladies of Purpose Social Group Inc. (NC)
- North Carolina Campus Compact (NC)
- North Carolina Service Learning Coalition (NC)
- Northern Marianas College (MP)
- John Carroll University Center for Service & Social Action (OH)
- Ohio Campus Compact (OH)
- The Hero Within You Network (OH)
- Oklahoma AmeriCorps (OK)
- Camp Fire Central Oregon (OR)
- Campus Compact of Oregon (OR)
- Ecumenical Ministries of Oregon: Northeast Emergency Food Program (OR)
- Drexel University School Improvement Project (OR)
- Drexel University Lindy Center for Civic Engagement (OR)
- My New Journeys (PA)
- University of Pennsylvania Netter Center for Community Partnerships (PA)
- Blackstone Academy (RI)
- Carter County Drug Prevention (TN)
- Carter County Drug Prevention/Keep Carter County Beautiful (TN)
- Volunteer Tennessee (TN)
- CAVALRY (TX)
- City of Houston Volunteer Initiative Programs Office (TX)
- El Paso Community College (TX)
- Student Advocacy Coalition (TX)
- The Leaders Readers Network (TX)
- Sunrise High School (UT)
- FYR is LIT (VI)
- EDGE Consulting Partners (VA)
- Independent Consultant K (VA)
- OccupyFaith (WA)
- Washington Campus Compact (WA)
- Volunteer Center of Racine County (WI)

PREPARED STATEMENT OF COLLEGE ON PROBLEMS OF DRUG DEPENDENCE

Thank you for the opportunity to submit testimony in support of the National Institute on Drug Abuse (NIDA). The College on Problems of Drug Dependence (CPDD), a membership organization with over 1000 members, has been in existence since 1929. It is the longest standing group of scholars in the U.S. addressing problems related to substance use disorders. CPDD serves as an interface among government, industry and academic communities maintaining liaisons with regulatory and research agencies as well as education, treatment, and prevention facilities in the substance use disorder field.

In the Fiscal Year 2022 Labor, Health and Human Services Appropriations bill we request that the subcommittee include the President's requested level of $51 billion for the National Institutes of Health (NIH), including no less than $46.1 billion for NIH's base program level budget. In addition, we greatly appreciate the President Budget's recognition of the need to significantly increase our nation's investment in the National Institute on Drug Abuse (NIDA) and its response to the opioid epidemic. The President's Fiscal 2022 Budget recommends a $372.2 million increase in NIDA's budget, a 25 percent increase. We strongly encourage the Subcommittee to include the President's recommended funding level of $1.852 billion for NIDA in the Senate version of the Fiscal Year 2022 Labor, Health and Human Services Appropriations bill.

We also respectfully request the inclusion of the following NIDA specific report language.

Opioid Initiative. The Committee continues to be concerned about the opioid overdose epidemic and appreciates the important role that research plays in the various federal initiatives aimed at this crisis. The Committee is also aware of the most recent data from the Centers for Disease Control and Prevention that shows opioid overdose fatalities increasing from 2018 to 2019, with the primary driver being the increased overdose deaths involving synthetic opioids, primarily illicitly manufactured fentanyls. To combat this crisis the Committee has provided within NIDA's budget no less than $270,295,000 for the Institute's share of the HEAL Initiative and in response to rising rates of stimulant use and overdose, the Committee has included language expanding the allowable use of these funds to include research related to stimulant use and addiction.

Methamphetamine and Other Stimulants. The Committee is concerned that, according to data released by the Centers for Disease Control and Prevention, 32,000 overdose deaths involved drugs in the drug categories that include methamphetamine and cocaine in 2019, an increase of over 700%. The sharp increase has led some to refer to stimulant overdoses as the "fourth wave" of the current drug addiction crisis in America following the rise of opioid-related deaths involving prescription opioids, heroin, and fentanyl-related substances. Methamphetamine is highly addictive and there are no FDA-approved treatments for methamphetamine and other stimulant use disorders. The Committee continues to support NIDA's efforts to address the opioid crisis, has provided continued funding for the HEAL Initiative, and supports NIDA's efforts to combat the growing problem of methamphetamine and other stimulant use and related deaths.

Barriers to Research. The Committee is concerned that restrictions associated with Schedule I of the Controlled Substance Act which effectively limits the amount and type of research that can be conducted on certain Schedule I drugs, especially opioids, marijuana or its component chemicals and new synthetic drugs and analogs. At a time when we need as much information as possible about these drugs and antidotes for their harmful effects, we should be lowering regulatory and other barriers to conducting this research. The Committee appreciates NIDA's completion of a report on the barriers to research that result from the classification of drugs and compounds as Schedule I substances including the challenges researchers face as a result of limited access to sources of marijuana including dispensary products.

COVID Pandemic and Impact on Substance Use Disorders. The Committee is acutely aware of the risks that the ongoing COVID–19 pandemic poses to individuals with substance use disorders. According to the Centers for Disease Control and Prevention, drug overdose deaths accelerated during the pandemic which saw over 81,000 drug overdose deaths in the United States in the 12 months ending in May 2020, the highest number of overdose deaths ever recorded in a 12-month period. Moreover, research supported by the National Institute on Drug Abuse found that individuals with substance use disorders are at increased risk for COVID–19 and its more adverse outcomes. The Committee commends NIDA for conducting research on the adverse impact of the pandemic on SUDs and encourages the Institute to expand its research on these issues.

Raising Awareness and Engaging the Medical Community in Drug Abuse and Addiction Prevention and Treatment. Education is a critical component of any effort to curb drug use and addiction, and it must target every segment of society, including healthcare providers (doctors, nurses, dentists, and pharmacists), patients, and families. Medical professionals must be in the forefront of efforts to curb the opioid crisis. The Committee continues to be pleased with the NIDAMED initiative, targeting physicians-in-training, including medical students and resident physicians in primary care specialties (e.g., internal medicine, family practice, and pediatrics). NIDA should continue its efforts in this area, providing physicians and other medical professionals with the tools and skills needed to incorporate substance use and misuse screening and treatment into their clinical practices. The Committee recommends that NIDA increase its support for the education of scientists and practitioners to find improved prevention and treatments for substance use disorders as the Institute has done for the COVID–19 pandemic.

Marijuana Research. The Committee is concerned that marijuana policies on the federal level and in the states (medical marijuana, recreational use, etc.) are being changed without the benefit of scientific research to help guide those decisions. NIDA is encouraged to continue supporting a full range of research on the health effects of marijuana and its components, including research to understand how marijuana policies affect public health.

Electronic Cigarettes. The Committee understands that electronic cigarettes (e-cigarettes) and other vaporizing equipment are increasingly popular among adolescents, and requests that NIDA continue to fund research on the use and consequences of these devices.

In addition, we request the following report language within the Office of the Director account:

> *The HEALthy Brain and Child Development (HBCD) Study*. The Committee recognizes and supports the NIH HEALthy Brain and Child Development Study, which will establish a large cohort of pregnant women from regions of the country significantly affected by the opioid crisis and follow them and their children for at least 10 years. This knowledge will be critical to help predict and prevent some of the known impacts of pre- and postnatal exposure to drugs or adverse environments, including risk for future substance abuse, mental disorders, and other behavioral and developmental problems. The Committee recognizes that the HBCD Study is supported in part by the NIH HEAL Initiative, and NIH Institutes, Centers, and Offices (ICOs), including OBSSR, ORWH, NIMHD, NIBIB, NIMHD, NIEHS, NICHD, NINDS, NIAAA, NIMH, and NIDA, and encourages other NIH ICOs to support this important study.

Substance use disorders (SUD) are costly to Americans; it ruins lives, while tearing at the fabric of our society and taking a financial toll on our resources. Over the past three decades, NIDA-supported research has revolutionized our understanding of SUD as a chronic, often-relapsing brain disease -this new knowledge has helped to correctly emphasize the fact that SUD is a serious public health issue that demands strategic solutions.

NIDA supports a comprehensive research portfolio that spans the continuum of basic neuroscience, behavior and genetics research through medications development and applied health services research and epidemiology. While supporting research on the positive effects of evidence-based prevention and treatment approaches, NIDA also recognizes the need to keep pace with emerging problems. We have seen encouraging trends in strategies to address these problems, but areas of continuing significant concern include the recent increase in fatalities due to heroin and synthetic fentanyl, as well as continued illicit use of prescription opioids. Our knowledge of how drugs work in the brain, their health consequences, how to treat people with SUDs, and what constitutes effective prevention strategies has increased dramatically due to research. However, because the number of individuals who are affected is still rising, we need to continue the work until this disease is both prevented and eliminated from society.

We understand that the FY2022 budget cycle will involve setting priorities and accepting compromise, however, in the current climate we believe a focus on substance use disorders deserves to be prioritized accordingly. Thank you for your support for the National Institute on Drug Abuse.

PREPARED STATEMENT OF THE CONGRESSIONAL FIRE SERVICES INSTITUTE

Dear Chair Murray and Ranking Member Blunt,

On behalf of the nation's fire and emergency services, we write to urge your support for a vital program addressing the health and safety of our nation's firefighters.

As you consider the Fiscal Year (FY) 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill, we urge you to fully fund the National Firefighter Registry at the authorized level of $2.5 million. We very much appreciate the program being funded at this level in FY2021 and we ask that it be maintained this year.

During the 115th Congress, both the House and Senate unanimously approved the Firefighter Cancer Registry Act (P.L. 115–194). The bipartisan legislation created a specialized national registry to provide researchers and epidemiologists with the tools and resources needed to improve research collection activities related to the monitoring of cancer incidence among firefighters.

Studies have indicated a strong link between firefighting and an increased risk of several major cancers. However, certain studies examining cancer risks among firefighters have been limited by the availability of important data and relatively small sample sizes that have an underrepresentation of women, minorities, and volunteer firefighters. As a result, public health researchers are unable to fully examine and understand the broader epidemiological cancer trends among firefighters. The National Firefighter Registry is an important resource to better understand the link between firefighting and cancer, potentially leading to better prevention and safety protocols.

Thank you for your consideration, and your continued leadership and support for America's fire and emergency services.

Sincerely,

Congressional Fire Services Institute
International Association of Arson Investigators
International Association of Fire Chiefs
International Association of Fire Fighters
International Fire Service Training Association
International Society of Fire Service Instructors
National Fallen Firefighters Foundation
National Fire Protection Association
National Volunteer Fire Council

[This statement was submitted by Michaela Campbell, Director of Government Affairs, Congressional Fire Services Institute.]

PREPARED STATEMENT OF THE CONSORTIUM OF SOCIAL SCIENCE ASSOCIATIONS

On behalf of the Consortium of Social Science Associations (COSSA), I offer this written testimony for inclusion in the official committee record. For fiscal year (FY) 2022, COSSA urges the Committee to appropriate:

—$46.1 billion for the National Institutes of Health;
—$10 billion for the Centers for Disease Control and Prevention, including $200 million for the National Center for Health Statistics;
—$500 million for the Agency for Healthcare Research and Quality;
—$800 million for the Bureau of Labor Statistics;
—At least $700 million for the Institute of Education Sciences; and
—$151.4 million for the Department of Education's International Education and Foreign Language programs.

First, allow me to thank the Committee for its long-standing, bipartisan support for scientific research. Strong, sustained funding for all U.S. science agencies is essential if we are to make progress toward improving the health and economic competitiveness of the nation. As you know, the need for increased investment in science has become even more pronounced by the disruptions caused over the past year by the COVID–19 pandemic.

NATIONAL INSTITUTES OF HEALTH

COSSA joins more than 360 organizations in support of $46.1 billion for the National Institutes of Health (NIH) in FY 2022. COSSA appreciates the Subcommittee's leadership and its long-standing bipartisan support of NIH, especially during difficult budgetary times. However, recent public health events continue to underscore the need for additional investment.

To be truly transformative, NIH will need to continue to embrace research from a wide range of scientific disciplines, including the social and behavioral sciences. The Office of Behavioral and Social Sciences Research (OBSSR), housed within the Office of the NIH Director, coordinates basic, clinical, and translational research in the behavioral and social sciences in support of the NIH mission, and co-funds highly rated grants in the behavioral and social sciences in partnership with individual

institutes and centers. Unfortunately, OBSSR's budget has been held roughly flat for several years despite the sizable increases to the NIH budget. Knowledge about contagion and social influences on health are needed now more than ever. In addition, understanding behavioral influences on health is needed to battle the leading causes of morbidity and mortality, namely, obesity, heart disease, cancer, AIDS, diabetes, age-related illnesses, accidents, substance abuse, and mental illness. We urge the Senate to emphasize support for OBSSR and encourage NIH to increase the Office's budget in FY 2022.

CENTERS FOR DISEASE CONTROL AND PREVENTION

COSSA urges the Subcommittee to appropriate $10 billion for the Centers for Disease Control and Prevention (CDC), including $200 million for CDC's National Center for Health Statistics (NCHS). Social and behavioral science research plays a crucial role in helping the CDC carry out its mission by informing the CDC's behavioral surveillance systems, public health interventions, and health promotion and communication programs that help protect Americans and people around the world from disease. One needs only to look at the varied responses across different communities to COVID–19 guidance and policies surrounding social distancing, mask-wearing, and vaccination to understand the critical role understanding the social aspects of public health plays in keeping Americans safe and healthy. As the Department of Health and Human Services' principal statistical agency, NCHS produces data on all aspects of our health care system, including opioid and prescription drug use, maternal and infant mortality, chronic disease prevalence, health care disparities, emergency room use, health insurance coverage, teen pregnancy, and causes of death. As a result of the rising costs of conducting surveys and years of flat or near-flat funding, NCHS has had to focus nearly all of its resources on continuing to produce the high-quality data that communities across the country rely on to understand their health. Additional funding would allow NCHS to respond to rising costs, declining response rates, and an ever-more complex health care system and capitalize on opportunities surrounding advances in statistical methodology, big data, and computing to produce better information more quickly and efficiently, while reducing the reporting burden on local data providers.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

COSSA urges the Subcommittee to appropriate $500 million for the Agency for Healthcare Research and Quality (AHRQ), which would allow AHRQ to rebuild portfolios terminated as a result of years cuts and expand its research and training portfolio to address our nation's pressing and evolving health care challenges. AHRQ funds research on improving the quality, safety, efficiency, and effectiveness of America's health care system. It is the only agency in the federal government with the expertise and explicit mission to fund research on improving health care at the provider level (i.e., in hospitals, nursing homes, and other medical facilities). Its work is complementary—not duplicative—of other HHS agencies and requires robust support, especially given the critical role hospitals and group care settings have played in the COVID–19 pandemic.

BUREAU OF LABOR STATISTICS

COSSA urges the Subcommittee to appropriate $800 million for the Bureau of Labor Statistics (BLS) for its core programs. BLS produces economic data that are essential for evidence-based decision-making by businesses and financial markets, federal and local officials, and households faced with spending and career choices. The BLS, like every federal statistical agency, must modernize in order to produce the gold standard data on jobs, wages, skill needs, inflation, productivity and more that our businesses, researchers, and policymakers rely on so heavily. The requested funding level would allow BLS to continue to support evidence-based policymaking, smart program evaluation, and confident business investment.

INSTITUTE OF EDUCATION SCIENCES

COSSA requests at least $700 million for the Institute of Education Sciences (IES) in FY 2022. Within the Department of Education, IES supports research and data to improve our understanding of education at all levels, from early childhood and elementary and secondary education, through higher education. Research further examines special education, rural education, teacher effectiveness, education technology, student achievement, reading and math interventions, and many other areas. IES-supported research has improved the quality of education research, led to the development of early interventions for improving child outcomes, generated

and validated assessment measures for use with children, and led to the establishment of the What Works Clearinghouse for education research, highlighting interventions that work and identifying those that do not. With increasing demand for evidence-based practices in education, adequate funding for IES is essential to support studies that increase knowledge of the factors that influence teaching and learning and apply those findings to improve educational outcomes.

INTERNATIONAL EDUCATION AND FOREIGN LANGUAGE PROGRAMS

The Department of Education's International Education and Foreign Language programs play a major role in developing a steady supply of graduates with deep expertise and high-quality research on foreign languages and cultures, international markets, world regions, and global issues. COSSA urges a total appropriation of $151.4 million ($134.3 million for Title VI and $17.1 million for Fulbright-Hays), which would help make up for lost investment and purchasing power over many years of flat-funding. In addition to broadening opportunities for students in international and foreign language studies, such support would also strengthen the nation's human resource capabilities in strategic areas of the world that impact our national security and global economic competitiveness.

Thank you for the opportunity to present this testimony on behalf of the social and behavioral science research community.

[This statement was submitted by Submitted by Wendy Naus, Executive Director, Consortium of Social Science Associations.]

PREPARED STATEMENT OF THE COUNCIL OF ACADEMIC FAMILY MEDICINE

The member organizations of the Council of Academic Family Medicine (CAFM) are pleased to submit testimony on behalf of programs under the jurisdiction of the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality (AHRQ). CAFM collectively includes family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, and research scientists. We urge the Committee to appropriate (1) at least $125 million for the HRSA Primary Care Training and Enhancement (PCTE) program and (2) at least $500 million for AHRQ, specifically funding $5 million to AHRQ's Center for Primary Care Research.

More than 44,000 primary care physicians will be needed by 2035; however, current primary care production rates will not meet demand, according to the authors of Annals of Family Medicine (Petterson, et al Mar/Apr 2015). The PTCE programs and AHRQ research enhance our nation's workforce and health infrastructure, creating better health outcomes and lower costs.

Primary Care Training and Enhancement—Title VII

The PCTE Program (Title VII, Section 747 of the Public Health Service Act) has a long history of funding training of primary care physicians. As experimentation with new or different models of care continues, departments of family medicine and family medicine residency programs will rely further on Title VII, Section 747 grants to help develop curricula and research training methods for transforming practice delivery. Future training needs include: training in new clinical environments that include integrated care with other health professionals (e.g. behavioral health, care coordination, nursing, oral health); development and implementation of curricula to give trainees the skills necessary to build and work in inter-professional teams that include diverse professions; and development and implementation of curricula to develop leaders and teachers in practice transformation.

We are concerned that the President's FY2022 Budget did not include additional funding for the Primary Care Training and Enhancement program. Additional funding for the PCTE program can help address many of the failings and flaws of the current primary health care and public health infrastructure that have been identified in the COVID–19 pandemic. For example, additional funding is needed for both residencies and departments to help address faculty retention, public health competencies, recruit and retain students into primary care, develop new, innovative curriculum related to the pandemic and to address segmented primary care workforce to reduce delivery system division and increase full scope primary care providers.

A 2021 report by The National Academy of Science, Engineering and Medicine (NASEM) on Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, identified the problems with under-funding Title VII programs finding that despite the demonstrably better patient outcomes that have resulted from Title VII investments, Title VII funding remains only a tiny fraction of the total

GME funding; reduced to less than 10% since the 1960s. Primary care training grants under Title VII are vital to the continued development of a workforce designed to care for the most vulnerable populations, including concerns related to health equity.

We urge your continued support for this program and an increase in funding levels to $125 million in FY 2022 to allow for a robust competitive funding cycle to fund new initiatives to help address issues related to the COVID–19 pandemic, and a shortage of primary care providers. An example of the type of program supported by the PCTE program was the Danbury and Griffin Hospital programs in Connecticut who used it to develop innovative programs and curricula related to interdisciplinary training.

Agency for Health Care Research and Quality (AHRQ)

Primary care clinical research (PCR) is a core function of AHRQ. Primary care research includes: translating science into patient care, better organizing health care to meet patient and population needs, evaluating innovations to provide the best health care to patients, and engaging patients, communities, and practices to improve health. AHRQ has proved to be uniquely positioned to support best practice primary care research and to help disseminate the research nationwide. However, reduced levels of AHRQ funding in the past have exacerbated disparities in funding primary care research. Important primary care research initiatives have been unfunded in recent years such as research for patients with Multiple Chronic Conditions (MCC) and the statutorily authorized Center for PCR.

AHRQ is in a unique position to further PCR as well as the implementation science to identify how to deploy new knowledge into the hands of primary care providers and systems in communities. However, more funding, above FY2021 levels, is needed to accomplish these goals. For this reason, we are supporting additional overall funding increases for FY 2022 to $500 million as well as specific funding for the Center for Primary Care Research of $5 million to help coordinate and direct primary care research funding at AHRQ. We hope additional funding will continue and expand the following goals: (1) development of clinical primary care research and researchers (2) real-world application of evidence, (3) the process of practice and health system transformation, (4) how high functioning primary care systems and practices should look, (5) how primary care practices serving rural and other underserved populations adapt and survive, while expanding their ability to address health inequities, and (6) how health extension systems serve as connectors of research institutions with practices and communities.

President's FY2022 Budget Request for AHRQ

The recently released Fiscal Year 2022 Budget request includes a major, new primary care initiative at AHRQ totaling $10 million. The Congressional Justification (CJ) for AHRQ, reminds Congress that "AHRQ is the only PHS agency that supports clinical, primary care research which includes translating science into patient care and better organizing health care to meet patient and population needs."

We support the CJ's assertion that "primary care research is critical to AHRQ's mission to make health care safer, higher quality, more accessible, equitable, and affordable." We are also pleased that the primary care initiative discussed in the CJ would support the work of practice-based research networks (PBRNs.) In order to fulfill the promise of this initiative, we recommend a related initiative—that at least $5 million of the amount Congress provides to AHRQ be directed to the statutorily authorized Center for Primary Care Research within the Agency. This would support the needed coordination and prioritization of primary care research investments within AHRQ, as two recent national studies have recommended.

Two Recent National Studies Support this Funding Request

In 2020, the RAND Corporation published a report appropriated by Congress and commissioned by AHRQ that assessed federally funded PCR since 2012 regarding gaps and to recommend improvements. The report emphasized the significant role AHRQ plays in PCR. RAND made several recommendations, including to provide targeted funds to create a proper hub for federal PCR. This is important because PCR is a distinct science that differs from health services research. With $5 million in dedicated funds for PCR, AHRQ could prioritize and coordinate investments in PCR directly improving the health and wellbeing of Americans. In 2021, The NASEM report on High Quality Primary Care concurs with RAND's assessment on the importance of targeted funding for PCR and recommends prioritization of funding for AHRQ's Center for Primary Care Research.

A real-world example of successful AHRQ work supporting primary care practice and patient safety is funding to the Oregon Health & Science University, the Rural Practice-based Research Network helped lead Healthy Hearts Northwest by recruit-

ing 100 primary care practices to develop team-based quality improvement infrastructure improvements in small to medium-size practices. The Evidence Now Initiative operated as health extension agents in Oregon's frontier communities. In another example, AHRQ funding has allowed the University of Missouri to build infrastructure for patient-centered outcomes research in three arenas. The first study evaluated the advantages and disadvantages of endovascular vs. open surgery for legs with inadequate blood flow. The second project focused on improved discharge plans from skilled nursing facilities through improved primary care connections. Missouri partnered with the AAFP to create a national research network to improve chronic pain for the third project.

In conclusion, we support increased funding for AHRQ at the level of $500 million for FY 2021 which would support important primary care and health services research efforts. We also support $5 million in new funding for the Center for Primary Care Research. CAFM looks forward to working with the Subcommittee to protect HRSA primary care programs and AHRQ—both entities enhance our nation's primary care workforce and infrastructure.

PREPARED STATEMENT OF THE COVENANT HOUSE INTERNATIONAL

Dear Chairwoman Murray and Ranking Member Blunt:

Covenant House is the largest charitable organization in North and Central America housing and serving children and youth facing homelessness including survivors of human trafficking. Every year, we reach tens of thousands of young people in 33 cities in six countries: The United States, Guatemala, Honduras, Mexico, Nicaragua, and Canada. Since our founding, we have reached more than 1.5 million children and youth. Our high-quality programs are designed to empower young people to overcome adversity, today and in the future.

Covenant House strongly supports the Runaway and Homeless Youth and Trafficking Prevention Act (RHYTPA) administered by HHS's ACF and McKinney-Vento Act's Education for Homeless Youth program (ECHY) administered by Department of Education, which have both proven to be effective in addressing child and youth homelessness. Covenant House is requesting significant investment increases in these main federal programs reaching children and youth facing homelessness.

Across our 23 U.S. communities which currently benefit from these programs, in FY20:

—9,300 youth were served through street outreach programs. 7,400 youth were served in residential programs and 6,400 youth were reached in drop-in centers and non-residential programs.

—49 percent of youth served by Covenant House across the United States reported a mental health diagnosis, nearly 50 percent had not yet completed high school, and 33 percent have a history of foster care.

—Over 80% of youth served were of young people of color, including Black/African American and Latino. And based on our groundbreaking research reported out in 2018:

  —1 in 5 of youth interviewed reported being survivors of trafficking, and

  —22% of youth interviewed were offered money for sex on their first night experiencing homelessness.

In addition to meeting basic needs, RHYTPA provides youth with housing stability and the necessary supports of mental health counseling, employment and training, education, and physical health services-needed to ensure youth remain stable, health and connected to caring adults. EHCY grants provide school stability and support to proactively mitigate the risk of homelessness—more critical than ever as schools recover from COVID. Covenant House also supports the Runaway and Homeless Youth's Street Outreach program to outreach and engage youth who are in unsafe living conditions.

Covenant House has received $4.8 million in RHYTPA grants since 2017 in regular grants and $861,000 from the CARES Act emergency funding. While this funding has been critical to our network maintaining services, the overall annual Runaway and Homeless Youth program does not have nearly enough resources to meet the demand in the field. Last year, there were 545 applications to the program but only 179 awards granted (less than 33 percent). The vast majority of these applications scored at the highest level and were worthy of funding if resources were available. As a result of this unmet demand, RHYA programs often turn away thousands of youth each year due to lack of available beds, leaving these children vulnerable without safe and stable housing and increasing their risk of predation and harm.

As for EHCY, even prior to the COVID–19 pandemic, the U.S. Department of Education reported record numbers of youth homelessness in the 2018–2019 aca-

demic year, with more than 1.4 million youth experiencing homelessness. The COVID–19 pandemic has only exacerbated this issue. With only a quarter of school districts receiving support through the EHCY program in a given year, it is clear that homeless children and youth are still under-identified and face significant barriers to school enrollment and education continuity.

The President's FY22 budget requested $145 million for RHYTPA consolidated programs, including the Street Outreach Program.

—Covenant House is joining with our coalition partners in requesting $300 million for RHYTPA to meet the basic safety and housing needs of youth experiencing or at risk of homelessness.

The President's FY22 budget requested level funding at $106 million for the McKinney-Vento Education for Homeless Children and Youth Act program.

—Covenant House is joining with our coalition partners in requesting $300 million for EHCY.

For additional information please contact Lori Maloney, SVP of Advocacy at Covenant House, at lmaloney@covenanthouse.org or Sally Schaeffer, consultant, at sally@uncorkedadvocates.com.

[This statement was submitted by Kevin Ryan, President and CEO, Covenant House International.]

PREPARED STATEMENT OF THE CREUTZFELDT-JAKOB DISEASE FOUNDATION

Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee:

We appreciate the opportunity to submit this testimony in strong support for funding of the crucial prion disease work being undertaken by the Centers for Disease Control and Prevention in partnership with public health agencies around the country and the National Prion Disease Pathology Surveillance Center (NPDPSC). We request Congressional support in increasing the Prion Disease Surveillance appropriation through the CDC, Emerging and Zoonotic Infectious Diseases, by $1 million, for a total of $7.5 million.

Overview

Creutzfeldt-Jakob Disease (CJD), is a rare,100% fatal, degenerative brain disease that causes rapidly progressive dementia. CJD is transmissible and presently has no treatment or cure. Approximately 1 in 6,200 individuals will die from this disease in their lifetime; however, the unreported and undiagnosed number of cases remains unclear.

CJD is caused by the presence of an abnormal "prion" protein in the brain and is known as a prion disease. CJD/prion disease surveillance receives modest support through the Centers for Disease Control and Prevention (CDC). We need your support to strengthen and continue the coordination of CJD and other prion disease surveillance activities and to assure the safety of the American public.

Variant CJD (vCJD), and Bovine Spongiform Encephalopathy (BSE)

One form of this disease in humans, variant CJD (vCJD), is known to be caused by ingesting tissues in beef contaminated with Bovine Spongiform Encephalopathy (BSE), commonly known as "mad cow" disease. The most recent U.S. case of variant CJD was announced in 2013 and confirmed by the National Prion Disease Pathology Surveillance Center (NPDPSC) in 2014. Limited BSE testing by the USDA adds another layer to the already deepening concerns regarding possible risks to humans. In recent years, the USDA has decreased random testing for BSE from 40,000 to 25,000 tests per year (12,719 tests in 6 months, or 1 test per 3,302 live cows). Hence, surveillance of BSE in this country is largely dependent on demonstrating the lack of transmission to humans through human disease surveillance. The vCJD case identified by NPDPSC in 2014 exemplifies the persistent risk for vCJD acquired in unsuspected geographic locations and highlights the need for continuing prion disease surveillance and awareness to prevent further dissemination of vCJD. The two most recent cases of vCJD in Europe are believed to be due to occupational exposure and several cases of vCJD have been transmitted between individuals via blood transfusions. Hence, vCJD risk is not confined to eating contaminated food.

Chronic Wasting Disease (CWD)

Emerging laboratory data show that Chronic Wasting Disease (CWD), a naturally occurring prion disease of deer and elk, could potentially transmit to humans and other mammals, posing a new threat to public health. Human surveillance through brain tissue examination is the only way to definitely diagnose human prion diseases, determine their origin, and determine whether the spread of CWD found in

elk and deer in 26 states in the U.S. and in 3 Canadian provinces has become a human risk. A study in progress has shown that CWD was transmitted to macaques (primates that are genetically similar to humans) by feeding them contaminated deer meat. Unlike the BSE outbreak in cattle, CWD prions are highly infectious and the disease transmits by contact and through contaminated environment, including soil and plants, in free ranging animals. Additionally, multiple lines of experimental evidence indicate that sheep and cows are susceptible to CWD. Since CWD has been proven to cross several species barriers, this opens up the possibility of oral transmission to humans as well, either directly by eating contaminated venison or indirectly through infected domestic animals. Continued prion disease surveillance, particularly through examination of human brain tissue, is imperative to evaluate whether CWD has or can spread to humans.

The NPDPSC, funded by the CDC and located at Case Western Reserve University in Cleveland, Ohio, is our line of defense against the possibility of an undetected U.S. human prion disease epidemic as experienced in the United Kingdom.

Prion disease surveillance is funded at $6.5 million/year. That figure has increased by just $500,000 over the past six years, despite increasing costs of surveillance. Expenses have since risen for the resources required to perform adequate surveillance such as increasing number of cases as expected by the aging American population, increasing autopsy costs over time, screening for COVID19, and taking extra precautions necessary for COVID19. Without an increase in funding commensurate with these increased expenses, surveillance will be compromised.

Request:

We ask for Congressional support in increasing prion disease surveillance's appropriation by $1 million, for a total of $7.5 million. This would allow the NPDPSC to meet increasing autopsy costs and continue to develop more efficient detection methods while providing an acceptable level of prion surveillance. Reduction of funding or maintaining static funding to the NPDPSC would eliminate an important safety net to U.S. public health, making the U.S. the only industrialized country lacking prion surveillance, which in turn would jeopardize the export of U.S. beef. The increase in funding would allow the NPDPSC to expand its scope to address the growth in CWD among deer and elk, and explore whether CWD could spread to humans. Additionally, increasing prion disease surveillance in the U.S. increases surveillance at the national (CDC) and state (state public health departments) levels, which has been severely affected by competing concerns within the CDC division (e.g., COVID19).

Background:

The NPDPSC is funded entirely by the CDC from funds allocated by Congress. The CDC traditionally keeps approximately half of the appropriation for national surveillance projects and funding prion disease surveillance at the state level.

Increasing the appropriation from $6.5M to $7.5M will allow the NPDPSC to persist and continue to develop more efficient detection methods while providing an acceptable level of prion disease surveillance. Acceptable national surveillance is not possible at a lower level of funding. The requested $1M addition to the appropriation (total of $7.5M) would enable the NPDPSC to maintain appropriate surveillance, tissue collection, diagnostics and diagnostic test development of prion disease cases from CWD endemic states to determine whether CWD is transmissible to humans and if so, to what extent this poses to public health (e.g., transmission risks from human to human).

The National Prion Disease Pathology Surveillance Center is the only laboratory based organization in the U.S. that monitors human prion diseases and is able to determine whether a patient acquired the disease through the consumption of prion contaminated beef ("mad cow" disease) or meat from elk and deer affected by chronic wasting disease (CWD).

The NPDPSC also monitors all cases in which a prion disease might have been acquired by infected blood transfusion, from the use of contaminated surgical instruments, or from contaminated human growth hormone. Because standard hospital sterilization procedures do not completely inactivate prions that transmit the disease, these incidents put a number of patients under unnecessary risk and require costly replacement of contaminated surgical equipment.

The NPDPSC also plays a decisive role in resolving suspected cases or clusters of cases of food-acquired and medically transmitted prion disease that are often magnified by the media, stirring intense public alarm. To date, the NPDPSC has examined over 7,500 suspected incidents of suspected prion diseases and has definitely confirmed presence and type of prion disease in more than 4,600 cases.

The NPDPSC is the primary line of defense in safeguarding U.S. public health against prion diseases because the U.S., unlike other BSE affected countries such as the UK, the European Union, and Japan, does not have a sufficiently robust animal prion disease surveillance system.

The NPDPSC offers assurances, to countries that import (or are considering importing) meat from the United States, that the U.S. is free of indigenous human cases of "mad cow" disease. In the past, South Korean and Chinese health officials resumed importation of U.S. beef to their country after a visit to the NPDPSC provided assurances regarding rigorous human prion surveillance.

Since its inception in 1997, the NPDPSC has collected and stored over 7,500 brains and many more samples of cerebrospinal fluid from cases of suspected prion disease, making it the largest prion disease biobank in the world. Increased funding is required to continue to preserve these precious specimens for future international research efforts as well as to serve as reference materials to evaluate potential emerging prion diseases (e.g., chronic wasting disease).

Thank you for the opportunity to submit this testimony.

[This statement was submitted by Deborah R. Yobs, President/Executive Director, Creutzfeldt-Jakob Disease Foundation.]

PREPARED STATEMENT OF AMANDA PEEL CROWLEY

Madam Chairwoman,

It is an honor to provide testimony to the Subcommittee on behalf of the thousands of children across the country who have had their lives turned upside down by Childhood Post-Infectious Neuroimmune Disorders, or CPINDs. These medical conditions develop after illnesses and are thought to reflect a misguided immune system and inflammatory response to infection.

I ask that the Committee consider providing language in the Committee's fiscal year 2022 report under the Department of Health and Human Services, Office of the Director, Multi-Institute Research Issues account, directing the National Institutes of Health (NIH) to identify research priorities for CPINDs, including PANDAS and PANS, and to investigate these disorders across disciplines, including neurobiology, neurology, immunology, rheumatology, infectious disease, and mental health. We are also asking that NIH report to the Committee on the incidence, causes, diagnostic criteria, and treatment of these conditions, especially including ways to advance understanding and improve clinical care. This year, there is an urgent need to better understand post-infectious conditions because of COVID–19 and for NIH to prioritize and fund CPINDs' research.

In 2020, the world woke up to the notion of post-infectious complications as we witnessed the impact of COVID–19 in daily reports of patients with chronic and delayed-onset symptoms. Growing research data has confirmed the association of debilitating psychiatric and neurological symptoms with the SARS–CoV–2 virus in both adults and children. A significant number of children have developed neurological symptoms with COVID–19 infection, including altered mental status. New research describing late-developing psychiatric changes, including anxiety, OCD, and aggression, in children following COVID–19 infection concludes that SARS–CoV–2 should in fact be considered in the differential diagnosis of a CPIND known as Pediatric Acute-onset Neuropsychiatric Syndrome (PANS). The time has come to connect the dots—it is more than clear that infections lead to neurological and psychiatric symptoms. Robust research is under way, and we ask for CPINDs to be included. We firmly believe that investigations into the mechanism of CPINDs will have a far-reaching impact.

Children with CPINDs experience the onset of debilitating neuropsychiatric and behavioral disorders following illness such as influenza, "strep throat," and COVID–19. Studies indicate that misdirected antibodies and immune cells assault structures in a region of the brain involved in emotion, cognition, and movement. It is not surprising that, as in well-described types of autoimmune encephalitis, the symptoms signal dysfunction is this same brain region.

Two neuroimmune conditions, Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), were described in 1998 and 2010, respectively. PANDAS is believed to be a variation of rheumatic fever. Rheumatic fever can develop if streptococcal infections are not treated properly, setting off an immune response where antibodies and immune cells attack the heart, kidneys, joints, or brain. The term PANS was developed as a broader diagnosis than PANDAS, with the same symptoms arising from infections other than strep. These disorders are often misdiagnosed as purely psychiatric, and early opportunities to treat medically,

by targeting the underlying infections, inflammation, and immune dysfunction, are missed or delayed leading to escalating severity and associated costs.

Families like mine are blindsided when children's personalities completely change, and our kids are suddenly overcome by crippling fears, obsessive thinking, compulsive behaviors and tragically, suicidal thoughts. Some children are unable to separate from parents and many cannot attend school, or even leave the house. When children are unable to participate in school, they often experience learning impairments and significant academic declines. Previously successful students now need special education services, including aides to support their learning and behavior. Children who previously wrote legibly have such serious declines that they are no longer able to hold a pencil. Some children are beset by severe motor and vocal tics leading to further educational and social challenges. There is no part of life that escapes unscathed.

There are other serious physical consequences to illness in these children. Some, as young as four or five, suddenly appear anorexic, restricting their eating to near starvation because of worries about contaminated food or fear of choking. In extreme cases, children have to be placed on feeding tubes.

Children experience massive mood swings and fly into aggressive rages, full of irrational explosive anger. Even seven- or eight-year-old children can become suicidal, with an obsessive feeling that they have to die. Several children have ended their lives, and many others have been hospitalized when their symptoms become serious or life-threatening.

All three of my children have PANDAS, and our family's journey is, sadly, typical. Their stories illustrate the need for standardized clinical care and for accurate early diagnosis and education concerning risks to children and the many burdens on families, schools, and health care systems.

My two older children acquired multiple misdiagnoses as their behaviors and symptoms worsened over years. We finally arrived at the true cause of their illness: an undiagnosed, untreated strep infection, the same bacteria that causes a sore throat. When they received medical treatment, they showed improvements far beyond traditional psychiatric therapies.

My children also exemplify the contrast between early diagnosis and misdiagnosis. My youngest child was treated successfully when her symptoms were new, but my oldest children have suffered more serious complications and required more extensive treatment. They have lost critical time between the onset of their symptoms and medical intervention that they cannot completely regain.

With delays in diagnosis and care, children are at risk for further decline and potential long-term disability as their brain inflammation remains untreated. As symptoms escalate, the burden on families, healthcare systems, and schools grows exponentially. Caregivers endure significant lost work time and out-of-pocket medical costs. Insurers pay for emergency room visits and inpatient treatment, as well as ongoing pharmacological and behavioral treatment to manage unlivable symptoms. Educational systems face an enormous financial burden when putting special education services into place for children who need increased academic and behavioral support.

There is a significant lack of NIH funding to support research into these disorders and to understand their true cost and prevalence. To date, the avenues for identifying, treating, and tracking post-infectious neuroimmune patients are minimally developed. Only through targeted research can we determine why some children develop psychiatric symptoms after infection, find diagnostic biomarkers, and demonstrate which treatments are most effective. We cannot achieve this alone. Action needs to be taken by NIH to increase funding for research into the causes and treatments of these conditions.

This year my family faced not only the ongoing trauma of PANDAS, but the horrors of COVID–19, first-hand. My father, who was in good health, was diagnosed last August and just weeks later was fighting for his life. He continues his long road to recovery, 10 months later. Like my children, the lasting damage was not done by the infection itself, but by the immune response. If we knew how to recognize and treat this complication early, we would have vastly different outcomes, not just for COVID–19 patients but for the thousands of children not in the spotlight who have CPINDs.

I want my family's experience with these devastating post-infectious conditions to help other families who are suffering. SARS–CoV–2 highlights both a pressing need and an opportunity for collaborative research across disciplines to better understand how neuropsychiatric complications develop and to find tools and treatments for early diagnosis and treatment. The world has rallied medicine and science in an unprecedented way this year. Let us also widen the scope to continue work on CPINDs, including PANDAS and PANS. The time to act is now—funding research

will be a vital next step for the health of our country and the future of our children. Parents are doing all we can to support our children. Won't you please join with us to help solve this nationwide health crisis?

[This statement was submitted by Amanda Peel Crowley, Founding Member, Massachusetts Coalition for Pans/Pandas Legislation.]

PREPARED STATEMENT OF THE CURE ALZHEIMER'S FUND

Chairwoman Murry, Ranking Member Blunt, and members of the Senate Labor, Health & Human Services, Education, and Related Agencies (LHHSE) Appropriations Subcommittee, I am Tim Armour, President and CEO of Cure Alzheimer's Fund. I want to thank Congress for past funding for Alzheimer's disease research at the National Institutes of Health (NIH), and to submit this written testimony to respectfully request at least an additional $289 million in Fiscal Year 2022 above the final enacted amount for Fiscal Year 2021 for Alzheimer's disease research at the NIH. Additionally, Cure Alzheimer's Fund respectfully requests at least $560 million in total appropriations for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The BRAIN Initiative is playing an increasingly important imaging role in the early detection and diagnosis of Alzheimer's disease.

Cure Alzheimer's Fund is a national nonprofit, based in Massachusetts, that funds research with the highest probability of preventing, slowing, or reversing Alzheimer's disease. Since its founding more than 15 years ago, Cure Alzheimer's Fund has invested more than $126 million in research through 530 grants in twenty-one states.

With the sustained commitment this Subcommittee has shown to Alzheimer's disease research at NIH, targeted investments into basic research made by private organizations such as Cure Alzheimer's Fund, have been leveraged into larger-scale research projects at NIH. An analysis by Cure Alzheimer's Fund found that the close to $17 million it invested in research in 2018, led to an additional investment of close to $121 million by NIH in the next two years. This shows the importance of continued and sustained investment for the Alzheimer's disease research portfolio at NIH because discoveries happening today will need to be funded in the future.

https://curealz.org/wp-content/uploads/2020/11/PV__Cure__Leverage__Annual AppealInsert__R5V1.pdf

Without the ongoing commitment demonstrated by this Subcommittee, investments made by private organizations, and the discoveries spurred by these investments, would not be able to be further explored, examined, and validated. The public-private partnership between groups like Cure Alzheimer's Fund and NIH is vital to Alzheimer's disease research because Cure Alzheimer's Fund can target investment in novel research ideas, allow researchers to collect initial data and strengthen their hypothesis, and then "hand-off" the project to NIH for larger-scale investment and research that is beyond the scope of Cure Alzheimer's Fund. The robust research portfolio at NIH allows this continuum of research to continue and thrive.

Two concrete examples of this are the brain lymphatic system and the role of the innate immune system in the development of Alzheimer's disease. As I described in my written testimony last year, as far back as 2010, Cure Alzheimer's Fund has supported research into the beta-amyloid protein and its role in fighting infection. This was a novel research concept that was not receiving federal support. However, because of the investment made by Cure Alzheimer's Fund, the role of the innate immune system and infection are now NIH research targets.

As Dr. Francis Collins, Director of the NIH, mentioned at a House LHHSE Subcommittee NIH hearing on March 4, 2020, one of the most promising areas of Alzheimer's disease research is the role of the innate immune system in the development of Alzheimer's disease.

NIH has convened meetings (September 23–24, 2019) around the topic of infection and viruses in the development of Alzheimer's disease. This would not have happened without early investment in research and the availability of larger-scale research funding made possible by this Subcommittee.

https://curealz.org/news-and-events/abeta-may-have-beneficial-function-as-part-of-the-innate-immune-system/

https://www.nia.nih.gov/about/naca/january-2020-directors-status-report

In the past, I have also highlighted the work of Dr. Jonathan Kipnis and the role of the brain lymphatic system, and I want to again highlight this research as an

example of the importance of basic research supported by Cure Alzheimer's Fund becoming a larger research project at NIH.

In 2016, Cure Alzheimer's Fund supported research by Dr. Kipnis and the role of Meningeal Lymphatics in cleansing the brain.

https://curealz.org/research/foundational-genetics/the-role-of-meningeal-lymphatics-in-cleansing-the-brain-implications-for-alzheimers-disease/

Cure Alzheimer's Fund's commitment to this research has continued while the research has also been supported by NIH. NIH recently highlighted this research in a press release at the end of April. Or five years after Cure Alzheimer's Fund made its initial investment.

https://www.nia.nih.gov/news/brains-waste-removal-system-may-offer-path-better-outcomes-alzheimers-therapy

Without Cure Alzheimer's Fund's first investment in 2016, and NIH's larger-scale investment after that, this research would not have been able to have been pursued so thoroughly. And this would not have been possible without the sustained and continued commitment to Alzheimer's disease research funding at NIH demonstrated by this Subcommittee.

As Cure Alzheimer's Fund continues to invest in research into novel research targets, there are more opportunities for NIH to be able to provide larger-scale research funding to help us better understand the pathology of Alzheimer's disease.

Cure Alzheimer's Fund has supported research by Dr. Caleb Finch into the role pollution and particulate matter play in the development of Alzheimer's disease. The first investment Cure Alzheimer's Fund made into this research was in 2014.

https://curealz.org/research/translational-research/air-pollution-and-app-processing/

Last year, the National Academies of Sciences, Engineering, and Medicine had a day-long symposium on Advancing the Understanding of Chemical Exposures Impact Brain Health and Disease. Dr. Finch was a presenter during this symposium.

https://www.nap.edu/read/25937/chapter/1

NIH is now supporting this research and it is becoming increasingly important to not only Alzheimer's disease research, but environmental justice research as well. We know that disadvantaged communities experience higher rates of Alzheimer's disease; research like Dr. Finch's is helping to identify environmental drivers like air-borne pollutants.

Cure Alzheimer's Fund is supporting research into vascular contributors to the development of Alzheimer's disease; African Americans have higher risk of neurovascular issues that are risk factors for Alzheimer's Disease as well as medical conditions of concern in and of themselves.

https://curealz.org/research/amyloid/the-role-of-picalm-in-vascular-clearance-of-amyloid-b-and-neuronal-injury/

https://curealz.org/research/foundational-genetics/neurobiological-basis-of-cognitive-impairment-in-african-americans-deep-phenotyping-of-older-african-americans-at-risk-of-dementia/

This is important research for both the understanding of Alzheimer's disease and reducing health disparities for disadvantaged communities. With sustained and continued support from this Subcommittee, Cure Alzheimer's Fund will be able to continue to invest in basic research knowing that NIH will have the necessary resources to be able to provide larger-scale investment into these important research topics.

Thank you for your continued support of Alzheimer's disease research, and for the opportunity to submit this written testimony and to respectfully request at least an additional $289 million above the final enacted level in Fiscal Year 2021 for Fiscal Year 2022 for Alzheimer's disease research at NIH, and at least $560 million in total appropriations for the BRAIN Initiative. Cure Alzheimer's Fund has worked closely with the Subcommittee in the past and looks forward to being your partner as we work toward Alzheimer's disease research having the necessary resources to end this awful disease.

Respectfully Submitted June 24, 2021.

[This statement was submitted by Timothy Armour, President and CEO, Cure Alzheimer's Fund.]

PREPARED STATEMENT OF DAVE PURCHASE PROJECT, THE NORTH AMERICAN SYRINGE EXCHANGE NETWORK, TACOMA NEEDLE EXCHANGE, AND COALITION PARTNERS

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, my name is Dr. Paul LaKosky and I serve as the Executive Director of Dave Purchase Project, the North American Syringe Exchange Network (NASEN), and the Tacoma Needle Exchange in Tacoma, Washington. I am pleased to submit testimony on behalf of these organizations and as a member of a large coalition of public health, HIV, viral hepatitis, and harm reduction organizations to urge Congress to appropriate $120 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) at the Department of Health and Human Services (HHS) to save lives and address the overdose crisis by supporting and expanding access to syringe services programs (SSPs).

Named in honor of its late, pioneering founder, Dave Purchase, Dave Purchase Project houses the nation's first legal syringe services program, created in 1988 at the height of the HIV epidemic in the United States. The program seeks to stop the spread of bloodborne pathogens, such as HIV and hepatitis C, among people who use drugs and to reduce the harm to individuals and communities associated with drug use. Although initially intended to address the spread of HIV, Dave Purchase Project now provides national leadership in its response to the opioid crisis. It also facilitates syringe services in Tacoma and throughout Pierce County, Washington.

Dave Purchase Project also houses the North American Syringe Exchange Network (NASEN). In 1992, NASEN formed to support syringe services programs (SSPs) and to expand the network of organizations and individuals that advocate for these life-saving programs. NASEN is the first and largest supplier of low-cost harm reduction resources in the US. In 2020, NASEN acquired and distributed approximately $18 million in harm reduction resources to the approximately 400 SSPs in the US, Puerto Rico, and the US Virgin Islands. NASEN also provided support valued at $25,000 to 28 newly emerging and/or struggling SSPs through start-up grant packages. As the Executive Director of these organizations, I am familiar with providing direct services to people who use drugs in Washington State, and with the significant gaps and need for resources and services nationwide.

The United States is experiencing an urgent and unprecedented drug overdose crisis, with approximately 100,000 overdose deaths expected to be counted in 2020 and potentially more in 2021. This would be an increase of more than 40% over the previous record year of 2019. According to the Washington State Department of Health, overdose deaths accelerated in 2020, increasing by 38% in the first half of 2020 as compared to the first half of 2019.

Overdose deaths have increased more dramatically among Black people and communities of color. From 2015 to 2018, overdose deaths among African Americans more than doubled (by 2.2 times) and among Hispanic people increased by 1.7 times while increasing among white, non-Hispanic people by 1.3 times. In Washington State, the increase in overdose deaths was highest among groups already dealing with inequitable health outcomes: American Indian/Alaska Natives, Hispanic/Latinx, and Black people. While overdose deaths affect all racial and ethnic groups, American Indian and Alaskan Native (AI/AN) populations are disproportionately impacted in Washington State. The death rate among AI/AN is more than 3 times the rate of overdose in the state (9.6 per 100,000). Preliminary 2019 data suggest that this pattern is continuing, with AI/AN having the highest opioid overdose death rate among all race/ethnic groups. (Washington State Opioid Overdose Prevention Data Brief: DOH 971–043 October 2020.)

SSPs are an essential component of preventing overdose deaths. Tacoma Needle Exchange provides sterile syringes, which helps prevent the spread of infectious diseases such as HIV, as well as services such as opioid overdose prevention and awareness training, naloxone training and distribution, wound care, and referrals for medication assisted treatment and other medical and social services. Our outreach staff meets people where they are and helps them address their needs in the safest and healthiest way possible, free of judgement and stigma.

The following is but one example of what we do, and why we do it. On Saturday, August 24, 2019, Tacoma Needle Exchange participated in an event sponsored by the Pierce County Recovery Coalition. At this event we conducted opioid overdose reversal trainings and distributed free Narcan, a nasal version of naloxone (a drug which reverses an opioid overdose), to any individual who requested it. Approximately 1 month later, at another community event, I was approached by an individual who had attended the August event. He told me that as he was driving home the night of the 24th, just after the event, when he stopped for gas. As he was filling his car, a panicked woman came out of the gas station and stated that someone had overdosed in the restroom. He ran to the restroom and using the training and

naloxone we had given him just 2 hours earlier, saved the life of that individual. He stated how grateful he was to us for providing him with the tools to save a life.

SSPs are the most effective way to get naloxone into the hands of people who use drugs and who are most likely to be at the scene of an overdose. In 2019/2020, our team distributed approximately 18,000 doses of naloxone and 1,259 overdose reversals were reported back to us (and many more occurred that went unreported). People who use drugs are essential partners in preventing overdose fatalities and are best reached by SSPs. In fact, more than 99% of the reported overdose reversals were performed by laypersons—other drug users, family members, friends, bystanders—not by first responders. With additional resources, SSPs can reach more people with naloxone, which would help reduce the dramatically increasing number of overdose deaths.

Congress must respond to the overdose crisis, as well as work to prevent and reduce infectious diseases related to drug use, such as HIV and hepatitis C, by supporting and expanding access to SSPs. Infectious diseases associated with opioid and other drug use have dramatically increased across the U.S. Since 2010, the number of new hepatitis C infections has increased by 380%. Outbreaks of viral hepatitis and HIV among people who inject drugs continue to occur nationwide. The CDC has documented over 30 years of studies that show that SSPs reduce overdose deaths and infectious diseases transmission rates as well as increase the number of individuals entering substance use disorder treatment. These studies also confirm that SSPs do not increase illicit drug use or crime and save money.

SSPs are among the only health care services trusted and used by people who use drugs and so can effectively engage this highly stigmatized population. SSPs help protect the community (including first responders) by ensuring safe disposal of syringes, reducing rates of infectious diseases, and can help providing a pathway to effective mental health and substance use treatment and other medical care.

Unfortunately, the nation has insufficient access to SSPs and the COVID–19 pandemic has decreased access to these life-saving services when the need for services has increased dramatically. In January 2021, Drug Policy Alliance conducted a survey of SSPs that showed that 91% of respondents experienced an increase in clients in 2020, many as a result of the COVID–19 pandemic. During this time of skyrocketing need, 42% of respondents experienced funding cuts in 2020 and expect such shortfalls to continue in 2021. In response to funding shortfalls, many SSPs have been forced to lay off staff and reduce services. Consequently, because of decreased and limited resources, SSPs cannot reach the millions of people who may benefit from their life-saving services.

Federal funding would expand access to critical and effective SSP programs. NASEN's own data show that there are only approximately 400 SSPs operating nationwide. Experts estimate that to sufficiently expand access to SSP programs, the U.S. would require at least 2,000 programs—5 times the number in existence now. NASEN routinely provides program support packages with essential harm reduction supplies to organizations wishing to start SSPs. We consistently have a wait list of 25–30 organizations seeking assistance, no matter how many support packages we distribute.

A recent study that assessed the startup costs of an individual program estimated that it would cost (in 2020 dollars) $490,000 for a small rural program and $2.1 million for a large urban program, resulting in an average start-up cost of $1.3 million per program. Based on these numbers, the requested funding could provide modest increases to currently operating SSPs to help address funding shortfalls and help expand the number of SSPs nationwide.

Finally, expanding access to SSPs would reduce health care costs, including for infectious diseases treatment. Hepatitis C treatment can cost more than $30,000 per person, while HIV treatment can cost upwards of $560,000 per person. Averting even a small number of cases would save millions of dollars in treatment costs in a single year.

The Infectious Diseases and Opioid Epidemic Program at CDC helps to eliminate infections related to injection drug-use and improve their prevention, surveillance, and treatment. It also strengthens and expands access to SSPs. In FY2019, CDC provided technical assistance to help ensure high-quality, comprehensive services and best practices for SSPs.

With additional FY22 funding, CDC could significantly expand SSPs at this critical time to help prevent overdose deaths, the spread of HIV and viral hepatitis, and connect people to life-saving medical care. Unfortunately, with just months in office during a historic COVID–19 pandemic and lacking a budget director, a director of the Office of National Drug Control Policy, and other key officials needed to respond to the overdose epidemic, the President's budget has only increased funding by $6.5 million. This amount is inadequate to reverse the dramatic increase in overdose

deaths and to prevent continuing outbreaks of HIV and hepatitis. Congress must respond now and forcefully to this crisis or more lives will be lost to overdose and countless people will continue to contract infectious diseases that seriously compromise their personal health as well as the public health, creating long-term costs for all.

Finally, on a personal note, I speak to you as a public health researcher and SSP supporter and provider, but also—and more importantly—as the older brother of someone who has struggled with addiction his entire adult life and recently overdosed on fentanyl, but thankfully survived. Over the years I have given him money and I have paid his rent. I have purchased him clothes and bought him food. Yes, there are days when I just did not have the emotional energy to pick up the phone when I knew it was him calling. I admit this sadly and shamefully. On those days, and particularly on those days, I am thankful for the kind of people who work at syringe services programs. They give without expectation of return and without judgement. They give when others cannot or will not. It is with this experience and the life of my brother in mind that I respectfully urge you to increase funding for these life-saving programs.

Thank you for your time and consideration of my testimony, and please do not hesitate to contact me or Jenny Collier at jcollier@colliercollective.org if you have questions or need additional information.

[This statement was submitted by Paul LaKosky, Ph.D., Executive Director, Dave Purchase Project, the North American Syringe Exchange Network.]

PREPARED STATEMENT OF THE DEADLIEST CANCERS COALITION

On behalf of the Deadliest Cancers Coalition, a collaboration of national nonprofit organizations and industry focused on addressing issues related to our nation's most lethal cancers, we submit this statement in support of strengthening the federal investment in deadliest cancers research conducted and supported by the National Institutes of Health (NIH) and the National Cancer Institute (NCI). For Fiscal Year 2022, we respectfully request $46.111 billion for the NIH's base program budget level, including $7.9 billion for the NCI, as well as the funding needed to establish a new Advanced Research Projects Agency for Health (ARPA–H) that includes a focus on finding tools to help patients diagnosed with one of the deadliest cancers. We further request report language in the LHHS bill that continues to hold NCI accountable for making progress on the goals and ideals of the Recalcitrant Cancer Research Act (RCRA).

In his address to Congress, President Biden called for an "end to cancer as we know it". As the national coalition that represents the cancers for which we've seen the least amount of progress, we wholeheartedly endorse this statement. We deeply appreciate Congress' continued strong leadership in support of cancer research through the steady increases you have provided to the NIH and NCI over the last six years. Funding for the existing components of the NIH and NCI is a critical component of making the goal of "ending cancer" a reality, which is why we have joined with our partners in the One Voice Against Cancer Coalition to support the funding requests for NIH and NCI listed above.

We also support President Biden's call for a new ARPA–H that has an initial focus on cancer and other diseases for the purpose of driving transformational innovation in health research and speeding application and implementation of health breakthroughs. As representatives of patients who have been diagnosed with our nation's most lethal cancers and those who currently have the fewest early detection and treatment options available, we believe that ARPA–H has the potential to provide a vital bridge between this dearth of effective tools and the improved survival rates that are so desperately needed.

The discussion between physicians and patients diagnosed with a deadliest cancer are currently focused on end-of-life instead of exploring treatment options that will provide the best quality of life and the extension of life. These cancers exemplify areas where medical practice would be dramatically changed through the technologies and platforms that could be developed under ARPA–H. For these reasons, we urge Congress and the Administration to ensure that ARPA–H focuses on the hardest problems and areas where medical practice will be dramatically changed, including the deadliest cancers, as it develops authorizing language.

We know that this Subcommittee will face many difficult decisions as it is developing the FY 2022 Appropriations Bills. As you are considering these bills, we further encourage you to structure ARPA–H so that no funding is diverted from the core mission and budgets of the NIH and NCI, but also allows for true innovation.

It is also essential that critical stakeholders in the cancer community be involved at the earliest outset in the design, structure and budget of these endeavors. "Cancer" is not one disease, so it is therefore vital that stakeholders representing the range of the "cancer experience" be involved in these efforts. For this reason, the Deadliest Cancers Coalition respectfully requests to be involved in the process, starting in the initial phase.

The deadliest cancers offer a powerful example of the need for continuing the path of sustained and robust increases for the NIH and NCI. While the overall five-year relative survival rate for all cancers combined has risen from 50 percent when the War on Cancer was first declared in 1971 to 67 percent today, we have seen relatively little success in improving survival for the deadliest cancers. Multiple myeloma is one of the few "success" stories among this group as the five-year survival rate was 34 percent when the coalition was founded in 2008 and is now 54 percent.

Next year (2022) will mark the 10-year anniversary of the passage of the RCRA, which requires that the NCI develop long-term strategic plans for addressing recalcitrant cancers beginning with pancreatic adenocarcinoma and small-cell lung cancer. The NCI has made progress in implementing the statute, particularly with respect to pancreatic adenocarcinoma and small-cell lung cancer. As a result of report language in the FY 2020 and FY 2021 LHHS Appropriations bills, NCI will undertake a scientific framework process for glioblastomas and gastroesophageal cancers and recently issued a notice of intent to publish a funding opportunity announcement for a Program on the Origins of Gastroesophageal Cancers. It is therefore crucial that Congress continue to shine a light on all recalcitrant cancers so they do not slip back into the shadows and so progress on implementing the RCRA for all of the deadliest cancers continues.

The Deadliest Cancers Coalition deeply appreciates the inclusion of report language focusing on these cancers in years past, including the FY 2021 language that reiterated Congress' intention that NCI develop a scientific framework using the process outlined in the RCRA for stomach and esophageal cancers and directed the NCI to identify future goals for each of the deadliest cancers in the fiscal year 2022 CJ.

We are seeking language in the FY 2022 LHHS Appropriations bills that continues to hold NCI accountable to the FY20 and FY21 language and the goals and ideals of the RCRA. Given that NCI has been responsive, to some degree, when Congress directs them to focus on specific cancers, we ask the language identify liver cancer as the next focus area. We are asking that the language specifies that the process should include cholangiocarcinoma, which is cancer that originates in the bile duct, but is grouped together with liver cancer, but want NCI to have flexibility on which other liver cancer subtype(s) should be included.

In addition, we continue to believe that it is critical that NCI stipulates how it will continue the goals of the RCRA to develop and implement strategic plans for the full range of recalcitrant cancers. The 2012 legislation was first introduced by Representatives Anna Eshoo and Leonard Lance and Senator Whitehouse and gained significant bi-partisan support because it was clear that just following "standard procedure" with respect to recalcitrant cancers was not working and there needed to be a specific focus on determining research priorities for these diseases. That need has not diminished.

The Deadliest Cancers Coalition was founded because we believe in a future in which there is no form of cancer for which a diagnosis is an automatic death sentence. All cancer patients should be able to select the best treatment option for them in consultation with their physician from a variety of effective treatments. Unfortunately, this year, approximately 44 percent of all cancer-related deaths will be due to one of the deadliest cancers, which means that we clearly have a long road ahead of us before that future is more than a dream. We therefore urge the Subcommittee to continue its leadership to ensure that NIH receives $46.111 billion for the NIH's base program budget level for FY 2022, including $7.9 billion for the NCI, as well as the funding needed to establish a new ARPA–H that includes a focus on the deadliest cancers. We further urge you to continue to hold the Institute accountable to making progress on the deadliest cancers through report language in the FY 2022 bill.

PREPARED STATEMENT OF THE DEPARTMENT OF PREVENTIVE MEDICINE AND DEPARTMENT OF MEDICINE, INFECTIOUS DISEASES

Dear Committee Members,

I am writing in support of a FY 2022 budget request for Department of Health and Human Services to develop a national strategy and implementation plan for the prevention, control and treatment of Herpes Simplex Virus, Types 1 and 2.

It is a critical public health imperative to address Herpes Simplex Virus (HSV), a chronic viral infection that impacts nearly half of Black women in our country, disproportionately impacts LGBTQ populations, and is a widely recognized driver of the HIV epidemic. Approximately 40% of new cases of HIV infection are attributable to chronic HSV infection. HSV also kills approximately 1,000 infants annually as a result of neonatal herpes which is currently not a reportable condition. Additionally, there is a growing body of research indicating HSV as a contributing factor to Alzheimer's Disease, Encephalitis, Bell's Palsy, among other neurodegenerative diseases.

There is currently no centralized national strategy to address HSV, it is not tracked or routinely tested for, and the majority of spread is via asymptomatic carriers unaware of their status. We can and should be doing more to stop the spread and provide better treatment to the nearly 1 in 3 Americans with this chronic condition.

If we prioritize women's and maternal health, the health of Black, Hispanic, LGBTQ, indigenous and other at-risk communities, we must prioritize Herpes Simplex Virus treatment and prevention. If we prioritize mental health, biomedical research for incurable diseases such as Alzheimer's or HIV, and dismantling systemic racism in healthcare, we must also prioritize Herpes Simplex Virus control. Addressing HSV addresses all of these national priorities and can improve the health, quality of life, and reduce the economic burden for millions of Americans.

Sincerely.

[This statement was submitted by Jeffrey D. Klausner, MD MPH, Clinical Professor, Department of Preventive Medicine and Department of Medicine, Infectious Diseases.]

PREPARED STATEMENT OF DUKE HEALTH

Duke Health (the conceptual integration of the Duke University Health System, the schools of Medicine and Nursing, the Private Diagnostic Clinic as the independent, multi-specialty physician practice, and other health and health research centers across Duke University) would like to express appreciation for federal support provided to academic health centers across the United States, especially during the COVID–19 public health emergency. COVID–19 has illustrated how vital the investments from this Subcommittee are for strengthening a health care infrastructure in the United States that can research and develop new vaccines and therapeutics and provide high-quality care to patients at all times.

Duke Health is committed to conducting innovative basic and clinical research, rapidly translating breakthrough discoveries to patient care and population health, providing a unique educational experience to future clinical and scientific leaders, improving the health of populations, and actively seeking policy and intervention-based solutions to complex global health challenges. Underlying these ambitions is a belief that Duke Health is a destination for outstanding people and a dedication to continually explore new ways to help people grow, collaborate, and succeed.

Reflecting Duke Health's mission of "Advancing Health Together," this written testimony outlines Duke Health's biomedical research and health care priorities that represent sound investments in vital programs at HHS that make a difference in the lives of patients across the United States. Thank you for this opportunity to submit written testimony.

NATIONAL INSTITUTES OF HEALTH (NIH)

Duke Health is grateful for Congress' robust investments in NIH, which has kept the United States on the cutting edge of new biomedical advances. For FY 2022, Duke Health respectfully requests at least $46.1 billion for the NIH. This represents a $3.177 billion increase over the comparable FY 2021 funding level for the NIH, which would allow for the NIH's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of 5%.

At Duke, NIH funding plays a critical role in the advancement of research and clinical care. NIH has supported research at the Duke Clinical Research Institute, the world's largest academic research organization working to improve patient care through innovative clinical research; the Duke Human Vaccine Institute, a national and international leader in the fight against major infectious diseases and home to

one of 12 Regional Biocontainment Labs; and the Duke Cancer Institute, a top comprehensive cancer center in peer-reviewed research support.

We are grateful for the emergency investments made by Congress over the past year to meet historical challenges, and it is critical that we continue to build upon the current foundation to sustain and grow our nation's research enterprise.

We also are deeply grateful for the $40 million appropriated to the National Institute of Allergy and Infectious Disease for Regional Biocontainment Laboratories (RBLs) in the Consolidated Appropriations Act, 2021. This investment bolstered the nation's preparedness for biodefense and emerging infectious disease agents, including COVID–19, as RBLs continue to provide some of the major advancements in understanding and combating the coronavirus through the development of vaccines, prophylactic and therapeutic treatments, and diagnostic tests for SARS–CoV–2 and COVID–19 disease. We respectfully request that RBLs be considered for an annual appropriation of $60 million to be shared evenly among the 12 RBL research institutions beginning in FY 2022. The assays for live virus neutralization for all the monoclonal antibodies at Duke are done in the Duke RBL and it is where all live virus cultures are done for CoV2 work. Additionally, Duke researchers have created a vaccine with the potential to protect against all forms of coronavirus that move from animals to humans, now and in the future. The new vaccine has been 100 percent effective in non-human tests.

Finally, Duke Health asks the Subcommittee to not include language that would limit the use of nonhuman primates in research that could cripple the search for treatments and cures for many human diseases, especially therapeutics and vaccines for COVID–19.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. Now, more than ever, investments in the nation's public health infrastructure and public health defense systems are critical. Duke Health urges the Subcommittee to provide at least $10 billion for the CDC in FY 2022. Among the CDC's many programs, the Prevention Epicenters Program connects CDC's Division of Healthcare Quality Promotion with academic investigators to conduct innovative infection control and prevention research. The Duke-UNC Epicenter has considerable experience and research expertise in hospital epidemiology, infection control, antimicrobial stewardship, epidemiologic studies of multidrug-resistant organisms, disinfection, and sterilization. In addition, the Duke Infection Control Outreach Network (DICON) and Duke Antimicrobial Stewardship Outreach Network (DASON) engage over 60 community hospitals in the United States.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Duke Health appreciates the Subcommittee's continued investment in Title VII health professions and training programs and Title VIII Nursing Workforce Development programs at HRSA. These programs ensure a well-trained pipeline of health professionals to meet the increasing health needs facing the United States. For FY 2022, Duke Health respectfully requests that the Subcommittee provide $1.51 billion for Title VII and VIII programs overall, including $980 million to Title VII programs and $530 million to Title VIII programs. Title VII and Title VIII are the only federal programs that support education/training opportunities for an array of aspiring and practicing health professionals, both facilitating career opportunities and bringing health care services to rural and underserved communities.

Duke Health urges the Subcommittee to provide $23 million in FY 2022 for the National Cord Blood Inventory (NCBI) at HRSA. This program is charged with building a genetically and ethnically diverse inventory of at least 150,000 new units of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program. Cord blood banks participating in the NCBI Program, including the Carolinas Cord Blood Bank in the Duke University School of Medicine, also make cord blood units available for preclinical and clinical research focusing on cord blood stem cell biology and the use of cord blood stem cells for human transplantation and cellular therapies.

Blood stem cell transplantation is potentially a curative therapy for many individuals with leukemia and other life-threatening blood and genetic disorders. Each year, nearly 18,000 people in the U.S. are diagnosed with illnesses for which blood stem cell transplantation from a matched donor is their best treatment option. Often, the first-choice donor is a sibling, but only 30 percent of people have a fully

tissue-matched brother or sister. For the other 70 percent, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed. The success of cord blood stem cell therapies in treating diseases and alleviating suffering makes an urgent and compelling case for funding this program.

Duke Health respectfully requests the Subcommittee provide $31 million for the C.W. Bill Young Cell Transplantation Program through the NCBI at HRSA in FY 2022. The Carolinas Cord Blood Bank (CCCB) at Duke is a member bank of the NCBI of the C.W. Bill Young Cell Transplantation Program. The goal of this program is to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and umbilical cord blood. The CCBB is one of the largest cord blood banks in the world. Cord blood units that are banked at CCBB are listed on the National Marrow Donor Program (NMDP) Be the Match(r) Registry, an accumulated listing of donated cord blood units from participating banks that are available to provide donors for patients needing a hematopoietic stem cell transplant to treat cancer or certain genetic diseases.

Thousands of mothers have donated their cord blood to the CCBB. Banked units are comprised of African-American, Hispanic-American, Asian-American, and Caucasian samples. This diversity helps patients of all racial and ethnic backgrounds find suitable matches for transplantation. The CCBB has distributed cord blood units for transplantation to several thousand patients since 1999. Cord blood recipients of CCBB units include children and adult patients facing life-threatening illnesses who need a "stem cell" transplant from an unrelated donor to provide them with healthy blood cells. Many of these patients have been affected by leukemia, lymphoma, severe aplastic anemia, or other fatal diseases of the blood or immune system, or certain inherited metabolic diseases. In addition to life-saving transplants, the CCBB also provides cord blood units for research. These units are made available to investigators for critical research in the area of cord blood and stem cell biology. The impact of funding has far reaching impacts, and Duke Health urges the Subcommittee to support this request.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

Duke Health urges the Subcommittee to provide $500 million for the Agency for Healthcare Research and Quality in FY 2022. This funding level is consistent with the FY 2010 level adjusted for inflation and would allow AHRQ to rebuild portfolios terminated as a result of years of past cuts and expand its research and training portfolio to address our nation's pressing and evolving health care challenges. As the agency that provides funding for health systems research, AHRQ is vital to improving health, safety, and health outcomes for patients. AHRQ is forward thinking, addressing issues such as data analytics, and is providing important resources for healthcare professionals during COVID–19.

Patients with sickle cell disease (SCD), an inherited red blood cell disorder, often have intense pain that brings them to hospital emergency departments (EDs) for immediate treatment. Their care can be fragmented, with frequent hospitalizations and specialist care, infrequent follow-up with primary care doctors, and repeat ED visits. Funding from AHRQ supports activities at the Duke University School of Nursing to improve the care of these patients in the ED department, particularly through the development and use of evidence-based decision support tools. In addition, 80 to 90 percent of medical center leaders at the Private Diagnostic Clinic (PDC), a multispecialty physician practice affiliated with Duke Health, reported fewer communications breakdowns and better handling of disagreements after using AHRQ's TeamSTEPPS(r) team training curriculum.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Duke Health appreciates investments in the National Child Traumatic Stress Network (NCTSN) grant program at SAMHSA, especially efforts to provide additional funding for this program during COVID–19. For FY 2022, Duke Health urges the Subcommittee to provide $81.9 million for NCTSN.

NCTSN, which is coordinated by the UCLA-Duke University National Center for Child Traumatic Stress, increases access to services for children and families who experience or witness traumatic events. This unique network of frontline providers, family members, researchers, and national partners is committed to changing the course of children's lives by improving their care and moving scientific gains quickly into practice across the U.S. In recent years, estimates from the NCTSN Collaborative Change Project (CoCap) have indicated that each quarter about 35,000 individuals—children, adolescents, and their families—directly benefited from services through this Network. Since its inception, the NCTSN has trained more than one million professionals in trauma-informed interventions. Hundreds of thousands

more are benefiting from the other community services, website resources, educational products, community programs, and more. Over 10,000 local and state partnerships have been established by NCTSN members in their work to integrate trauma-informed services into all child-serving systems, including child protective services, health and mental health programs, child welfare, education, residential care, juvenile justice, courts, and programs serving military and veteran families.

OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

Duke Health requests that the Subcommittee provide $11.5 million, full authorized funding, for the Military and Civilian Partnership for the Trauma Readiness Grant Program for FY 2022 within ASPR. Originally known as MISSION ZERO, this critical program would provide funding to ensure trauma care readiness by integrating military trauma care providers into civilian trauma centers. These partnerships allow military trauma care providers to gain exposure to treating critically injured patients in communities and keep their skills sharp to increase readiness for deployment. Additionally, they allow civilian trauma care providers to gain insight into best practices from the battlefield that can be integrated into civilian care. Fully funding this program will help to improve the nation's response to public health and medical emergencies.

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2022

—Provide $46.1 billion for the National Institutes of Health (NIH) and proportional increases across its Institutes and Centers.
—Continue dystonia research supported by NIH through the National Institute on Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and other Communication Disorders (NIDCD), and the National Eye Institute (NEI).
—Provide the Centers for Disease Control and Prevention (CDC) with at least $10 billion to facilitate timely public health efforts.
—Please provide $5 million for the new Chronic Disease Education and Awareness Program at CDC.

Dystonia is a neurological movement disorder that causes muscles to contract and spasm involuntarily. It affects men, women and children. Dystonia can be generalized, affecting all major muscle groups, and resulting in twisting, repetitive movements and abnormal postures or focal, affecting a specific part of the body such as legs, arms, hands, neck, face, mouth, eyelids and vocal cords. Currently, it is estimated that at least 300,000 individuals in North America suffer from dystonia, making it more common than Huntington's, muscular dystrophy, and ALS. There is no known cure for dystonia.

In 1967 at the age of 10, I lost the ability to write with either hand. Five years later, my father (at the age of 53) and I were diagnosed with focal dystonia, affecting our hands, which spasm and twist when we attempt to write. My sister, her son, and my daughter were later given the same diagnosis. Unlike the others, with every passing year, my daughter's dystonia began to affect other regions. By 19, she was unable to walk or feed herself. Later that year, she underwent deep brain stimulation (DBS) surgery which changed her life. She was later able to return to and graduate from college and now lives a relatively normal and active life.

I realized at the time of my daughter's diagnosis that I needed to do more. I became a clinical trial participant at the NIH and volunteered for any studies that could help researchers in finding a cure and or better treatments. I also became a passionate advocate for dystonia research funding.

DYSTONIA RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH (NIH)

The Dystonia Medical Research Foundation urges the Subcommittee to continue its support for natural history studies on dystonia that will advance the pace of clinical and translational research to find better treatments and a cure. In addition, we encourage Congress to continue supporting NINDS, NIDCD, and NEI in conducting and expanding critical research on dystonia.

Currently, dystonia research at NIH is supported by the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), and the National Eye Institute (NEI).

The majority of dystonia research at NIH is supported by NINDS. NINDS has utilized a number of funding mechanisms in recent years to study the causes and mechanisms of dystonia. These grants cover a wide range of research including the genetics and genomics of dystonia, the development of animal models of primary and secondary dystonia, molecular and cellular studies in inherited forms of dystonia, epidemiology studies, and brain imaging. We continue to work with the leadership of NINDS on the recommendations stemming from our 2018 meeting that focused on defining emerging opportunities in dystonia research.

Key findings include 1) noting that the heterogeneity of dystonia poses challenges to research and therapy development. 2) There is more to be learned from genetic subtypes, along clinical, etiology, and pathophysiology axes. 3) In order to facilitate key advancements in research technology, there needs to be more research collaboration. 4) New research priorities should include the generation and integration of high-quality phenotypic and genotypic data. 5) Reproducing key features in cellular and animal models, both of basic cellular mechanisms and phenotypes, leveraging new research technologies. 6) Collaboration is necessary both for collection of large data sets and integration of different research methods.

It is of great significance that a number of dystonia patient advocacy group, led by the Dystonia Medical Research Foundation, actively took part in the meeting and are working to ensure that Congress continues to support robust NIH funding.

NIDCD and NEI also support research on dystonia. NIDCD has funded many studies on brainstem systems and their role in spasmodic dysphonia, or laryngeal dystonia. Spasmodic dysphonia is a form of focal dystonia which involves involuntary spasms of the vocal cords causing interruptions of speech and affecting voice quality. NEI focuses some of its resources on the study of blepharospasm. Blepharospasm is an abnormal, involuntary blinking of the eyelids which can render a patient legally blind due to a patient's inability to open their eyelids. We were pleased to see that Congress has encouraged both NIDCD and NEI to expand their research into both spasmodic dysphonia and blepharospasm.

We thank the committee for the increase for NIH in fiscal year 2021. We know firsthand that this will further NIH's ability to fund meaningful research that benefits our patients.

CDC'S CHRONIC DISEASE EDUCATION AND AWARENESS PROGRAM

We strongly support and thank the Subcommittee for the creation of the new Chronic Disease Education and Awareness Program at CDC. This critical program would provide a dedicated pool of resources that could be deployed to support meritorious public health projects with stakeholders. This program seeks to provide collaborative opportunities for chronic disease communities that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

PATIENT PERSPECTIVES

Blepharospasm

I drive through Atlanta's brutal traffic when suddenly, my eyes clamp shut. I pry my left eye open with thumb and forefinger, steer with my right hand. My eyes open for a few seconds, then close with no warning. What is happening? Over the next few months, these spasms progress from eyes to lower face, neck and shoulders. A year later I am diagnosed with Dystonia, a debilitating, little-known disease. A healthy 49-year-old mother of three, I now fight constant pain; can no longer work, drive or perform basic activities. Even walking our dog is a dangerous fall risk.

Spasmodic dysphonia

Spasmodic dysphonia (SD), a focal form of dystonia, is a neurological voice disorder that involves "spasms" of the vocal cords causing interruptions of speech and affecting voice quality. My voice sounds strained or strangled with breaks where no sound is produced. When untreated, it is difficult for others to understand me. I receive injections of botulinum toxin into my vocal cords every three months for temporary relief of symptoms. This has worked well for me for over a decade. At the start of this year, my insurance coverage changed when my husband's company changed providers. As a result, I had to undergo an extensive review process and change methods for obtaining my medicine. The review lasted for four weeks. Multiple times during this time period, my doctor and I were told that I had been denied coverage. We had to make numerous phone calls to encourage the company and specialty pharmacy to review my case again and again. These phone calls were extremely difficult as my voice deteriorated from the delay in treatment. The auto-

mated phone systems were the worst, but the representatives also had trouble understanding my broken voice and I had to repeat my information over and over. Finally, the company determined my treatment is medically necessary and has approved it for one year. After a seven week delay, I am scheduled for my injection and am looking forward to a period of spasm-free speaking.

We are grateful to those persons who share their stories with the DMRF and other dystonia patient groups to help raise awareness of dystonia. The DMRF was founded in 1976 and since its inception, the goals have remained to advance research for more effective treatments of dystonia and ultimately find a cure; to promote awareness and education; and support the needs and wellbeing of affected individuals and their families.

Thank you for the opportunity to present the views of the dystonia community, we look forward to providing any additional information.

[This statement was submitted by Carole Rawson, Vice President of Public Policy, Dystonia Medical Research Foundation.]

PREPARED STATEMENT OF EDUCATION FINANCE COUNCIL

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Education Finance Council (EFC) is submitting this testimony because we have great concerns over the fast-approaching expiration of the COVID–19 payment pause on federally-owned student loans and the lack of certainty and guidance surrounding the September 30, 2021 date. There is speculation about an extension of that pause, and we must be cognizant of the herculean task of assisting more than 40 million borrowers in transitioning back into repayment. We request that you seek such certainty from the U.S. Department of Education (Department)/Federal Student Aid (FSA) and require them to provide servicers of federally-owned student loans, borrowers, and other stakeholders with the date when the COVID–19 payment pause for federally-owned loans will end.

This date certain must come as soon as possible as federal student loan servicers need appropriate time to hire and train staff and begin communication to borrowers in order to be fully prepared to successfully transition borrowers into repayment. The pause, which began in March 2020, is currently scheduled to end on September 30, 2021, and servicers are currently prohibited from communicating with affected borrowers regarding entering repayment.

It is imperative that FSA communicate clearly and consistently, as early as possible, with federal student loan servicers, borrowers, and all stakeholders about when the COVID–19 payment pause on federally-owned student loans will end. Borrowers need to have certainty about when their loans will enter repayment, and communication about this needs to begin as soon as possible with unified messaging. It all begins with the Department/FSA providing servicers, borrowers, and other stakeholders certainty of the end of the payment pause date so that the information borrowers receive from servicers and other sources is consistent.

This document describes what EFC members that service federally-owned student loans must do to help borrowers prepare for the start of repayment, ensure a smooth transition, and remain in compliance with FSA requirements—a process that takes several months.

COMMUNICATION WITH BORROWERS

There are approximately 40 million borrowers that will enter repayment when the COVID–19 payment pause for federally-owned student loans ends. Outreach to these borrowers must begin many months before repayment begins, particularly to those who are at a high risk for falling into delinquency when payments resume,[1] and to borrowers who completed undergraduate study during the payment pause

[1] The Department of Education's Congressional Budget Justification for Student Aid Administration for Fiscal Year 2022 acknowledges this risk for certain groups of borrowers: "...approximately 3.9 million borrowers shifted out of delinquency status through the government-provided-forbearance. The Department acknowledges that these borrowers are at high risk of re-entering delinquency, and eventually defaulting, once the payment pause ends. In addition, many borrowers who completed undergraduate study during the payment pause have never had to make student loan payments at all, which could also present special challenges. Further, some Americans have experienced unemployment or decreased earnings during the pandemic, and as a result, some borrowers who were current on their payments prior to the pause may be at higher risk of delinquency." (Department of Education, Congressional Budget Justification for Student Aid Administration for Fiscal Year 2022, AA–28).

and have never had to make student loan payments. However, servicers have been instructed to temporarily cease communication with borrowers until notified differently by the Department. It is critical that servicers are allowed to begin this outreach as soon as possible to provide the borrowers the information they need to prepare to enter repayment on their student loans, especially certainty of the date that repayment will begin.

Informing borrowers that they will be entering repayment, when it will occur, and what will be required of them as early as possible and via as many channels as possible will prevent unnecessary delinquencies and default. Borrowers need time to budget and update their accounts. For example, borrowers using direct debits need to know as soon as possible if the direct debit will be automatically reapplied and the amount and date of when the first debit will occur. If it is not automatically reapplied, the borrower needs to know when and how to reestablish that process long before payment becomes due.

Furthermore, the pandemic has disrupted the living situation of many borrowers, making early outreach more important than ever. Many borrowers have experienced changes in their living situations. Some may have moved home with parents or relocated due to employment changes or for other reasons but may not have updated their contact information with servicers. It takes time to find those borrowers and ensure they receive the proper notifications. Servicers must comply with regulations that dictate how early different types of notices regarding repayment and repayments plans must be sent to borrowers, which is an impossibility until they are permitted to resume borrower communications.

STAFFING AND IT NEEDS

Many servicers experienced a reduction in staff during the COVID–19 pandemic and payment pause period due to attrition and the need for fewer employees. Servicers need to begin hiring and training additional staff as soon as possible to ensure that borrowers experience a smooth transition back into repayment. However, uncertainty about whether the payment pause will end on September 30, 2021, as scheduled is delaying this process.

It takes time to locate, hire, train and prepare individuals to service federal student loans. This process includes advertising and interviewing appropriate candidates, completing federally required background checks, completing application for and receiving FSA security clearance (a process that can take weeks to months), and training of new employees. Federal student loan programs and repayment options and rules are very complex and servicing federal student loans requires specialized training that can span 4 to 8 weeks, depending on the servicer's training process and the employees' position with the organization. In most cases, training will need to begin by mid-July to be completed in time. Ongoing training occurs with personnel even after they are released to communicate with borrowers to ensure they remain current with any regulatory or statutory changes that may impact a borrower.

There are also system changes that need to be implemented to get millions of accounts back into repayment. This will require IT staff time, and servicers need to know as soon as possible when this process can begin.

We appreciate your consideration of this request for timely communication to all parties in order to ensure we are collectively prepared to best communicate and assist federal student loan borrowers as they transition back to active repayment.

About Education Finance Council (EFC): EFC is the national trade association representing nonprofit and state-based higher education finance organizations that, as mission-driven, public purpose organizations, are dedicated to improving college access, success, and affordability in their states and nationwide. EFC members operate as loan servicers and supplemental loan originators and provide a wide array of college access and student success and support services and resources.

[This statement was submitted by Gail daMota, President, Education Finance Council.]

PREPARED STATEMENT OF THE ENDOCRINE SOCIETY

The Endocrine Society thanks the Subcommittee for the opportunity to submit the following testimony regarding Fiscal Year (FY) 2022 federal appropriations for biomedical research and public health programs. The Endocrine Society is the world's oldest and largest professional organization of endocrinologists representing approximately 18,000 members worldwide. The Society's membership includes basic and clinical scientists who receive support from the National Institutes of Health (NIH)

for research on endocrine diseases that affect millions of Americans, such as diabetes, thyroid disorders, cancer, infertility, aging, obesity and bone disease. Our membership also includes clinicians who depend on new scientific advances to better treat and cure these diseases. The Society is dedicated to promoting excellence in research, education, and clinical practice in the field of endocrinology. The impact of the coronavirus is a compelling illustration of why we must increase funding for the NIH and CDC to protect public health. To support necessary advances in biomedical research to improve health, the Endocrine Society recommends the NIH receive funding of at least $46.1 billion for fiscal year (FY) 2021; to facilitate the translation of these advances to improve public health, the Endocrine Society recommends the Centers for Disease Control and Prevention (CDC) receive funding of at least $10 billion; and to ensure that women have access to appropriate health services, we recommend that the Title X program be funded at $737 million. This request does not reflect emergency supplemental funds or new programs situated in NIH including the Advanced Research Projects Agency for Health proposed by the administration.

ENDOCRINE RESEARCH IMPROVES PUBLIC HEALTH

Sustained investment by the United States federal government in biomedical research has dramatically advanced the health and improved the lives of the American people. The United States' NIH-supported scientists represent the vanguard of researchers making fundamental biological discoveries and developing applied therapies that advance our understanding of, and ability to treat human diseases. Their research has led to new medical treatments, saved innumerable lives, reduced human suffering, and launched entire new industries.

Endocrine scientists are a vital component of our nation's biomedical research enterprise and are integral to the healthcare infrastructure in the United States. Endocrine Society members study how hormones contribute to the overall function of the body and how the glands and organs of the endocrine system work together to keep us healthy. Physiological functions governed by the endocrine system are essential to overall wellbeing: endocrine functions include reproduction, the body's response to stress and injury, sexual development, energy balance and metabolism, and bone and muscle strength. Endocrinologists also study interrelated systems, for example how hormones produced by fat influence the development of cancer or susceptibility to infections.

ENDOCRINE RESEARCH IS SUPPORTED BY NUMEROUS NIH INSTITUTES

Endocrine diseases and disorders are studied by researchers funded by multiple NIH Institutes and Centers (ICs). As such, it is critical for NIH to receive a strong base appropriation with proportional increases for all ICs. For example:

—Diabetologists funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) are advancing knowledge of inequities contribute to health disparities in outcomes associated with COVID–19.[1] Despite the critical importance of this issue, NIDDK received a much lower increase in funding in FY 2021, relative to other ICs.

—Endocrine researchers funded by the National Institute of Aging increased our understanding of how hormonal treatment for menopause might improve stress responses in women.[2]

—Researchers funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) are discovering how hormones influence the gut microbiome, which in turn can influence the development of polycystic ovarian syndrome (PCOS).[3]

—Endocrine oncologists supported by the National Cancer Institute (NCI) discovered how certain drugs used during pregnancy can contribute to cancer risk in offspring.[4]

—National Institute of Environmental Health Science (NIEHS)-funded researchers are investigating how chemicals found in cosmetic products can disrupt endocrine systems resulting in increased cancer risk.[5]

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[1] Ebekozien, O., et al., The Journal of Clinical Endocrinology & Metabolism, Volume 106, Issue 4, April 2021, Pages e1755-e1762, https://doi.org/10.1210/clinem/dgaa920.

[2] https://www.endocrine.org/news-room/press-release-archives/2017/treating-menopausal-symptoms-can-protect-against-stress-negative-effects Accessed March 11, 2018.

[3] Torres, PJ, et al., The Journal of Clinical Endocrinology & Metabolism, jc.2017–02153.

[4] https://www.endocrine.org/news-and-advocacy/news-room/featured-science-from-endo-2021/drug-used-during-pregnancy-may-increase-cancer-risk-in-mothers-adult-children.

[5] https://endocrinenews.endocrine.org/edc-exposure-during-pregnancy-may-reduce-breast-cancer-protection/.

NIH REQUIRES STEADY, SUSTAINABLE FUNDING INCREASES

The Endocrine Society appreciates increases to the NIH budget in recent fiscal years; however, the biomedical research community requires steady, sustainable increases across the biomedical research enterprise in funding to ensure that the promise of scientific discovery can efficiently be translated into new cures. Research budgets have been further stretched across NIH to drive research to help us address the COVID–19 pandemic, and emergency supplemental funds have not provided sufficient resources to advance necessary research on COVID–19 while also sustaining progress on other national priorities. Consequently, NIH grant success rates are predicted to remain close to historically low averages, meaning highly skilled scientists will continue to spend more time writing highly meritorious grants that will not be funded. Young scientists will also continue to be driven out of biomedical research careers due to the lack of funding.

ADEQUATE FUNDING OF CDC PROGRAMS IS NECESSARY TO PROTECT THE PUBLIC'S HEALTH

The CDC plays a critical role in protecting the public's health by applying new knowledge to the promotion of health and prevention of chronic diseases, including diabetes. The Division of Diabetes Translation administers the National Diabetes Prevention Program (National DPP), which addresses the increasing burden of prediabetes and Type 2 Diabetes in the United States. The National DPP creates public and private partnerships to provide evidence-based, cost-effective interventions that prevent diabetes in community-based settings. Through structured lifestyle change programs at local YMCAs or other community centers, individuals with prediabetes can reduce the risk of developing diabetes by 58% in those under 60 and by 71% in those 60 and older.[6] In addition to supporting public health and prevention activities, CDC's Clinical Standardization Programs in the Center for Environmental Health are critical to improving accurate and reliable testing of hormones, appropriate diagnosis and treatment of disease, and reproduceable public health research. Adequate funding is critically important to ensure that CDC has the capacity to address existing and emerging threats to public health in the United States and around the world.

TITLE X FUNDING PROVIDES NECESSARY SERVICES AND REDUCES HEALTHCARE COSTS

Title X is an important source of funding for ensuring reproductive health benefits including both contraceptive and preventive services to women. In 2015, a study found that Title X-funded health centers prevented 822,000 unintended pregnancies, resulting in savings of $7 billion to federal and state governments. Offering affordable access to contraception can have a measurable impact on these costs. For every public dollar invested in contraception, short-term Medicaid expenditures are reduced by $7.09 for the pregnancy, delivery, and early childhood care related to births from unintended pregnancies, resulting in savings of $7 billion to federal and state governments.[7] Title X is the main point of care for low income, under- or uninsured, adults and adolescents for affordable contraception, cancer screenings, sexually transmitted disease testing and treatment, and medically-accurate information on family planning options. However, to provide these services to the over 4 million people who depend on Title X-funded centers, Title X is significantly underfunded.

FISCAL YEAR 2022 FUNDING REQUESTS

In conclusion, to avoid loss of promising research opportunities, allow budgets to keep pace with inflation, support our public health infrastructure, and assure high-quality, evidence-based, and patient-centered family planning care, the Endocrine Society recommends that the Subcommittee provide at least the following funding amounts through the FY 2022 Labor, Health and Human Services, Education, and Related Agencies appropriations bill:

—$46.1 billion for the National Institutes of Health
—$10 billion for the Centers for Disease Control and Prevention
—$737 million for Title X

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[6] The Diabetes Prevention Program (DPP) Research Group Diabetes Care. 2002 Dec;25(12):2165–71.

[7] Frost JJ, et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017.

PREPARED STATEMENT OF THE ENTOMOLOGICAL SOCIETY OF AMERICA

The Entomological Society of America (ESA) respectfully submits this statement for the official record in support of funding for vector-borne diseases (VBD) research at the U.S. Department of Health and Human Services (HHS). ESA joins the research community by requesting $46.1 billion in fiscal year (FY) 2022 for the National Institutes of Health (NIH), including increased support for vector-borne disease (VBD) research at the National Institute of Allergy and Infectious Diseases (NIAID); $10 billion for the Centers for Disease Control and Prevention (CDC), including investments in the budgets for VBD, global health, and core infectious diseases; and robust funding for the Institute of Museum and Library Services (IMLS), including $42.7 million for the Office of Museum Services.

ESA urges the subcommittee to support VBD research programs that incorporate the entomological sciences as part of a comprehensive approach to addressing infectious diseases. These efforts can help mitigate the enormous impact that insect carriers of disease have on human health. NIH, the nation's premier medical research agency, advances human health by supporting research on basic human and pathogen biology and by developing prevention and treatment strategies. Cutting-edge research in the biological sciences, including in the field of entomology, is essential for addressing societal needs related to environmental and human health. Many species of insects and arachnids, including ticks and mites, are carriers or vectors of an array of infectious diseases that threaten the health and well-being of people worldwide. This threat impacts citizens in every U.S. state and territory, as well as military personnel serving at home and abroad. The mosquitoes that carry and transmit diseases are responsible for more human deaths than all other animal species combined, including other humans.[1] VBD can be particularly challenging to manage due to insect and arachnid mobility and their propensity to develop pesticide resistance. Further, effective preventative treatments, including vaccines, are not available for most VBD.

Within NIH, NIAID conducts and supports fundamental and applied research related to understanding, preventing, and treating infectious diseases. The risk of emerging infectious diseases grows as global travel increases in speed and frequency and as environmental conditions conducive to population growth of vectors, like mosquitoes and ticks, continue to expand globally. Entomological research to understand and characterize the relationships between insect vectors and the diseases they transmit is essential to enable scientists to reliably monitor and predict outbreaks, prevent disease transmission, and rapidly diagnose and treat diseases. For example, NIAID-funded researchers are working to understand how common prevention tools like mosquito repellent work at the molecular level. Although topical mosquito repellents such as DEET are a popular tool for preventing mosquito bites and mosquito-borne diseases like malaria, the mechanism they use to repel mosquitoes is not understood. Using grant funding from NIAID, researchers from Johns Hopkins University have determined that DEET is an effective mosquito repellent because it masks human odors from female mosquitoes.[2] Researchers can use these findings to develop similar safe, low-cost mosquito repellents to prevent mosquito bites, reducing the burden of mosquito-borne diseases.

ESA requests robust support for CDC programs addressing VBD and support for the Centers of Excellence on VBD as authorized by the Kay Hagan Tick Act in 2022 and beyond with at least $10 million per year as well as $20 million for the Epidemiology and Laboratory Capacity (ELC) program. CDC, serving as the nation's leading health protection agency, conducts research and provides health information to prevent and respond to infectious diseases and other global health threats. Within the core infectious diseases budget of CDC, the Division of Vector-Borne Diseases (DVBD) aims to protect the nation from the threat of viruses, bacteria, and parasites transmitted primarily by mosquitoes, ticks, and fleas. DVBD's mission is carried out by a staff of experts in several scientific disciplines, including entomology.

CDC plays a key role in tracking new and emerging diseases, as well as in supporting health care professionals in identifying and diagnosing these diseases. From 2016 to 2017, there was a 46% increase in reported cases of a group of tick-borne diseases known as spotted fever rickettsioses (spotted fevers), which includes the notably fatal Rocky Mountain spotted fever (RMSF).[3] Disability and death from RMSF are preventable if the antibiotic doxycycline is administered within the first five

[1] https://www.gatesnotes.com/Health/Most-Lethal-Animal-Mosquito-Week.
[2] https://www.sciencedirect.com/science/article/abs/pii/S0960982219311674.
[3] https://www.ncbi.nlm.nih.gov/pubmed/?term=30969821.

days of illness: without treatment, 1 in 5 RMSF cases lead to death.[4] Importantly, spotted fevers have non-specific symptoms, and fewer than 1% of the spotted fever cases reported in 2016–2017 had sufficient laboratory evidence for diagnosis. In response to this issue, the CDC has created a first-of-its-kind education module that will help healthcare providers recognize the early symptoms of RMSF and distinguish it from other diseases, enabling affected patients to get the life-saving treatment they need as quickly as possible.[5] CDC funding is crucial in the development of this and other educational tools that equip health care providers to effectively combat tick-borne diseases.

Using funding appropriated during the 2016 Zika crisis to help respond to that emergency and develop the necessary future workforce, CDC awarded $50 million to five universities to establish regional Centers of Excellence (COE) to address existing and emerging VBD. The five centers, for which current funding expires in 2021, generate research, education, outreach, and capacity to enable appropriate and timely local public health action for VBD throughout the U.S. The COE model requires collaboration between the research institutions and the local and regional departments of health (DOH), important relationships which have not generally arisen organically. This is critical given significant regional differences in vector ecology, disease transmission dynamics, and resources.

The Kay Hagan Tick Act also expands authorized support for the ELC program, critical to supporting state and local departments of health vector surveillance and management. For the last several years, the CDC has only been able to fund a third of the $50 million in requests they receive from states to meet these needs. ESA supports fully funding the $20 million authorized in the Kay Hagan Tick Act to support the ELC grants.

ESA requests robust funding for IMLS, including no less than $42.7 million for the Office of Museum Services in FY 2022. The services and funding provided by IMLS are critical in several areas—research infrastructure, workforce development, and economic impact. IMLS provides for the expansion of collections capabilities at American museums, which are key for the identification, documentation of locations, and classification of entomological species. The 21st Century Museum Professionals Program provides opportunities for diverse and underrepresented populations to become museum professionals, expanding participation in an industry with an annual economic contribution of $21 billion. Museums are critical to the public understanding of science through exhibits and programs, and in so doing, support science education as an integral part of the nation's educational infrastructure. They also make significant long-term contributions to economic development in their local communities.

Thank you for the opportunity to offer the Entomological Society of America's support for NIH, CDC, and IMLS research programs.

[This statement was submitted by Michelle S. Smith, BCE, President, Entomological Society of America.]

PREPARED STATEMENT OF THE EPILEPSY FOUNDATION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—Please provide $10 billion for the Centers for Disease Control and Prevention (CDC) including:
  —$13 million for the National Center for Chronic Disease Prevention and Health Promotion's Epilepsy program, an increase of $2.5 million over FY 2021.
  —$5 million for the CDC's National Neurological Conditions Surveillance System (NNCSS).
—Please provide at least $46.1 billion for the National Institutes of Health (NIH).
  —Please provide proportional increases for various NIH Institutes and Centers, including the National Institute of Neurological Disorders and Stroke (NINDS).

Thank you for the opportunity to submit testimony on behalf of the Epilepsy Foundation and the people with the epilepsies whom we serve. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, we

[4] https://www.cdc.gov/media/releases/2019/p0513-rocky-mountain-spotted-fever-training.html.
[5] https://www.cdc.gov/rmsf/resources/module.html.

deeply appreciate the robust investments in medical research and public health programs over recent years which are helping us better understand and treat the epilepsies and better support people with epilepsy and their families day-to-day. As you and your colleagues work on appropriations for FY 2022, please continue this commitment and provide timely investments in the NIH and public health and research programs at the CDC. Thank you for your time and for your consideration of these requests.

ABOUT THE EPILEPSY FOUNDATION

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the approximately 3.4 million living with epilepsy and seizures. We foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services.

ABOUT THE EPILEPSIES

Epilepsy is a disease or disorder of the brain which causes reoccurring seizures affecting a variety of mental and physical functions. It is a spectrum disease comprised of many diagnoses including an ever-growing number of rare epilepsies. There are many different types of seizures and varying levels of seizure control.

3.4 million Americans live with active epilepsy including 470,000 children and teenagers. Thirty to forty percent of people with epilepsy live with uncontrolled seizures despite available treatments. Delayed recognition of seizures and inadequate treatment increase a person's risk of subsequent seizures, brain damage, disability, and death. Epilepsy imposes an annual economic burden of $19.4 billion on the country.

Please provide $10 billion for CDC including $13 million for CDC's Epilepsy program.

The Institute of Medicine's (IOM) report on epilepsy, *Epilepsy Across the Spectrum: Promoting Health and Understanding,* identifies the Epilepsy Foundation and the CDC as leaders in addressing many of its national recommendations to eliminate stigma, improve awareness and education and better connect people with the epilepsies to health and community services. The CDC Epilepsy program is the only public health program specifically related to epilepsy with a national scope and community programs. Focus areas requiring continued and increased investment include:

—In FY 20, 481 law enforcement and first responders, 5,033 school nurses, 214,702 school personnel, and 4,071 students have been trained on seizure recognition and seizure first aid. On-demand training modules are being developed to scale up training of these key, frontline community members.

—10,000 people have been certified in seizure first aid, though more focus is needed on rural and ethnically and racially diverse communities as nearly 40% of persons diagnosed with epilepsy are African American or Hispanic and many people with epilepsy in those communities have poorer health outcomes.

—To improve care in rural and underserved communities, Project ECHO has educated more than 400 healthcare providers about managing epilepsy, though more focus is needed on management of severe, drug-resistant epilepsy and quality of care improvement methods.

—60 community health workers in Texas and Illinois have been trained to implement self-management programs resulting in improved health outcomes for people with epilepsy. More funding could scale up this evidence-based training in other states.

—By screening and addressing barriers to medication adherence, an Epilepsy Learning Healthcare System is reducing healthcare utilization and costs.

—Mental health screenings have been implemented and people with epilepsy are being connected to self-management programs that prevent and decrease depression since people with epilepsy at increased risk for depression and anxiety.

Testimonials from Participants in CDC Epilepsy Program-Funded Efforts

Margaret, Fairfield, CT: "Participating in HOBSCOTCH and learning more about epilepsy and the brain helped me realize this diagnosis is not something to be afraid or embarrassed of. By facing and dealing with my diagnosis head on, I can take control of certain aspects of epilepsy and improve my quality of life. HOBSCOTCH taught me strategies that I now use every day to improve my memory."

Kelsey, Seattle, WA: "During the 8 weeks that I participated in the PACES program, I learned a lot valuable information and had a wonderful time meeting other people experiencing similar struggles as me. I loved that the program integrated both a personable, solidarity like approach while providing evidence-based informa-

tion with the most up to date epilepsy research. Having had epilepsy for over 15 years, I thought that I had a strong grasp on most epilepsy topics. However, the PACES program brought up different areas which I hadn't considered before and I found really useful for personal introspection and to share with other people in my life. I believe the PACES program is a wonderful opportunity for individuals who both have either been recently diagnosed or lived with epilepsy for a long time to share their own experiences in a way that might change another person's life and to learn important facts about the condition."

Nancy Tindell, Geneva County, Alabama: After taking the school nurse seizure training program myself in 2020, I strongly encouraged all school nurses and school personnel in my county to take the course because even I, as a nurse, learned a lot about both seizure types, new rescue therapies on the market and more. As a school nurse in a small town in Alabama, I am thankful for the support and trainings that empower us to support the students with seizures and epilepsy in our classroom and extracurricular settings.

Jon D. Brown, Founder and Chief Advocate, Black Men's Health, Tallahassee, FL: We had an opportunity to collaborate with the Epilepsy Foundation to not only bring awareness to and educate on the topic of Epilepsy, but together we were able to specifically leverage June, as Men's Health Month, to focus on a Seizure First Aid Certification Training. Throughout virtual discussions with Lowell Evans, who spoke on "Living with Epilepsy While Changing the World," and Michael Brown, who spoke on "Are You Certified in Epilepsy First Aid? You Should and Can Be," I learned so much vital information that provided me new-found awareness, information, education, and confidence (key!) to act if I am to find myself in the presence of someone having a seizure. And, the subsequent training, facilitated by Michael Brown and Luis Garcia, emphasized that this scenario might likely happen, as we learned that 1 in 10 people will experience a seizure in their lifetime. Mind-blowing, life-changing, and potentially life-saving information; important conversations that I am committed to continue having for broader reach throughout communities of color.

Fernando A., Columbus, Indiana: Project Uplift was very helpful to help my wife understand my daily struggles. It helped me learn ways to cope with my anxiety and to better communicate my thoughts and needs. I feel that Project Uplift is a very valuable resource to spread knowledge and awareness about the epilepsy community. I know that if the program continues, it will help reduce the stigma around what it means to be epileptic and create a safe community for those of us who just want to feel heard and understood.

Also as part of the $10 billion for the CDC, please provide $5 million for the CDC's National Neurological Conditions Surveillance System.

In 2016, Congress authorized the CDC to establish the NNCSS and it first received funding in FY 2019. The CDC is initially focusing on MS and Parkinson's, in order to learn through the process before extending to other neurological conditions. Extending to additional neurological conditions such as the epilepsies is contingent on continued funding for this program so the Foundation requests $5 million for the NNCSS in FY 2022.

Please provide at least $46.1 billion for NIH along with proportional increases for various NIH Institutes and Centers, including NINDS.

As a result of sustained investment in NIH, the epilepsy research portfolio has grown from about $150 million in FY 2017 to over $200 million in FY 2020. These resources have fueled scientific advancement and led to support for a variety of research initiatives including: Epilepsy Centers without Walls, The Epilepsy 4,000 (Epi4K) collaborative, The Center for Sudden Unexplained Death in Epilepsy (SUDEP) Research, The Epilepsy Bioinformatics Study for Antiepileptogenic Therapy (EpiBiosS4Rx), The Channelopathy Associated Epilepsy Research Center (CAREC), The Epilepsy Multiplatform Variant Prediction (EpiMVP) Center.

https://www.ninds.nih.gov/Current-Research/Focus-Disorders/Epilepsy

Much more can be done though, particularly in the area of bold cross-cutting initiatives and multi-center efforts. For FY 2022, we ask the subcommittee to include key committee recommendations, like the language below, to encourage additional epilepsy research in emerging areas.

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

Epilepsy.—The Committee notes the significant opportunities for the NINDS to advance research on the epilepsies through multi-center, multidisciplinary approaches like the Epilepsy Centers Without Walls that help address the need for biomarkers of epilepsy and precision medicine for new treatments and prevention

for etiologically-defined populations. This approach is also suited for nation-wide, coordinated clinical and translational research frameworks to advance disease modifying or prevention strategies for the epilepsies.

The Epilepsy Foundation thanks the subcommittee for its consideration of these requests. If you have any questions, please contact me.

[This statement was submitted by Laura Weidner, Esq., Vice President, Government Relations & Advocacy.]

PREPARED STATEMENT OF EVERMORE

Chairwoman Murray, Ranking Member Blunt, and members of the Committee, thank you for the opportunity to provide testimony pertaining to fiscal year (FY) 2022 appropriations for the Centers for Disease Control and Prevention (CDC). Your leadership has resulted in major advances in the health and wellbeing of Americans, as well as ensuring that our taxpayer dollars are appropriated to our nation's most pressing health and human needs.

I submit this testimony on behalf of Evermore, a nonprofit dedicated to making the world a more livable place for bereaved families by raising awareness of the consequences and implications of bereavement for society, advancing sound research that drives policy and program investments, and advocating on behalf of bereaved families for whom very limited legal protections are available in the aftermath. The purpose of my testimony today is to alert you to an emerging public health concern—bereavement—and its impact on millions of families throughout the nation. Bereavement shares a powerful intersectionality with multiple national public health emergencies, including COVID–19, overdose, homicide, and suicide. As such, bereavement plays a key gatekeeping role in determining whether we as a nation can turn the corner on these ongoing public health crises towards national recovery and wellbeing. This watershed moment offers us a rare opportunity to effect long-needed and long-awaited systemic changes. These changes can bring together a diverse array of seemingly disconnected, separately raging crises to support our nation's grieving individuals, families, and communities; compassionately lighten the burden of bereavement that encumbers and shortens so many lives, and re-enable them to reach their full potential.

Bereavement is a pernicious social concern threatening nearly every aspect of family wellbeing and solvency for millions across the country. The unexpected death of a loved one poses a dual threat to our national well-being, as it is both among the most common major life stressors, and the single worst lifetime experience, reported by Americans in national surveys. Losing a loved one is not only a personal tragedy, but casts a long shadow that can extend for decades as it places surviving parents, children, siblings, and spouses at significant risk for impaired health, premature death, and underachievement. Some additional risks include serious mental health disorders, teen pregnancy, violent crime involvement, youth delinquency, substance abuse, diminished academic attainment, diminished lifetime income, and less purpose in life, among many others.

Perhaps most concerning, our national life expectancy—an index of overall population health—has dropped by more than one full year. This last happened nearly 80 years ago following the United States' entry into World War 2. The implications of these statistics are sobering: They not only indicate that many middle-aged people of child-bearing and child-rearing years are dying, but that many children and adolescents are losing their parents, grandparents, aunts, uncles, and mentors. Recurring bereavement under tragic and often-traumatic circumstances has now become a commonplace fact of life for many US residents. Further, COVID and our other spiking epidemics have set back progress in closing the racial health disparities gap by some 20 years. Racial inequalities in bereavement are magnified across the life course as Black Americans are more likely than White Americans to experience the death of children, spouses, siblings, and parents. Black Americans are three times as likely as White Americans to have two or more family members die by the time they reach the age of 30. Black children are three times as likely to lose a mother and more than twice as likely to lose a father by age 10 when compared to White children.

To facilitate and inform future policymaking and national investments, as well as develop an evidenced-based bereavement care response system, Evermore encourages a budget increase of $2.5 million in CDC's Office of Surveillance, Epidemiology, and Laboratory Services/Division of Behavioral Health to collect bereavement prevalence and incidence data via its Behavioral Risk Factor Surveillance Survey (BRFSS). BRFSS is the nation's premier survey tool collecting data from 400,000

adults living in the 50 states, the District of Columbia, and three U.S. territories. It is the largest continuously-conducted health survey in the world.

The CDC is one the nation's most-trusted sources of data and evidence on population and public health. Our nation requires consistent and reliable data on the prevalence and sequelae of bereavement on which to formulate sound policy and practice. Today, the CDC collects mortality data, but not data pertaining to the bereaved families who survive these death events, and what the ramifications are. With five million individuals losing a loved one to COVID–19, including an estimated 46,000 children who lost a parent, the need for sound data collection to frame a federal response has never been greater. Indeed, we have relied on private researchers—including Ashton Verdery, Ph.D. of The Pennsylvania State University and Emily Smith-Greenaway of the University of Southern California—to provide these estimation models because the federal government does not measure bereavement exposure.

By extension, bereavement prevalence and incidence for homicide, suicide or overdose are currently unavailable, leaving us with no accurate means of capturing its impact (perhaps better designated as shockwaves) on individuals, families, and communities. This is a major missed opportunity for our social and health systems to surveil, monitor, and learn from our national epidemics and mount an effective response. Adding bereavement exposure to BRFSS would provide key demographic data, trends by race and geography, resulting in both a better understanding of the scope of the problem and informing future policymaking and program priorities and investments.

In 2019, Toni Miles, M.D., Ph.D. of the University of Georgia piloted three bereavement exposure questions in Georgia's BRFSS module, prior to the COVID–19 epidemic (see Figure 1). Her work found that 45 percent of Georgia BRFSS respondents were bereaved in the previous two years. Extrapolating this figure to the overall state population, she estimates that 3.7 million Georgian adults were recently bereaved. Her work also estimates that approximately 400,000 Georgia adults had two or more close family members die. African American adults are at particular risk, with 58 percent reporting a loss. Those in their prime working years are affected, with 48 percent of adults ages 35–64 experiencing a loss. Preliminary evidence indicates that bereavement exposure may undermine capacity to work; 53 percent of those newly out of work had experienced a family death.

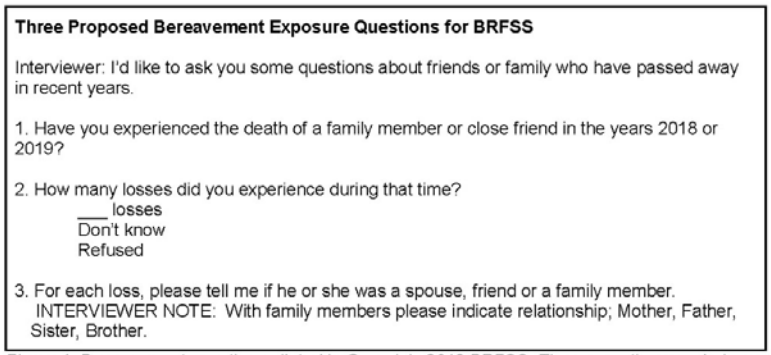


Figure 1. Bereavement questions piloted in Georgia's 2019 BRFSS. These questions are being proposed for inclusion in the 2022 CDC BRFSS.

Dr. Miles and her team found that persons who experienced any family loss in the past two years were at a heightened risk of reporting poor health, as well as physical and mental health problems over the past two weeks within taking the survey. Persons experiencing three or more losses were at the greatest risk of multiple health concerns, ranging from obesity to binge drinking, relative to those with no losses.

Appropriations Request
An increase of $2.5M to support the addition of an optional module to determine incidence and prevalence of bereavement exposure in CDC's annual BRFSS for all 50 states and U.S. territories. Module offering would commence in 2022.

In addition, we are requesting 1) the creation of a publicly available dataset featuring bereavement for use by behavioral health analysts and 2) a special highlight section in CDC's Health US, 2022, an annual snapshot of population health in the U.S.

Bill Language requested:
Of the funds made available under this heading, $2,500,000 shall be directed to the inclusion of three bereavement measures in the BRFSS.

Report Language requested:
The death of a loved one impacts millions of American residents leading to poor health, social and economic outcomes. This agreement includes $2.50 million for the Office of Surveillance, Epidemiology, and Laboratory Services to better understand the scope of bereavement exposure by including three new items to the Behavioral Risk Factor Surveillance Survey. Measures should be previously tested and fielded in at least one statewide survey. This data set should be available publicly to encourage and inform additional extramural research activities. This agreement encourages CDC to include a special highlight section in its Health US, 2022.

Figure 2. Appropriations request, bill and report language.

ADDITIONAL JUSTIFICATION FOR REQUESTS

Publicly-available bereavement dataset. We request the creation of a publicly available bereavement dataset enabling social and health scientists to extrapolate risk factors and potential implications for U.S.-based populations. Researchers will be able to examine interrelationships between exposure and outcomes, ask new research questions and begin to integrate this data into their existing research endeavors intended to help individuals reach their fullest potential. To that end, these data may influence CDC's Healthy People 2030 goals.

CDC's Health US, 2022. We request a special highlight section in CDC's 2022 health status report to the nation, Health, United States. This report presents key highlights and findings from federal health data systems.

CONCLUSION

To date, there is no national dataset capturing bereavement prevalence and incidence as our nation is facing unprecedented loss. Unequivocally, COVID–19 has reshaped our national landscape and is a seminal moment detailing how lack of quality bereavement care taxes individuals, families and the nation. Bereavement and its unintended outcomes are inextricably linked to many of our federal health agencies missions, priorities, and programs.

With more than millions of individuals in the United States suffering the loss of a loved one to COVID–19 and countless others who have lost a loved one to suicide, homicide, overdose, and chronic disesaes like cancer and Alzheimer's disease, combined with the growing evidence base about the profound long-lasting effects of bereavement on individuals and community health, bereavement (as a marker of risk) and quality bereavement care should be a priority for CDC and the federal government. Bereavement exposure and by extension its care is an essential element to any comprehensive public health strategy.

Thank you for the opportunity to present this testimony on behalf of millions of bereaved Americans and thank you for your continued leadership.

Sincerely.

[This statement was submitted by Joyal Mulheron, Executive Director, Evermore.]

PREPARED STATEMENT OF THE EVIDENCE-BASED LEADERSHIP COLLABORATIVE

Chair Murray and Ranking Member Blunt, and members of the Subcommittee, first, thank you for the opportunity to submit testimony to the Subcommittee to outline critical federal funding priorities for FY 2022. As we emerge from the health and economic crisis of the last year, the funding decisions that federal lawmakers make in FY 2022 will determine whether we have learned from the devastating consequences of the COVID–19 pandemic, or whether we default to a perilous status quo. It is with optimism that we will collectively improve upon the tragic lessons of the coronavirus crisis that we submit our funding requests for FY 2022.

In this sprit, we sincerely hope that Congressional Appropriators will recognize the value of evidence-based programs (EBPs) to promote health and prevent disease among older adults and make investments that increase support for, and expand access to, these vital activities. On behalf of the Evidence-Based Leadership Collaborative (EBLC)—a 501c3 organization that represents EBP developers, administrators, and providers with more than 200 combined years in developing, evaluating, scaling, implementing, and sustaining EBPs—we urge Subcommittee Members to include relatively modest, but meaningful, funding increases for the following programs within the Administration for Community Living (ACL):

—$50,000,000 for Older Americans Act Title III D, Preventative Health Services
—$16,000,000 for Older Americans Act Title IV, Chronic Disease Self-Management Education (CDSME) Programs
—$10,000,000 for Older Americans Act Title IV Falls Prevention Programs

Additionally, within the Centers for Disease Control and Prevention (CDC), we urge the Subcommittee to make important additional investments in chronic disease prevention programs, which are especially important given the significant impact of COVID–19 on older adults living with multiple chronic diseases.

These funding requests align with those of other national aging advocacy organizations and coalitions that focus on disease prevention, health promotion, and home and community-based services (HCBS) provision for older Americans, including the National Council on Aging (NCOA), the National Association of Area Agencies on Aging (n4a), and the Leadership Council of Aging Organizations (LCAO).

THE CASE FOR EVIDENCE-BASED PROGRAMING FOR OLDER AMERICANS

Evidence-based programs offer proven ways to promote health and prevent disease among older adults. These interventions have a decades-long track record of improving health and reducing costs when delivered within community settings across the country. Community and home-based delivery means improved access to quality care for older adults who are traditionally underserved, by organizations that also address those social needs that drive poor health and costs of care. These evidence-based programs include, but are not limited to:

—the Chronic Disease Self-Management suite of programs, which teach individuals how to manage ongoing health conditions;
—a Matter of Balance, EnhanceFitness, and Fit & Strong!, which increase awareness of and target interventions to help prevent fall-related injuries;
—Healthy IDEAS and PEARLS, which help to address and identify the underlying symptoms of depression; and
—Healthy MOVES and other programs focused on improving physical and emotional health through physical activity.

All of these programs, which are represented by the Evidence-Based Leadership Collaborative, meet the Administration for Community Living's criteria for the highest level of evidence. In addition to ACL, the Centers for Disease Control and Prevention Arthritis Program, Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs, and the Agency for Healthcare Research and Quality Innovations Exchange recommend these programs and find them to be the strongest of evidence-based programs.

The scale and scope of the challenges that the suite of EBPs address demonstrates the importance of investing in effective interventions. For example, chronic diseases are the leading causes of death and disability in the U.S., whose costs constitute 90 percent of the nation's $3.8 trillion in health expenditures. Older Americans are disproportionately affected by chronic conditions; 80 percent have at least one chronic condition, and nearly 70 percent of Medicare beneficiaries have two or more. Older adults living with chronic conditions, particularly Black, Indigenous, and other Persons of Color (BIPOC), were more vulnerable to COVID–19 hospitalizations and deaths, highlighting inequities in both health outcomes and access to quality care.

Furthermore, falls are the primary cause of injuries and deaths from injuries among older adults. Each year, an estimated one in four older adults falls. Annu-

ally, more than three million fall injuries are treated in emergency departments, resulting in nearly 800,000 hospitalizations. Yearly spending to treat injuries resulting from falls totals $50 billion, 75 percent of which is paid for by Medicare and Medicaid. These costs are expected to exceed $101 billion by 2030.

The pandemic exacerbated these challenges and contributed to other emerging widespread concerns. For example, social isolation and loneliness-a major contributor to poor physical, behavioral, and cognitive health-increased drastically for high-risk older Americans adhering to long-term stay-at-home orders and community shut-downs. The spike in social isolation and loneliness among older adults also spurred declines in physical functioning for many older Americans because of reduced access to community supports and evidence-based programs health promotion programs.

OPPORTUNITIES TO EXPAND EVIDENCE-BASED HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS WITH INCREASED FEDERAL INVESTMENTS

Despite the growing and widespread barriers to EBP delivery during COVID–19, program developers and community-based providers were quick to adapt to the new reality and adopt program delivery models suitable to a virtual world. Rapidly pivoting previously in-person programs to online and telephonic delivery methods ensured that many of these trusted, proven, and popular health promotion and disease prevention strategies could continue and remain accessible during the health crisis. Additionally, adapting EBPs to remote delivery demonstrated long-term potential to address program participation barriers for especially high-risk and historically marginalized populations including rural and home-bound older adults.

Increasing FY 2022 investments in evidence-based disease prevention and health promotion programs will allow providers to expand their reach to older Americans whose health conditions worsened because of the prolonged pandemic. Increased investments will also allow EBP interventions to continue to offer, expand, and improve upon remote program delivery options to overcome long-standing barriers for older adults lacking access to in-person programing and to reaching underserved communities with culturally and linguistically appropriate services. This opportunity is a potential paradigm shift for these proven, trusted, cost-effective interventions.

Given the potential to expand these programs as we recover from the pandemic, we respectfully request that the Subcommittee prioritize the following FY 2022 federal investments to support these important disease prevention and health promotion programs.

OAA TITLE III D PREVENTIVE HEALTH SERVICES

Title III D of the Older Americans Act delivers evidence-based health promotion and disease prevention programs to prevent or better manage the conditions that most affect quality-of-life, drive up health care costs and reduce an older adult's ability to live independently. However, investments have not been sufficient to ensure the diverse array of proven, cost-effective interventions can be implemented in communities nationwide, nor do they allow the to-date underfunded network to amass the critical evidence-based data lawmakers seek. Additional resources are needed to maintain the new reach and means of both in-person and remote delivery so older adults maintain access to these key services. We urge Congress to double appropriations funding for OAA Title III D programs in FY 2022 to $50 million.

OAA TITLE IV CHRONIC DISEASE SELF-MANAGEMENT EDUCATION (CDSME)

CDSME is a low-cost, evidence-based disease management intervention which studies show to be effective at helping people with all types of chronic conditions adopt healthy behaviors, improve health status, and reduce use of hospital stays and emergency room visits. Prevention and Public Health Fund allocations to ACL for CDSME have remained at $8 million since FY 2016, supporting over 14,000 community-based delivery sites which have provided services to more than 550,000 individuals. However, given that nearly 200 million people report having a chronic disease, the reach of these programs has been only 0.25 percent of the full population reach potential. We urge appropriators to increase FY 2022 funding for these programs to $16 million to expand access to evidence-based, cost-effective chronic disease management programs to a greater number of states and older adults in need across the country.

OAA TITLE IV FALLS PREVENTION

Evidence-based fall prevention programs offer cost-effective interventions by reducing or eliminating risk factors, promoting behavior change, and leveraging community networks to link clinical treatment and community services. These programs have been shown to reduce the incidence of falls by as much as 55 percent and produce a return on investment of as much as 509 percent. In fact, in an October 2019 report on falls prevention, the Senate Special Committee on Aging recommended continued investment and expanded access to EBPs aimed at mitigating the risk of falls among older adults. Despite this bipartisan support, falls prevention has been flat funded while the incidence and costs of falls continues to climb. Therefore, we urge your Subcommittee to increase the investment in these cost-effective programs to $10 million to make these programs more widely available to at-risk older Americans in every community.

In closing, these vital federal efforts that support health promotion and disease prevention interventions across the country have a profound impact on the quality-of-life of older Americans. On behalf of myself, the Evidence-Based Leadership Collaborative, and other national aging advocates, I implore you and your Subcommittee to support FY 2022 funding levels for these programs that recognize the value of, and expand access to, proven solutions for older Americans.

[This statement was submitted by Paul Hepfer, CEO, Project Open Hand & Evidence-Based Leadership Collaborative Board Chair.]

PREPARED STATEMENT OF THE FEDERAL AIDS POLICY PARTNERSHIP'S RESEARCH WORK GROUP

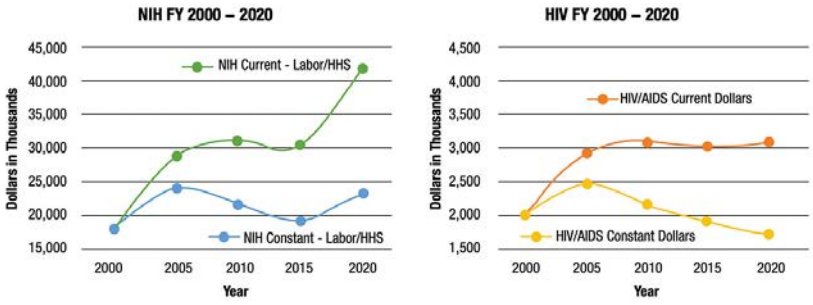
On behalf of the Federal AIDS Policy Partnership's Research Working Group, we thank Chairwoman Senator Murray, Ranking Member Senator Blunt, and members of the subcommittee for the opportunity to submit testimony to the Senate LHHS Subcommittee on Fiscal Year 2022 (FY 2022) Appropriations for the National Institutes of Health (NIH) in regards to protecting, strengthening, and expanding our nation's HIV/AIDS research agenda. The Research Work Group (RWG) of the Federal AIDS Policy Partnership (FAPP) is a coalition of more than 60 national and local HIV/AIDS research advocates, patients, clinicians and scientists from across the country. Our goal is to advance and support U.S. leadership to accelerate progress in the field of HIV/AIDS research. The FAPP RWG urges the subcommittee to recommend a FY 2022 budget request level of at least $46.1 billion for the NIH consistent the request of the Ad Hoc Group for Medical Research. We also ask that $3.845 billion be allocated for HIV research at the NIH in FY 2022, which is the research need identified by the Office of AIDS Research in their Congressionally mandated FY 21 Professional Judgment Budget.

Public investments in health research via NIH have paid enormous dividends in the health and wellbeing of people in the U.S. and around the world, particularly for people living with, or vulnerable to, HIV. NIH funded AIDS research has supported innovative basic science for better drug therapies, and evidence-based behavioral and biomedical prevention interventions which have saved and improved the lives of millions. NIH funding has contributed to over 210 approvals for a range of novel therapeutics between 2010 through 2016, with new anti-infectives for HIV and HCV receiving the second largest fraction of those approvals. Additionally, NIH support was crucial in the development of pre-exposure prophylaxis (PrEP), an HIV prevention tool that is upwards of 99% effective in preventing sexual transmission. NIH-supported HIV research is now critical to advancement of possible treatments and several vaccines against COVID–19.

HIV research advances at the NIH hold the potential to end the AIDS epidemic, as well as update prevention approaches and improve outcomes along the treatment cascade—a cornerstone of the initiative to End the HIV Epidemic in the U.S. In addition, the average age of people living with HIV in the United States is increasing, so it also remains critically important to make substantial investments in research on co-morbidities and new antiretroviral therapies. NIH research is critical to ensuring that aging population stays healthy and virally suppressed.

Since 2003, funding for NIH HIV research has failed to keep up with our existing research needs—damaging the success rate of approved grants and leaving very little money to fund promising new research—despite increases to the overall NIH budget. According to the Biomedical Research and Development Price Index (BRDI)—which calculates how much the NIH budget must change each year to maintain purchasing power—between FY 2003 and FY 2020, the NIH budget in constant dollars according to BRDI will have declined by almost half.

Inflation Effect on Research Purchasing Power



Note: The above funding does not include COVID-19 appropriations.
Source: Biomedical Research and Development Price Index (BRDPI).

Investment by the NIH has transformed the HIV epidemic from a terrible, untreatable disease to a chronic condition that can be managed through once-a-day drug regimens. Now is the time to increase investment for the NIH to finish the job and end the HIV epidemic through strategic, science-based interventions. NIH funding of HIV/AIDS research provides an example of innovation at work where investment in basic and translational research, working in partnership with industry and community, can move quickly to develop solutions. NIH investments in HIV/AIDS research add value by seeding ideas later taken up in industry partnerships and creating innovation incubators for important medical advances with significant health impact.

Federal support for HIV/AIDS research has also led to new treatments for other diseases, including cancer, COVID–19, heart disease, Alzheimer's, hepatitis, osteoporosis, and a wide range of autoimmune disorders. Several HIV/AIDS treatments have been researched as treatments for the novel coronavirus—saving months of research time and, in the process, potentially countless lives. Coronavirus vaccine research is now ongoing using platforms and technology, such as Ad26 and mRNA, previously developed for use as an HIV vaccine.

Robust funding for NIH overall enables research universities to pursue scientific opportunity, advance public health, and create jobs and economic growth. NIH funding puts approximately 300,000 scientists to work at research institutions across the country. According to NIH, each of its research grants creates or sustains six to eight jobs and NIH-supported research grants and technology transfers have resulted in the creation of thousands of new independent private sector companies.

The race to find better treatments and a cure for cancer, Alzheimer's, heart disease, HIV/AIDS, and other diseases, and for controlling global epidemics like AIDS, tuberculosis, coronavirus, and malaria, all depend on a robust long-term investment strategy for health research at NIH. There can be no innovation without reliable and adequate research funding. Congress should ensure the nation does not delay vital HIV/AIDS research progress. We must protect HIV/AIDS research funding to sustain research capacity and maintain our worldwide leadership in HIV/AIDS research and innovation.

To that end, we urge the subcommittee to consider a needed increase to the overall FY 2022 budget request level of at least $46.1 billion for the National Institutes of Health (NIH) consistent with the request of the Ad Hoc Group for Medical Research. While this increase may get us closer to meeting the OAR By-Pass Budget Estimate for FY 2022, we ask the committee direct that increased funding be allocated for HIV research at the NIH in FY 2022. We urge the subcommittee to consider approaches to ensure the HIV research budget receives increases alongside other important and intersecting biomedical research at NIH.

In conclusion, the RWG calls on Congress to continue the bipartisan federal commitment towards combating HIV as well as other chronic and life-threatening illnesses by increasing funding for NIH in FY 2022. A meaningful commitment towards maintaining the U.S. pre- eminence in HIV research and fostering innovation cannot be met without prioritizing the research investment at NIH that will lead to tomorrow's lifesaving vaccines, treatments, and cures that are needed to end the

HIV epidemic here and abroad. Thank you for the opportunity to provide these written comments.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

My testimony is in support of FY22 funding for the National Institutes of Health under the Department of Health and Human Services , Agency Subdivision: National Institutes of Health, Account: 550.

SUMMARY

Federal investments in fundamental research have led to remarkable progress in the biological and biomedical sciences. Basic research was the groundwork for the speed—months instead of years—in the development of COVID–19 vaccines, and pre-clinical research, such as animal studies, has been essential to every step of achieving medical progress.

Despite Congress' bipartisan support for investing in science, federal funding for research has not kept pace, posing a threat to our nation's competitiveness. We face a real threat of losing our edge in industries such as biotechnology if we do not prioritize increasing investments in science and building a diverse workforce [1] The U.S. spends less on research and development (R&D) than many countries. If the U.S. is to be prepared to respond to future threats, our scientific leadership must progress. According to Science Is Us, there is the added benefit of jobs. STEM supports 69 percent of U.S. gross domestic product, touches two out of three workers, and generates $2.3 trillion in tax revenue.[2]

The federal government should commit to robust, predictable, and sustained funding increases for science agencies.

NATIONAL INSTITUTES OF HEALTH

The NIH is the nation's largest funder of biomedical research, providing competitive grants to support the work of 300,000 scientists at universities, medical centers, independent research institutions, and companies nationwide. NIH supports biomedical discoveries, innovations, and treatments that were made possible because of scientific research using animals.

Congress has renewed its commitment to this critical research agency, providing robust, sustained, and predictable budget increases over the last five fiscal years (Table 1).[3] With these resources, NIH has accelerated progress across all areas of medical science, including regenerative medicine, cancer immunotherapy, and neurological health.[4,5,6] The agency is also committed to supporting the next generation of our biomedical research enterprise.[7]

Though the NIH is in a stronger position than it was a few years ago, Congress must continue to increase biomedical research funding. Our nation is confronting public health threats, especially given global climate change negatively impacting biodiversity and geohealth—the intersection of biological science, Earth sciences, and ecology—on mankind. More research will be needed to address increased risks posed by future pandemics, infectious diseases, and greater exposure to environmental pollutants.[8]

In the U.S., we continue to address the needs of an aging population and obesity.[9,10] NIH research is developing therapies for a whole spectrum of age-related

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[1] NSF Science Indicators 2018.

[2] STEM and the American Workforce. You've heard it before: STEM jobs—... | by Science is US | Medium.

[3] FASEB Federal Funding Data.

[4] NIH Regenerative Medicine Innovation Project, National Institutes of Health, Bethesda, MD.

[5] NCI's Role in Immunotherapy Research, National Cancer Institute, Bethesda, MD.

[6] The BRAIN Initiative Summary, National Institutes of Health, Bethesda, MD.

[7] NIH Grants and Funding, Next Generation Research Initiative, National Institutes of Health, Bethesda, MD.

[8] IPCC AR5 Climate Change 2014, Chapter 11: Human Health: Impacts, Adaptation, and Co-Benefits.

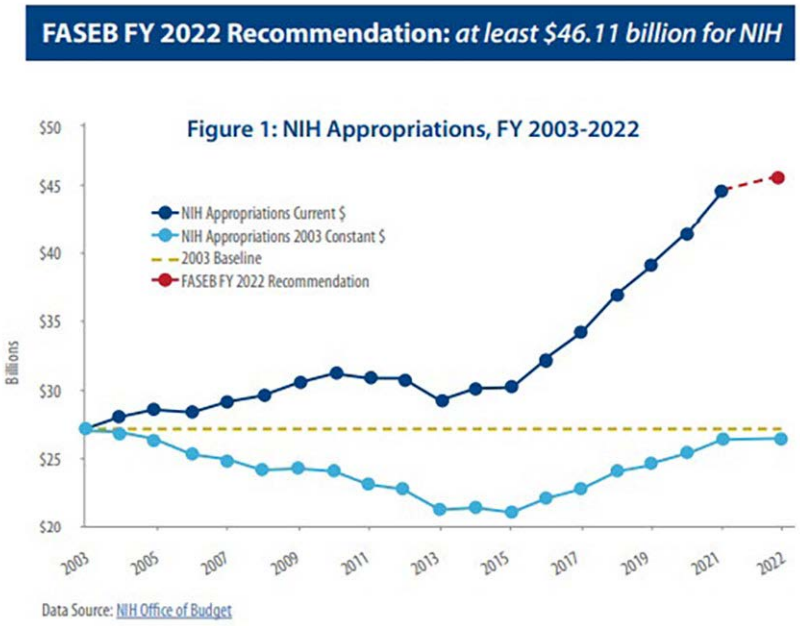
[9] https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html.

[10] NIDDK Health Information.

disorders.[11] Obesity impacts 42% of the U.S. population and increases the likelihood of developing costly medical conditions.[12]

Our recommendation of $46.11 billion is $3.2 billion above FY 2021 allowing NIH to continue support for the Next Generation Researchers Initiative; provide a five percent increase across NIH institutes and centers; and expand dual purpose research in biomedicine and agriculture among NIH and other federal agencies.[13]

FASEB FY 2022 Recommendation: at least $46.11 billion for NIH (chart below):



[This statement was submitted by Ellen Kuo, Associate Director, Legislative Affairs, Federation of American Societies for Experimental Biology.]

Prepared Statement of the Federation of Associations in Behavioral and Brain Sciences

Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee:

The Federation of Associations in Behavioral and Brain Sciences (FABBS) is grateful for the opportunity to submit testimony for the record in support of the National Institutes of Health (NIH) and the Institute of Education Sciences (IES) budgets for fiscal year (FY) 2022. FABBS represents twenty-seven scientific societies and over sixty university departments whose members and faculty share a commitment to advancing knowledge of the mind, brain, and behavior. For fiscal year (FY) 2022, FABBS encourages your subcommittee to provide the National Institutes of Health (NIH) with a budget of at least $52 billion and the Institute of Education Sciences (IES) within the Department of Education a budget of $700 million.

Our members are thankful that appropriators were able to secure $42.9 billion for NIH and over $646 million for IES in FY21. We also appreciate the supplemental appropriations to NIH and IES included in COVID–19 response legislation. At NIH, these funds have played a central role in the pandemic response, not only developing vaccines and treatments but also supporting behavioral research to inform public health strategies. At IES, these investments are already helping to conduct essential research into the learning disruptions caused by the pandemic and pro-

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[11] Aging Well in the 21st Century: Strategic Directions for Research on Aging, National Institute on Aging, Bethesda, MD.

[12] CDC Obesity Data.

[13] BILLS–116RCP68–JES–DIVISION–H.pdf (house.gov) pg. 63.

viding educators the tools to chart a path forward for students. We hope to see similar success funding these agencies' vital contributions in FY22.

NATIONAL INSTITUTES OF HEALTH

We sincerely thank the Subcommittee for its diligent work and considerable increases to NIH in recent years. As members of the Ad Hoc Group for Medical Research and the Coalition for Health Funding, FABBS recommends at least $52 billion for NIH in FY 2022. FABBS members contribute to the NIH mission of seeking fundamental knowledge about the behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. FABBS members contribute to the advances in numerous NIH Institutes and Centers (IC).

FABBS members have a particular interest in the Office of Behavioral and Social Science Research. OBSSR was created to coordinate and promote basic, clinical, and translational behavioral and social science research at NIH and plays an essential role, enhancing trans-NIH investments in longitudinal datasets, technology in support of behavior change, innovative research methodologies, and promoting the inclusion of behavioral science in initiatives in partnership with ICs. OBSSR co-funds highly rated grants that the ICs cannot fund alone.

OBSSR is an integral component of many high-profile NIH programs and initiatives:

—OBSSR has played a role in the fight against COVID–19, supporting behavioral and social science research to address the pandemic and disseminating best practices to encourage uptake of COVID–19 vaccines. The Office, for example, has made over 50 awards to study mitigation efforts, the long-term health and health care effects of the resulting economic downturn, and potential interventions to limit these effects.

—The Office also coordinates NIH's high-priority program on gun violence prevention research, identifying effective public health interventions to prevent firearm violence, and the trauma, injuries, and mortality resulting from it.

—Additionally, OBSSR is central to the NIH UNITE initiative to end structural racism and racial inequalities in health research. A working group of the Behavioral and Social Sciences Research Coordinating Committee is responsible for examining OBSSR-funded research on racism and health to inform broader agency-wide efforts to promote inclusion within NIH and in the research it funds.

While the NIH budget has grown in recent years, funding for OBSSR has not seen commensurate increases. We recognize that, located in the Office of the Director, OBSSR does not have a specific appropriation. Nonetheless, FABBS appreciates the opportunity to express support for OBSSR and highlight that additional funding should enable the Office to expand its work addressing the behavioral, social, and economic impacts of the COVID–19 pandemic, measuring the effects of mitigation strategies on vulnerable individuals and communities in preparation for future pandemics, while maintaining its broad work in support of the NIH mission.

INSTITUTE OF EDUCATION SCIENCES (IES), U.S. DEPARTMENT OF EDUCATION

As members of the Friends of IES, FABBS encourages the subcommittee to appropriate at least $700 million to IES in FY 2022. At this critical juncture, a significant increase in IES funding is essential to addressing learning loss caused by the COVID–19 pandemic and better preparing American students for the future.

IES is a semi-independent, nonpartisan branch of the U.S. Department of Education and is the research foundation for improving and evaluating teaching and learning. The four centers-the National Center for Education Statistics (NCES), National Center for Education Research (NCER), National Center for Special Education Research (NCSER) and National Center for Education Evaluation (NCEE)-work collaboratively to efficiently and comprehensively produce and disseminate rigorous research and high-quality data and statistics.

Already, the Institute has done important work to gauge the impact of school closures on students, teachers, and school leaders, while providing evidence-based guidance and technical assistance to inform school reopening plans and support instruction in remote and hybrid learning. IES launched Operation Reverse the Loss to identify specific and actionable interventions that can reverse learning losses for clearly identified populations of students.

Robust funding for IES in FY22 will allow the Institute to continue its important work studying the effects of and developing strategies to address learning loss due to COVID–19 and create a stronger educational system.

Thank you for considering this request.

FABBS Member Societies:

Academy of Behavioral Medicine Research, American Educational Research Association, American Psychological Association, American Psychosomatic Society, Association for Applied Psychophysiology and Biofeedback, Association for Behavior Analysis International, Behavior Genetics Association, Cognitive Neuroscience Society, Cognitive Science Society, International Congress of Infant Studies, International Society for Developmental Psychobiology, Massachusetts Neuropsychological Society, National Academy of Neuropsychology, The Psychonomic Society, Society for Behavioral Neuroendocrinology, Society for Computation in Psychology, Society for Judgement and Decision Making, Society for Mathematical Psychology, Society for Psychophysiological Research, Society for the Psychological Study of Social Issues, Society for Research in Child Development, Society for Research in Psychopathology, Society for the Scientific Study of Reading, Society for Text & Discourse, Society of Experimental Social Psychology, Society of Multivariate Experimental Psychology, Vision Sciences Society

FABBS Affiliates:

APA Division 1: The Society for General Psychology; APA Division 3: Experimental Psychology; APA Division 7: Developmental Psychology; APA Division 28: Psychopharmacology and Substance Abuse; Arizona State University; Binghamton University; Boston University; California State University, Fullerton; Carnegie Mellon University; Columbia University; Cornell University; Duke University; East Tennessee State University; Florida International University; Florida State University; George Mason University; George Washington University; Georgetown University; Georgia Institute of Technology; Harvard University; Indiana University Bloomington; Indiana University—Purdue University Indianapolis; Johns Hopkins University; Kent State University; Lehigh University; Massachusetts Institute of Technology; Michigan State University; New York University; North Carolina State University; Northeastern University; Northwestern University; The Ohio State University, Center for Cognitive and Brain Sciences; Pennsylvania State University; Princeton University; Purdue University; Rice University; Southern Methodist University; Stanford University; Syracuse University; Temple University; Texas A&M University; Tulane University; University of Arizona; University of California, Berkeley; University of California, Davis; University of California, Irvine; University of California, Los Angeles; University of California, Riverside; University of California, San Diego; University of Chicago; University of Colorado, Boulder; University of Delaware; University of Houston; University of Illinois at Urbana-Champaign; University of Iowa; University of Maryland, College Park; University of Massachusetts Amherst; University of Michigan; University of Minnesota; University of Minnesota, Institute of Child Development; University of North Carolina at Greensboro; University of Pennsylvania; University of Pittsburgh; University of Texas at Austin; University of Texas at Dallas; University of Washington; Vanderbilt University; Virginia Tech; Wake Forest University; Washington University in St. Louis; Yale University

[This statement was submitted by Juliane Baron, Executive Director, Federation of Associations in Behavioral and Brain Sciences.]

PREPARED STATEMENT OF FLORIDA A&M UNIVERSITY

Chairman Leahy, Chair Murray, Vice Chairman Shelby, Ranking Member Blunt, and Members of the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee, thank you for the opportunity to submit public testimony on the subcommittee's Fiscal Year (FY) 2022 appropriations bill. Florida A&M University (FAMU) supports maintaining or enhancing funding for programs of interest to the University and our students, including the Department of Education's Historically Black Colleges and Universities (HBCU) programs, the HBCU Capital Financing Program, and the federal Pell Grants program. FAMU also supports two programs at the Department of Health and Human Services—the National Institutes of Health's Research Centers in Minority Institutions and the Health Resources and Services Administration's Health Careers Opportunity Program. These federal programs provide critical support to the University, our students as well as other institutions of higher education and the nation.

Florida A&M University, based in the State capitol of Tallahassee, Florida, was founded in 1887 with only 15 students and two instructors. Today, FAMU has grown to nearly 10,000 students and we are proud to be the highest ranked among public Historically Black Colleges and Universities (HBCU) according to the U.S. News and World Report National Public Universities. Our University offers 56 bach-

elor's degrees, 29 master's degrees, 12 doctoral degrees and three professional degrees. We are a leading land-grant research institution with an increased focus on science, technology, research, engineering, agriculture, and mathematics. As noted by Diverse Issues, FAMU is a top producer of African American doctoral degrees in pharmacy and pharmaceutical sciences.

Federal support is critical for institutions of higher education, particularly HBCUs, which are historically under-resourced. Robust federal funding for programs that help to improve our institutions, broaden access for students, and improve student success is paramount. The Department of Education HBCU programs help us achieve these goals and the federal Pell Grant program is an imperative resource for our students as the majority of our students are Pell-eligible. Furthermore, the Department of Health and Human Services' research and career development programs that support minority students also benefit FAMU, our students, and the nation. FAMU strongly supports funding for these vital federal programs.

DEPARTMENT OF EDUCATION HISTORICALLY BLACK COLLEGES AND UNIVERSITIES PROGRAMS

FAMU strongly supports robust funding for the Department of Education HBCU programs under the Higher Education, Aid for Institutional Development Programs account. These programs, authorized under Title III of the Higher Education Act, provide critical support to higher education institutions that enroll large proportions of minority and financially disadvantaged students. One of the primary missions of the Title III programs has been to support the nation's HBCUs. The Strengthening Historically Black Colleges and Universities program and the Historically Black Graduate Institutions program provide FAMU and other HBCUs with formula grants to help strengthen our academic, administrative, and fiscal capabilities.

The President's FY 2022 budget requests $402.6 million for the Strengthening Historically Black Colleges and Universities program. These formula grants provide critical support to HBCUs that help to improve our facilities, develop faculty, support academic programs, strengthen institutional management, enhance our development and recruitment activities, and provide tutoring and counseling services to students. In FY 2019, FAMU received $7 million under the program.

We also support the President's FY 2022 budget request of $102.3 million for the Strengthening Historically Black Graduate Institutions, which funds five-year grants to provide for scholarships for disadvantaged students, academic and counseling services to improve student success, and supports infrastructure and facilities improvements. FAMU received $3.8 million under the current five-year grant period for this program.

FAMU, like other HBCUs, has a critical need for funding to support equipment upgrades and purchases, construction and renovation of our facilities, and development of our academic programs. This includes a wide variety of projects to strengthen the University and its programs, such as expansion of our online education offerings to enhance pathways to degree attainment, upgrading our information technology infrastructure, construction of laboratories, research and education facilities, and upgrading our health sciences and technology equipment and facilities. Continued funding for these HBCU programs and other Aid for Institutional Development programs is essential to postsecondary institutions, like FAMU, that educate the nation's minority students.

DEPARTMENT OF EDUCATION HISTORICALLY BLACK COLLEGES AND UNIVERSITIES CAPITAL FINANCING PROGRAM

FAMU supports maintaining the FY 2021 enacted level of $48.848 million for the Department of Education's HBCU Capital Financing Program, which provides low-cost capital to finance improvements to the infrastructure of the nation's HBCUs. Specifically, the program provides accredited HBCUs with access to capital financing or refinancing for the repair, renovation, and construction of classrooms, libraries, laboratories, dormitories, instructional equipment, and research instrumentation.

FAMU, like other HBCUs, has a critical need to upgrade and rehabilitate our aging facilities. This program makes capital available for HBCUs to improve our academic facilities, which will enhance the learning experience for our students. The requested funding would be used to pay the loan subsidy costs in guaranteed loan authority under the program. We urge the Subcommittee to maintain the current level of funding for FY 2022, which will allow HBCUs to continue to refinance previous capital project loans, renovate existing facilities, or build new facilities to improve our institutions.

DEPARTMENT OF EDUCATION PELL GRANT PROGRAM

FAMU supports robust funding for the Pell Grant program under the Department of Education's Student Financial Assistance account. The federal Pell Grant program, authorized by Title IV of the Higher Education Act, is the largest source of federal grant aid supporting college students. The Pell Grant Program provides need-based grants to low-income undergraduate students to promote access to postsecondary education.

For 2017–2018, there were 5,543 Pell Grant recipients attending FAMU, amounting to $27.7 million in Pell Grant awards. Over 60% of our enrolled students rely on Pell grants to attend our institution. Given the ongoing coronavirus crisis, which will have devastating impacts on the economy for the foreseeable future, we expect that our current and prospective students will be dependent on financial assistance, including Pell Grants, in order to continue pursuing their postsecondary education goals.

The President's FY 2022 budget requests $25.475 billion for Discretionary Pell Grants and proposes an increase in the maximum award to $8,370 in academic year 2021–2022. FAMU would encourage Congress to support the President's budget request substantially increasing the total maximum Pell grant award in FY 2022 to provide critical support for economically disadvantaged college students as we continue to rebound from one of the most challenging periods in our nation's history.

NATIONAL INSTITUTES OF HEALTH RESEARCH CENTERS IN MINORITY INSTITUTIONS

FAMU supports funding at the FY 2022 President's budget request of $80 million for the NIH National Institute on Minority Health and Health Disparities (NIMHD), Research Centers in Minority Institutions (RCMI) Program. The RCMI Program, established in 1985, supports critical infrastructure development and scientific discovery in historically minority graduate and health professional schools. The program serves the dual purpose of bringing more racial and ethnic minority scientists into mainstream research and promoting minority health research because many of the investigators at RCMI institutions study diseases that disproportionately affect minority populations. The RCMI Program develops and strengthens the research infrastructure necessary to conduct state-of-the-art biomedical research and foster the next generation of researchers from underrepresented populations.

Since program inception, the FAMU RCMI Center has received over $85 million from NIH, which has provided critical infrastructure to enable the College to achieve national prominence and become a competitive biomedical research center nationally. The RCMI support of FAMU led the College to implement four doctoral tracks in pharmaceutical sciences, including pharmacology/toxicology, medicinal chemistry, pharmaceutics, and environmental toxicology. Moreover, as an outcome of the RCMI support, our College of Pharmacy has graduated more than 60 percent of the African American doctoral recipients in the pharmaceutical sciences nationally.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), HEALTH CAREERS OPPORTUNITY PROGRAM

FAMU supports the President's budget request of $15 million for HRSA's Health Careers Opportunity Program (HCOP). First authorized in 1972, the HCOP competitive grant program aims to provide individuals from disadvantaged backgrounds an opportunity to develop the skills needed to successfully compete for, enter, and graduate from health or allied health professions schools. HCOP focuses on three key milestones of education: high school completion; acceptance, retention and graduation from college; and acceptance, retention and completion of a health professions degree program. The ultimate goal of the HCOP program is to diversify the health professions workforce by narrowing the educational achievement gaps between individuals from higher-income and lower-income households.

The Health Careers Opportunity Program (HCOP) High School Summer Institute, conducted on FAMU's campus, is designed for high school students interested in pursuing a career in a health profession. The four-week program provides a wide-range of educational and social experiences for rising 10th, 11th and 12th grade students. The entire experience is designed to enhance participants' academic abilities, social skills, and other competencies to increase their competitiveness for admission to a post-secondary health professions program.

The President's FY 2022 budget maintains funding for HRSA's Health Workforce, Training for Diversity Programs, including the HCOP. Continued funding is critical for these programs that help to increase the supply of underrepresented minorities in health professions.

We urge the Subcommittee to support continued and/or enhanced funding for these critical education programs at the Departments of Education and Health and Human Services. We thank you for your continued support of federal postsecondary initiatives that not only directly benefit the University and our students, but the region and the nation as well. Thank you for your consideration.

[This statement was submitted by Larry Robinson, Ph.D., President, Florida A&M University.]

PREPARED STATEMENT OF THE FRED HUTCHINSON CANCER RESEARCH CENTER

The Fred Hutchinson Cancer Research Center (Fred Hutch) is grateful to Congress for providing robust, reliable funding for the National Institutes of Health (NIH), a key national priority. The nation's investment in NIH research pays a lifetime of dividends in better health and improved quality of life for all Americans. The impact of the COVID–19 pandemic on the nation has demonstrated the importance of a well-funded research enterprise. Thanks to decades of strong congressional support for NIH, the scientific community was well-equipped to rapidly respond to COVID–19. In fiscal year (FY) 2022, Fred Hutch recommends at least $46.1 billion for the NIH. As the research enterprise recovers from pandemic-related disruptions, now, more than ever, it is essential to continue the trend of recent budget increases to NIH to support lifesaving research.

Through strong, bipartisan leadership over the last six budget cycles, the Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies (Labor-HHS) has helped the NIH regain lost ground after a period of effectively flat budgets. In the FY 2021 omnibus bill, the Subcommittee's leadership continued this trajectory by providing a substantial increase to all NIH institutes and centers in addition to supplemental funding dedicated to COVID–19 research.

The federal investment in biomedical research has yielded a significant number of scientific advances that improve health outcomes for patients. Fred Hutch is committed to working with Labor-HHS, Congress and the Administration to further bipartisan support for increasing federal investment in biomedical science and ensuring NIH remains a top priority in FY 2022. Because of NIH funding, Fred Hutch can pursue fearless science and collaborations across its five scientific divisions.

Founded in 1975, Fred Hutchinson Cancer Research Center is guided by a mission to eliminate cancer and related diseases as causes of human suffering and death. Fred Hutch's interdisciplinary teams of world-renowned scientists and humanitarians work together to prevent, diagnose, and treat cancer, HIV/AIDS and emerging infectious diseases. Our Nobel Prize winning discoveries began in the 1970s with Dr. E. Donnall Thomas' work in bone marrow transplantation, providing the first definitive and reproducible example of the power of the human immune system's ability to cure cancer. The leadership, depth and breadth of Fred Hutch's transdisciplinary research makes the center one of the National Cancer Institute's 51 designated Comprehensive Cancer Centers, serving patients in five northwestern states.

In addition to groundbreaking discoveries in science, Fred Hutch is investing in research to help narrow health inequities, implementing initiatives that embrace diversity and inclusion in science and empowering early career researchers. Below are some examples of how NIH funding fuels Fred Hutch innovation and fosters future generations of scientists:

—*Responding to COVID–19.* Researchers across Fred Hutch have moved at lighting speed to test and develop potential therapies and vaccines, increase and expand testing capacity, model the course of the pandemic and emerging variants and study the molecular interactions between SARS–CoV–2 and the human body. Utilizing the expertise and clinical infrastructure of the HIV Vaccine Trials Network (HVTN), headquartered at Fred Hutch, the center also leads operations for the COVID–19 Prevention Network (CoVPN), funded by the National Institute of Allergy and Infectious Diseases, and co-leads the five large-scale COVID–19 vaccine efficacy trials with over 200 clinical trial sites in the U.S. and abroad.

—*Mitigating Health Inequities.* Fred Hutch understands the importance of community engagement to overcome the pandemic and the HVTN's community engagement experts have worked tirelessly for inclusive and diverse participation in each of the CoVPN's 30,000 person vaccine trials. In just six months, the team registered nearly 600,000 volunteers and has expanded recruitment to volunteers for pediatric COVID–19 trials, long COVID, and anticipated trials testing vaccines for variants. Fred Hutch is also utilizing the decades-long work of

its public health scientists to disrupt the flood of misinformation during the pandemic, so underrepresented communities receive reliable, scientifically sound and understandable information about COVID–19 and the vaccines.

—*Embracing Diversity and Inclusion in Science.* Fred Hutch recognizes the importance of programs that promote diversity, equity and inclusion. As the first U.S. Cancer Center to commit to the CEO Action for Diversity & Inclusion plan and a member of the Washington Employers for Racial Equity, Fred Hutch strives to establish itself as a national exemplar in academia for its Diversity, Equity and Inclusion (DEI) approaches and practices. DEI is integrated as core values, principles and practices in Fred Hutch's approach to research, its workforce development, workplace culture and the communities Fred Hutch engages with. The NIH's emphasis on DEI, including the Agency's DEI initiative, UNITE and the FIRST faculty cohort program for early career researchers are instrumental in ensuring the most creative minds have the opportunity to contribute to the nation's research and health goals. Congress' continued support of the NIH funds vital efforts to increase representation and promote varied perspectives throughout the entire biomedical research enterprise.

—*Empowering Early Career Researchers.* Fred Hutch is inspiring the next generation of researchers who will work at the frontiers of life sciences. The center invests $2 million annually on science education programs ranging from internship opportunities for high school and college students, to development resources and mentorship for graduate students, postdoctoral fellows and early career faculty. The COVID–19 pandemic had an acute impact on these early career researchers, and it revealed the need for a well-trained, motivated scientific workforce. Ongoing investment in the NIH improves the quality and cultural proficiency of science by increasing access to scientific research and prepares young scientists to become tomorrow's leaders.

The federal government has an irreplaceable role in supporting biomedical research. No other public, corporate or charitable entity is willing or able to provide the broad and sustained funding for cutting-edge research that catalyzes innovative breakthroughs. The partnership between NIH and America's research institutions and scientists is highly productive.

As an independent research institute (IRI) with a mission to eliminate cancer and related diseases, Fred Hutch depends on NIH funding to conduct basic, translational, clinical, public health and infectious disease research, and to respond quickly to the research needs of the country. In addition to supporting robust funding, Fred Hutch opposes provisions—such as directives to reduce salary support for extramural researchers—which would harm the appeal of academic research and disproportionately affect IRIs. Policies to cut salary support undermine Fred Hutch's ability to recruit and retain the talented researchers who keep U.S. institutions at the vanguard of biomedical sciences.

Robust increases to the NIH budget do more than bolster important research programs; it secures the future of science. Budget increases enable initiatives that reduce barriers to academia, provides training and education for young scientists starting independent careers and encourages culturally inclusive research. Fred Hutch supports these initiatives and principles and is applying them to its own workplace and research pursuits.

Fred Hutch thanks the Labor-HHS Subcommittee for its leadership and dedication to ensuring the health of the nation and your unwavering support for NIH funding in FY 2022. We appreciate the opportunity to urge the Subcommittee to provide at least $46.1 billion in FY 2022 for NIH. Advances in bioscience, technology and data science have given the life sciences tremendous momentum. This is not a time to pull back. Given the abundance of scientific opportunity, this recommendation represents a minimum investment to sustain progress that would be amplified through an even more robust commitment.

[This statement was submitted by Thomas J. Lynch Jr., MD, President and Director, Fred Hutchinson Cancer Research Center.]

PREPARED STATEMENT OF THE FRED HUTCHINSON CANCER RESEARCH CENTER

Dear Senator Murray,

I am writing in support of the FY 2022 budget request for the Department of Health and Human Services (DHHS) to develop a strategic plan and national strategy for herpes simplex virus requested by Herpes Cure Advocacy, an international patient-oriented nonprofit group dedicated to alleviate the morbidity and mortality from herpes simplex virus type-1 & type 2 (HSV–1 & HSV–2). While HSV as an infectious disease is more than worthy of a public health research effort to develop

vaccines and curative therapies, recent work has suggested HSV may also be a major player in Alzheimer's disease. Specifically, the strategic plan and national strategy will request $2.5 billion from the NIH and CDC over the next 3 years to address the immediate and critical need for research into prevention, treatment and cure options to end this silent pandemic of herpes simplex infections in our country.

I have been an advocate and investigator on herpesviruses for over 40 years, having founded the first patient advocacy group for genital herpes (THE HELPER). Over 400 million new cases of genital herpes occur each year. The disease is underappreciated due to its asymptomatic spread, and in the normal host, HSV–2 mucosal ulcerations are normally self-limited. However, systemic complications such as recurrent meningitis, hepatitis, and pneumonitis occur during acquisition or reactivation of infection, particularly among patients with poor T-cell immunity due to AIDS, organ transplantation or chemotherapy. The major complication of HSV worldwide is it increases the risk of HIV acquisition 3–4 fold. The HIV prevention literature indicates that 40% of HIV acquisitions are HSV-related; thus, 420,000 of the 1.2 million new HIV cases yearly.

Recent epidemiological observations suggest many causes of Alzheimer's disease are HSV–1-related. This is a plausible hypothesis as HSV resides in the brain and the concept is that its presence spreads the development of the protein plaques associated with Alzheimer's. There are suggestions that treating HSV early may slow progression of Alzheimer's. Better research is needed to define this and see if novel therapies can be developed. The first antiviral drug—acyclovir—invented by Dr. Gertrude Elion, one of the first women scientists to receive a Nobel Prize, was developed in the early 1980s. I was lucky enough to be a disciple of Dr. Elion and did the first studies of the drug for genital herpes. It paved the way for HIV drugs, yet it's 40 years later and we have the tools to make better drugs and, more importantly, vaccines; vaccines to provide a cure and vaccines to prevent HSV from being acquired. Imagine a vaccine that reduces HIV and Alzheimer's disease. This is possible by preventing HSV infection.

One thing the COVID–19 pandemic has done is brought the injustice and inequality of health care and resources for infectious diseases to light in a way not previously advertised. We are at a crossroads now with great levels of advocacy and the ability to make real change with new technologies to tackle these silent epidemics.

Sincerely.

[This statement was submitted by Lawrence Corey, MD, Past President and Director, Fred Hutchinson Cancer Research Center.]

PREPARED STATEMENT OF THE FRIENDS OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Friends of HRSA coalition is a nonpartisan coalition of nearly 170 national organizations representing tens of millions of public health and health care professionals, academicians and consumers invested in the Health Resources and Services Administration's mission to improve health outcomes and achieve health equity. We are pleased to submit our request of at least $9.2 billion for the Health Resources and Services Administration in FY 2022. We are grateful for the increases provided for HRSA programs in FY 2021 and for the emergency supplemental funding to battle the COVID–19 pandemic, but HRSA's discretionary budget authority is far too low to effectively address the nation's current public health and health care needs. We urge Congress to continue efforts to build upon these investments to strengthen all of HRSA's programs.

HRSA's 90-plus programs and more than 3,000 grantees support tens of millions of geographically isolated, economically or medically vulnerable people, in every state and U.S. territory, to achieve improved health outcomes by increasing access to quality health care and services; fostering a health care workforce able to address current and emerging needs; enhance population health and address health disparities through community partnerships; and promote transparency and accountability within the health care system. The agency is a national leader in improving the health of Americans by addressing the supply, distribution and diversity of health professionals and supporting training in contemporary practices, and providing high-quality health services to populations who may otherwise not have access to health care.

HRSA programs work in coordination with each other to maximize resources and leverage efficiencies. For example, Area Health Education Centers, a health professions training program, was originally authorized at the same time as the National Health Service Corps to increase the number of primary care providers at health

centers and other direct providers of health care services for underserved areas and populations. AHECs play an integral role to recruit providers into primary health careers, diversify the workforce and develop a passion for service to the underserved among future providers.

HRSA's programs also work in collaboration across the federal government to enhance health outcomes. For example, HRSA's HIV/AIDS Bureau partners with the Office of the Assistant Secretary for Health, the Centers for Disease Control and Preventions, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, the Indian Health Services, the National Institutes of Health, the Agency for Healthcare Research and Quality, the Department of House and Urban Development, the Department of Veterans Affairs and the Department of Justice to ensure an effective use of resources, and a coordinated and focused public health response to the HIV epidemic. This federal response has contributed to the number of annual diagnosed HIV infections dropping 7 percent between 2014 and 2018, with HRSA's Ryan White HIV/AIDS Program serving as the foundation for delivering health care and support services to reach the public health goal of ending the HIV epidemic. Despite this success, an estimated 1.2 million people in the U.S. are living with HIV today, and approximately 36,400 become newly infected every year—1 in 7 of whom are unaware of their infection. HRSA programs will play an integral role in achieving the public health goal of ending the HIV epidemic.

HRSA grantees also play an active role in addressing emerging health challenges. For example, HRSA's grantees provide outreach, education, prevention, screening and treatment services for populations affected by health emergencies such as the opioid epidemic. However, much of this work required additional funding to increase capacity in health centers, support National Health Service Corps providers to deliver relevant care and expand rural health services. Strong, sustained funding would allow HRSA to quickly and effectively respond to emerging and unanticipated future health needs across the U.S., while continuing to address persistent health challenges.

HRSA programs and grantees are providing innovative and successful solutions to some of the nation's greatest health care challenges including the rise in maternal mortality, the severe shortage of health professionals, the high cost of health care, and behavioral health issues related to substance use disorder—including opioid misuse. We recommend Congress build upon the important increases they provided for HRSA programs in FY 2021 and provide at least $9.2 billion for HRSA's total discretionary budget authority in FY 2022. Additional funding will allow HRSA to pave the way for new achievements and continue supporting critical HRSA programs, including:

—Primary care programs support nearly 13,000 health center sites in every state and territory, improving access to preventive and primary care for nearly 30 million people in geographic areas with few health care providers. Health centers coordinate a full spectrum of health services including medical, dental, vision, behavioral and social services in the nation's most underserved communities. Health centers reach 1 in 3 people living at or below the federal poverty line; 1 in 5 rural residents; 1 in 4 uninsured persons; and 1 in 8 children.

—Health workforce programs at HRSA support the entire training continuum by strengthening the workforce and connecting skilled professionals to communities in need. Programs such as the Public Health Training Centers assess and respond to critical workforce needs through training, technical assistance and student support.

—Maternal and child health programs, including the Title V Maternal and Child Health Block Grant, Healthy Start and others, support initiatives designed to promote optimal health, reduce disparities, combat infant and maternal mortality, prevent chronic conditions and improve access to quality health care for mothers and babies. MCH programs help assure that nearly all babies born in the U.S. are screened for a range of serious genetic or metabolic diseases, and that coordinated long-term follow-up is available for babies with a positive screen. They also help improve early identification and coordination of care for children with sensory disorders, autism and other developmental disabilities. The MCH Block Grants funded 59 states and jurisdictions to provide health care and public health services for an estimated 60 million people, reaching 92% of pregnant women, 98% of infants, and 60% of children nationwide.

—HIV/AIDS programs provide the largest source of federal discretionary funding assistance to states and communities most severely affected by HIV/AIDS. The Ryan White HIV/AIDS Program delivers comprehensive care, prescription drug assistance, and support services to more than 519,000 people impacted by HIV/AIDS. HRSA's Ryan White HIV/AIDS Program effectively engages clients in

comprehensive care and treatment, including increasing access to HIV medication, which has resulted in 88.1% of clients achieving viral suppression, compared to just 64.7% of all people living with HIV nationwide. Additionally, the program provides education and training for health professionals treating people with HIV/AIDS, and works toward addressing the disproportionate impact of HIV/AIDS on communities of color.

—Title X ensures access to a broad range of reproductive, sexual and related preventive health services for over 3.1 million women, men and adolescents, with priority given to low-income individuals. Services include patient education and counseling for family planning; provision of contraceptive methods; cervical and breast cancer screenings; sexually transmitted disease prevention education, testing and referral; and pregnancy diagnosis. This program helps improve maternal and child health outcomes and promotes healthy families.

—Rural health programs improve access to care for people living in rural areas. The Office of Rural Health Policy serves as the nation's primary advisor on rural policy issues, conducts and oversees research on rural health issues and administers grants to support health care delivery in rural communities. Rural health programs support community-based disease prevention and health promotion projects and expand health information technology and telehealth.

—Special programs include the Organ Procurement and Transplantation Network, the National Marrow Donor Program, the C.W. Bill Young Cell Transplantation Program and National Cord Blood Inventory. These programs facilitate organ marrow and cord blood donation, support transplantation and research and increase organ donation rates. The Poison Control Program oversees poison control centers which contribute to decreasing a patient's length of stay in a hospital and save the government $1.8 billion each year in medical costs and lost productivity.

—HRSA is well positioned to respond to infectious disease outbreaks and has been active in the COVID–19 pandemic response, awarding billions of dollars to health centers to administer COVID–19 tests and reimbursing providers who offer COVID–19 care to uninsured individuals.

To meet the many ongoing public health challenges facing the nation, including those outlined above, we urge you to support at least $9.2 billion for HRSA's programs in FY 2022.

[This statement was submitted by Jordan Wolfe, Manager of Government Relations, American Public Health Association.]

PREPARED STATEMENT OF THE FRIENDS OF THE INSTITUTE OF EDUCATION SCIENCES

Chair Murray, Ranking Member Blunt, and Members of the Subcommittee, thank you for the opportunity to submit written testimony on behalf of the Friends of IES, a consortium of scientific and professional societies, research universities, and independent research organizations committed to supporting the mission of IES and the use of research and statistics. We recommend $737.47 million for the Institute of Education Sciences (IES) in the FY 2022 Labor, Health and Human Services, and Education Appropriations bill. This request is aligned with the top line amount included for IES in the president's budget request.

IES is the independent and nonpartisan statistics, research, and evaluation arm of the U.S. Department of Education charged with supporting and disseminating rigorous scientific evidence on which to ground education policy and practice. As such, it serves as the critical federal source for funding groundbreaking research in myriad aspects of teaching and learning, as well as rigorous analysis of educational programs and initiatives. Throughout the pandemic, IES has sought to meet the demand for evidence-based resources to help facilitate remote instruction, address academic and socioemotional needs of students, and support teachers and school leaders in adapting to the ever-changing conditions resulting from the pandemic.

Its four centers-the National Center for Education Statistics (NCES), National Center for Education Research (NCER), National Center for Special Education Research (NCSER), and National Center for Education Evaluation (NCEE)-work collaboratively to efficiently and comprehensively deliver rigorous research and high-quality data and statistics to educators, parents, and policymakers.

Our member organizations rely on IES to support vital research that addresses many of the most important issues in our nation's schools. We are deeply thankful for the increases provided to IES in recent years to further invest in the education research and statistical infrastructure and to respond to the impact of COVID–19 on our most marginalized populations.

At the same time, IES remains constrained in its flexibility to fully fund emerging research areas and scale up promising interventions and resources. Only one of every ten grant proposals receives funding support, limiting the ability of IES to tackle pressing questions in education, such as what can be done to support student learning in informal settings, address challenges facing rural districts, and improve literacy for adult learners. Additional investment in Research, Development, and Dissemination could support new high-risk, high-reward research with the potential for transforming education, along with funding research in foundational and emerging areas in education and supporting the synthesis of research findings for use by all education stakeholders.

The National Center for Education Statistics (NCES) is the primary federal entity dedicated to collecting data related to education and is the only principal statistical agency dedicated to this mission. NCES compiles and disseminates important, trustworthy, and scientifically valid data on the condition of education that is essential to policy, practice, and research being conducted across the nation. Most recently, NCES' pivoting and partnering with the Census Bureau and four other federal statistical agencies to get weekly estimates of the impact of COVID–19 is just one palpable example of its vital role. Sufficient funding for NCES can enhance the ability of NCES to develop and administer surveys, analyze data on timely education issues, and link administrative education data to health and employment data for evidence-based policymaking and to understand the broader context of outcomes.

NCES importantly provides the funding support and infrastructure for the Statewide Longitudinal Data Systems (SLDS), providing critical investment for states to link K–12, postsecondary, and workforce systems to gain a better understanding of education and workforce outcomes. IES is also promoting the research use of SLDS to measure the effects of interventions on long-term student outcomes. Additional resources for SLDS can support states in linking data across education and workforce systems.

In addition to the research supported by the National Center for Education Research, the Regional Educational Laboratories (RELs) conduct applied research that is directly relevant to state and district administrators, principals and teachers. RELs also ensure that research is shared widely through its deep dissemination networks. During the pandemic, the RELs have provided a wide range of evidence-based resources to guide teachers, school leaders, and state and local officials on COVID–19 response. This work is all driven by the state education agencies and other stakeholders in the regions. Additional funding is needed to research and support growing local and regional needs to respond to the impact of the pandemic on academic, social and emotional learning.

The National Center for Special Education Research (NCSER) is the only federal agency specifically designated to develop and provide evaluations for programs for students with disabilities. Research funded by NCSER has resulted in programs such as those that support youth with high functioning autism experiencing high levels of anxiety, individuals with Down syndrome learning to read, and students with learning disabilities studying to master math word problems. NCSER also provides special educators and administrators research-based resources that support the provision of a free appropriate public education and interventions to foster self-determination in students with disabilities as they transition into adulthood. COVID–19 has had a disproportionate impact on students with or at-risk of disabilities who have faced significant barriers to educational access over the past year. Although funding from the American Rescue Plan will support such research in an FY 2022 grant competition, NCSER will not hold a competition for non-pandemic-related research due to limited funding. With additional funding, NCSER could support data and evidence-based resources to guide teachers, administrators, and policymakers in state and local agencies.

Alongside the recommendation regarding the investment in IES, we encourage you to include language in the Program Administration line to allow for IES to hire additional staff. Understanding that the Department of Education approves hiring authority, IES can be more innovative and flexible in carrying out its mission and support emerging areas of research and statistical collection with additional staff. As one example, NCES staff have technical expertise but are also responsible for managing contracts for its surveys. Providing authority for NCES to hire more staff can allow the agency to fully discharge its responsibilities, including the integration of new forms of massive and fast data. To execute these functions effectively requires staff of adequate size.

To this end, we recommend that the Committee provide IES $737 million in FY 2022. As our country emerges from a year of the greatest national disruption our schools have ever seen, it is clear that there is a demand for evidence-based resources for our teachers, school leaders, students, and families to support learning

and instruction. A commitment at this level will enable IES to more fully support research that addresses the challenges of preparing young Americans to succeed in the knowledge-based economy that is not only upon us now, but also the key to future American prosperity.

[This statement was submitted by Felice J. Levine, Chair, Friends of the Institute of Education Sciences.]

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

I write on behalf of the Friends of NICHD, a coalition of more than 100 organizations representing patients, providers, scientists, and caregivers who are united in our support for ensuring the health and welfare of women, children, families, and people with disabilities through research funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and the National Institutes of Health (NIH). We urge the subcommittee to provide NICHD with no less than $1.7 billion in Fiscal Year (FY) 2022, an increase of $117 million over FY 2021. We also respectfully ask the subcommittee to maintain its commitment to increasing funding for the National Institutes of Health (NIH) by providing no less than $46.1 billion in FY 2022.

We are pleased to support the extraordinary achievements of NICHD in meeting the objectives of its biomedical, social, and behavioral research mission, including research on child development before and after birth; women's health throughout the life cycle; maternal, child, and family health; learning and language development; reproductive biology; population health; and medical rehabilitation. With these necessary resources, NICHD can ensure proportional growth to that of its counterpart institutes and build upon the initiatives we've listed below to provide new insights and solutions to benefit women, children, and families in your districts and states.

COVID–19: NICHD has played a key role in understanding the impact of the COVID–19 pandemic on the institute's populations, including pregnant and postpartum women, children and adolescents, people with intellectual and developmental disabilities, and people with physical disabilities and mobility impairments. This work includes intramural research studies, collaborations with other NIH institutes and centers, and major undertakings like the Gestational Research Assessments for COVID–19 (GRAVID) study and the Predicting Viral-Associated Inflammatory Disease Severity in Children with Laboratory Diagnostics and Artificial Intelligence (PreVAIL kIds) which are advancing our knowledge of understudied COVID–19 research questions. NICHD also continues to advocate for inclusion of its key populations in major trans-NIH programs like the Rapid Acceleration of Diagnostics (RADx) initiative.

Maternal Mortality: The Pregnancy and Perinatology Branch, through networks including the Maternal-Fetal Medicine Units (MFMU) Network, supports research to improve the health of women before, during and after pregnancy. Maternal mortality rates are at an unprecedented high in the United States and significant racial and ethnic disparities persist. Research to better understand the mechanisms of disparities, to include social determinants of health and genetic factors that adversely affect pregnancy outcomes, are vitally needed.

Data on Pediatric Enrollment in NIH Trials: NIH requires investigators to submit deidentified demographic data on study participants, including age at enrollment. It is important for NIH to analyze and publicly report on this data to ensure that all populations, including children, benefit from research. This data should be used proactively NIH-wide to address recruitment issues in ongoing studies in real time and to drive forward the inclusion of individuals across the lifespan, including children. NICHD should play a leading role in the implementation of this policy vis-á-vis age.

Infant and Childhood Health: Through the Best Pharmaceuticals for Children Act (BPCA), NICHD funds the study of old, off-patent drugs important to children but inadequately studied in pediatric populations. We urge continued funding for this research and for training the next generation of pediatric clinical investigators. We also strongly support NICHD's ongoing research into the causes and prevention strategies for the major causes of death in infancy and childhood, including sudden unexpected infant death, accidents, and suicide.

Behavioral Health Research: NICHD supports a range of research on child development and behavior and has made great progress developing sophisticated tools to measure children's cognitive, emotional, and social functioning. To build on these successes, we encourage more integrated behavioral and biobehavioral work on child

developmental trajectories, across infancy, childhood, and adolescence, in both normative and at-risk environments, across diverse contexts (school, home, and community) and including underrepresented and vulnerable groups. More research is also needed on integrated behavioral health in primary care settings, including cost effectiveness comparisons, and the impact of behavioral interventions on mental health, physical health, and quality of life. Child health would also benefit from additional work on the role of technology to support optimal development in children, including those with disabilities, and increased access to and engagement with effective psychological and behavioral interventions for childhood conditions.

Poverty and Child Health: Poverty can be especially detrimental in childhood and adolescence, leading to adverse impacts on physical health, mental health, social well-being, cognitive and emotional development, and the acquisition of motor and language skills. NICHD is in the unique position to examine the biological, psychological, social, cultural, and environmental factors that impact the developing child in high-poverty environments—including challenges due to chronic stress, neighborhood safety, school environments, family health status, education, job instability, unstable family structures, and substandard living conditions—and to evaluate interventions aimed at improving the developmental trajectories of these children.

Reproductive Sciences: Research on the basic biological mechanisms of reproduction is a crucial foundation for all NICHD's work. Understanding reproductive biology and associated biological phenomena provides the foundation for innovative medical therapies and technologies and improves existing treatment options for gynecologic conditions. Often, this research focuses on serious conditions that are overlooked and underfunded, even though they impact many women. Future work could address infertility and the need for treatments for endometriosis, polycystic ovarian syndrome (PCOS) and uterine fibroids.

Pelvic Floor Disorders Network (PFDN): Female pelvic floor disorders represent a major public health burden with high prevalence, impaired quality of life and substantial economic costs affecting 25% of American women. The PFDN conducts research to improve treatment of these painful gynecological conditions. Current research aims to improve female urinary incontinence outcome measures and ensure high-quality outcomes.

PregSource: NICHD's PregSource™ Initiative enables pregnant women to track their health data from gestation to early infancy and access evidence-based information about healthy pregnancies. It will also allow researchers to utilize aggregated data and potentially recruit participants for clinical trials so that knowledge gaps can be eliminated and care for pregnant and post-partum women can be improved.

Task Force Specific to Research in Pregnant Women and Lactating Women (PRGLAC): We urge Congress to continue its strong support of the NICHD-led PRGLAC Task Force, and to support the recommendations contained in the report to achieve broader inclusion of pregnant and lactating women in research and expansion of the workforce of clinicians and researchers with expertise in obstetric and lactation pharmacology and therapeutics, so that lifesaving treatments for this population are known to be safe and effective.

NIH Pediatric Research Consortium (N-PeRC): N-PeRC is an NICHD-led, trans-NIH initiative that aims to harmonize pediatric research and training activities across the NIH. N-PeRC capitalizes on pediatric expertise at the NIH by enabling collaboration to explore gaps in the overall pediatric research portfolio and share best practices to advance science. N-PeRC has played a vital role throughout the COVID–19 pandemic in identifying key child and adolescent research needs related to SARS–CoV–2.

Human Development, Infancy Through Adulthood: NICHD supports research on infant-through-adult development, including how father-child relationships and co-parenting positively impacts children's socio-emotional development and decreases behavior problems; children's adjustment after the birth of a sibling; pathways and outcomes associated with mothers' postseparation co-parenting relationships, with a particular focus on experiences of intimate partner violence and negative outcomes; and the health and well-being across three generations of lesbians, gay men, and bisexuals.

Intellectual and Developmental Disabilities Research Centers (IDDRC): The IDDRCs are a critical national resource for basic research into the genetic and biological basis of human brain development, greatly improving our understanding of the causes of developmental disabilities and contributing to the development and implementation of evidence-based practices by evaluating the effectiveness of biological, biochemical, and behavioral interventions. These centers have contributed to new treatments for genetic disorders through the study of intellectual and developmental disabilities, such as Everolimus for epilepsy in TSC. We must build on progress in the understanding and treating this class of disorders that affect so

many. We urge resources and support for the IDDRCs for research infrastructure and expansion to conduct basic and translational research to develop effective prevention, treatment and intervention strategies for children and adults with developmental disabilities.

Preterm Birth: NICHD supports a comprehensive research program on the causes, prevention and treatment of preterm birth, the leading cause of infant mortality and intellectual and physical disabilities. Research shows the survival rate and neurological outcomes may be improving for very early preterm infants, but continued prioritization is needed through extramural preterm birth prevention research, the MFMU Network, the Neonatal Research Network, and intramural research program. Robust funding is needed for research to determine the complex interaction of behavioral, social, environmental, genetic, and biological influences on preterm birth with the goal of developing the interventions necessary to decrease prematurity.

Population Dynamics: The NICHD Population Dynamics Branch supports research on how population change affects the health, development, and well-being of children and their families. Longitudinal surveys, such as the Fragile Families and Child Wellbeing Study, have demonstrated the role that family stability and parental involvement play in the long-term health and development of children, facilitating tremendous progress in the population sciences. NICHD also supports the Population Dynamics Centers Research Infrastructure Program, which supports research and research training in demographic or population research. These centers focus on research such as family demography and intergenerational relationships; education, work, and inequality; population health; and reproductive health.

Male Infertility: Male infertility is another relevant area of inquiry that would benefit from NICHD-sponsored research. For instance, the biological mechanisms associated with common causes of male infertility, such as varicoceles, remain poorly understood. These research domains represent important opportunities to develop better treatments for male infertility.

[This statement was submitted by KJ Hertz, 2021 Chair, Friends of the National Institute of Child Health and Human Development.]

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

On behalf of the 35 patient, physician, and research organizations that are members of the Friends of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), we want first to thank you for your ongoing bipartisan investment in the National Institutes of Health (NIH). We ask you to support our FY 2022 NIH funding recommendation of at least $46.111 billion, a $3.177 billion increase over the comparable FY 2021 funding level for the NIH, which would allow for the NIH's base budget to keep pace with the biomedical research and development price index of 2.3% and allow meaningful growth of 5%. We also request a proportionate increase for the NIDDK of at least $157 million for a total of $2.289 billion in FY 2022. This level of increase over its FY 2021 funding is necessary for NIDDK to fulfill its mission to conduct and support medical research, research training, and to disseminate science-based information on diabetes and other endocrine and metabolic diseases; digestive diseases, nutritional disorders, and obesity; and kidney, urologic, and hematologic diseases and to support the Institute's multi-pronged efforts toward the goal of health equity. We also strongly encourage you to provide supplemental emergency funding of $10 billion for NIH, ensure dedicated support for the NIDDK to enable critical COVID-related research, and support research recovery from the impact of the pandemic.

NIDDK supports and conducts research to combat a portfolio of diseases that encompass some of the most chronic, common, consequential, and costly diseases and conditions affecting people in this country. Many of these diseases and disorders are also associated with health disparities. These disparities are exacerbated by the COVID–19 pandemic, with increased rates of infection and poor outcomes from COVID–19 seen in people with these same conditions.

We want to share just a few NIDDK-supported research highlights to demonstrate the great impact and promise of NIDDK research to improve people's health and quality of life (more thorough descriptions are in NIDDK's Recent Advances & Emerging Opportunities):

—Research on an immune-targeting drug has delayed type 1 diabetes progression in high-risk individuals for at least 3 years. This is the first time ever that early preventive therapy was found to delay onset of clinical type 1 diabetes.

—Research defining subgroups of people with chronic kidney disease is paving the way for kidney precision medicine.
—Adult and pediatric studies are testing potential therapies and uncovering genetic and racial/ethnic risk factors for nonalcoholic fatty liver disease and nonalcoholic steatohepatitis.
—The Intestinal Stem Cell Consortium is studying intestinal stem cells' roles in intestinal health and disease, aiming to identify and develop novel therapies to regenerate the human intestine.
—The NIDDK sponsored Symptoms of Lower Urinary Tract Dysfunction Research Network (LURN) is working to improve the lives of patients affected by lower urinary tract dysfunction (LUTD) through overcoming barriers to diagnosis and treatment.
—Innovative research by NIDDK scientists showed the potential importance of speech-generated droplets in SARS–CoV–2 transmission.
—NIDDK research has led to better treatments such as new drugs that can dramatically reduce disease burden for many with cystic fibrosis; increased understanding and treatment of inflammatory bowel diseases such as Crohn's disease and ulcerative colitis; and to new Type 2 diabetes drugs that provide cardiovascular health benefits in people with diabetes.

Our organizations are grateful for the funding that you have provided to the NIH and the NIDDK as part of the appropriations process and the support Congress has given to the NIH, including several of its institutes and centers, to respond to the public health emergency. However, we note that NIDDK's FY 2021 appropriation was proportionally less than other Institutes and NIDDK and has not received any emergency funding despite researching diseases that are associated with increased risk of severe COVID–19 outcomes and are themselves public health crises.

As health professionals and researchers continue to respond to this pandemic, our understanding of COVID–19 continues to evolve. What we originally understood to be an infectious, respiratory virus, we now know disproportionately impacts individuals with diabetes, obesity, liver diseases and kidney diseases. COVID–19 infection damages a variety of organ systems, including the kidneys and it may even contribute to new onset of kidney failure and diabetes. Patients also are experiencing hematologic complications, including issues related to coagulation and blood cell production. Yet, without additional funding, NIDDK will be forced to continue to divert crucial funds from its existing priorities to better understand these characteristics of COVID–19, a loss to the patients who ultimately benefit from research funded by NIDDK.

With emergency supplemental funding, NIDDK will be able to support research on SARS–CoV–2/COVID–19 as it intersects with and affects people with or at risk for diabetes and other metabolic diseases, obesity, and endocrine, digestive, hepatobiliary, pancreas, kidney, urological and hematologic diseases. Specific areas of research include: determining the basis for the link between COVID–19 severity and diseases in the NIDDK's portfolio; identifying novel pathogenic pathways and potential translational targets for the treatment or prevention of kidney, gastrointestinal, and endocrine/metabolic diseases associated with SARS–CoV–2 infection; and understanding the roles of health disparities associated with SARS–CoV–2 infection, organ injury, and adverse disease outcomes.

Further, the occurrence of Post-Acute Sequelae of SARS–CoV–2 infection (PASC), in which individuals experience persistent symptoms involving multiple body systems after recovering from their initial illness, shows that while new infections with SARS–CoV–2 have decreased in the US, our understanding of the long-term consequences of COVID–19 is far from over and creates another important and emerging research opportunity.

In addition to new areas of research, the pandemic has created additional barriers and expenses that complicate restarting research. Supplemental funds are needed to:

—Restart research projects, programs, and clinical trials that were underway before the onset of the pandemic and were stopped or delayed for safety reasons, consequently stalling or delaying new discoveries.
—Support early-stage investigators as they face uncertainties and challenges in making progress in their careers, especially women investigators and others who are disproportionately affected by caregiving roles during the pandemic and members of groups underrepresented in research.
—Provide financial support so that critical research support staff can be retained and to accelerate the eventual resumption of research activities post-pandemic.
—Address increasing research costs. The burden of restarting clinical trials, animal colonies, and other programs and resources has made conducting research more challenging and expensive during the pandemic. Costs for personal protec-

tive equipment (PPE), comprehensive cleaning, and "time sharing" in laboratories are a few examples.

All of this leads to a simply put yet challenging goal: While addressing the immediate challenges of COVID–19, we also need to continue to combat the diseases within NIDDK's mission, which will continue to place an enormous personal and financial toll on this country long after the pandemic is over. Bolstering support for NIDDK will help ensure that critical research in these areas continues and will support the institute's commitment to understanding the roles of social determinants of health and health disparities with the goal of improving health for all. Our nation's progress against COVID–19—and every other health threat—is built on the longstanding bipartisan commitment to medical research. Preserving that investment will be key to continued advances. We urge you to support the NIH with a $3.1 billion increase for FY 2022 with a proportionate increase of $157 million for NIDDK and provide emergency supplemental funds for NIH, including dedicated support for the NIDDK, to ensure we lead the world in providing new and better cures, diagnostics, and treatments while protecting all patients and the research enterprise.

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE OF MENTAL HEALTH

Chair Murray, Ranking Member Blunt, and Members of the Subcommittee:

I write on behalf of the Friends of NIMH, a newly formed coalition of more than 30 organizations representing scientists, physicians, health care providers, individuals, families, and communities. The members of the Friends of NIMH are dedicated to supporting the mission of the National Institute of Mental Health (NIMH) to transform the understanding of mental health and the treatment of mental illnesses through basic biomedical, behavioral, and clinical research, to best inform prevention, early intervention, recovery, and cures. We write to encourage you to provide robust funding for NIMH in FY 2022 so that the institute can build upon the significant achievements to advance the behavioral, biomedical, and social research mission and important initiatives to provide new insights and solutions to benefit your constituents. Our member organizations represent communities with interest across the National Institutes of Health (NIH). Individually and collectively, our members also belong to the Ad Hoc Group for Medical Research, a coalition of over 330 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry that support enhancing the federal investment in the behavioral and biomedical research conducted and supported by the NIH. Aligned with the Ad Hoc request, we respectfully request that the subcommittee provide at least $46.1 billion for the agency in Fiscal Year (FY) 2022, $3.2 billion above the final FY21 funding level.

Thank you for considering this request.

The Friends of NIMH Executive Committee:

Juliane Baron
Federation of Associations in Behavioral and Brain Sciences

Diana E. Clarke
American Psychiatric Association

Brian Hepburn
National Association of State Mental Health Program Directors

Pat Kobor
American Psychological Association

Theresa Nguyen
Mental Health America

Anna Platt
Research!America

Andrew Sperling
National Alliance on Mental Illness

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE ON AGING

On behalf of the Friends of the National Institute on Aging (FoNIA), we are grateful for your leadership in advancing the mission of National Institutes of Health (NIH), and the research supported and conducted by the National Institute on Aging

(NIA). FoNIA is a coalition of more than 50 academic, patient-centered and nonprofit organizations supporting NIA's mission to understand the nature of aging and the aging process, and diseases and conditions associated with growing older in order to extend the healthy, active years of life.

We are writing to request that federal resources continue to be dedicated to sustaining and enhancing timely and promising aging research at NIA and across NIH.

Specifically, FoNIA requests:

—No less than $46.1 billion—a $3.3 billion increase—in fiscal year (FY) 2022 for total spending at NIH for current institutes and operations, including funds from the 21st Century Cures Act for targeted initiatives which corresponds with the overall recommendation of the Ad Hoc Group for Medical Research.

—An increase of least $500 million specifically dedicated to support cross-Institute aging research at the NIH, including but not limited to biomedical, behavioral and social sciences aging research. This increase must be separate from whatever funds are allocated to the Advanced Research Projects Agency for Health (ARPA–H) at NIH. Investment in ARPA–H should not come at the cost of the existing NIH institutes and centers conducting and supporting research on aging.

—A minimum increase of $289 million specific to research on Alzheimer's disease and related dementias (ADRD). NIA is the primary federal agency supporting and conducting Alzheimer's disease and related dementias research.

FoNIA understands that during this time, Congress is working hard to stem fallout of both the human and fiscal toll of COVID. In this rapidly evolving crisis, NIH/NIA has played an extremely vital role in examining how COVID impacts older adults, why they may be more susceptible to the virus, how they can be protected, and the social and economic effects of the pandemic on older adults.

NIA sponsors and conducts the lion's share of federal aging-related research, and this pioneering science contributes significantly to the improved care and quality of life of older adults. A key NIA priority is translating research into better and more efficient care through the development of effective interventions that are disseminated to health care providers, patients, and caregivers. These interventions for the prevention, early detection, diagnosis, and treatment of disease will help reduce the burden of illness for older adults and reduce the cost of care.

NIA's COVID response has been wide and varied. NIA has been heavily involved in the work of the Rapid Acceleration of Diagnosis (RADx) program designed to speed innovation in the development, commercialization, and implementation of technologies for COVID testing. NIA is especially active in the RADx Underserved Populations (RADx-UP) program, which strives to understand the factors associated with disparities in COVID morbidity and mortality.

In the area of dementia, NIA supports vital research where more scientific investigation is needed to improve AD/ADRD prevention, diagnosis, treatment and care; basic science approaches to illuminate neurodegenerative mechanisms/pathways; and computational/biological systems approaches to identify, model and predict the architecture and dynamics of the molecular interactions underlying AD/ADRD pathogenesis.

NIH's Brain Research through Advancing Innovative Technologies (BRAIN) Initiative works to develop a dynamic picture of how neurons act, both individually and together in circuits. The initiative revolutionizes our understanding of the human brain and provides insight into how to treat, prevent and cure brain disorders. In addition to NIH, this public-private partnership involves other federal agencies such as the National Science Foundation (NSF), Defense Advanced Research Projects Agency (DARPA), Intelligence Advanced Research Projects Activity (IARPA), the Food and Drug Administration (FDA) and the Department of Energy (DOE).

Lastly, NIH funding provides a vital economic boost to local economies. Most of NIH/NIA funding is distributed as grants to universities and other research institutions across the US, and acts as an economic engine and multiplier in local and regional communities. According to United for Medical Research, total FY 2020 NIH research spending of $34.65 billion supported more than 536,338 American jobs and generated nearly $91.35 billion in economic activity across the country.

Thanks to your support, NIH/NIA is continuing to accelerate scientific discoveries which will benefit us all as we age. Only through continued, and meaningful investments in NIH/NIA will it be possible to enhance the quality of care for older adults across the nation.

Thank you for your consideration of this funding request. Should you need additional information, feel free to contact me at esokol@alzfdn.org.

Sincerely.

[This statement was submitted by Eric W. Sokol, Chair, Friends of the National Institute on Aging.]

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE ON DRUG ABUSE

Thank you for the opportunity to submit testimony in support of the National Institute on Drug Abuse (NIDA). The Friends of the National Institute on Drug Abuse is a coalition working with about 150 scholarly organizations with a total membership of at least 2 million scholars, clinicians and educators who are committed to eliminating substance use disorders in society. We coordinate the opinions of the participating organizations, who also actively participate on their own to provide important information to policy makers to make decisions that will lead to the elimination of this disease which now is killing so many of our citizens. For example, former research which led to the creation of drugs such as naloxone and buprenorphine has provided important mechanisms which have prevented the death rate from being even much higher. We need more research in all areas of basic and clinical science to make additional advances.

In the Fiscal Year 2022 Labor, Health and Human Services Appropriations bill we request that the subcommittee include the President's requested level of $51 billion for the National Institutes of Health (NIH), including no less than $46.1 billion for NIH's base program level budget. In addition, we greatly appreciate the President Budget's recognition of the need to significantly increase our nation's investment in the National Institute on Drug Abuse (NIDA) and its response to the opioid epidemic. The President's Fiscal 2022 Budget recommends a $372.2 million increase in NIDA's budget, a 25 percent increase. We strongly encourage the Subcommittee to include the President's recommended funding level of $1.852 billion for NIDA in the Senate version of the Fiscal Year 2022 Labor, Health and Human Services Appropriations bill.

We also respectfully request the inclusion of the following NIDA specific report language.

Opioid Initiative. The Committee continues to be concerned about the opioid overdose epidemic and appreciates the important role that research plays in the various federal initiatives aimed at this crisis. The Committee is also aware of the most recent data from the Centers for Disease Control and Prevention that shows opioid overdose fatalities increasing from 2018 to 2019, with the primary driver being the increased overdose deaths involving synthetic opioids, primarily illicitly manufactured fentanyls. To combat this crisis the Committee has provided within NIDA's budget no less than $270,295,000 for the Institute's share of the HEAL Initiative and in response to rising rates of stimulant use and overdose, the Committee has included language expanding the allowable use of these funds to include research related to stimulant use and addiction.

Methamphetamine and Other Stimulants. The Committee is concerned that, according to data released by the Centers for Disease Control and Prevention, 32,000 overdose deaths involved drugs in the drug categories that include methamphetamine and cocaine in 2019, an increase of over 700%. The sharp increase has led some to refer to stimulant overdoses as the "fourth wave" of the current drug addiction crisis in America following the rise of opioid-related deaths involving prescription opioids, heroin, and fentanyl-related substances. Methamphetamine is highly addictive and there are no FDA-approved treatments for methamphetamine and other stimulant use disorders. The Committee continues to support NIDA's efforts to address the opioid crisis, has provided continued funding for the HEAL Initiative, and supports NIDA's efforts to combat the growing problem of methamphetamine and other stimulant use and related deaths.

Barriers to Research. The Committee is concerned that restrictions associated with Schedule I of the Controlled Substance Act which effectively limits the amount and type of research that can be conducted on certain Schedule I drugs, especially opioids, marijuana or its component chemicals and new synthetic drugs and analogs. At a time when we need as much information as possible about these drugs and antidotes for their harmful effects, we should be lowering regulatory and other barriers to conducting this research. The Committee appreciates NIDA's completion of a report on the barriers to research that result from the classification of drugs and compounds as Schedule I substances including the challenges researchers face as a result of limited access to sources of marijuana including dispensary products.

COVID Pandemic and Impact on Substance Use Disorders. The Committee is acutely aware of the risks that the ongoing COVID–19 pandemic poses to individuals with substance use disorders. According to the Centers for Disease Control and

Prevention, drug overdose deaths accelerated during the pandemic which saw over 81,000 drug overdose deaths in the United States in the 12 months ending in May 2020, the highest number of overdose deaths ever recorded in a 12-month period. Moreover, research supported by the National Institute on Drug Abuse found that individuals with substance use disorders are at increased risk for COVID–19 and its more adverse outcomes. The Committee commends NIDA for conducting research on the adverse impact of the pandemic on SUDs and encourages the Institute to expand its research on these issues.

Raising Awareness and Engaging the Medical Community in Drug Abuse and Addiction Prevention and Treatment. Education is a critical component of any effort to curb drug use and addiction, and it must target every segment of society, including healthcare providers (doctors, nurses, dentists, and pharmacists), patients, and families. Medical professionals must be in the forefront of efforts to curb the opioid crisis. The Committee continues to be pleased with the NIDAMED initiative, targeting physicians-in-training, including medical students and resident physicians in primary care specialties (e.g., internal medicine, family practice, and pediatrics). NIDA should continue its efforts in this area, providing physicians and other medical professionals with the tools and skills needed to incorporate substance use and misuse screening and treatment into their clinical practices. The Committee recommends that NIDA increase its support for the education of scientists and practitioners to find improved prevention and treatments for substance use disorders as the Institute has done for the COVID–19 pandemic.

Marijuana Research. The Committee is concerned that marijuana policies on the federal level and in the states (medical marijuana, recreational use, etc.) are being changed without the benefit of scientific research to help guide those decisions. NIDA is encouraged to continue supporting a full range of research on the health effects of marijuana and its components, including research to understand how marijuana policies affect public health.

Electronic Cigarettes. The Committee understands that electronic cigarettes (e-cigarettes) and other vaporizing equipment are increasingly popular among adolescents, and requests that NIDA continue to fund research on the use and consequences of these devices.

In addition, we request the following report language within the Office of the Director account:

> *The HEALthy Brain and Child Development (HBCD) Study.* The Committee recognizes and supports the NIH HEALthy Brain and Child Development Study, which will establish a large cohort of pregnant women from regions of the country significantly affected by the opioid crisis and follow them and their children for at least 10 years. This knowledge will be critical to help predict and prevent some of the impacts of pre- and postnatal exposure to drugs or adverse environments, including risk for future substance abuse, mental disorders, and other behavioral and developmental problems. The Committee recognizes that the HBCD Study is supported in part by the NIH HEAL Initiative, and NIH Institutes, Centers, and Offices (ICOs), including OBSSR, ORWH, NIMHD, NIBIB, NIMHD, NIEHS, NICHD, NINDS, NIAAA, NIMH, and NIDA, and encourages other NIH ICOs to support this important study.

Substance use disorders (SUD) are costly to Americans; it ruins lives, while tearing at the fabric of our society and taking a financial toll on our resources. Over the past three decades, NIDA-supported research has revolutionized our understanding of SUD as a chronic, often-relapsing brain disease -this new knowledge has helped to correctly emphasize the fact that SUD is a serious public health issue that demands strategic solutions.

NIDA supports a comprehensive research portfolio that spans the continuum of basic neuroscience, behavior and genetics research through medications development and applied health services research and epidemiology. While supporting research on the positive effects of evidence-based prevention and treatment approaches, NIDA also recognizes the need to keep pace with emerging problems. We have seen encouraging trends in strategies to address these problems, but areas of continuing significant concern include the recent increase in fatalities due to heroin and synthetic fentanyl, as well as continued illicit use of prescription opioids. Our knowledge of how drugs work in the brain, their health consequences, how to treat people with SUDs, and what constitutes effective prevention strategies has increased dramatically due to research. However, because the number of individuals who are affected is still rising, we need to continue the work until this disease is both prevented and eliminated from society.

We understand that the FY2022 budget cycle will involve setting priorities and accepting compromise, however, in the current climate we believe a focus on sub-

stance use disorders deserves to be prioritized accordingly. Thank you for your support for the National Institute on Drug Abuse.

PREPARED STATEMENT OF FSHD SOCIETY

Honorable Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, thank you for the opportunity to testify. We are requesting the FY2022 appropriation of an amount of $33 million for the agency U.S. DHHS National Institutes of Health (NIH) program on research specifically directed at facioscapulohumeral disease and facioscapulohumeral muscular dystrophy (hereafter called FSHD).

FSHD is a heritable disease and one of the most common neuromuscular disorders with a prevalence of 1:8,000.[1] It affects 934,000 children and adults of both sexes worldwide. FSHD is characterized by progressive loss of skeletal muscle strength that is asymmetric in pattern and widely variable. Muscle weakness typically starts at the face, shoulder girdle and upper arms, often progressing to the legs, torso and other muscles. In addition to affecting muscle it can bring with it respiratory failure and breathing issues,[62] mild-profound hearing loss, eye problems and cardiac bundle blockage and arrhythmias.[79] FSHD causes significant disability and death according the U.S. Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities, Atlanta, Georgia and others.[80,81]

FSHD is associated with epigenetic changes on the tip of human chromosome 4q35 in the D4Z4 DNA macrosatellite repeat array region leading to an inappropriate gain of expression (function) of the D4Z4-embedded double homeobox 4 (DUX4) gene.[2] DUX4 is a transcription factor that kick starts the embryonic genome during the 2- to 8-cell stage of development.[3 5] Ectopic expression of DUX4 in skeletal muscle is associated with the disease and the disease's pathophysiology that leads to muscle death. DUX4 is never expressed in 'healthy' muscle. FSHD has had few clinical trials,[6 10] and currently there is no cure or therapeutic option available to patients. DUX4 requires and needs to activate its direct transcriptional targets for DUX4-induced gene aberration and muscle toxicity.[11 24] The genetics of FSHD are so remarkable, that NIH Director Dr. Francis Collins said on the front page of the New York Times, "If we were thinking of a collection of the genome's greatest hits, this [FSHD] would go on the list."[78]

Blocking DUX4's DNA, DUX4's RNA or DUX4's protein ability to activate its targets has profound therapeutic relevance.[25] The FSHD scientific community has in recent years pioneered inroads to treating FSHD using the enormous potential of genomic sequencing, genomic medicine, gene editing and next generation diagnostics. Table 1 lists a dozen approaches detailed in thirty-eight proof-of-concept publications that molecular and genetic treatment approaches work in cellular and animal models for FSHD. All with the central paradigm of the reduction of: DUX4, DUX4 expression, DUX4 protein activity, or the effects of DUX4-mediated toxicity. Strategies include modulating DUX4 repressive pathways, targeting DUX4 mRNA, DUX4 protein, or cellular downstream effects of DUX4 expression. Simply unfathomable as to why NIH funding is this area is not increasing with the pace of discovery.

TABLE 1: Genetic Approaches with Potential to Treat FSHD

—Targeting the DUX4 gene itself by repression using CRISPR/dSaCas9 or CRISPR/dCas9–KRAB;
—Targeting and correcting the FSHD2 SMCHD1 gene mutation with CRISPR/Cas9;
—Knockdown and silencing of the DUX4 gene by going after DUX4 mRNA with antisense oligonucleotides and with RNA interference; U7-asDUX4 snRNAs;
—Targeting DUX4 protein expression using through DNA aptamers; proteins homologous to DUX4; and DNA decoys;
—Going after and controlling expression target downstream [post-expression] of DUX4;
—Going after genetic modifiers of DUX4 expression and DUX4-mediated toxicity between the DUX4 gene and DUX4 mRNA; G-quadruplexes (GQs); and
—Targeting proteins that perturb DUX4-mediated toxicity or secondary features of FSHD pathology.[26 63]

The clinical trials readiness priorities remain similar to last year's testimony. The FSHD scientific community has listed emphasis areas as: 1.) clinical trials readiness infrastructure and therapeutics; 2.) direct and surrogate biomarkers; 3.) genetic testing, genetics and epigenetics; 4.) imaging and outcome measures; and, 5.) registries

and patient focused and reported outcomes.[73] The way to measuring disease progression and the effectiveness and safety of drugs remains deep and hard-going for industry, clinical partners and patients.

Serendipitously, new NextGen genomic sequencing and diagnostic technologies, as well as gene-targeted therapeutic approaches have emerged that will be game changing for FSHD patients and families. Understanding one's disease or condition is key for both mental and physical health. This can also aid with family and life planning decisions. With certainty many barriers to matching FSHD disease severity to outcome measures would rapidly fall. We could better align drug and therapeutic modalities with proper phenotypic/genotypic silos of FSHD based on repeat unit, methylation ranges and other requisites for FSHD. The current testing approach in the US, albeit excellent, has created a drag on the momentum towards clinical trials. With therapies on the way, identifying asymptomatic carriers and those that will decades later have later onset or mild symptoms, will allow us to then halt the disease in its early formative stages.[64,66 69,72]

Recently in 2021, two excellent papers were published on FSHD and DUX4. Both were outstanding—one was using Oxford Nanopore long read sequencing of direct-RNA to locate DUX4 gene targets and the other was a careful study of DUX4 expression in its endogenous [native] form versus the more common recombinant [created] form used in the laboratory.[70,71] As I read, I asked myself of each: "does this tell us anything more about what DUX4's function is? No. How DUX4 works? Nada. Or how DUX4 causes FSHD pathophysiology? Nothing at all. How and if DUX4 itself is toxic to skeletal muscle? Zilch. If all research using FSHD transgenic cells an animals is simply result of an artifact? Not sure now." Both papers yield the same thought: though DUX4 is the prime therapeutic target—we know next to nothing about it. It is still a complete black box; yet the central focus for FSHD therapy. Questions and areas of research interest emerge from these publications and allied considerations; flowing fast—each one hypothesis worthy of several NIH grants. "Is DUX4 cytotoxicity pathogenic in vivo? How does expression of DUX4 lead to muscle loss? What is the role of non-muscle cells in FSHD pathology? Can muscle pathology be stopped once it has started (as visualized via MRI images) or is it too late? How is DUX4 bursting regulated in vivo? What other cell types express DUX4 in FSHD and/or healthy individuals? Does the DUX4 mRNA play a nuclear role in FSHD? Are there noncoding RNA roles for DUX4? Are DUX4 induced protein aggregates cause or consequence for FSHD? Does autoimmunity play a role in FSHD? Are there other DUX4-dependent therapeutic targets?" NIH should certainly encourage proposals here. New data/information generated on the basic mechanism of DUX4 and how it causes muscle disease has the potential to focus the design of future clinical trials on muscles and measurements that will increase the rigor of the design and decrease the number of individuals necessary for initial tests of drug activity. It is absolutely necessary to increase our resolution, clarity and understanding of what DUX4 is and what it does to muscle in FSHD. The gains in this area will effectively unpin or untether FSHD from the difficulty category of "slowly progressing neuromuscular diseases remaining recalcitrant" to timely ascertainment that a clinical intervention can work.

Your Subcommittee and Congress in partnership with NIH, patients and scientists have made truly outstanding progress in understanding and treating the nine major types of muscular dystrophy through the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 (MD–CARE Act, Public Law 107–84). Since passing the MD CARE Act in 2001, NIH funding for FSHD has not kept up pace with scientific opportunities listed herein. The NIH is the principal worldwide source of funding of research on FSHD. Currently active projects are $16.554 million FY2022 (current actual 23June2021), a 21% portion of the estimated $80 million spent on all muscular dystrophies. (source: NIH Research Portfolio Online Reporting Tools (RePORT) keyword 'FSHD or facioscapulohumeral or landouzy-dejerine').

FSHD RESEARCH DOLLARS & FSHD AS A PERCENTAGE OF TOTAL NIH MUSCULAR DYSTROPHY FUNDING

[Dollars in millions]

Fiscal Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
All MD ($ millions) ..	$83	$86	$75	$75	$76	$78	$77	$79	$81	$81	$83	$88e	$80e
FSHD ($ millions)	$5	$6	$6	$5	$5	$7	$8	$9	$11	$11	$10	$11e	$10e
FSHD (% total MD)	6%	7%	8%	7%	7%	9%	10%	11%	14%	14%	12%	13%	13%

Sources: NIH/OD Budget Office & NIH OCPL & NIH RePORT RCDC (e=estimate, a=actual)

We request for FY2022, a doubling of the NIH FSHD research portfolio to $33 million. At this moment in time, FSHD needs an infusion of NIH grants both submitted and funded. NIH needs to increase funding by adding exploratory/developmental research grants (parent R21) and research project grants (parent R01) in areas outlined by experts both in this testimony and in the 2015 DHHS NIH MD Plan.[77] NIH can issue targeted funding announcements covering FSHD. These efforts will help NIH receive more grant applications. This is NIH's wheelhouse and forte without a doubt.

Madam Chairman, this is my sixty-second testimony before the U.S. Congress' Appropriations Subcommittee on this matter. My FSHD is a strong fort; it has lasted my lifetime of fifty-nine years. That is a long time to live with a disease of this burden.[80] I hope with your help and action to be able to outlive my disease. I need your help, my friends and fellow FSHD patients and families need your help. Please implore NIH to double funding on FSHD and kindly remember that our lives matter. Madam Chairman, thank you again for your help and efforts.

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[This statement was submitted by Daniel Paul Perez, Co-Founder & Director Emeritus and past Chairman, President & Chief Executive Officer, Chief Scientific Officer, FSHD Society.]

PREPARED STATEMENT OF THE GBS|DCIDP Foundation International

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2022

—Provide $46.1 billion for the National Institutes of Health (NIH) and proportional increases across its Institutes and Centers
—Continue expanding GBS research supported by NIH with proportional funding increases for the National Institute of Neurological Disorders and Stroke (NINDS), and the National Institute of Allergy and Infectious Diseases (NIAID)
—Provide $10 billion for the Centers for Disease Control and Prevention (CDC) and $5 million for the Chronic Disease Education and Awareness Program

Chairwoman Murray, Ranking Member Blunt and distinguished members of the Subcommittee, thank you for your time and your consideration of the priorities of the community of individuals impacted by Guillain-Barré Syndrome (GBS), Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), and related conditions as you work to craft the FY2022 L–HHS Appropriations Bill.

ABOUT GBS, CIDP, VARIANTS, AND RELATED CONDITIONS

Guillain-Barré Syndrome

Guillain-Barré Syndrome (GBS) is an inflammatory disorder of the peripheral nerves outside the brain and spinal cord. GBS is characterized by the rapid onset

of numbness, weakness, and often paralysis of the legs, arms, breathing muscles, and face. Paralysis is ascending, meaning that it travels up the limbs from fingers and toes towards the torso. Loss of reflexes, such as the knee jerk, are usually found. Usually, a new case of GBS is admitted to ICU (Intensive Care) to monitor breathing and other body functions until the disease is stabilized. Plasma exchange (a blood "cleansing" procedure) and high dose intravenous immune globulins are often helpful to shorten the course of GBS. The acute phase of GBS typically varies in length from a few days to months. Patient care involves the coordinated efforts of a team such as a neurologist, physiatrist (rehabilitation physician), internist, family physician, physical therapist, occupational therapist, social worker, nurse, and psychologist or psychiatrist. Recovery may occur over six months to two years or longer. A particularly frustrating consequence of GBS is long-term recurrences of fatigue and/or exhaustion as well as abnormal sensations including pain and muscle aches.

Chronic Inflammatory Demyelinating Polyneuropathy

CIDP is a rare disorder of the peripheral nerves characterized by gradually increasing weakness of the legs and, to a lesser extent, the arms. It is the gradual onset as well as the chronic nature of CIDP that differentiates it from GBS. Like GBS, CIDP is caused by damage to the covering of the nerves, called myelin. It can start at any age and in both genders. Weakness occurs over two or more months. Unlike GBS, CIDP is chronic, with symptoms constantly waxing and waning. Left untreated, 30% of CIDP patients will progress to wheelchair dependence. Early recognition and treatment can avoid a significant amount of disability. Post-treatment life depends on whether the disease was caught early enough to benefit from treatment options. The gradual onset of CIDP can delay diagnosis by several months or even years, resulting in significant nerve damage that may take several courses of treatment before benefits are seen. The chronic nature of CIDP differentiates long-term care from GBS patients. Adjustments inside the home may need to be made to facilitate a return to normal life.

ABOUT THE FOUNDATION

The Foundation's vision is that every person afflicted with GBS, CIDP, or variants has convenient access to early and accurate diagnosis, appropriate and affordable treatments, and dependable support services.

The Foundation's mission is to improve the quality of life for individuals and families across America affected by GBS, CIDP, and their variants by:

—Providing a network for all patients, their caregivers and families so that GBS or CIDP patients can depend on the Foundation for support, and reliable up-to-date information.

—Providing public and professional educational programs worldwide designed to heighten awareness and improve the understanding and treatment of GBS, CIDP and variants.

—Expanding the Foundation's role in sponsoring research and engaging in patient advocacy.

CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) have resources that could be brought to bear to improve public awareness and recognition of GBS, CIDP and related conditions. The Foundation supports a meaningful increase to the Centers for Disease Control and Prevention as well as continued support of the Chronic Disease Education and Awareness Program. This program seeks to provide collaborative opportunities for chronic disease communities such as ours that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

NATIONAL INSTITUTES OF HEALTH

NIH hosts a modest research portfolio focused on GBS, CIDP, variants, and related conditions. This research has led to important scientific breakthroughs and is well positioned to vastly improve our understanding of the mechanism behind these conditions. We ask that resources continue to be used to support the important collaboration between NIAID, NINDS and the GBS|DCIDP community. Last May we participated in a conference with NINDS that discussed how intramural and extramural researchers can develop a roadmap that would lead research into these conditions into the next decade, and encourage younger investigators to apply for grants

that lead to sustained research activities. We are continuing to have conversations with the leadership of both institutes to facilitate follow up and plan for a more robust agenda and list of goals for a future in person conference. In our meetings with the leadership, we also spoke about the possibilities of cross-institute work between NINDS and NIAID to expand the research and understanding of the link between Zika and GBS. While such a conference would not require additional appropriations, the Foundation urges you to provide NIH with meaningful funding increases to facilitate growth in the GBS, CIDP, and related conditions research portfolio.

PATIENT ACCESS

As we have seen from communities that currently have access to home infusion, such as primary immunodeficiency diseases, the ability to choose the home as the preferred site of care has tremendous benefit in terms of health outcomes and overall convenience for patients. Individuals with CIDP and MMN often face mobility issues as limbs suffer nerve damage. Traveling to receive an infusion presents a tremendous hardship to many patients and their families. This hardship greatly affects rural patients who have to travel hundreds of miles to major cities in order to receive treatment, which can be both inconvenient and costly. The Foundation has seen that when there are obstacles to receiving regular infusions, patients tend to skip scheduled infusions, which leads to progressive disability. Many CIDP and MMN patients have access to IVIG home infusion through private insurance, which allows them to lead productive and active lives. When these individuals age on to Medicare, they can face disruption in their routine and suboptimal circumstances when managing their condition. Further, because the body's immune system is depressed at the end of an infusion cycle, CIDP and MMN patients face an elevated risk of contracting illness from visiting well-traveled sites of care for infusions. Most importantly, patients and physicians should have the authority to choose their preferred site of care. We hope that members of this subcommittee and Congress as a whole support legislation that will grant our patients this important access.

The Foundation was founded 40 years ago, and the four pillars that guide our mission are: support, education, advocacy, and research. Our patients rely on the premier research that is carried out at the NIH to improve the diagnosis and treatment process of these devastating illnesses. Without appropriate funding to the NIH and CDC, my fear as a parent of a GBS survivor and the Executive Director of the Foundation, is that many patients will needlessly suffer. There is so much to learn; there is no bio-marker and we do not know why the immune system reacts to trigger these conditions. I ask the Committee to provide $46.1 billion to the NIH with proportional increases to NIAID and NINDS to continue the potentially lifesaving work being done for our community, and ask for Congressional support of our initiative to improve access to life-saving treatments.

[This statement was submitted by Lisa Butler, Executive Director, GBS|DCIDP Foundation International.]

PREPARED STATEMENT OF GEAR UP

Distinguished members of the Senate Labor-Health and Human Services-Education Appropriations Subcommittee, thank you for the giving me the opportunity to provide testimony on the profound impact that the Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative has had on my life. My name is William Ruiz, and it is my honor and pleasure to be writing this testimonial on behalf of GEAR UP alumni and over half a million GEAR UP students across the country. Given the program's return on investment, I urge the committee to appropriate $435,000,000 for GEAR UP in fiscal year 2022 to support an additional 100,000 students across our country so that they, too, can have the support I received through GEAR UP.

GEAR UP provides 6- or 7-year grants to states and partnerships comprised of K–12, higher education, and community-based organizations that strengthen pathways to college and careers in low-income communities. GEAR UP exposes students, and their families, starting in the 7th grade to comprehensive interventions that follow them through high school graduation and optionally through the first year of postsecondary education. GEAR UP uses early and sustained interventions to ensure that students are successful in rigorous courses, are prepared for life beyond high school, and ultimately enroll in a high-quality certificate, associates', or bachelors' degree program that suits their goals. In the most recent year in which we had a large class of graduating seniors, the postsecondary enrollment rates of GEAR UP students were over 31% higher than the rates for low-income students nation-

ally.[1] Considering that GEAR UP achieves this critical goal at a cost of approximately $694 per student, per year, I strongly believe that the investment in GEAR UP pays significant dividends. GEAR UP is a powerful catalyst for sustained community improvement.

Being the son of immigrant parents and growing up in a low-socioeconomic neighborhood in Los Angeles, California, I never envisioned myself going to college. My parents worked exceptionally hard to provide for my siblings and me, but because they had to drop out of school at a very young age to leave Mexico and move to the United States, they had very little knowledge of the education system. While I wasn't introduced to higher education by my family, my parents did teach me about the value of hard work and made sure that I attained good grades throughout my time in K–12 education. As I navigated my way through elementary and middle school, I always looked forward to high school graduation because I thought that that would be the end of my educational journey. It was always my plan to graduate high school and enter the workforce full-time, just like how my older siblings did. It wasn't until I was introduced to the GEAR UP program in 7th grade that I was exposed to college. At that time, college was the last thing on my mind, but the GEAR UP staff continued to remind us that they would pack up their office and follow us to our local high school.

Fast forwarding to my first day at Benjamin Franklin High School, I remember the first adult I saw on campus: GEAR UP Counselor Mr. Burton. I was shocked to see that they were serious when they said they would follow us. Throughout the rest of my freshman year, we would participate in various workshops with GEAR UP. I always enjoyed talking to the GEAR UP team, but I still couldn't see myself pursuing higher education. At the end of my first year of high school, GEAR UP started recruiting students for their peer mentor and summer programs.

After signing up for summer school and participating in the peer mentor camps with GEAR UP, I immersed myself in all things GEAR UP. At the beginning of my sophomore year, I met an individual who, to this day, has a special place in my heart. I can never truly thank Mr. Robert Aguirre for all the help and support he has provided me with since 2009. While I had the grades to attend college and pursue a degree, Mr. Aguirre provided me with the structure and gave me all the resources I needed to pursue higher education. Growing up in a neighborhood with a lot of gang violence and having friends who dropped out of school a young age, it was reassuring to have a positive male role model that I could look up to. I always heard that it only takes one adult to care for a student to do well in school. I can undoubtedly say Mr. Aguirre was that person for me. I always knew that if I had any issues regarding school, I could easily walk to the GEAR UP office to talk to him.

I wouldn't have gone to a 4-year university if it wasn't for Mr. Aguirre and GEAR UP. Not only did GEAR UP teach me about admission requirements and financial aid, but they also exposed me to different colleges and universities. One of my fondest memories of high school was traveling up the California coastline on a bus to visit colleges in Northern California. Because of the field trips and the exposure to colleges, I began to imagine myself on college campuses. When I started my senior year of high school, the GEAR UP staff sat me down in the school's computer lab to apply to college. As someone who had simply gone through the motions, I really appreciated GEAR UP for giving me that extra push to take education more seriously.

I will always be grateful for all the love and support that GEAR UP provided as I navigated high school. Yes, GEAR UP is an acronym and a federally funded program, but to me, GEAR UP is family.

Because of what GEAR UP gave me, I wanted to give back to GEAR UP. I currently have the honor and privilege of working with over 800 students in the Compton Unified School District as a GEAR UP Program Coordinator. I am also a Founding Board Member of the GEAR UP Alumni Association. The GEAR UP Alumni Association aims to support GEAR UP Alumni so that GEAR UP students can not only get to college but also graduate. Our vision is to eventually branch out and support GEAR UP students across the country.

I am also happy to share with you that beginning in August 2021, I will be pursuing my Master of Arts in Diverse Community Development Leadership (DCDL) at California State University, Northridge. As a GEAR UP alum and current educator, I want to continue my educational journey so that I can best assist students like me. My initial goal was only to graduate high school. Now, I am proud of the

[1] U.S. Department of Education (2016). FY 2017 Department of Education Justifications of Appropriation Estimates to the Congress: Higher Education (Volume II). Retrieved from: https://www2.ed.gov/about/overview/budget/budget17/justifications/index.html.

fact that I am the first in my family to graduate college and will be the first to receive a graduate degree.

None of this would have been possible without GEAR UP. I will always be open and honest about my journey because there are a lot of students who have similar backgrounds as me. I wake up every day grateful that I was able to be a GEAR UP student because it changed my life for the better.

As you take on the work of preparing for the fiscal year 2022 appropriations, I urge you to consider increasing the investment in the GEAR UP program to $435,000,000 so that 100,000 more students just like me can benefit from the program. Thank you to the committee for taking the time to read my testimony.

PREPARED STATEMENT OF GLOBAL HEALTH COUNCIL

Global Health Council (GHC) is the leading membership organization for nonprofits, businesses, universities, and individuals dedicated to saving lives and improving the health of people worldwide. GHC thanks the Subcommittee for the opportunity to share this testimony in support of global health programs under the jurisdiction of the Departments of Labor and Health and Human Services. For Fiscal Year (FY) 2022, GHC encourages continued support for global health at a minimum of FY21 levels enacted by Congress. However, in order to achieve U.S. global health goals and commitments, we ask that you support a greater investment in global health programs for FY22, which includes at a minimum: $6,356,000,000 for the National Institute of Allergy and Infectious Disease (NIAID), $3,845,000,000 for the Office of AIDS Research, and $91,000,000 for the Fogarty International Center at the National Institutes of Health (NIH); an investment of $735,000,000 for the Center for Emerging Zoonotic and Infectious Diseases, $300,000,000 for the Infectious Diseases Rapid Response Fund, and no less than $898,000,000 for the Center for Global Health at the Centers for Disease Control and Prevention (CDC).

In light of the COVID–19 pandemic, we must urge Congress to appropriate funds to sustain America's legacy abroad and to support existing programs in their ongoing response to the coronavirus. It is our hope that appropriators will consider the additional needs and negative effects of the COVID–19 pandemic when making appropriations for FY22. We have seen significant declines across global health programs in their capacity to reach the same or more people for preventative care, ongoing care for diseases ranging from HIV/AIDS, tuberculosis, non-communicable diseases, malaria, and more.

We know that these programs work and have secured their place as some of the most critical and successful tools for U.S. global health. By investing in these programs, the United States is continuing to build healthier and more self-reliant communities, which ultimately become economically and politically stable. We have seen the COVID–19 pandemic exacerbate weak points in health systems in rich and poorer countries alike, ultimately weakening our own health system. It highlighted inefficiencies and a sheer lack of access to care around the world. We cannot afford to lose more ground on the progress that the United States has already made towards building healthier communities. A failure to backstop these investments would roll back the progress we have spent decades achieving and ultimately undermine U.S. foreign policy and global health priorities.

We undeniably live in a global environment. Global health is important for medical professionals here at home, too. Every year, more than 500 million people cross borders in planes, and with them the potential for infectious diseases to enter our country, demanding more of our health workforce. But U.S.-based providers and other responders have the opportunity to learn from health programs abroad about how best to tackle diseases whenever they arrive. We have an opportunity here, to mobilize everyone involved in health, from scientists, pharmaceutical companies, frontline workers, advocates, and policymakers, to create a world where health threats can become a thing of the past.

We must continue to build upon the hard work and achievements of previous years in order to prevent the persistent global health challenges of our time and ensure a healthy future for citizens around the world. In our current environment, in response to COVID–19, we must consider increasing investments in global health and development assistance funding. We have a moral obligation to resolve the challenges that U.S. global health programs now face in light of the pandemic. And it is in our national interest to demonstrate that these are essential commitments.

Thank you for your consideration of this request.

[This statement was submitted by Kiki Kalkstein, Director of Advocacy & Engagement, Global Health Council.]

PREPARED STATEMENT OF THE GLOBAL HEALTH TECHNOLOGIES COALITION

On behalf of the Global Health Technologies Coalition (GHTC), a group of 37 nonprofit organizations, academic institutions, and aligned businesses advancing policies to accelerate the creation of new drugs, vaccines, diagnostics, and other tools that bring healthy lives within reach for all people, I am providing testimony on fiscal year 2022 (FY22) appropriations for the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Biological Advanced Research and Development Authority (BARDA). These recommendations reflect the needs expressed by our members working across the globe to develop new and improved technologies for the world's most pressing health issues. We appreciate the Committee's support for global health, particularly for continued research and development (R&D) to advance new drugs, vaccines, diagnostics, and other tools for longstanding and emerging health challenges, including COVID–19. To accelerate progress toward lifesaving tools for a range of health threats, we respectfully request increased funding for NIH, including an additional $10 million for the Fogarty International Center (FIC); funding to match CDC's increased responsibilities in global health and global health security-in line with the overall increase for CDC proposed in the President's Discretionary Budget Request, which should be reflected in increases for the Center for Global Health (CGH) and National Center for Emerging Zoonotic and Infectious Diseases (NCEZID)—and the creation of a new, dedicated funding line to support BARDA's critical work in emerging infectious diseases (EIDs), which accelerated to unprecedented levels over the past year and should be sustainably funded beyond the COVID–19 pandemic.

GHTC members strongly believe that sustainable investment in R&D for a broad range of neglected diseases and health conditions is critical to tackling both longstanding and emerging global health challenges that impact people around the world and in the United States. Coordination is also key: we urge the Committee to request that leaders of Department of Health and Human Services agencies work with counterparts at the State Department and the US Agency for International Development to develop a cross-government global health R&D strategy to ensure that US investments are efficient, coordinated, and streamlined.

While we have made tremendous gains in global health over the past 15 years, millions of people around the world are still threatened by neglected diseases and conditions. In 2019, tuberculosis (TB) killed 1.4 million people, surpassing deaths from HIV/AIDS, while 1.7 million people were newly diagnosed with HIV. Nearly half the global population remains at risk for malaria, and drug-resistant strains are growing. Women and children remain the most vulnerable with around 68 percent of all global maternal and child deaths occurring in sub-Saharan Africa and 1 out of every 13 children in the region dying before the age of 5. These figures highlight the tremendous global health challenges that remain and the need for sustained investment in global health R&D to deliver new tools, both to address unmet global health needs and to address challenges of drug resistance, toxic treatments, and health technologies that are difficult to administer in poor, remote, and unstable settings.

The COVID–19 pandemic has again demonstrated that we do not have all the tools needed to prevent, diagnose, and treat many neglected and EIDs—a reality foreshadowed by the recent Zika and Ebola epidemics. The lifesaving effects of the first COVID–19 vaccines demonstrate the power of having the right tools to respond to a health emergency. These new vaccines, developed with critical funding from BARDA, NIH, and other US government partners, are highly effective and built upon past global health research advances. Notably, the Johnson & Johnson vaccine is based on technology used in its Ebola vaccine and Zika, respiratory syncytial virus, and HIV/AIDS vaccine candidates, and the Moderna-National Institute of Allergy and Infectious Diseases (NIAID) vaccine platform was previously being used to develop vaccines against other respiratory viruses and the chikungunya virus. This demonstrates how strong, sustained investment in R&D allows us to tackle today's health threats and prepare for those of the future. The United States remains at the forefront of global health innovation because of long-term investments in R&D agencies such as NIH, CDC, and BARDA.

NIH: The groundbreaking science conducted at NIH has long underpinned US leadership in biomedical research. Within NIH, NIAID, the Office of AIDS Research, and FIC all play critical roles in developing new health technologies that save lives at home and around the world. FIC, in particular, is a leader in accelerating global scientific progress through international research partnerships, technical assistance, and training. Many FIC-trained scientists have led their countries' responses to COVID–19, Zika, and Ebola, as well as long-standing challenges such as HIV/AIDS. COVID–19 has underscored that science capacity gaps remain between low- and

middle-income countries and high-income countries. With additional funding, FIC could leverage its extensive network and training capacity to improve global genomic surveillance and coordination. We urge Congress to request information from FIC on how it might address global scientific capacity gaps in modeling, genomic surveillance, researcher training, and pandemic preparedness and urge appropriators to consider sustainably increasing FIC's relatively modest budget by $10 million dollars in each of the next five fiscal years to enable work in new areas.

Across NIAID, FIC, and other institutes and centers, NIH leadership has long supported the vital role the agency plays in global health R&D and has named global health as one of the agency's top five priorities. It remains critical that support for NIH extend to all pressing areas of research—including research in neglected diseases and EIDs.

CDC: CDC makes significant contributions to global health research, particularly through CGH and NCEZID. CDC's ability to respond to disease outbreaks is essential to protecting the health of citizens both at home and abroad, and the work of its scientists is vital to advancing the development of tools, technologies, and techniques to detect, prevent, and respond to urgent public health threats. CDC monitors 30 to 40 international public health threats each day, has identified disease outbreaks in more than 150 countries, responded to more than 2,000 public health emergencies, and discovered 12 previously unknown pathogens—and in complement to these disease monitoring and detection functions, plays a leading role in related R&D. Important work at NCEZID includes the development of diagnostics, including the first diagnostic test for COVID–19 with authorization from the US Food and Drug Administration and Trioplex, a diagnostic that can differentiate Zika, dengue, and chikungunya viruses. NCEZID is a leader in early-stage R&D for vaccines for infectious diseases such as Nipah virus and dengue, Lassa, and Rift Valley fevers. The Center also plays a leading role in the National Strategy for Combating Antibiotic-Resistant Bacteria, to prevent, detect, and control outbreaks of antibiotic-resistant pathogens, such as drug-resistant TB.

In complement, CGH is a global leader in immunization, public health capacity-building, and preventing, detecting, and responding to infectious diseases. Programs at CGH—including the Divisions of Global HIV and TB, Global Immunization, Parasitic Diseases and Malaria, and Global Health Protection—have yielded advances in the development of vaccines, drugs, and other tools to combat HIV/AIDS, TB, malaria, and neglected tropical diseases like leishmaniasis and dengue fever. CGH develops and validates innovative tools for use by US bilateral and multilateral global health programs and leads laboratory efforts to monitor and combat drug and insecticide resistance to ensure that global health programs are tailored for maximum impact.

As global disease outbreaks have grown in frequency and intensity, CDC's work in novel technology development and global health security has only become more important. This includes the agency's work to end the recent Ebola outbreaks in Africa through its international leadership on the Global Health Security Agenda. GHTC supports the funding increase to CDC proposed by the administration for FY22 and urges the Committee to increase funding for CDC's critical global health R&D work at CGH and NCEZID.

BARDA: BARDA plays an unmatched role in global health R&D by using unique contracting authorities and targeted incentive mechanisms to advance the development and purchase of critical medical technologies for public health emergencies. BARDA partners with diverse stakeholders from industry, academia, and nonprofits to bridge the valley of death between basic research and advanced-stage product development for medical countermeasures—an area where other R&D agencies do not operate. BARDA has been a critical funder of countermeasures for naturally occurring health security threats including EIDs such as COVID–19, Ebola, and Zika, as well as pandemic influenza and antimicrobial resistance. To date, BARDA's work in advancing tools for EIDs has largely been funded through emergency supplemental funding. A dedicated funding line of at least $300 million annually for EID R&D would ensure that BARDA is resourced to respond quickly to future threats, rather than wait on haphazard infusions of supplemental funding during health emergencies.

In addition to bringing lifesaving tools to those who need them most, investment in global health R&D is also a smart economic investment in the United States with 89 cents of every US dollar invested in global health R&D going directly to US-based researchers. US government investment in global health R&D between 2007 and 2015 generated an estimated 200,000 new jobs and $33 billion in economic growth. Investments in global health R&D today can help achieve significant cost-savings in the future—a fact made plain by the economic devastation of the COVID–19 pandemic.

Now more than ever, Congress must make smart investments. Global health R&D, which improves the lives of people around the world while supporting US health security, creating jobs, and spurring economic growth, is a win-win.

PREPARED STATEMENT OF HARVEY FRIEDMAN, MD

I am an Infectious Disease physician scientist on faculty at the Perelman School of Medicine of the University of Pennsylvania. My research interest is herpes simplex virus. I am working on a vaccine that uses messenger RNA technology for the herpes vaccine that is like that applied to COVID 19 messenger RNA vaccines by Pfizer and Moderna.

My research has caught the interest of the public. I have received thousands of emails from people globally expressing their hope that the vaccine works. Most of the people are already infected with genital herpes. Their stories are heart-wrenching! Genital herpes is not a life-threatening infection; however, for many people, it is a life altering infection, while for some it leads to life ending decisions.

My laboratory has focused on preventing genital herpes, but we are now turning our attention to preventing oral herpes (HSV–1) and the many dreaded complications of both viruses, including fever blisters, infection of the cornea (eye), infection of the brain (encephalitis), infection of newborns, genital herpes, increasing susceptibility to HIV infection, and possibly contributing to dementia.

Medical research is at a point that we have the tools to come up with vaccines that will prevent genital herpes for those not yet infected, and approaches to rid the body of the dormant (latent) virus as a cure for subjects already infected.

Please set a priority to establish a strategic plan and national strategy for treating and preventing herpes infections, particularly genital herpes.

Sincerely,

Harvey Friedman, MD, Email: hfriedma@pennmedicine.upenn.edu, Office address: Infectious Disease Division, 522E Johnson Pavilion, 3610 Hamilton Walk, Philadelphia, PA 19104–6073.

PREPARED STATEMENT OF THE HEALTH PROFESSIONS AND NURSING EDUCATION COALITION

The Health Professions and Nursing Education Coalition (HPNEC) is an alliance of over 90 national organizations representing schools, students, health professionals, and communities dedicated to ensuring that the health care workforce is trained to meet the needs of our diverse population. Together, the members of HPNEC advocate for adequate and continued support for the health professions and nursing workforce development programs authorized under Titles VII and VIII of the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA). For fiscal year (FY) 2022, HPNEC encourages the subcommittee to adopt at least $1.51 billion for HRSA Titles VII and VIII programs.

The HRSA Titles VII and VIII programs are essential to educating our health care workforce to manage health care crises, such as the COVID–19 pandemic. The immense challenges of the pandemic have underscored the need to increase and reshape our health workforce, and the HRSA Titles VII and VIII programs successfully recruit, train, and support public health practitioners, nurses, geriatricians, advanced practice registered nurses, mental health providers, and other frontline health care workers critical to addressing COVID–19. Additionally, HRSA tasked Title VII and Title VIII grantees to utilize innovative models of care, such as training providers in telehealth, to improve patients' access to care during the pandemic.

The U.S Census Bureau projects that by 2045:

—the US population will grow by over 18%,

—more than half the country will come from a racial or ethnic minority group, and

—one in five Americans will be over 65.

To prepare for these changing demographics, we urge Congress to increase funding for the HRSA Title VII and Title VIII programs to educate current and future providers that serve these ever-growing needs while preparing for the health care demands of tomorrow.

Diversity Pipeline Programs.—The COVID–19 pandemic has underscored the pervasive health inequities facing minority communities, as well as gaps in care for our most vulnerable patients, including an aging population that requires more health care services. The HRSA Title VII and Title VIII programs play an essential role in improving the diversity of the health workforce and connecting students to health careers by supporting recruitment, education, training, and mentorship opportuni-

ties. Inclusive and diverse education and training experiences expose providers to backgrounds and perspectives other than their own and heighten cultural awareness in health care, resulting in benefits for all patients.

HRSA diversity programs include the Health Careers Opportunity Program (HCOP), Centers of Excellence (COE), Faculty Loan Repayment, Nursing Workforce Diversity, and Scholarships for Disadvantaged Students (SDS). Studies have demonstrated the effectiveness of such pipeline programs in strengthening students' academic records, improving test scores, and helping minority and disadvantaged students pursue careers in the health professions. Title VII diversity pipeline programs reached over 13,500 students in the 2019–2020 academic year (AY), with SDS graduating nearly 1,400 students, and COE reaching nearly 5,000 health professionals, 72% of which were located in medically underserved communities.

Title VIII's Nursing Workforce Diversity Program increases nursing education opportunities for individuals from disadvantaged backgrounds through stipends and scholarships and a variety of pre-entry and advanced education preparation. In AY 2019–20, the program supported more than 11,000 students, with approximately 45% of the training sites located in underserved communities.

Primary Care Workforce.—The Primary Care Medicine Programs expand the primary care workforce, including general pediatrics, general internal medicine, family medicine, and physician assistants through the Primary Care Training and Enhancement (PCTE) and Primary Care Medicine and Dentistry Career Development programs. The primary care programs are also intended to encourage health professionals to work in underserved areas. In AY 2019–20, PCTE grantees trained over 14,000 individuals at over 1,100 sites, with 54% in medically underserved communities and 26% in rural areas; 30% of sites trained providers in telehealth services.

The Medical Student Education program, which supports the health care workforce by expanding training for medical students to become primary care clinicians, targets higher education institutions in states with the highest primary care workforce shortages. The program help develop partnerships among institutions, federally recognized tribes, and community-based organizations to train medical students to provide primary care that improves health outcomes for those living in rural and other underserved communities. In AY 2019–2020, Medical Student Education grantees trained over 1,100 health professionals, 88% of which located in primary care settings, 68% in medically underserved communities, and 66% in rural areas.

Interdisciplinary, Community Based Linkages.—Support for community-based training of health professionals in rural and urban underserved areas is funded through Title VII. By assessing the needs of the local communities they serve, HRSA Title VII programs can fill gaps in the workforce and increase access to care for all populations. The programs emphasize interprofessional education and training, bringing together knowledge and skills across disciplines to provide effective, efficient, and coordinated care.

Programs such as Graduate Psychology Education (GPE), Opioid Workforce Enhancement Program, Mental and Behavioral Health, and Behavioral Health Workforce Education and Training (BHWET) respond to changing delivery systems and models of care, and timely address emerging health issues in their communities. The BHWET and Mental and Behavioral Health programs, provide training to expand access to mental and behavioral health services for vulnerable and underserved populations. In AY 2019–20, nearly 50% of all BHWET and GPE grantees provided substance use disorder treatment services.

Area Health Education Centers (AHEC) support the recruitment and training of future physicians in rural areas and provide interdisciplinary health care delivery sites, which respond to community health needs. In AY 2019–20, AHECs supported 192,000 pipeline program participants and provided over 34,000 clinical training rotations for health professions trainees.

Title VII Geriatric Workforce programs integrate geriatrics and primary care to provide coordinated and comprehensive care for older adults. These programs offer training across the provider continuum, focusing on interprofessional and team-based care and academic-community partnerships to address gaps in health care for older adults. To advance the training of the current workforce, the Geriatrics Workforce Enhancement Program (GWEP) provided 2,068 unique continuing education courses to over 200,000 faculty and practicing professionals in AY 2019–20, including 906 courses on Alzheimer's and dementia-related diseases.

Nursing Workforce Development.—HRSA Title VIII nursing workforce development programs provide federal support to address all aspects of nursing workforce demands, including education, practice, recruitment, and retention, focusing on rural and medically underserved communities. These programs include Advanced Nursing Education; Nursing Workforce Diversity; Nurse Education, Practice, Quality, and Retention; NURSE Corps; and Nurse Faculty Loan Program. In AY 2019–

2020, the Title VIII Advanced Education Nursing programs supported more than 8,000 nursing students in primary care, anesthesia, nurse-midwifery, and other specialty care, all of whom received clinical training in primary care in medically underserved communities and/or rural settings.

Oral Health.—The Primary Care Dentistry program invests in expanding programs in primary dental care for pediatric, public health, and general dentistry. The Pre- and Postdoctoral Training, Residency Training, Faculty Development, and Faculty Loan Repayment programs encourage integrating dentistry into primary care.

Public Health.—Public Health Workforce Development programs support education and training in public health and preventive medicine through different initiatives, including the only funding for physicians to work in state and local health departments. Public health student trainees partnered with 278 sites in AY 2019–20, with 74% of these training sites located in medically underserved communities and 29% in primary care settings.

Workforce Information and Analysis.—The Workforce Information and Analysis program provides funding for the National Center for Health Workforce Analysis as well as grants to seven Health Workforce Research Centers across the country that perform and disseminate research and data analysis on health workforce issues of national importance.

While HPNEC's members acknowledge the competing demands facing appropriators, funding for HRSA's workforce development programs is critical to creating a culturally competent workforce that can respond to future health threats and challenges facing all Americans. Therefore, HPNEC encourages the subcommittee to provide at least $1.51 billion in the FY 2022 appropriations bill for HRSA's Title VII and VIII programs to continue the nation's investment in our health workforce.

PREPARED STATEMENT OF THE HEARING INDUSTRIES ASSOCIATION AND THE HEARING LOSS ASSOCIATION OF AMERICA

Dear Chairwoman Murray, Ranking Member Blunt, and Members of the Subcommittee,

Thank you for the opportunity to submit testimony concerning Fiscal Year 2022 (FY22) Labor, Health and Human Services, Education and Related Agencies appropriations. The Hearing Industries Association (HIA) and the Hearing Loss Association of America (HLAA) are requesting inclusion of report language to direct the National Institutes of Health (NIH) Office of the Director to provide an accounting of funds currently used for hearing screening research and encourage NIH to prioritize funding for studies that address the research needs and gaps identified by the U.S. Preventive Services Task Force (USPSTF).

HIA is the national organization of the manufacturers, suppliers and distributors of hearing aids, implants, assistive listening devices, component parts and power sources. HIA's mission is to be a trusted voice on product innovation, patient safety and education, and public policy. HLAA is the nation's leading organization representing consumers with hearing loss and seeks to enable people with hearing loss to live life fully and without compromise. We are pleased to work together to support the more than 38 million individuals in the United States with untreated hearing loss,[1] including one in three people between the ages of 65 and 74 and over half of those older than 75. Hearing loss is associated with many comorbidities, including cognitive decline, dementia, falls, depression, reduced quality of life, and an increased number of emergency department visits and hospitalizations.

In March 2021, the USPSTF, a volunteer panel of national experts in prevention and evidence-based medicine tasked with providing recommendations regarding preventive screening and services, issued its final recommendations regarding hearing screening for older adults over the age of 50. The USPSTF ultimately declined to make a recommendation in support of hearing screening, finding that "current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in older adults."[2] The final recommendation notes that more research is needed.

We understand the gaps in research identified by the USPSTF's recommendations and agree that additional research to support a universal hearing screening recommendation for older adults is needed. Given the significant associated

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[1] "How Many People Have Hearing Loss in the United States?", Johns Hopkins Cochlear Center for Hearing and Public Health, https://www.jhucochlearcenter.org/how-many-people-have-hearing-loss-unaited-states.html.

[2] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hearing-loss-in-older-adults-screening.

comorbidities of hearing loss discussed below, we also believe this research should be prioritized. Therefore, we urge this Subcommittee to support inclusion of report language to convey the importance of building the research base for older adult hearing screening, as follows:

Hearing Health Screening. The Committee recognizes the associated comorbidities and costs of untreated hearing loss and, with the growing aging population, the importance of hearing screening for older Americans. The Committee directs the National Institutes of Health (NIH) Office of the Director to provide an accounting of all funds used for hearing screening research across all Institutes within 90 days of enactment of this Act. The Committee encourages NIH to prioritize funding through the Office of the Director and engage appropriate Institutes like the National Institute on Deafness and Other Communication Disorders (NIDCD) and National Institute on Aging (NIA) for studies that address the research needs and gaps identified by the U.S. Preventive Services Task Force (USPSTF). These research needs may include gaps identified in USPSTF review of hearing screening recommendations for older Americans.

Earlier diagnosis of hearing loss and appropriate intervention are crucial to avoiding the negative social, emotional, and health consequences of hearing loss. Age-related hearing loss is the third leading cause of chronic disability in older adults and has shown to be associated with predisposing cognitive impairment and dementia.[3] According to the Lancet Commission, as of 2020, there are twelve behaviorally modifiable risk factors associated with dementia prevention, accounting for approximately 40 percent of dementias globally. Of note, hearing impairment accounts for approximately nine percent of the modifiable risk and the Lancet Commission recommends reducing noise-related hearing loss and treating hearing loss with the use of hearing aids.[4] Additionally, a recent study found that mild hearing loss doubled the risk of dementia, moderate loss tripled risk, and those with severe hearing impairment were five times more likely to develop dementia.[5] Emerging evidence indicates that hearing interventions can delay the onset or reduce the rate of cognitive decline.[6,7] Additional studies, including the Aging and Cognitive Health Evaluation in Elders (ACHIEVE) study,[8] are expected to further address the role and efficacy of hearing treatment in reducing cognitive decline in older adults.

As hearing loss progresses, it manifests via profound consequences on verbal communication and social, functional, and psychological wellbeing of the person. The National Institutes of Health (NIH) has found that over 78 percent of participants with insufficient or poor hearing suffered from at least one additional chronic condition, leading to increased health care costs in any given year.[9] For adults over 60 years of age, untreated hearing loss is associated with approximately 46 percent higher total health care costs over a 10-year period compared with costs for those without hearing loss.[10] People with even a mild hearing loss are also three times more likely to fall, compared to individuals with normal hearing.[11] When hearing loss does occur, early diagnosis and intervention are crucial for avoiding the negative social, emotional, and health consequences already described.

There is evidence that rates of hearing loss begin to rise around the age of 50, but the prevalence of hearing loss dramatically increases as an individual grows older (Figure 1).[12] Individuals may underestimate their hearing difficulty and fail to pursue potentially beneficial treatment for their hearing loss that could lead to better health outcomes. Thus, hearing screening should be a part of every wellness

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[3] Jafari Z, Kolb BE, Mohajerani MH. Age-Related Hearing Loss and Tinnitus, Dementia Risk, and Auditory Amplification Outcomes. Ageing research reviews. 2019:100963.

[4] Livingston G, Huntley J, Sommerland A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. Lancet. 20202 [Aug 8]; 396 (10248); 413–446.

[5] "The Hidden Risks of Hearing Loss", Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/wellness-and-prevention/the-hidden-risks-of-hearing-loss.

[6] Maharani A, Dawes P, Nazroo J, Tampubolon G, Pendleton N, on behalf of the SENSE-Cog WP1 group. Am Geriatr Soc. 2018;66(6):1130–1136. https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15363.

[7] Sarant J, Harris D, Busby P, Maruff P, Schembri A, Lemke U, & Launer S (2020). The Effect of Hearing Aid Use on Cognition in Older Adults: Can We Dely Decline or Even Improve Cognitive Function? Journal of Clinical Medicine, 9(1), 254.

[8] https://clinicaltrials.gov/ct2/show/NCT03243422.

[9] Maharani A, Dawes P, Nazroo J, Tampubolon G, Pendleton N, on behalf of the SENSE-Cog WP1 group. Am Geriatr Soc. 2018;66(6):1130–1136. https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/jgs.15363.

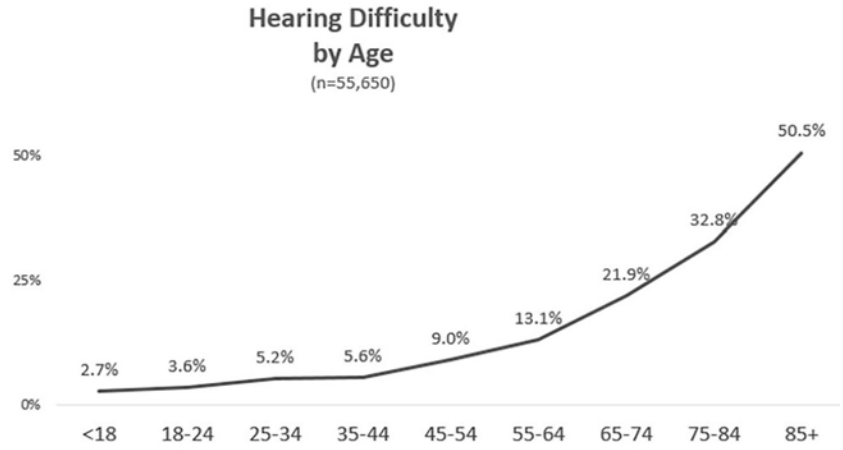
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6439810/.

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3518403/.

[12] Jorgensen, L. & Novak, M. (2020). Factors Influencing Hearing Aid Adoption. Seminars in Hearing, 41(1), 7. https://doi.org/10.1055/s-0040-1701242.

check or physical exam for older adults, the population most at risk of age-related hearing loss.

Figure1.



As the Subcommittee develops its FY22 Labor-HHS-Education appropriations bill and accompanying report language, we respectfully request your support for the millions of Americans suffering from hearing loss by encouraging NIH to pursue hearing screening research. Hearing health is essential and hearing screening is the first step. We look forward to working with you and appreciate your attention to this important issue.

[This statement was submitted by Kate Carr, President, Hearing Industries Association, and Barbara Kelley, Executive Director, Hearing Loss Association of America.]

PREPARED STATEMENT OF THE HEPATITIS B FOUNDATION

HEPATITIS B FOUNDATION RECOMMENDATIONS FOR FISCAL YEAR 2021 APPROPRIATIONS

National Institutes of Health

—Along with the biomedical research community, the Hepatitis B Foundation (HBF) supports the President's request for $51 billion for the National Institutes of Health. While we are anxious to see the details of the President's request, specifically the details of the proposed ARPA–H initiative, we appreciate President Biden's commitment to allowing for meaningful growth in the base budget and expanding NIH's capacity to support promising science in all disciplines.

—HBF commends NIAID, NIDDK, NCI for the development of a Trans-NIH Strategic Plan to Cure Hepatitis B and urges the Institutes to issue targeted calls for research to implement and fund the Strategic Plan.

Centers for Disease Control and Prevention

—HBF supports $10 billion for the Centers for Disease Control and Prevention programs in FY 2021, and within that $134 million for the Division of Viral Hepatitis. HBF further urges the CDC to allocate the necessary resources to address serious surveillance shortcoming without adversely impacting other CDC hepatitis B programs.

—HBF urges the Division of Viral Hepatitis to fund both the Hepatitis B and the Hepatitis C community infrastructure grants in order to maintain and grow progress to address the public health threats of both hepatitis B and hepatitis C.

HHS Office of the Secretary

—HBF supports the newly released Viral Hepatitis National Strategic Plan and urges the establishment of an office or initiative to lead this elimination strategy and the provision of adequate staff and other resources needed for success.

Mrs. Chairwoman and Members of the Subcommittee, thank you for the opportunity to provide testimony as you consider funding priorities for Fiscal Year (FY) 2022. I am Tim Block, President of the Hepatitis B Foundation (HBF). The Hepatitis B Foundation and its associated Baruch S. Blumberg Institute in Bucks County, Pennsylvania has grown to more than 100 researchers and public health professionals and has one of the largest, if not the largest, concentration of nonprofit scientists working on the problem of hepatitis B and liver cancer in the United States. The Foundation is a national disease advocacy organization that has become the world's leading portal for patient-focused information about hepatitis B. The Baruch S. Blumberg Institute is internationally recognized, and we believe, home to some of the most exciting and promising work in the field.

Mrs. Chairwoman, HBF strongly supports the President's $51 billion request for NIH funding in FY 2022. HBF further urges that NIH increase investments in hepatitis B research in order to find a cure for the 2.4 million Americans infected with the hepatitis B virus (HBV) and more than 10 deaths each day as a direct result of hepatitis B.

In addition to the NIH, there are a number of programs within the jurisdiction of the subcommittee that are important to HBF, including the Centers for Disease Control and Prevention. We join the CDC Coalition, an advocacy coalition of more than 140 national organizations, in recommending $10 billion for the Centers for Disease Control and Prevention in the FY 2022 bill. Within that total, we join the Hepatitis Appropriations Partnership in urging $134 million for the CDC's Division of Viral Hepatitis.

Finally, we would urge that the newly released Viral Hepatitis National Strategic Plan be led and funded fully as necessary to move us toward the goal of the elimination of viral hepatitis in the United States.

RECOGNIZING THE LEADERSHIP OF THE SUBCOMMITTEE

Mrs. Chairwoman, HBF appreciates your leadership and the leadership of this Subcommittee in supporting public health service programs. Your support is greatly recognized and appreciated. We applaud the Committee's leadership in making progress in these important areas and to allocating increased funding to these programs during periods of fiscal austerity.

NATIONAL INSTITUTES OF HEALTH

As previously noted, HBF supports the President's request for $51 billion for the NIH. We look forward to learning more about the proposed ARPA–H initiative to accelerate the implementation of research findings. While we appreciate the President's bold vision to promote transformational innovations against the range of diseases facing humankind, we want to be sure that new investments are not made at the expense of the important basic science that is critical to our scientific enterprise. In addition to overall funding for the NIH, HBF urges that NIH investments in hepatitis B research be increased at least $38.7 million a year for 6 years to fund identified research opportunities that would help cure and eliminate the disease once and for all. The Hepatitis B Foundation appreciated the creation of the Hepatitis B Trans-NIH Working Group and was even more encouraged by the release of a Strategic Plan for Trans-NIH Research to Cure Hepatitis B in December of 2019. Report language is requested in the FY 2022 Report urging the NIAID and NIDDK to issue targeted calls for hepatitis B research proposals in FY 2022 focused on the many new research opportunities identified by the Strategic Plan.

In the U.S., an estimated 2.4 million are chronically infected with hepatitis B virus (HBV). Worldwide, HBV is associated with 840,000 deaths each year, making it the 10th leading cause of death in the world. Left undiagnosed and untreated, 1 in 4 of those with chronic HBV infection will die prematurely from cirrhosis, liver failure and/or liver cancer. Although HBV is preventable and treatable, there is still no cure for this disease. In view of the epidemic scope of hepatitis B and the fact that the virus was discovered 50 years ago, it is disappointing that funding for HBV research at the NIH is only expected to be funded at $66 million in FY 2021.

There is the need, the know- how, and the tools to find a cure that will bring hope to almost 300 million people worldwide suffering from chronic hepatitis B. A cure was accomplished for hepatitis C with increased federal attention and funding. It can be accomplished for hepatitis B as well. Each year, despite an effective vaccine, 3–7 million people worldwide are infected, and the epidemic continues to grow. Moreover, despite the availability of seven approved medications to manage chronic HBV infection, none are curative, most require lifelong use, and only reduce the likelihood of developing liver cancer by 40–60%.

In addition to the devastating toll on patients and their families, ignoring hepatitis B is costing the United States an estimated $4 billion per year in medical costs. By increasing the NIH budget for hepatitis B we have a good chance of success in finding a cure in the next few years. There are exciting new research developments and opportunities in the field that make finding a cure very possible.

Centers for Disease Control and Prevention

Given the challenges and burdens of chronic disease and disability, public health emergencies, new and reemerging infectious diseases and other unmet public health needs, HBF joins the 140 organizations in the CDC Coalition and urges a funding level of at least $10 billion for CDC's programs in FY 2022. This is $1.3 billion more than the Administration's request. The CDC serves as the command center for the nation's public health defense system against emerging and reemerging infectious diseases. States, communities, and the international community rely on CDC for accurate information and direction in a crisis or outbreak. While recent emergency funding has supported efforts to defeat COVID–19, we must provide stable, sufficient public health preparedness funding to allow our state and local health departments to maintain a standing set of core capabilities, so they are ready when needed, regardless of the next challenge or threat.

The CDC's Division of Viral Hepatitis (DVH) is part of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) at CDC. In collaboration with domestic and global partners, DVH provides the scientific and programmatic foundation and leadership for the prevention and control of hepatitis virus infections and their manifestations. HBF joins the Hepatitis Appropriations Partnership in recommending $134 million for the DVH in FY 2022 and within this level urges the Division to fund both the Hepatitis B and Hepatitis C community infrastructure grants. To discontinue one of these grants would be a step backward in the progress being made.

The CDC Division of Viral Hepatitis spends less than 10% of its budget on HBV focused projects, despite hepatitis B infected patients comprising more than 35% of all those infected with viral hepatitis in the U.S. Furthermore, tremendous HBV-related health disparities exist for Asian Americans and Pacific Islanders and recent African immigrants. These groups represent less than 6% of the U.S. population but make up 50%-80% of the U.S. burden of chronic HBV infection. CDC has not adequately addressed the issue of chronic HBV infections among high-risk, foreign-born populations and their children. Of particular concern is that the CDC surveillance

program is not robust enough to accurately report the prevalence of hepatitis B in high incidence states such as California and Hawaii. In view of the fundamental importance of good surveillance data to develop, manage and analyze public health programs and interventions, HBF urges CDC to allocate the necessary resources to address this shortcoming without adversely impacting other CDC hepatitis B programs.

HBF is further concerned that despite the availability of an effective hepatitis B (HBV) vaccine, less than 25% of adults age 19 and older are vaccinated. According to CDC's most recent survey of Vaccination Coverage Among Adults, this poor vaccination rate remains flat and has not improved in several years. We are encouraged that CDC is evaluating new universal HBV vaccination recommendations including a comprehensive plan to increase adult HBV vaccinations. The CDC is further urged to promote awareness about the importance of hepatitis B vaccination among medical and health professionals, communities at high risk, and the public, and to improve collaboration and coordination across CDC to achieve this goal.

SUMMARY AND CONCLUSION

Mrs. Chairwoman, again we wish to thank the Subcommittee for its past leadership. Significant progress has been made in meeting the many public health concerns facing this Nation, due to your efforts. HBF appreciates the opportunity to provide testimony to you on behalf of these paramount needs of the Nation.

[This statement was submitted by Timothy Block, Ph.D., President, Hepatitis B Foundation.]

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, my name is Dr. Marwan Haddad, MD, MPH, Chair-elect of the HIV Medicine Association (HIVMA), and I serve as the Medical Director of the Center for Key Populations at the Community Health Center, Inc. (CHCI), in Middletown, Connecticut, one of the largest Federally Qualified Health Center in the country. I am pleased to submit testimony on behalf of HIVMA. HIVMA represents nearly 5,000 physicians, scientists, and other health care professionals around the country on the frontlines of the HIV epidemic. Our members provide care and treatment to people with HIV, lead HIV prevention programs, and conduct research in communities across the country. Many of them have been on the frontlines of their community's coronavirus (COVID–19) response.

For the FY2022 appropriations process, we urge you to increase funding for the Ryan White HIV/AIDS Program at the Health Resources and Services and Administration (HRSA); increase funding for the Centers for Disease Control and Prevention's (CDC) HIV, hepatitis, and STD prevention programs; increase investments in HIV research supported by the National Institutes of Health (NIH); appropriate additional funding to support the "Ending the HIV Epidemic" (EHE) Initiative; and the implementation of the EHE initiative as well as the response to the COVID–19 pandemic. As the United States responds to the global COVID–19 pandemic, it is paramount to provide robust funding for public health, including these vital programs which support global and domestic health security measures and our public health infrastructure.

The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership, a coalition of HIV organizations from across the country. For a chart of current and historical funding levels, along with coalition requests for each program, please click here.

ENDING THE HIV EPIDEMIC INITIATIVE—U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Over the last two years, on a bipartisan basis, Congress has appropriated funding for the EHE Initiative, which sets the goal of reducing new HIV infections by 50% by 2025, and 90% by 2030. We recommend funding the EHE initiative at least at the President's budget request for $670 million in support of ending HIV as an epidemic to be used for expanded access to antiretroviral treatment and PrEP to prevent HIV transmissions as well as improved access to routine and critical health services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION—HIV/AIDS BUREAU

HRSA's Ryan White HIV/AIDS Program provides medical care and treatment services to over half a million people living with HIV. Over three-quarters of Ryan

White clients are Black, Latinx or other people of color, and nearly two-thirds have incomes under the federal poverty level. To continue providing comprehensive, life-saving treatment and to bring many more people into care through the EHE Initiative, we urge Congress to fund the Ryan White HIV/AIDS Program at a total of $2.768 billion in FY2022, an increase of $345 million over FY2021. We strongly recommend providing at least $222 million in EHE funding for the Ryan White Program.

HIVMA urges an allocation of $225.1 million, or a $24 million increase over current funding, for Ryan White Part C programs. The flexibility of the Ryan White Program and its providers' expertise has also allowed Part C clinics to respond to the changing needs of patients and the health care system throughout the COVID–19 pandemic. Ryan White clinics serve a significant number of individuals living with both substance use disorder and HIV, delivering a range of medical and support services, including overdose prevention and harm reduction services, needed to prevent, intervene, and treat substance use disorder as well as related infectious diseases, including HIV, HCV, and sexually-transmitted infections (STI).

CHCI's Ryan White-Funded Clinic in Connecticut is Leading on Expanding Access to HIV Prevention, Care, & Treatment

CHCI's Center for Key Populations, Ryan White-funded Early Intervention Services Program, has served as the leading source of HIV primary care in Connecticut for 22 years. Each year our Ryan White program serves more patients from almost every city and town across Connecticut.

The needs of both established and newly diagnosed patients with HIV are growing more complex. In 2020, even as HIV care was innovatively transformed to mostly telehealth due to COVID–19, CHCI experienced an increase in the number of patients living with HIV who accessed services at our sites. Of all new patients enrolled in care at CHCI in 2020, 69% self-reported as racial and ethnic minorities and 56% reported food and housing insecurity as major barriers to achieving optimal healthcare. Additionally, 4% of all Ryan White patients were uninsured, 87.9% had at least one clinical co-morbidity, and 62% reported unmet mental health needs at the time of intake. Among Ryan White Program patients at CHCI, 12% reported unstable housing, which means they were living in a shelter, vehicle, or completely unsheltered, creating additional challenges to retention in care.

CHCI's Ryan White Program eligible patients who are engaged in care are screened for substance use disorders routinely and 63% screened positive with 11% considering those needs urgent or severe. CHCI, like most Ryan White Part C programs, also receives funding from other parts of the Ryan White Program, and these help us provide support services that were particularly important during the COVID–19 pandemic. These services included home medical monitoring equipment, transportation, case management, patient navigation, home-delivered meals, grocery delivery, check-in phone calls, and other key components of care unique to the Ryan White Program care model and contribute to optimal healthcare outcomes for all patients.

HEALTH RESOURCES AND SERVICES ADMINISTRATION—BUREAU OF PRIMARY HEALTH CARE

We recommend appropriating $152 million in new funding for HRSA's Community Health Center program for the EHE initiative. In those community health centers funded by the EHE Initiative, they were able to increase PrEP uptake from 19,000 in 2020 to nearly 50,000 people in early 2021. CDC estimates only 10% of those who could benefit from PrEP have had it prescribed to them, and those who need it most—black and Latino gay and bisexual men at high risk—are prescribed it at a much lower rate. Scaling up PrEP among the most affected populations is critical to reducing health disparities and ending HIV as an epidemic.

CENTERS FOR DISEASE CONTROL AND PREVENTION—NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, SEXUALLY TRANSMITTED DISEASES, AND TUBERCULOSIS PREVENTION

From the CDC's leadership role in responding to the COVID–19 pandemic to its ongoing efforts to address persistent public health epidemics and threats, such as HIV, STIs, and viral hepatitis, the CDC is a critical national and global expert resource and response center. To meaningfully address these epidemics and the co-occurring crisis of substance use disorder—especially injection drug use—we request a $731 million overall increase above FY2021 levels for a total of $2.045 billion.

For the Division of HIV/AIDS Prevention (DHAP), we request a total of $1.293 billion, which is a $328 million increase over FY2021 levels. DHAP conducts our national HIV surveillance and funds state and local health departments and commu-

nities to conduct evidence-based HIV prevention activities. CDC's national surveillance system is critical to monitoring populations and regions impacted by the HIV epidemic and identifying outbreaks. We also strongly recommend appropriating at least the $371 million requested by the Administration for the EHE initiative, allowing the CDC to scale up HIV testing to ensure early diagnosis and care linkage and PrEP programs to prevent new infections.

Additionally, we urge the appropriation of $120 million for the CDC to fund surveillance and programming to monitor and prevent opioid-related infectious diseases as well as expand access to syringe services programs, harm reduction, and overdose prevention. Funding for CDC's Infectious Diseases and Opioid Epidemic programming is critical to respond to increases in serious infections linked to substance use, including HIV, hepatitis B and C, and life-threatening bacterial infections such as endocarditis.

For the Division of Viral Hepatitis (DVH), we request a total of $134 million, which is a $94.5 million increase over FY2021 levels. We have the tools to prevent this growing epidemic, but increased funding is urgently needed to expand testing and screening, prevention, and surveillance to put the U.S. on the path to eliminate hepatitis as a public health threat.

For the Division of STD Prevention (DSTDP), we request a total of $272.9 million, which is a $111.1 million increase over FY2021 levels. For the sixth year in a row, the CDC reports dramatic increases in STIs in the U.S. These historic increases have created a public health emergency with devastating long-term health consequences, including infertility, cancer, HIV transmission, and infant and newborn deaths.

NATIONAL INSTITUTES OF HEALTH—OFFICE OF AIDS RESEARCH

In order to advance discoveries important to end HIV epidemic as an epidemic, including improved HIV prevention modalities and treatment options and ultimately a cure and a vaccine, we ask that at least $3.854 billion be allocated for HIV research in FY2022, an increase of $755 million over FY2021. The return on investment in HIV research extends beyond HIV and includes contributing to the record-breaking timelines for the development of COVID–19 vaccines.

INDIAN HEALTH SERVICE—ELIMINATING HIV AND HEPATITIS C IN INDIAN COUNTRY

Between 2011 and 2015, there was a 38% increase in new HIV diagnoses among the American Indian/Alaska Native population overall, and a rise of 58% among AI/AN gay and bisexual men. We urge for the Indian Health Service component of the EHE Initiative to be funded at $27 million.

CONCLUSION

The COVID–19 pandemic highlights the importance of preparing for infectious diseases outbreaks by fully funding programs that support public health services, infrastructure and workforce so that we are better prepared for the next pandemic. Thank you for your time and consideration of these important requests and for strengthening our nation's ability to end the HIV epidemic in the U.S. Please contact me or HIVMA's Senior Policy & Advocacy Manager, Jose A. Rodriguez, at JRodriguez@hivma.org, if you have any questions or need additional information. HIVMA is located at 4040 Wilson Boulevard Suite 300, Arlington, VA 22203.

[This statement was submitted by Marwan Haddad, MD, Chair-elect, HIV Medicine Association, MPH.]

PREPARED STATEMENT OF THE HIV + HEPATITIS POLICY INSTITUTE

On behalf of the HIV + Hepatitis Policy Institute, we respectfully submit this testimony in support of increased funding for domestic HIV and hepatitis programs in the FY 2022 Labor, HHS spending bill. The HIV+Hepatitis Policy Institute is a leading HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions.

This June 5th our nation commemorated the 40th anniversary of AIDS. Over the last four decades the U.S. has made great advances in HIV prevention, care, and treatment; but much work remains. While between 2015 and 2019 the U.S. saw slight decreases in the number of new HIV infections, disparities continue to exist, and some populations saw increases in infections. HIV continues to disproportionately impact Black and Latino gay men, Black women, people who inject drugs, and who live in the South. The Centers for Disease Control and Prevention (CDC) re-

ports that over half of all new HIV infections in 2019 were in the South. Recently, the Department of Health and Human Services released updated strategic plans to guide our nation in responding to the HIV and hepatitis epidemics, including for the first time ever calling for the elimination of viral hepatitis. In each of the plans, the need to address the syndemics of HIV and hepatitis is prioritized.

As our country continues to respond and recover from the COVID–19 pandemic, which has impacted HIV and hepatitis services, we know we have the science to end two other infectious diseases that have been impacting our country for decades: HIV and hepatitis C. While there still is no cure or vaccine for HIV, we have preventive tools along with treatments that suppress the virus, and together can bring the number of new infections down to a point that we can end HIV. For hepatitis C, there are curative treatments. However, federal leadership and funding for our public health system is necessary to ramp up efforts to address these two epidemics. The programs and funding increases detailed below are pivotal to our nation's ability to end both HIV and hepatitis.

ENDING THE HIV EPIDEMIC IN THE U.S.

Over the past two years, Congress has appropriated over $400 million in new funding for the Ending the HIV Epidemic in the U.S. initiative, which sets the goal of reducing new HIV infections by 75 percent by 2025, and 90 percent by 2030. Priority jurisdictions have used initial funding to develop ending HIV plans with the help of community partners that build on existing HIV programs and utilize new innovations and strategies. Even while battling COVID, the Ryan White HIV/AIDS Program reports that in these priority jurisdictions, with the additional funding, they were able to bring nearly 6,300 new clients into the program and re-engage an additional 3,600 between March and August of 2020. In the community health centers funded by the EHE initiative, they were able to increase pre-exposure prophylaxis (PrEP) uptake from 19,000 in 2020 to nearly 63,000 people within 11 months.

We are pleased that President Biden has proposed to increase funding for the Ending the HIV Epidemic initiative by $267 million as part of his FY22 budget. Additionally, the Biden administration has proposed increases in other domestic HIV programs. Since many of these increases fall short of what was proposed last year and what is needed, we urge the Congress to do better and significantly increase funding for the Ending the HIV Epidemic in the U.S. initiative for FY2022 so that this important work can be properly ramped up. In particular we ask for increased funding for the following programs:

—CDC Division of HIV/AIDS Prevention for testing, linkage to care, and prevention services, including PrEP (+$196 m);

—HRSA Ryan White HIV/AIDS Program to expand comprehensive treatment for people living with HIV (+$107 m); and

—HRSA Community Health Centers to increase clinical access to prevention services, particularly PrEP (+$50 m)

The success of the EHE initiative rests upon our underlying public health prevention, care, and treatment programs at the CDC and HRSA. Congress must ensure that these are adequately funded to provide services in all areas of the country.

The Ryan White HIV/AIDS Program at the Health Resources and Services Administration provides medical care, medications, and essential coverage completion services to over 567,000 low-income, uninsured, and/or underinsured individuals with HIV. For over 30 years, the Ryan White program has pioneered innovative models of care which has resulted in 88 percent of Ryan White clients achieving viral suppression, a critical marker for decreasing new infections in the U.S. Currently Ryan White Programs, and particularly the AIDS Drug Assistance Programs (ADAPs), are facing increased demand as people have lost health coverage and incomes due to the economic impact of COVID–19, and state and local budgets have become increasingly stressed. Without increased funding some ADAPs may be forced to institute wait lists for medications or other cost containment measures. We urge Congress to fund the Ryan White HIV/AIDS Program at a total of $2.768 billion in FY2022, an increase of $345 million over FY2021 including an increase of $68 million for ADAPs for total funding of $968.3 million.

In addition, HIV+Hep opposes any efforts through the appropriations process to alter the intent of the program to use Ryan White-derived funds for activities outside the scope of the original intent of current legislative language.

The CDC Division of HIV Prevention funds state and local public health departments and community-based organizations to implement and enhance targeted, tailored, and high-impact prevention programs aimed at addressing racial and geographic health disparities. This includes HIV testing, condom distribution programs,

and other HIV awareness campaigns. CDC also funds our national surveillance system which is critical to identifying new HIV clusters and outbreaks and provides the data necessary to tailor resources and programming. Funding from the CDC also allows communities to focus on increasing access to and use of PrEP, which is critical to ending the HIV epidemic. Recent CDC data show that in 2019, nearly 285,000 or 23 percent of people eligible for PrEP were prescribed it, up from 3 percent in 2015. While this increase is moving in the right direction, some of the communities most in need of PrEP are not receiving it and we must continue building programs to provide outreach to communities and education about PrEP.

A holistic response to the HIV epidemic also depends on fully funding other priority programs at HHS, including the CDC's Division of School and Adolescent Health and STI Prevention, the Minority HIV/AIDS Initiative, AIDS Research at the NIH, the Title X Family Planning Program, and the Teen Pregnancy Prevention Program (TPPP).

VIRAL HEPATITIS

We respectfully request that you provide increased funding for viral hepatitis programs at the CDC. The CDC estimates that more than 4.5 million people in the United States live with hepatitis B (HBV) or hepatitis C (HCV), with nearly half unaware they are living with the disease. The opioid epidemic has significantly increased the number of viral hepatitis cases in the United States, with available data suggesting that more than 70 percent of new HCV infections are among people who inject drugs. There are several curative treatments available for HCV, but individuals must have access to screening and linkage to care programs to be able to take advantage of these medications. The number of acute hepatitis C cases reported in the U.S. has increased every year since 2012. CDC recently reported an increase of 63 percent in acute hepatitis C cases between 2015 and 2019, with 67 percent of the cases in 2019 associated with injection drug use.

CDC Division of Viral Hepatitis

The viral hepatitis programs at the CDC are severely underfunded, receiving only $39.5 million-far short of what is needed to build and strengthen our public health response and to eventually end hepatitis. States' ability to conduct enhanced HCV surveillance activities is severely hampered by a lack of funding. Additional resources would allow the CDC to enhance testing and screening programs, link people to treatment, conduct additional provider education, and increase services related to hepatitis outbreaks and injection drug use. We urge you to provide the CDC Division of Viral Hepatitis with $134 million, an increase of $94.5 million over FY 2021 enacted levels.

CDC's Eliminating Opioid-Related Infectious Diseases Program

This CDC program focuses on addressing the infectious disease consequences of increased rates of injection drug use due to the opioid crisis. Providing full support for this program is another key step in preventing new cases of viral hepatitis and HIV and putting the country on the path towards elimination. We urge the committee to fund this program to eliminate opioid-related infectious diseases at no less than $120 million, an increase of $107 million.

SYRINGE SERVICE PROGRAMS (SSPS)

We also ask that the committee support ending any prohibition on the use of federal funds to purchase sterile needles or syringes for SSPs. A wealth of scientific evidence has shown that SSPs reduce the spread of infectious diseases, such as HIV and hepatitis. Full federal funding for these programs will only serve to make the programs stronger and more effective.

In conclusion, we urge the committee to continue its investment in our nation's public health infrastructure specifically as it relates to addressing the ongoing HIV and HCV epidemics. Fortunately, we have the tools available to end both these epidemics; however, we must provide the necessary resources to achieve these goals.

[This statement was submitted by Carl Schmid, Executive Director, HIV + Hepatitis Policy Institute.]

PREPARED STATEMENT OF THE HUMAN FACTORS AND ERGONOMICS SOCIETY

On behalf of the Human Factors and Ergonomics Society (HFES), we are pleased to provide this written testimony to the Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies for the official record. HFES

urges the Subcommittee to provide no less than $500 million for the Agency for Healthcare Research and Quality (AHRQ) and a minimum of $375.3 million for the National Institute for Occupational Safety and Health (NIOSH), including $34 million for the Education and Research Centers (ERCs), in fiscal year (FY) 2022.

AHRQ supports research to improve health care quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. As the lead federal agency for funding health services research (HSR) and primary care research (PCR), AHRQ is the bridge between cures and care, and ensures that Americans get the best health care at the best value. The RAND Corporation released a report in 2020 as called for by the Consolidated Appropriations Act of 2018, which identified AHRQ as "the only agency that has statutory authorizations to generate HSR and be the home for federal PCR, and the unique focus of its research portfolio on systems-based outcomes (e.g., making health care safer, higher quality, more accessible, equitable, and affordable) and approaches to implementing improvement across health care settings and populations in the United States."

HFES requests a minimum of $500 million for AHRQ, which is consistent with the FY 2010 level adjusted for inflation and reflects the demonstrated needs of pandemic response. This funding level will allow AHRQ to rebuild portfolios terminated after years of cuts. AHRQ is the federal vehicle for studying and improving the United States healthcare system, and it needs the resources to meet its mission and this moment. Through this appropriation level, AHRQ will be better able to fund the "last mile" of research from cure to care.

Additionally, HFES requests $375.3 million for NIOSH, including $34 million for the Education and Research Centers (ERCs). NIOSH supports education and research in occupational health through academic degree programs and research opportunities. With an aging occupational safety and health workforce, ERCs are essential for training the next generation of professionals. The Centers establish academic, labor, and industry research partnerships to achieve these goals. Currently, ERCs are responsible for supplying many of the country's OSH graduates who will go on to fill professional roles.

HFES strongly believes that investment in scientific research serves as an important driver for innovation and the economy as well as for protecting and promoting the health, safety, and well-being of Americans. We thank the Subcommittee for its longtime recognition of the value of scientific and engineering research and its contribution to innovation and public health in the U.S.

THE VALUE OF HUMAN FACTORS AND ERGONOMICS SCIENCE

HFES is a multidisciplinary professional association with over 3,000 individual members worldwide, including psychologists and other scientists, engineers, and designers, all with a common interest in designing safe and effective systems and equipment that maximize and adapt to human capabilities.

For over 50 years, the U.S. federal government has funded scientists and engineers to explore and better understand the relationship between humans, technology, and the environment. Originally stemming from urgent needs to improve the performance of humans using complex systems such as aircraft during World War II, the field of human factors and ergonomics (HF/E) works to develop safe, effective, and practical human use of technology. HF/E does this by developing scientific approaches for understanding this complex interface, also known as "human-systems integration." Today, HF/E is applied to fields as diverse as transportation, architecture, environmental design, consumer products, electronics and computers, energy systems, medical devices, manufacturing, office automation, organizational design and management, aging, farming, health, sports and recreation, oil field operations, mining, forensics, and education.

With increasing reliance by federal agencies and the private sector on technology-aided decision-making, HF/E is vital to effectively achieving our national objectives. While a large proportion of HF/E research exists at the intersection of science and practice—that is, HF/E is often viewed more at the "applied" end of the science continuum—the field also contributes to advancing "fundamental" scientific understanding of the interface between human decision-making, engineering, design, technology, and the world around us. The reach of HF/E is profound, touching nearly all aspects of human life from the health care sector to the ways we travel and to the hand-held devices we use every day.

CONCLUSION

HFES urges the Subcommittee to provide $500 million for AHRQ and $375.3 million for NIOSH, including $34 million for the Education and Research Centers (ERCs) in FY 2022. These investments fund important research studies, enabling

an evidence base, methodology, and measurements for improving healthcare, safety, and public health for Americans.

On behalf of the HFES, we would like to thank you for the opportunity to provide this testimony. Please do not hesitate to contact us should you have any questions about HFES or HF/E research. HFES truly appreciates the Subcommittee's long history of support for scientific research and innovation.

[This statement was submitted by Peter Hancock, DSc, PhD, President, and Steven C. Kemp, CAE, Executive Director, Human Factors and Ergonomics Society.]

PREPARED STATEMENT OF I AM ALS

Chairwoman Murray, Ranking Member Blunt thank you for the opportunity to submit written testimony. My name is Brian Wallach and I have enjoyed the opportunity to work with both of you and your colleagues in the Senate ALS Caucus over the past several years.

I am grateful for all you and your colleagues have done for the ALS community. Thanks to you and others like Senators Dick Durbin, Lisa Murkowski, Chris Coons, and Mike Braun, and our incredible ALS grassroots advocates, we have increased federal spending on ALS research by $83 million in just two years. And this past December, Congress overwhelmingly passed a bill to give ALS patients access to SSDI benefits upon diagnosis, averting bankruptcy for so many.

As a result of this work, the path towards ending ALS is clearer. The question now is when do we reach the end of that path and will any of those of us living with ALS now be here to see that day?

I desperately want to be here, but my body is failing. You can hear it in my voice and see it in the videos I post on Twitter. Odds are that unless something changes, I won't be. The average patient lives 2–5 years post-diagnosis and of those diagnosed in 2017 with me, four out of five-80%-are dead.

So I come with two urgent asks. Ones that if you make real will change my and millions of others' futures.

First, fund ARPA–H and include ALS among its core disease areas. During the 2020 campaign then-candidate Joe Biden promised ALS patient Ady Barkan that he would seek to create ARPA–H, modeled after DARPA, to solve issues relating to the diagnosis and treatment of disease. He also promised that ALS-along with cancer, diabetes and Alzheimer's-would be among the first diseases it tackled.

I was elated when President Biden's administration submitted a proposal to fund ARPA–H to Congress. I was devastated when I saw that only ALS was left out of the list of identified diseases it would target.

To cure ALS, we need an ARPA–H. We need both a focus on high risk/high reward research and to break down the antiquated, bureaucratic red tape facing ALS patients seeking promising therapies. Moreover, if we cure ALS, we can help unlock cures for Alzheimer's, Parkinson's, Frontotemporal Dementia and beyond.

Today, despite the increases in funding over the last 2 years, our government still spends less than $6,000 on ALS research per year per person in the U.S. living with ALS. You have the power to fix this by putting ALS back into ARPA–H.

Second, we need you to hold the FDA accountable for failing ALS patients by denying any type of approval for two promising therapies this year. On June 7th, we watched the FDA grant accelerated approval of aducanumab for the treatment of Alzheimer's disease and wondered why that same urgency has not been applied to ALS.

In September 2019, FDA released an updated Guidance for ALS Clinical Trials. It stressed the need for "regulatory flexibility in applying the statutory standards to drugs for serious diseases with unmet medical needs." The Guidance explicitly stated that "[w]hen making regulatory decisions about drugs to treat ALS, FDA will consider patient tolerance for risk and the serious and life-threatening nature of the condition in the context of statutory requirements for safety and efficacy."

The first two tests of FDA's promise of regulatory flexibility and urgency for ALS came this year with AMX0035, an oral medication, and NurOwn, a stem cell therapy. The Phase II/III trial for AMX0035 showed that AMX0035 slowed the progression of ALS and enabled patients on average to live 6.5 months longer. NurOwn's Phase III trial did not show the same overall benefit, but did show a "clinically meaningful" slowing of progression for a subgroup of ALS patients.

FDA's response: No approval for either therapy. No regulatory flexibility. No consideration of the terminal nature of ALS. No regard for the tens of thousands of patients, caregivers and advocates who signed petitions to the FDA pleading for access to these therapies.

Instead, the FDA reverted to the same inflexible position for both therapies: they asked each company to run another large, long placebo-controlled trial and then come back. Let me make crystal clear what these two decisions by FDA mean: at best these therapies won't be accessible to patients for 4 years. By then nearly every ALS patient alive today will be dead.

Why weren't these therapies approved? Both therapies showed efficacy for at least a subgroup of ALS patients. And if the concern was safety, both trials showed a strong safety profile-particularly in the context of a 100% fatal disease. Moreover, the denials deprived patients of the chance to access FDA-regulated drugs under the supervision of an ALS specialist. So, instead, patients are forced to try to replicate the formula for AMX0035 on their own and to travel abroad for risky stem cell procedures.

I've been told that the FDA has claimed to members of Congress and their staff that they are doing everything they can and that there was nothing else they could do with respect to these two therapies. This is simply not true or, if FDA actually believes this, they have provided Congress a clarion call to reform how FDA regulates treatments for diseases like ALS.

I am a former federal government employee. I come from a family of former and current federal government employees. I truly believe the FDA is filled with honorable, dedicated public servants. However, their actions here are impossible to square with their own Guidance. This is most clearly demonstrated by the fact that AMX0035 appears headed towards approvals in Canada and Europe based on the same data presented to FDA. FDA stands alone as an immovable obstacle.

I implore Congress to hold hearings on these denials to bring transparency and accountability to a process that has left the ALS community devastated.

In addition to hearings, I ask you to pass and fund 2 bills to ensure this does not happen again. Over the last year, the fight against COVID–19 showed how much regulatory flexibility FDA has when it wants to use it. Since FDA appears unwilling to use it to give ALS patients a chance to live, we have worked with members of Congress to reform how FDA approaches diseases like ALS.

The first, ACT for ALS, will, among other items, make a significant amount of funding available to establish expanded access programs. Programs that will make promising therapies available to ALS patients now while fueling additional research into a therapy's safety and efficacy.

The second, The Promising Pathways Act, will, among other things, allow for conditional approval of promising therapies after Phase II for life-threatening diseases like ALS. This would put us on par with Europe.

Today, the science needed to cure ALS is moving faster than ever and finally producing therapies that may be able to slow or stop this disease. This reality must be matched by a new regulatory approach that speeds promising therapies to patients. As I have outlined, despite programs aimed to do just that which have worked in other diseases, we do not have that approach for ALS today. It is our moral obligation to change this broken approach for all those facing ALS just as we did for HIV and cancer.

If we do, I will have a chance to see my daughters graduate from kindergarten, high school, and college.

You have the power to make that happen.

I thank you for having the courage to do so.

And I look forward to working with each of you to finally defeat ALS.

[This statement was submitted by Brian Wallach, Co-Founder, I AM ALS.]

PREPARED STATEMENT OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

On behalf of the Infectious Diseases Society of America (IDSA), which represents more than 12,000 physicians, scientists, public health practitioners and other clinicians specializing in infectious diseases prevention, care, research and education, I urge the Subcommittee to provide robust FY2022 funding for public health and biomedical research activities that save lives, contain health care costs and promote economic growth. IDSA asks the Subcommittee to provide $10 billion for the Centers for Disease Control and Prevention (CDC), $46.111 billion for the National Institutes of Health (NIH), $300 million for the Biomedical Advanced Research and Development Authority (BARDA) Broad Spectrum Antimicrobials and CARB–X programs and $200 million for the Strategic National Stockpile Special Reserve Fund program.

While we must continue to direct substantial resources to tackle the COVID–19 pandemic, we must also address other domestic and global infectious diseases threats and epidemics, including those for which progress has stalled and/or wors-

ened during the pandemic. For example, routine immunization rates have fallen, and access to care for diseases like HIV has been disrupted. In addition, high levels of antibiotic use likely exacerbated existing antibiotic resistance, deepening the need for antimicrobial stewardship, surveillance and new antimicrobial drugs. The COVID–19 pandemic has shown us all too clearly the fundamental importance of expanding the infectious diseases workforce, public health infrastructure and biomedical research enterprise necessary to successfully confront the panoply of infectious threats facing our increasingly interconnected world.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Antibiotic Resistance Solutions Initiative (ARSI)

We urge $672 million in funding for the Antibiotic Resistance Solutions Initiative in FY2022. IDSA members see the impact that antimicrobial resistance (AMR) has on patients daily. Antimicrobial resistance is one of the greatest public health threats of our time. Drug-resistant infections sicken at least 2.8 million each year and kill at least 35,000 people annually in the United States. Antibiotic resistance accounts for direct healthcare costs of at least $20 billion. If we do not act now, by 2050 antibiotic resistant infections are expected to be the leading cause of death in the world.

We therefore recommend $672 million for the Antibiotic Resistance Solutions Initiative to achieve the goals outlined in the 2020–2025 National Action Plan for Combating Antibiotic-Resistant Bacteria. The ARSI is the cornerstone of the nation's efforts to detect, prevent, and respond to AMR. The program is also a critical building block of CDC's public health infrastructure that directly supports broader agency activities, including COVID–19 first responders, foodborne illness pathogen detection, sexually transmitted infections, health care associated infections and global health. Increased funding would help expand antibiotic stewardship across the continuum of care; double grant awards at the state and local level; expand the Antibiotic Resistance Laboratory Network globally and domestically to strengthen the identification, tracking and containment of deadly pathogens; support AMR research and epicenters; and increase public and health care professional education and awareness activities. Since FY2016, funding for the initiative has improved antibiotic use, increased state and regional laboratory capacity to rapidly detect resistant infections and enhanced tracking of health care-associated infections. However, many state laboratories still do not monitor for and report resistance data on pathogens of importance and the program will be unable to effectively address current and newly emerging threats and prepare for future challenges without a significant increase in funding in FY2022. Increased funding is vital to achieving the plan's goals, including a 20 percent decrease in health care-associated antibiotic-resistant infections and a 10 percent drop in community-acquired antibiotic-resistant infections by 2025.

Advanced Molecular Detection

Advanced Molecular Detection (AMD) strengthens CDC's epidemiologic and laboratory expertise to effectively detect and track pathogens, including how they mutate, to inform responses and improve clinical care of patients. AMD provides more rapid identification of pathogens which can positively benefit antimicrobial stewardship to improve patient outcomes and reduce AMR. Requested FY2022 funding of $60 million would further enhance federal, state and local laboratory capabilities and spur innovation, including through further integration of genomics and other advanced laboratory technologies into AMR surveillance. Increased funding would help CDC apply the work of SPHERES, a national genomics consortium led by AMD that coordinates large-scale, rapid SARS–CoV–2 sequencing across the U.S., to bolster AMR surveillance, detection and response.

National Healthcare Safety Network

FY2022 funding of $100 million for the National Healthcare Safety Network (NHSN) will enable the program to meet its current and projected demands. Requested funding would expand data collection on antibiotic use and resistance in health care facilities as outlined in the 2020–2025 National Action Plan for Combating Antibiotic-Resistant Bacteria. In 2020, many additional health care facilities began reporting COVID–19 data to NHSN, and new funding will help expand that reporting to include antibiotic use and resistance data. FY2022 funding would help achieve the National Action Plan goals for 75 percent of acute care hospitals and 25 percent of critical access hospitals reporting to the NHSN Antibiotic Resistance Option and 100 percent of acute care and 50 percent of critical access hospitals reporting to the NHSN Antibiotic Use Option. These data help measure and drive progress toward optimizing antibiotic use. Additionally, increased funding would

provide access to technical support for more than 65,000 staff at health care facilities who use NHSN.

CDC Center for Global Health

IDSA urges the Subcommittee to provide $857.8 million in FY2022 funding, including $456.4 million for CDC's Division of Global Health Protection. Public health experts address more than 400 diseases and health threats in 60 countries, including SARS–CoV–2. An emerging infection in any part of the world is just a plane ride away from the U.S. (or any other location). As highlighted by the COVID–19 pandemic, increased resources for this vital CDC program are needed to improve global capacity to prevent, detect and respond to health threats at their source before international spread. As a key implementor of the Global Health Security Agenda, the division works to improve health emergency preparedness and response, enhance infectious disease surveillance systems, strengthen laboratory capacity, train health care workers and disease detectives and build and support emergency operations centers in countries with limited public health capacities. The current COVID–19 tragedy in India and Brazil underscores the critical importance of global public health infrastructure. The program also works to address AMR by providing technical assistance to 30 countries, working to detect resistant threats; prevent and contain resistance pathogens; and improve antibiotic use. Other divisions in the CDC Center for Global Health are instrumental in providing technical assistance on HIV, tuberculosis (TB) and malaria and other parasitic diseases, and also ensuring access to essential immunization services for children in low- and middle-income countries. U.S. leadership of global health security efforts is essential, and the resources allocated to those efforts have been inadequate. Until all countries have laboratory monitoring and surveillance capacities and the trained staff and equipment necessary to detect and respond swiftly to emerging infectious threats, we all will remain vulnerable.

Elimination of Opioid Related Infectious Diseases

$120 billion in funding for the Opioid-Related Infectious Diseases program would allow CDC to address the significant and growing burden of the opioid epidemic by expanding surveillance for infectious diseases commonly associated with injection drug use, including HIV, viral hepatitis and infective endocarditis. CDC has found steep increases in multiple viral, bacterial and fungal infections due to injection drug use, and CDC estimates that individuals who inject drugs are 16 times more likely to develop an invasive Methicillin-resistant Staphylococcus aureus (MRSA) infection. We are very concerned about how the opioid crisis is driving higher rates of infectious diseases including hepatitis C, endocarditis, HIV, and pneumonia, as well as skin, soft tissue, bone, and joint infections. Support systems for individuals with substance use disorders are suffering disruptions due to the COVID–19 pandemic, which may be worsening the opioid epidemic and associated infectious diseases.

ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

Biomedical Advanced Research and Development Authority (BARDA), Broad Spectrum Antimicrobials and Combating Antibiotic-Resistant Bacteria Biopharmaceutical Accelerator (CARB–X)

The BARDA Broad Spectrum Antimicrobials program and CARB–X leverage public/private partnerships to develop products that directly support the government-wide National Action Plan for Combating Antibiotic-Resistant Bacteria and have been successful in developing new FDA-approved antibiotics. To help achieve the plan's goals to accelerate basic and applied research for developing new antibiotics and other products, $300 million in FY2022 funding is needed. This funding will help prevent a situation in which we lose many modern medical advances that depend upon the availability of antibiotics, such as cancer chemotherapy, organ transplantation and other surgeries.

Project BioShield Special Reserve Fund (SRF), Broad Spectrum Antimicrobials

We recommend $200 million in funding for the Project BioShield SRF. The SRF is positioned to support the response to public health threats, including AMR. BARDA and National Institute of Allergy and Infectious Diseases efforts have helped companies bring new antibiotics to market, but those companies now struggle to stay in business and two filed for bankruptcy in 2019. In December 2019, SRF funds supported a contract for a company following approval of its antibiotic—a phase of drug development during which small biotech firms are particularly vulnerable. $200 million in funding would expand this approach to better support the antibiotics market.

NATIONAL INSTITUTES OF HEALTH

National Institute of Allergy and Infectious Diseases (NIAID)

$6.520 billion for NIAID, including $600 million for AMR research, would allow NIAID to address AMR while carrying out its broader role in supporting infectious diseases research, including emerging infectious diseases, HIV, TB and influenza. Increased FY2022 funding would strengthen investment in the biomedical research workforce, including training and efforts to support early-career physician-scientists and promote diversity, update the national clinical trials infrastructure to include community hospitals and enable access for underserved populations.

The COVID–19 pandemic has demonstrated the need to better prepare our biomedical research infrastructure to respond to emerging infectious diseases and future emergencies, including the need to strengthen and diversify the ID research workforce. High educational debt, low research salaries, and competing work-life demands have driven many promising researchers from the field. The current pandemic has reportedly increased interest in infectious diseases as a career, but translating increased interest into recruitment and retention remains a challenge. Infectious diseases as a specialty only filled 88% of positions and 75% of programs in the recent match; further, 80% of counties in the US do not have an ID physician. Strong NIAID support for career development through increased FY2022 funding and other initiatives is critical to maintaining and improving the pipeline of physician scientists committed to a career in ID. NIAID should use increased resources to provide additional K, T, and F awards, and Early Investigator Awards as well as new opportunities for community-based ID physicians to participate in clinical trials and other research to enhance recruitment, training and diversity of the physician-scientist workforce.

The COVID–19 pandemic has exposed systemic deficits that threaten our ability to combat future outbreaks and threats, such as AMR. FY2022 funding will allow NIAID to continue to respond to the pandemic and prepare for future outbreaks while carrying out its broader role in infectious diseases research. Such efforts include research on antimicrobial mechanisms of resistance, therapeutics, vaccines and diagnostics; development of a clinical trials network to reduce barriers to research on emerging and difficult-to-treat infections; and support for training more physician scientists and clinical investigators to improve research capacity, for example, as outlined in the 2020–2025 National Action Plan to Combat Antibiotic-Resistant Bacteria.

CONCLUSION

Thank you for the opportunity to submit this statement. The nation's ID physicians and scientists rely on strong federal partnerships to keep Americans healthy and urge you to support these efforts. Please forward any questions to Lisa Cox at lcox@idsociety.org.

[This statement was submitted by Barbara D. Alexander, MD, MHS, FIDSA, IDSA, President, Infectious Diseases Society of America.]

PREPARED STATEMENT OF THE INTEGRATIVE HEALTH POLICY CONSORTIUM

Thank you, Chair Murray and Ranking Member Blunt, for this opportunity to testify in support of programs at the Department of Health and Human Services under your Subcommittee's jurisdiction that are important to the members of the Integrative Health Policy Consortium (IHPC) (www.ihpc.org). Specifically, IHPC is writing to express its support for funding the National Center for Complementary and Integrative Health (NCCIH), a component of the National Institutes of Health (NIH), and the Federally Qualified Health Centers (FQHCs) program within the Health Resources and Services Administration (HRSA). In addition, our testimony respectfully asks the Subcommittee to support the inclusion of report language urging the Department of Health and Human Services (HHS) to implement recommendations issued by the HHS Pain Management Best Practices Inter-Agency Task Force.

The Integrative Health Policy Consortium (IHPC) IHPC is a broad-based coalition of organizations whose mission is to eliminate barriers to health. IHPC includes 26 organizations representing more than 650,000 state licensed, certified and/or nationally certified healthcare professionals, including medical doctors, registered nurses, doctors of chiropractic, naturopathic doctors, licensed acupuncturists, licensed massage therapists, and academic, research, clinical, and public education organizations. IHPC has championed the Congressional Integrative Health & Wellness Caucus and functions to support the federal agencies overseeing America's health and health re-

search needs. IHPC envisions a world with no barriers to health and is focused on promoting a healthier world that incentivizes health creation for all individuals, communities, and the planet.

NATIONAL CENTER FOR COMPLEMENTARY AND INTEGRATIVE HEALTH

IHPC appreciates the strong support that the Chair and Ranking Member have given the NIH. IHPC shares your enthusiasm for the agency's research and research training mission and encourages the subcommittee to continue prioritizing NIH funding. In addition, we urge the Subcommittee to provide the National Center for Complementary and Integrative Health (NCCIH) with similar, commensurate increases. With this additional support, NICCH could support its ongoing mission as well as embark fully on a new, promising research initiative, the Whole Health Perspective. This initiative would promote research looking at the interactions between systems in the body, such as connections between the brain and the heart, that predispose people to disease and expand our understanding of integrative health and pathways to improving health and preventing disease.

IHPC specially wants to draw attention to the importance of including all the regulated integrative health systems and professions in whole person research. One of the major lessons of the COVID–19 pandemic and the importance of optimal health is the need for each of the major systems as well as integrative protocols to be studied in real world environments to determine the whole person effect of regular care through specific approaches such as acupuncture, naturopathic medicine, chiropractic, homeopathy, holistic nursing, massage therapy, lifestyle and functional medicine approaches, direct entry midwifery, and traditional healing approaches from Native American and indigenous communities.

IHPC joins other organizations in asking the Subcommittee to provide NIH with $46.1 billion in FY 2022. This request, which is a $3.177 billion (7.4%) increase over the comparable FY 2021 funding level for the NIH, would allow for the agency's base budget to keep pace with the biomedical research and development price index (BRDPI) and allow meaningful growth of 5%. Further, such an increase would expand NIH's capacity to support promising science across all disciplines, particularly including the new Whole Health initiative underway at NCCIH. IHPC asks the subcommittee to provide NCCIH with at least a similar 7.4% funding increase in FY 2022.

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. In recent years, especially with the onset of the nation's opioid crisis, FQHCs have emerged as a platform for Integrative Whole Health innovation and for the delivery of non-pharmacologic pain management services. During the COVID–19 pandemic, select FQHCs have expanded their services to deliver pain management services to an increased number of uninsured and underinsured individuals. To advance and expand the FQHC mission, IHPC endorses the recommendation issued by the National Association of Community Health Centers to provide community health centers with $2.2 billion in discretionary funding in FY 2022. Further, we respectfully request the Subcommittee to request a report from HRSA in FY 2022 regarding the inclusion of regulated complementary and integrative health professionals and services system wide, Medicare and Medicaid reimbursement for services within the FQHC system and barriers to access and reimbursement for non-pharmacologic pain management services; and possible solutions to the elimination of noted barriers.

HHS PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE

IHPC respectfully asks that the Subcommittee support the inclusion of proposed report language, urging HHS to facilitate adoption of recommendations from The Pain Management Best Practices Inter-Agency Task Force and launch a public awareness campaign to educate Americans about the differences between acute and chronic pain and the evidence-based non-opioid (non-pharmacologic) treatment options that are available. In 2019, this congressionally established task force issued a ground-breaking report regarding best practices for managing acute and chronic pain. Of note, the report underscores the philosophical and cultural shift to focus on addressing chronic and acute pain by using complementary and integrative health including non-pharmacologic approaches that have been proven effective and are widely supported by practitioners working in all healthcare settings. These treatment options include acupuncture, massage therapy, physical and occupational therapies, chiropractic, cognitive behavioral therapy, manipulative therapy, yoga, tai

chi, and meditation. If implemented, these recommendations will have profound public health and positive national economic impact on a significant percent of the U.S. population. The IHPC stands ready to assist the agency and the Congress in advancing this important public awareness.

Thank you for considering our views. The IHPC looks forward to working with you to enact the FY 2022 Labor, Health and Human Services and Education Appropriations bill and to help ensure our priorities are addressed in the final version of this important funding legislation.

Integrative Health Policy Consortium Partners for Health

American Holistic Nurses Credentialing Corporation (AHNCC) https://www.ahncc.org/	Life University The Octagon http://www.octagon.life.edu/	American Nutrition Association Board of Certification Nutrition of Specialists (BCNS) https://theana.org/certify
International Chiropractors Association (ICA) https://www.chiropractic.org/	Alliance for Massage Therapy Education (AFMTE) https://www.afmte.org/	American Holistic Nurses Association (AHNA) https://www.ahna.org/
Southern California University of Health Sciences (SCU) https://www.scuhs.edu/	Integrative Medicine for the Underserved (IM4US) https://im4us.org/	American Association of Naturopathic Physicians (AANP) https://naturopathic.org/
Palmer College of Chiropractic https://www.palmer.edu/	Naturopathic Medicine Student Association (NMSA) https://naturopathicstudent.org/	National Center for Homeopathy (NCH) https://www.homeopathycenter.org/
Council for Homeopathic Certification (CHC) https://www.homeopathicdirectory.com/	American Academy of Medical Acupuncture (AAMA) https://medicalacupuncture.org/	Northwestern Health Sciences University, Center for Healthcare Innovation and Policy https://www.nwhealth.edu/research/policy-in-action/
Institute for Natural Medicine (INM) https://naturemed.org/	Upledger Institute https://www.upledger.com/	National Foundation for Integrative Medicine (NFIM) https://nfim.org/
American Society of Acupuncturists https://www.asacu.org/	Academy of Integrative Health and Medicine (AIHM) https://aihm.org/	American Massage Therapy Association (AMTA) https://www.amtamassage.org/
Midwives of Alliance of North America (MANA) https://mana.org/	National Association of Certified Professional Midwives https://nacpm.org/	

[This statement was submitted by Margaret Erickson, PhD, RN, CNS, APRN, APHN-BD, Co-Chair, Integrative Health Policy Consortium.]

PREPARED STATEMENT OF INTERNATIONAL FOUNDATION FOR GASTROINTESTINAL DISORDERS

FISCAL YEAR 2022 L–HHS APPROPRIATIONS RECOMMENDATIONS

—At least $46.1 billion in program level funding for the National Institutes of Health (NIH).
—Proportional funding increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).
—Please provide $10 billion for the Centers for Disease Control and Prevention (CDC).
—Please provide $5 million for the Chronic Disease Education and Awareness Program.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, as you work with your colleagues to develop the FY2022 Labor-Health and Human Services (L–HHS) appropriations bill, please keep in mind the needs and concerns of the functional GI and motility disorders community. Nearly two decades ago, I was diagnosed with one of these diseases, irritable bowel syndrome (IBS). As a young adult, I underwent extensive testing and workups over many years in a difficult effort to discover what was causing my symptoms and how best to treat them. I often relied on self-treatment as best as I could, but this was not sustainable. Unfortunately, I am not alone in these experiences. As President of IFFGD, I have heard my story echoed back to me by thousands of others. Patients affected by these disorders often face similar delays in diagnosis, frequent misdiagnosis, and inappropriate treatments including unnecessary and costly surgery. These are common concerns for our community, and they underscore the need for increased research, improved provider education, and greater public awareness.

ABOUT THE FOUNDATION

The International Foundation for Gastrointestinal Disorders (IFFGD) is a registered nonprofit education and research organization dedicated to informing, assisting, and supporting people affected by gastrointestinal (GI) disorders. IFFGD works with patients, families, physicians, nurses, practitioners, investigators, regulators, employers, and others to broaden understanding about GI disorders, support and encourage research, and improve digestive health in adults and children.

ABOUT GASTROINTESTINAL (GI) AND MOTILITY DISORDERS

GI and motility disorders are the most common digestive disorders in the general population. These disorders are classified by symptoms related to any combination of the following: motility disturbance, visceral hypersensitivity, altered mucosal and immune function, altered gut microbiota, and altered central nervous system (CNS) processing. Some examples of functional GI disorders are: dyspepsia, gastroparesis, irritable bowel syndrome (IBS), gastroesophageal reflux disease (GERD), bowel incontinence, and cyclic vomiting syndrome. The costs associated with these diseases range from $25-$30 billion annually; economic costs are also reflected in work absenteeism and lost productivity.

CENTERS FOR DISEASE CONTROL AND PREVENTION

We greatly appreciate the support from the Subcommittee in creating the Chronic Disease Education and Awareness Program in FY2021. Patients with FGIMDs frequently suffer for years before receiving an accurate diagnosis, exposing them to unnecessary and costly tests and procedures including surgeries, as well as needless suffering and expense. Functional GI and motility disorders are among the most common digestive disorders in the general population. They affect an estimated 1 in 4 people in the U.S. and account for 40% of GI problems seen by medical providers. A CDC program focused on surveillance, provider education, and public awareness would increase diagnoses and improve patient outcomes. We ask that the Subcommittee provide $5 million for the Chronic Disease Education and Awareness Program in FY2022.

NATIONAL INSTITUTES OF HEALTH

Strengthening the nation's biomedical research enterprise through NIH fosters economic growth and sustains innovations that enhance the health and well-being of the American people. Functional GI disorders are prevalent in about 1 in 4 people

in the U.S., accounting for 40% of GI problems seen by medical providers. NIDDK supports basic, clinical, and translational research on aspects of gut physiology regulating motility and supports clinical trials through the Motility and Functional GI Disorders Program.

Several of NIH's crosscutting initiatives are currently advancing science in meaningful ways for patients with gastrointestinal disorders. The Stimulating Peripheral Activity to Relieve Conditions (SPARC) Initiative supports research on the role that nerves play in regulating organ function. Methods and medical devices that modulate these nerve signals are a potentially powerful way to treat many chronic conditions, including gastrointestinal and inflammatory disorders. The Human Microbiome Project is also unlocking important discoveries that will help to inform and advance emerging treatment options for many in the community.

PATIENT PERSPECTIVE—JACQUI'S STORY

I got sick after an emergency appendectomy on Thanksgiving 2010 while I was in Army basic training. I was able to fight off the inevitable and did four years in the Army during which I did a tour in Afghanistan. When I got back, my health really started declining.

I fought and fought and fought for an answer, but it took just over seven years to be diagnosed with gastroparesis. My main symptoms were nausea, vomiting and pain. It got so bad that I had to give up my dream career and was medically retired from the service.

Because we had tried pretty much every conservative treatment, they told me I would just have to live with it. It got to the point where I was going weeks without eating and was in and out of the ER getting fluids, because anything that went in my stomach came back up. My hair thinned, so I shaved it, and I was having memory problems and confusion, which got so bad that my neuropsych tests came back with my score being in the range of dementia.

My gastroenterologist even told me at one point that she couldn't do anything "drastic" to help me until my blood work was "bad enough."

Thank you for the opportunity to submit our community's perspective, as you consider appropriations priorities for FY 2022. We look forward to continuing to work with you on these critical issues.

[This statement was submitted by Ceciel T. Rooker, President and Executive Director, International Foundation for Gastrointestinal Disorders.]

PREPARED STATEMENT OF THE INTERSTATE MINING COMPACT COMMISSION

We are writing in regard to the fiscal year 2022 Budget for the Mine Safety and Health Administration (MSHA), U.S. Department of Labor. In particular, we urge the Subcommittee to support a full appropriation for state assistance grants for safety and health training of our Nation's miners pursuant to section 503(a) of the Mine Safety and Health Act of 1977 (the Act). MSHA's budget for at least the last five fiscal years has included an amount of not less than $10,537,000 for state assistance grants. We are pleased to see that President Biden's fiscal year 2022 budget proposes to continue funding at this level. We urge the Subcommittee to fund these grants at this statutorily authorized level for state assistance grants so that states are able to meet the training needs of miners and to fully and effectively carry out important state responsibilities under section 503(a) of the Act. We believe the states can more than justify the need for funding at the statutorily authorized level.

The Interstate Mining Compact Commission is a multi-state governmental organization that represents the natural resource, environmental protection and mine safety and health interests of its 26 member states. The states are represented by their Governors who serve as Commissioners.

We support full funding $10,537,000 for the state assistance grants that enable the states to provide essential safety and health training for the nation's coal miners, undiminished by use of these funds for other purposes. Section 503 of the Act was structured to be broad in scope and to stand as a separate and distinct part of the overall mine safety and health program. In the Conference Report that accompanied passage of the Federal Coal Mining Health and Safety Act of 1969, the conference committee noted that both the House and Senate bills provided for "Federal assistance to coal-producing States in developing and enforcing effective health and safety laws and regulations applicable to mines in the States and to promote Federal-State coordination and cooperation in improving health and safety conditions in the Nation's coal mines." (H. Conf. Report 91–761). The 1977 Amendments to the

Mine Safety and Health Act expanded these assistance grants to both coal and metal/non-metal mines and increased the authorization for annual appropriations to $10 million. The training of miners was only one part of the obligation envisioned by Congress.

With respect to the training component of our mine safety and health programs, IMCC's member states are concerned that without full, stable funding of the State Grants Program, the federally required training for miners employed throughout the U.S. will suffer. Our experience over the past 40 years has demonstrated that the states are often in the best position to design and offer mine safety and health training in a way that insures that the goals and objectives of Sections 502 and 503 of the Mine Safety and Health Act are adequately met. We greatly appreciate Congress' recognition of this fact and this Subcommittee's strong support for state assistance grants, especially in past years when the Administration sought to eliminate or substantially reduce those moneys.

We also appreciate the recognition by Congress that the availability of these funds to states should not be diminished by allowing them to be used for other purposes. We urge Congress to reject any attempt to diminish the funds available to states in the budget it adopts for fiscal year 2022 and future years. The budget that is adopted should include the full amount of $10,537,000 for state assistance grants, without any provisos or other qualifications that could reduce the amount of money states receive.

Thank you for the opportunity to present our views on the proposed fiscal year 2022 budget for MSHA.

[This statement was submitted by Thomas L. Clarke, Executive Director, Interstate Mining Compact Commission.]

PREPARED STATEMENT OF THE INTERSTITIAL CYSTITIS ASSOCIATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2022

—Provide $1.5 million for the IC Education and Awareness Program and the IC Epidemiology Study at the Centers for Disease Control and Prevention (CDC)
—Provide $46.1 billion for the National Institutes of Health (NIH) and Proportional Increases Across all Institutes and Centers
—Support NIH Research on IC, including the Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network and Chronic Pain

Thank you for the opportunity to present the views of the Interstitial Cystitis Association (ICA) regarding interstitial cystitis (IC) public awareness and research. ICA was founded in 1984 and is the only nonprofit organization dedicated to improving the lives of those affected by IC. The Association provides an important avenue for advocacy, research, and education. Since its founding, ICA has acted as a voice for those living with IC, enabling support groups and empowering patients. ICA advocates for the expansion of the IC knowledge-base and the development of new treatments. ICA also works to educate patients, healthcare providers, and the public at large about IC.

IC is a condition that consists of recurring pelvic pain, pressure, or discomfort in the bladder and pelvic region. It is often associated with urinary frequency and urgency. This condition may also be referred to as painful bladder syndrome (PBS), bladder pain syndrome (BPS), and chronic pelvic pain (CPP). It is estimated that as many as 12 million Americans have IC symptoms. Approximately two-thirds of these patients are women, though this condition does severely impact the lives of as many as 4 million men. IC has been seen in children and many adults with IC report having experienced urinary problems during childhood. However, little is known about IC in children, and information on statistics, diagnostic tools and treatments specific to children with IC is limited.

The exact cause of IC is unknown and there are few treatment options available. There is no diagnostic test for IC and diagnosis is made only after excluding other urinary/bladder conditions. It is not uncommon for patients to experience one or more years delay between the onset of symptoms and a diagnosis of IC. This is exacerbated when healthcare providers are not properly educated about IC.

The effects of IC are pervasive and insidious, damaging work life, psychological well-being, personal relationships, and general health. The impact of IC on quality of life is equally as severe as rheumatoid arthritis and end-stage renal disease. Health-related quality of life in women with IC is worse than in women with endo-

metriosis, vulvodynia, and overactive bladder. IC patients have significantly more sleep dysfunction, and higher rates of depression, anxiety, and sexual dysfunction.

Some studies suggest that certain conditions occur more commonly in people with IC than in the general population. These conditions include allergies, irritable bowel syndrome, endometriosis, vulvodynia, fibromyalgia, and migraine headaches. Chronic fatigue syndrome, pelvic floor dysfunction, and Sjogren's syndrome have also been reported.

IC PUBLIC AWARENESS AND EDUCATION THROUGH CDC

ICA recommends a specific appropriation of $1.5 million in fiscal year 2022 (FY2022) for the CDC IC Program. This will allow CDC to fund the Education and Awareness Program, per ongoing congressional intent, as well as the IC Epidemiology Study.

CDC had shifted the focus of the IC program to an epidemiology study and away from education and awareness, but thanks to the Subcommittee the ICA and IC community have been able to open discussions with CDC to ensure a renewed focus on education and awareness activities. The IC community had been concerned that focusing solely on an epidemiology study instead of on education and awareness activities was detrimental to patients and their families. We have recently met with CDC thanks to the actions of this Subcommittee where we openly and effectively communicated the need for CDC to include ICA in any collaboration along with the epidemiology study. We know that CDC has not received as generous increases as NIH over the past few fiscal years, but it is important the CDC continue supporting both critical components of the IC Program. The CDC IC Education and Awareness Program is the only federal program dedicated to improving public and provider awareness of this devastating disease, reducing the time to diagnosis for patients, and disseminating information on pain management and IC treatment options. ICA urges Congress to provide funding for IC education and awareness in FY2022.

The IC Education and Awareness program has utilized opportunities with charitable organizations to leverage funds and maximize public outreach. Such outreach includes public service announcements in major markets and the internet, as well as a billboard campaign along major highways across the country. The IC program has also made information on IC available to patients and the public though videos, booklets, publications, presentations, educational kits, websites, self-management tools, webinars, blogs, and social media communities such as Facebook, YouTube, and Twitter. For healthcare providers, this program has included the development of a continuing medical education module, targeted mailings, and exhibits at national medical conferences.

The CDC IC Education and Awareness Program also provided patient support that empowers patients to self-advocate for their care. Many physicians are hesitant to treat IC patients because of the time it takes to treat the condition and the lack of answers available. Further, IC patients may try numerous potential therapies, including alternative and complementary medicine, before finding an approach that works for them. For this reason, it is especially critical for the IC program to provide patients with information about what they can do to manage this painful condition and lead a normal life. With the recent developments in our conversations with the CDC we are confident that we will continue to provide key education and awareness that will continue to benefit the IC community.

IC RESEARCH THROUGH THE NATIONAL INSTITUTES OF HEALTH

ICA recommends a funding level of $46.1 billion for NIH in FY2022. ICA also recommends continued support for IC research including the MAPP Study administered by NIDDK.

The National Institutes of Health (NIH) maintains a robust research portfolio on IC with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) serving as the primary Institute for IC research. The NIDDK Multidisciplinary Approach to the Study of Chronic Pelvic Pain (MAPP) Research Network has continued to include cross-cutting researchers who are currently identifying different phenotypes of the disease. Phenotype information will allow physicians to prescribe treatments with more specificity. Research on chronic pain that is significant to the community is also supported by the National Institute of Neurological Disorders and Stroke (NINDS) as well as the National Center for Complementary and Integrative Health (NCCIH). The vast majority of IC patients often suffer major and multiple quality of life issues due to this condition. Many IC patients are unable to work full time because pain affects their mobility, sleep, cognition, and mood. These are people that simply want to lead productive lives, and need pain medication to do so. Due to the fact that IC is categorized as a non-cancer pain condition,

IC patients already have a difficult time obtaining pain meds. IC doctors do not have time nor the inclination to effectively prescribe or monitor the distribution of the opioid class of medication. They often refer their patients to Pain Management Specialists, many who have never heard of IC, who often refuse to treat them. In addition, antidepressants and benzodiazepines are often used to treat both mood and sleeping disorders for IC patients. Additionally, the NIH investigator-initiated research portfolio continues to be an important mechanism for IC researchers to create new avenues for interdisciplinary research.

PATIENT PERSPECTIVE

IC is a tough disease to diagnose, and it is one of the most challenging things to deal with, finding a doctor that specializes in IC that can help diagnose and treat. I can't stress enough how important finding the right doctor is. IC patients need a doctor who understands and is willing to go along with them on this long, frustrating, painful and confusing road. I have found strength through having this that I never knew I had, strength to keep going when all treatments so far have failed me.

There are a small number of treatments available for managing IC symptoms, but they only work on a small percentage of patients. I have tried those treatments and some drugs that "might" help. I manage my diet, take lots of supplements and have to see all kinds of doctors now. I have six! That includes holistic medicine doctors, physical therapists, and acupuncturist. That's along with my regular MD, urologist and two different gynecologists. This is what my life has become. The life of an IC patient. I deal with one or more symptoms of IC EVERY SINGLE DAY. Some days definitely better than others, but every single day. It affects my life in so many ways. Work, social, travel and my intimate relationships. I never know how I'm going to feel from one day to the next. Anxiety and fear included.

Thank you for the opportunity to present the views of the interstitial cystitis community.

[This statement was submitted by Lee Lowery, Executive Director, Interstitial Cystitis Association.]

PREPARED STATEMENT OF THE LEARNING AND EDUCATION ACADEMIC RESEARCH NETWORK

The Learning and Education Academic Research Network (LEARN), a coalition of 38 of the nation's leading research colleges of education across the country, advocates for the importance of research on learning and development. Education research provides the bedrock of knowledge used by our principals, teachers, counselors and professors to help preK–12 students and those seeking a postsecondary education succeed. With the staggering learning loss being experienced by students due to the COVID–19 pandemic, it is critical that Congress provides education research with the resources to guarantee that educational interventions are innovative, evidence-based and effective. LEARN urges the Subcommittee to meet the President's fiscal year (FY) 2022 budget request of 737.5 million for the Institute of Education Sciences (IES) overall with $267.9 million dedicated to Research, Development and Dissemination (RD&D). LEARN also requests that the Subcommittee provide $70 million for the National Center for Special Education Research (NCSER). In addition to requesting that the Subcommittee meet the President's FY2022 budget request of $1.94 billion for National Institute of Child Health and Human Development (NICHD), LEARN requests that the Subcommittee provide $2.21 billion for National Institute of Mental Health (NIMH) in FY2022.

While advocating for these increased resources for FY2022, we want to express our appreciation for the increases for IES that were made in FY2021. We would also like to thank Congress for the inclusion of $100 million for IES in the American Rescue Plan Act; this investment marks Congress' awareness of the importance of education research in addressing the nation's most difficult educational challenges. An increased investment in IES for FY2022 would allow for a more robust development, and dissemination of valuable education research to innovatively address the vast array of educational challenges posed before, during and after the COVID–19 pandemic.

INSTITUTE OF EDUCATION SCIENCES

The work of IES and its grantees can guide the nation's learning recovery so that we can exit the pandemic with a stronger, more equitable, educational system than we entered with. As the primary Federal agency charged with supporting research

for education practice and policy, IES is essential to developing a comprehensive, reliable evidence base, and ensuring that teaching and learning practices are grounded in scientifically valid research. Unfortunately, IES is only able to fund one out of every 10 applications it receives due to the limitations in its budget, despite a far greater percentage of such applications being rated excellent and worth of funding.

Without a critical examination of what works and what does not work to further knowledge, our education systems would be left to the same curriculum, instructional techniques and assessments, regardless of whether they spur student success. Examples of critical education research funded by IES include the development and adoption of a statewide approach to math instruction in one State that is now utilized in other States; the development and implementations of a reading curriculum now being adopted as a statewide literacy approach by a State legislature and improved instructional and behavioral practices for children with disabilities. Without continued support for general education research infrastructure, notable programs like these would not exist to address some of the nation's longest standing educational challenges and support the nation's most at-risk students.

The physical closure of schools and transition to virtual learning due to the COVID–19 pandemic has greatly disrupted education research at a time when it is more critical than ever before. Although IES grantees have adjusted their research where possible to remote and hybrid instruction, this pivot has also resulted in unanticipated costs, delays and cancellations; these increased costs are likely to persist through 2022. Nevertheless, IES funded work has provided insightful research findings and valuable tools for educators and caregivers throughout the pandemic. This includes a longitudinal study on the impact of COVID–19 on the educational attainment of economically disadvantaged undergraduates and an interactive tool guide on teaching math to young children at home. The work of IES and its grantees have already begun guiding the nation towards a strong and successful educational recovery.

The focus IES drives on education research is especially important today as our schools must ensure that efforts to reduce learning loss because of the COVID–19 pandemic are rooted in research and evidence-based practice. Given the importance of developing reliable evidence, LEARN is requesting that the Subcommittee meet President Biden's FY2022 request for $737.5 million for IES overall and $267.9 million for the Research, Development, and Dissemination (RD&D) line item within IES. These resources for the RD&D line item will build upon the critical resources provided in the American Rescue Plan Act for IES to further combat the negative learning outcomes resulting from the COVID–19 pandemic. The President's request for a 15 percent increase towards IES and a 35 percent increase for the RD&D line item is further evidence of the importance of supporting education research and evidence-based practices in response to the challenges of the COVID–19 pandemic.

In addition, we recommend that funding for research in special education, through the National Center for Special Education Research (NCSER), should be increased to $70 million. NCSER is the only Federal agency specifically designated to develop and provide evaluations for programs for students with disabilities, but currently has a budget that has remained relatively flat since FY2014. Research funded by NCSER provides special educators and administrators research-based resources that improve educational academic outcomes for children with or at risk of disabilities. During a time when special education students have been dramatically impacted by the change in schooling due to COVID–19, additional funding to NCSER is necessary to support data and evidence-based resources to guide the continued COVID–19 response and recovery for these students. Funding of $70 million would allow for a new competition in FY2022, allowing further resources to address COVID–19 learning issues.

NATIONAL INSTITUTES OF HEALTH

There are critical education research programs within the National Institutes of Health (NIH) that also need additional support. NICHD is essential to education research as it examines brain functions and the impact of different educational services on learning and development. LEARN supports an increase in NICHD funding to $1.94 billion. This increase will ensure that researchers can build on the knowledge already gained, evaluate what works best in treating developmental disorders and develop new research-based strategies to improve student's learning and development. Additionally, it will support NICHD's efforts to understand the effects of COVID–19 on key at-risk populations, including the cognitive development of children and adolescents.

LEARN also supports an increase in funding for NIMH to $2.21 billion. This increase will help further understanding of the behavioral, biological and environmental mechanisms necessary for developing interventions to reduce the burden of mental and behavioral disorders and optimize learning and development. The untraditional school year and strains of the COVID–19 pandemic has had a largely negative impact on the mental health of children and adolescents nationwide, it is important that research in this field is supported to address these challenges.

LEARN believes it is critical that evidence-based research is implemented and applied to schools nationwide as they work to address the myriad of educational challenges that existed prior, and were exacerbated, by the COVID–19 pandemic. As the nation looks towards recovery, IES and NIH must be at the forefront of any effort to ensure that Federal resources are going towards effective programming and interventions. The LEARN Coalition strongly believes that key investments in education research through IES and NIH will drive improvements in teacher and student performance in the coming years and allow for the beginning of a successful recovery from the COVID–19 pandemic. Thank you for your commitment to sustaining and strengthening the nation's education research infrastructure.

Respectfully submitted,

[Camilla P. Benbow, Ed.D., Co-Chair, Learning and Education Academic Research Network]

[Patricia and Rodes Hart Dean of Education and Human Development of the Peabody College of Education and Human Development, Vanderbilt University]

[Rick Ginsberg, Ph.D., Co-Chair, Learning and Education Academic Research Network, Dean of the School of Education, University of Kansas]

[Glenn E. Good, Ph.D., Co-Chair, Learning and Education Academic Research Network, Dean of the College of Education, University of Florida]

PREPARED STATEMENT OF THE LYMPHATIC EDUCATION & RESEARCH NETWORK

KEY RECOMMENDATIONS

—Establish a National Commission on Lymphatic Disease Research at the NIH to identify emerging opportunities, challenges, gaps, structural changes, and recommendations on lymphatic disease research

—Provide the National Institutes of Health (NIH) with $46.1 billion for FY 2022 and advance lymphatic disease research by expanding resources and encouraging better coordination among relevant institutes and centers

—Provide the Centers for Disease Control and Prevention (CDC) with $10 billion for FY 2022 and enable $5 million for the Chronic Disease Education and Awareness Program.

Chairwoman Murray, Ranking Member Blunt and distinguished members of the Subcommittee, thank you for the opportunity to submit the priorities of the lymphatic diseases community you as you consider FY 2022 appropriations for the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC).

ABOUT LE&RN

The Lymphatic Education & Research Network (LE&RN) is an internationally recognized non-profit organization founded in 1998 to fight lymphatic diseases and lymphedema through education, research and advocacy. With chapters throughout the world, LE&RN seeks to accelerate the prevention, treatment and cure of these diseases while bringing patients and medical professionals together to address the unmet needs surrounding lymphatic diseases, which include lymphedema and lipedema.

ABOUT LYMPHEDEMA AND LYMPHATIC DISEASES

The lymphatic system is a circulatory system that is critical to immune function and good health. When it is compromised and lymph flow is restricted, the physical impact to patients can be devastating, life altering, and can lead to shortened lifespan. Lymphedema (LE) is one such lymphatic disease. LE is a chronic, debilitating, and incurable swelling that can be a result of cancer treatment, inherited or genetic causes, and damage to the lymphatic system from surgery or an accident, or from parasites as in lymphatic filariasis. Stanford University estimates that up to 10 mil-

lion Americans have lymphedema. This represents more Americans than those living with AIDS, Multiple Sclerosis, Parkinson's disease, Muscular Dystrophy and ALS—combined. The World Health Organization puts the global number of people with this disease at 250 million. There is no cure. There is no approved drug therapy. And there are currently only three drug studies worldwide seeking a treatment. Psychosocially bruised by a disease that leaves us deformed, we do our best to hide our lymphedema. We are currently isolated and alone.

Lymphedema is an equal opportunity disease, affecting women, men and children alike. Many are born with congenital or hereditary lymphedema. Others, like our veterans, get the disease as a result of physical trauma, bacterial infection, or as result of exposure to burn pits. Lymphedema is an ignored disease. A study concluded that physicians are currently getting an average of only 15–30 minutes of study on the lymphatic system in their entire medical training. This leaves them ill-prepared to diagnose the disease. Misdiagnosis leads to improper treatment. Those who are diagnosed find it difficult to find certified lymphedema therapists. Few medical centers exist that are prepared to address lymphatic diseases. Surgeons are experimenting with treatment that could alter the course of the disease. However, the necessary basic research is not being done to inform their procedures. And currently, Medicare and Medicaid do not cover some of the basic treatment needs of these patients—such as compression garments, which must be worn daily by patients.

FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

We have been hopeful with recent advancements, but more needs to be done. We ask that within 20 years, we will make lymphedema a truly treatable disease. To reach this goal will require a commitment to important medical research. LE&RN joins the broader medical research community in thanking Congress for continuing to provide the National Institutes of Health with proportional and sustainable funding increases over the past several fiscal years, and we ask you all to continue to prioritize these activities by providing at least a $46.1 billion for NIH in FY 2022.

We continue to urge the Subcommittee to work to expand and advance the lymphatic disease portfolio at the NIH. In late 2015, the NIH hosted a Lymphatic Symposium, where experts in the field identified a scientific roadmap that could build the research portfolio up to a level of at least $70 million annually over subsequent years by funding meritorious grants on critical topics. In an effort to further support and enhance emerging lymphedema and lymphatic disease research activities, we ask the Subcommittee to encourage further collaboration among relevant institutes and centers conducting research in this area. We are grateful to the Subcommittee for continuing to support the establishment of a National Commission on Lymphatic Disease Research, which can thoroughly examine the portfolio and make recommendations on how best to advance this emerging scientific area under NIH's current structure. We ask that you continue to impress on NIH the critical need for this Commission and how they can work with relevant stakeholders such as ourselves. Currently, the National Institutes of Health spends approximately $25 million annually on lymphatic research, and only $5 million of this is dedicated to clinical lymphedema research. Experts state with confidence that there is no other disease affecting more Americans that receives so little attention. It must also be noted that study of the lymphatic system is poised to bring miracles for a host of diseases that are part of the lymphatic continuum: obesity, heart disease, diabetes, Rheumatoid arthritis, cancer metastasis, AIDS, Crohn's disease, lipedema, and a host of other diseases. Recent research discovered lymphatics surrounding the brain, which now has us studying its impact on Alzheimer's disease and multiple sclerosis. We appreciate the Subcommittee's continued support for the establishment of a National Commission on Lymphatic Diseases and ask that NIH be held accountable for the lack of progress on its establishment.

LE&RN also joins the public health community in asking Congress to provide the Centers for Disease Control and Prevention (CDC) with $10 billion through FY 2022 and to increase funding to increase awareness, education, and surveillance of lymphatic diseases. We encourage the Subcommittee to support $5 million for the Chronic Disease Education and Awareness Program in FY2022 which will allow CDC to work with stakeholder organizations to expand important initiatives on chronic diseases such as lymphedema and lymphatic diseases. Formal study of the lymphatic system and of lymphatic diseases is virtually nonexistent in the current curricula of U.S. medical schools, and misinformation routinely leads to misdiagnosis and under-treatment. This delay and misdirection of treatment results in irreparable physical and psychosocial harm to patients suffering from these already

debilitating diseases. CDC can help to address this lack of public and provider awareness.

Thank you for the opportunity to testify before you today. LE&RN looks forward to working with you all to advance medical research and public health activities that will improve patient outcomes for the members of our community suffering from these debilitating diseases.

[This statement was submitted by William Repicci, President and CEO, Lymphatic Education & Research Network.]

PREPARED STATEMENT OF THE MARCH OF DIMES

MARCH OF DIMES: FISCAL YEAR 2022 FEDERAL FUNDING PRIORITIES

PROGRAM	FISCAL YEAR 2022 REQUEST
National Institutes of Health (total)	No less than $46,100,000,000
National Institute of Child Health and Development	No less than $1,708,021,938
National Institute of Environmental Health Sciences	No less than $874,961,000
National Children's Study Alternative (ECHO)	$180,000,000
Centers for Disease Control and Prevention (total)	**$10,000,000,000**
National Center for Birth Defects and Developmental Disabilities	$280,000,000
Emerging Threats to Moms and Babies	$100,000,000
Section 317 Immunization Program	$1,100,000,000
Newborn Screening Quality Assurance Program	$28,000,000
Polio Eradication	$176,000,000
Division of Reproductive Health	$102,500,000
Safe Motherhood Initiative	No less than $40,500,000
Preterm Birth	$2,000,000
Perinatal Quality Collaboratives	$30,000,000
Maternal Mortality Review Committees	No less than $30,000,000
Office on Smoking and Health	$310,000,000
National Center for Health Statistics	$200,000,000
Health Resources and Services Administration (total)	**$9,200,000,000**
Title V Maternal and Child Health Block Grant	No less than $750,000,000
Heritable Disorders	$28,883,000
Healthy Start	$145,000,000
Grants for Maternal Depression Screening and Treatment	$10,000,000
Maternal Mental Health Hotline	No less than $3,000,000
Title X Family Planning Program	$737,000,000
Office of the Secretary Health - Teen Pregnancy Prevention	**$150,000,000**
Agency for Healthcare Research and Quality (total)	**$500,000,000**

March of Dimes, the nation's leading nonprofit organization fighting for the health of all moms and babies, appreciates this opportunity to submit testimony for the record on fiscal year (FY) 2022 appropriations for the Department of Health and Human Services (HHS). March of Dimes leads the fight for the health of all mothers and infants through our research, community services, education, and advocacy.

Our organization strongly supports President Biden's historic HHS budget proposal for FY 2022 which includes strong increases for critical programs supporting families, and we recommend the following funding levels for programs and initiatives that are essential investments in maternal and child health.

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD): March of Dimes recommends that Congress provide no less than $1.7 billion for NICHD's groundbreaking biomedical research activities in FY 2022. Increased funding will allow NICHD to sustain vital research on preterm birth, maternal mortality, maternal substance use, prenatal substance exposure and related issues through extramural grants, Maternal-Fetal Medicine Units, the Neonatal Research Network and the intramural research program.

Additionally, now that the Task Force on Research Specific to Pregnant and Lactating Women (PRGLAC) has laid the foundation for addressing research on safe

and effective therapies for pregnant and lactating women in clinical trials by releasing recommendations in September 2018, as mandated by Congress in the 21st Century Cures Act (P.L. 114–255), and provided an additional implementation plan increased funding will allow for NICHD to more closely look at ways to include and integrate pregnant and lactating women in clinical trials. NICHD funding also supports research to address gaps in our understanding of the best way to treat mothers with opioid use disorder and the long-term impact of opioid exposure in utero. We support the inclusion of this dedicated funding to address the nation's preterm birth crisis.

Surveillance for Emerging Threats to Mothers and Babies Initiative: March of Dimes recommends funding the Surveillance for Emerging Threats to Mothers and Babies Initiative Program (known as SET–NET) within the National Center for Birth Defects and Developmental Disabilities at Centers for Disease Control and Prevention (CDC) at $100 million. SET–NET was created during the Zika outbreak, which allowed CDC to create, a unique nationwide mother-baby linked surveillance network to monitor the virus' impact in real-time to inform clinical guidance, educate health care providers and the community, and connect families to care. Unfortunately, states were unable to sustain systems due to the program being chronically underfunded, and we were left without a national system to mobilize when COVID–19 struck.

Consequently, we have an incomplete picture on how to best care for mothers and babies with confirmed or suspected virus infection as the CDC currently only supports 29 state, local, and territorial health departments. The increased funding will allow for CDC to address these knowledge gaps and expand the initiative to provide real-time clinical and survey data from all 50 states, territories and jurisdictions on the impact of COVID–19 and new public health threats.

Perinatal Quality Collaboratives: PQCs are state or multistate networks working to improve the quality of obstetric care and improve outcomes. Currently, CDC funds 13 state-based PQCs that are implementing recommendations across health facility networks. However, many PQCs lack adequate resources to meet demands and reach their maximum potential. We request no less than $30 million to fully scale these programs in all states, an increase of $26.5 million.

Maternal Mortality Review Committees: Under the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program, CDC provides funding, technical assistance, and guidance to state maternal mortality review committees. These multidisciplinary committees identify, review and characterize maternal deaths and prevention opportunities. Currently, CDC has made 24 awards and supports 25 state agencies and organizations that coordinate and manage MMRCs. However, more standardized data collection is needed to help examine all the factors contributing to severe maternal mortality, preventable deaths, and poor birth outcomes. To this end, we request no less than $30 million, an increase of $15 million, to reach all 50 states, DC, and Puerto Rico and tribes with enhanced technical assistance to maximize MMRCs.

Newborn Screening: Newborn screening is one of our nation's most successful public health programs. Each year, nearly every one of the approximately 4 million infants born in the United States is screened for certain genetic, metabolic, hormonal and/or functional conditions. The early detection afforded by newborn screening ensures that infants who test positive for a screened condition receive prompt treatment, saving or improving the lives of more than 12,000 infants each year.

Both the Newborn Screening Quality Assurance Program at CDC and the Heritable Disorders program at Health Resources and Services Administration's (HRSA) have significantly improved the quality of newborn screening programs throughout the country. NSQAP works hand-in-hand with state laboratories by performing quality testing for more than 500 laboratories to ensure the accuracy of newborn screening tests. Where the Heritable Disorders program provides assistance to states to improve and expand their newborn screening programs and supports the work of the Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC), which provides recommendations to the HHS Secretary for conditions to be included in the Recommended Uniform Screening Panel (RUSP). To continue sustaining, improving, and enhancing these programs, March of Dimes urges funding of $28 million for NSQAP and $28.883 million for the Heritable Disorders program for FY22.

Grants for Maternal Depression Screening and Treatment: 1 in 5 women are affected by anxiety, depression, and other maternal mental health (MMH) conditions during pregnancy or the year following pregnancy. These illnesses are the most common complication of pregnancy and childbirth, impacting 800,000 women in the United States each year. Sadly, MMH conditions often go undiagnosed and untreated, increasing the risk of multigenerational long-term negative impact on the

mother's and child's physical, emotional, and developmental health, increasing the risk of poor health outcomes of both the mother and baby. Furthermore, women of color and women who live in poverty are disproportionately impacted by MMH conditions, experiencing them 2–3 times the rate as White women.

At the current funding level, only seven states have received grants to provide real-time psychiatric consultation, care coordination, and training for front-line providers to better screen, assess, refer and treat pregnant and postpartum women for depression and other behavioral health conditions. March of Dimes urges the Committee to provide $10 million in FY 2022 to add five programs and provide technical assistance to non-grantee states.

Maternal Mental Health Hotline: We thank the Committee for funding $3 million in FY21 to the new maternal mental health hotline. This funding will allow qualified counselors to staff a hotline 24 hours a day and conduct outreach efforts on maternal mental health issues. COVID–19 has exacerbated maternal mental health conditions at 3–4 times the rate prior to the pandemic and leaving these conditions untreated can have a long-term effects. We urge the Committee to provide $5 million to allow for the hotline to provide text messaging services, culturally-appropriate support, and continue public awareness efforts.

Conclusion: March of Dimes looks forward to working with you and all Members of Congress to secure the resources needed to improve our nation's health. Federal public health programs are essential to preventing preterm birth, ending preventable maternal deaths, and addressing the maternal mental health that impacts mother, infants and families.

PREPARED STATEMENT OF MEALS ON WHEELS AMERICA

Dear Chair Murray, Ranking Member Blunt, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony concerning Fiscal Year 2022 (FY22) appropriations for the Older Americans Act (OAA) Nutrition Program, administered by the Department of Health and Human Services' (HHS) Administration for Community Living (ACL). On behalf of Meals on Wheels America, the nationwide network of community-based senior nutrition providers and the individuals they serve, we are grateful for your ongoing support for the program, particularly in response to the COVID–19 pandemic. With Congress' help in securing much-needed emergency relief funding for the OAA network, local senior nutrition programs (e.g., Meals on Wheels) continue to serve on the front lines of the ongoing public health crisis, delivering essential nutrition assistance and so much more to older Americans. Despite the historic emergency supplemental funding and recent investments in annual appropriations, senior nutrition programs continue to be challenged by a soaring need for services which not only preexisted COVID–19 but have been rendered far worse as a result of the pandemic. For this reason, we request a total of $1,903,506,000 for the OAA Title III C Nutrition Program—Congregate Nutrition Services, Home-Delivered Nutrition Services, and Nutrition Services Incentive Program (NSIP)—in FY22. As programs will continue to serve a greater number of older adults through the new fiscal year and costs remain high, our specific appropriations requests are:

—$965,342,000 for Congregate Nutrition Services (Title III C–1)

—$726,342,000 for Home-Delivered Nutrition Services (Title III C–2)

—$211,822,000 for Nutrition Services Incentive Program (Title III)

While this FY22 request is double the FY21-enacted funding levels for the program, it reflects the amount necessary to maintain current levels of service, while enabling the network to expand and adapt to serve more seniors. As our country strives to respond, recover and rebuild from the health and economic crisis, these nutrition programs are a lifeline for millions of older adults and the services they provide must flex to meet the need.

Overseen by ACL's Administration on Aging and implemented at the local level through more than 5,000 community-based providers, the OAA Nutrition Program delivers nutritious meals, opportunities for social connection and safety checks to adults 60 and older—either in a group setting or directly in the home—and has been at the forefront of addressing senior hunger and isolation for nearly fifty years. Amid the pandemic, older adults face unprecedented demands on their physical and mental health, independence and financial well-being. The local providers that serve them are seeing a far greater demand for their services as operational expenses and/or overall costs to safely deliver meals continue to rise. Accordingly, additional federal funding and flexibility of use of OAA nutrition resources are needed for senior nutrition programs to adequately adapt and expand operations to meet the growing and evolving needs of the communities they serve.

Before the coronavirus pandemic, nearly 9.7 million (13%) older adults ages 60 and older were threatened by hunger (i.e., marginally food insecure)—5.3 million (7%) of which were food insecure or very low food secure.[1] Social isolation—which has been amplified amidst safety and social distancing measures—is yet another threat for the nearly 17.5 million (24%) seniors that lived alone in 2019.[2] One in five older adults reported frequent feelings of loneliness prior to the pandemic, and many more seniors have experienced feeling lonely or lack of social connection since then.[3] Most older Americans possess at least one trait that puts them at increased risk of experiencing food insecurity, malnutrition, social isolation and/or loneliness, thereby increasing the likelihood of experiencing myriad adverse health effects. Despite the wide recognition of the relationship between healthy aging and access to nutritious food and regular socialization, millions of seniors were struggling to meet these basic human needs pre-COVID; and these issues have only been exacerbated as a result of the pandemic.

The OAA Nutrition Program is designed to reduce hunger, food insecurity and malnutrition, and to promote socialization and the overall health and well-being of older adults. Providers across the country have long played a pivotal role in supporting the independence and quality of life of the 2.4 million older adults they serve. Meals served by the program must also meet the dietary guidelines set by the OAA Nutrition Program and are often tailored to meet medical needs and cultural preferences. OAA services are targeted toward seniors with the greatest social and economic need-including those who are low-income; are a racial or ethnic minority; live in a rural community; have limited English proficiency; and/or are at risk of institutionalization.[4] For many program participants, the volunteer or staff member who delivers meals to their homes may be the only individual(s) she or he sees that day.

The profile of home-delivered meal clients reveals the high degree of vulnerability among recipients, with the majority being age 75 or older, female, living alone, taking multiple prescription medications daily and/or having three or more chronic conditions. A significant number of those served belong to a racial and/or ethnic minority group, as 19% of participants are Black or African American, 7% are Hispanic or Latino, and 5% are Native American or Hawaiian or Pacific Islander. Additionally, among participants:

—35% live at or below the poverty level;

—25% live in rural areas;

—15% are veterans.[5]

A third (33%) of home-delivered meal recipients report not having enough money to purchase food.[6] Fortunately, the vital services financed by the OAA Nutrition Program enable seniors with these risk factors to remain safer, healthier and less isolated in their own homes and communities.

The results of a 2015 study commissioned by Meals on Wheels America found that seniors who received daily home-delivered meals were more likely to report improvements in mental health, self-rated health and feelings of isolation and loneliness, as well as reduced rates of falls and decreased concerns about their ability to remain in their home.[7] Additional research has found home-delivered meal program participants experience less healthcare utilization and lower expenditures than the non-

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[1] J. Ziliak & C. Gundersen, The State of Senior Hunger in America 2018: An Annual Report, prepared for Feeding America, 2020. https://www.feedingamerica.org/research/senior-hunger-research/senior.

[2] U.S. Census Bureau, American Community Survey 2018, available on the Administration for Community Living Aging, Independence, and Disability Program Data Portal (AGID), 2020. https://agid.acl.gov/CustomTables/.

[3] AARP, Loneliness and Social Connections: A National Survey of Adults 45 and Older, 2018. https://www.aarp.org/research/topics/life/info-2018/loneliness-social-connections.htm.

[4] Administration for Community Living (ACL), State Program Reports 2019, available on AGID, 2021. https://agid.acl.gov/CustomTables/.

[5] Mabli et al. Evaluation of the Effect of the Older Americans Act Title III–C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality, Mathematica Policy Research, report prepared for ACL, 2017. https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf.

[6] ACL. National Older Americans Act Participants Survey (NPS), 2018, available on AGID Custom Tables and NPS Data Files, 2020. https://agid.acl.gov/.

[7] Meals on Wheels America. More Than a Meal Pilot Research Study, report prepared by K. S. Thomas & D. Dosa, 2015, https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study.

participant controls, suggesting the program's potential to reduce costs among patients with high-cost or complex healthcare needs.[8]

Additionally, the OAA Nutrition Program is a true public-private partnership that provides critical support and resources to local community-based organizations. By serving seniors in their homes and communities, local programs generate a powerful social and economic return on investment for older adults and taxpayers alike. They leverage funds granted to states through the OAA to offer nutrition and social services with the help of millions of volunteers, who provide innumerous in-kind contributions to support daily operations. In the aggregate, funding from the OAA accounted for 40% of the total amount spent to provide over 223 million congregate and home-delivered meals in 2019, based on the latest available data.[9] As public spending on healthcare rises each year—largely attributable to a rapidly growing senior population with complex health needs and disproportionate risk to severe illness and complications due to COVID–19—it is imperative that we invest in these cost-effective programs that safely promote health and independence and reduce costly healthcare utilization among many of our country's most at-risk seniors. To further underscore, Meals on Wheels can serve a senior for an entire year for approximately the equivalent cost of one day in the hospital or 10 days in a nursing home.

Prior to the pandemic, federal funding for the senior nutrition network was not keeping pace with increasing demand, rising costs and inflation, leaving a huge gap between seniors served and those in need of services but not receiving them. Nationally, the OAA Nutrition Program network served 17+ million fewer meals in 2019 than in 2005—a 7% decline—despite the population of adults 60 and older growing 53% over that same period.[10] Further illustrating the need for more funding, a 2015 Government Accountability Office study estimated that 83% of low-income, food insecure seniors do not receive the congregate or home-delivered meals that they likely needed.[11] Among Meals on Wheels America members surveyed in 2019, nearly half of all local programs reported maintaining an active waiting list due to insufficient resources, and 85% of programs surveyed saw unmet need for services in their communities at that time.[12] The emergency funding provided through COVID–19 relief legislation not only enabled programs to provide services for those individuals in their communities who have long been eligible and underserved but also helped address a huge influx of older adults newly in need of nutrition services because of the pandemic. An increase in FY22 appropriations is needed to ensure that these individuals can continue to receive the nutritional and social support unique to the OAA Nutrition Program that helps them remain healthier and independent at home and out of far more costly institutional or healthcare settings.

With the onset of the pandemic in March 2020, as mentioned above, the Meals on Wheels network faced an unprecedented surge in demand as the number of older adults sheltering in place increased and congregate centers shifted ways of operating—including transitioning congregate services to fully home-delivered or to grab-and-go and curbside pick-up alternatives, as well as offering virtual socialization activities and wellness checks over the phone. Most Meals on Wheels programs overcame significant challenges to continue and then rapidly scale their operations to serve more older Americans in need. In a survey conducted in November 2020 on behalf of Meals on Wheels America, programs reported delivering an average of 100% more home-delivered meals at their pandemic peak than they served before.[13] At that time, programs also reported serving home-delivered meals to 84% more clients on a weekly basis, and four out of five local programs agreed that these "new clients are here to stay."

Despite the incredible response from the senior nutrition network to quickly scale services, barriers remain in addressing the full demand. According to the November 2020 survey, 88% of Meals on Wheels programs reported increased costs due to the necessary purchase of personal protective equipment (PPE) and safety supplies,

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[8] Berkowitz et al. Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries. Health Affairs (Vol. 37, No. 4), 2018. https://doi.org/10.1377/hlthaff.2017.0999.

[9] See note 4 above.

[10] ACL. State Program Reports 2005–2019, available on AGID, 2021. https://agid.acl.gov/CustomTables/.

[11] U.S. Government Accountability Office (GAO). Older Americans Act: Updated Information on Unmet Need for Services, 2015. https://www.gao.gov/products/GAO-15-601R.

[12] Meals on Wheels America. More Than a Meal Comprehensive Network Study, research conducted by Trailblazer Research, 2019. www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/comprehensive-network-study.

[13] Meals on Wheels America. COVID–19 Impact Survey, research conducted by Trailblazer Research, November 2020.

meal production expenses and/or labor needs. Local programs reported that costs are expected to remain high, and nine in 10 Meals on Wheels programs reported unmet need for home-delivered meals in their community. Nearly a third of programs said they would need to, at minimum, double their home-delivered efforts to fill the gap in their community, as many reported increased numbers of seniors forced to go on waiting lists. More than 15 months into this public health crisis, local programs are continuing to deliver these life-saving services at high rates and have cited funding as the primary factor impacting their ability to serve individuals most directly affected by the pandemic. Without additional funding through the OAA, many nutrition providers will not be able to support their current client base, much less expand to reach more seniors who need services but are not receiving them.

We understand the difficult decisions you face with respect to annual appropriations bills and other budgetary challenges as Congress works to mitigate the impacts of the global pandemic and recover from this prolonged national emergency. However, to address the current level of nutrition services needed in communities, increased federal funding through the regular appropriations cycle is critically needed for the next fiscal year and beyond. With approximately 12,000 individuals turning 60 every day, the requested appropriations increase will help provide the levels needed for community-based nutrition programs to reach eligible older adults, especially as the demand for these essential services continues to rise.

As the Subcommittee develops its FY22 Labor-HHS-Education appropriation bill, we request you provide a minimum of $1,903,506,000 for the OAA Nutrition Program so that local community-based Meals on Wheels programs can ensure the health, safety and social connectedness of our nation's seniors, build the capacity of OAA programs and services, and bridge the growing gaps and unmet need for services in communities nationwide. Thank you for your leadership, support and consideration. We look forward to working together to ensure that no senior in America is left hungry and isolated.

[This statement was submitted by Ellie Hollander, President and CEO, Meals on Wheels America.]

Prepared Statement of the Medical Library Association and Association of Academic Health Sciences Libraries

I, Mary M. Langman, Director, Information Issues and Policy, Medical Library Association (MLA), submit this statement on behalf of MLA and the Association of Academic Health Sciences Libraries (AAHSL). MLA is a global, nonprofit, educational organization with a membership of more than 400 institutions and 3,000 professionals in the health information field. AAHSL supports academic health sciences libraries and directors in advancing the patient care, research, education and community service missions of academic health centers through visionary executive leadership and expertise in health information, scholarly communication, and knowledge management.

We thank the Subcommittee for the opportunity to submit testimony supporting appropriations for the National Library of Medicine (NLM), an agency of the National Institutes of Health (NIH), and recommend $475 million for NLM in FY22, a 3% (+$12.9 million) increase. Working in partnership with the NIH and other Federal agencies, NLM is the key link in the chain that translates biomedical research into practice, making the data and other results of research readily available to all who need it. As NLM works to achieve key objectives of its Strategic Plan—to accelerate data powered discovery and health, reach new users in new ways, and prepare a workforce for a future of data-driven research and health, it also supports NIH-wide efforts to answer the call to respond to national priorities, close the gap in health disparities, and capitalize on fundamental investments. NLM accomplishes this through effective preservation of valued scientific and data resources, judicious investments in extramural and intramural research, informed stewardship of Federal resources, and innovative partnerships to align priorities and leverage investments across HHS, the Federal government, and the biomedical research community.

As health sciences librarians who use NLM's programs and services every day, we can attest that NLM resources literally save lives. Therefore, investing in NLM is an investment in good health.

Leveraging NIH Investments in Biomedical Research

NLM's budget supports information services, research, and programs that sustain the nation's biomedical research enterprise. In FY22 and beyond, NLM's budget

must continue to be augmented to support modernization and expansion of its information resources, services, research, and programs which collect, organize, and develop new ways to make readily accessible rapidly expanding biomedical knowledge resources and data. NLM maximizes the return on investment in research conducted by the NIH and other organizations. It makes the results of biomedical information accessible to researchers, clinicians, business innovators, students, and the public, enabling such data and information to be used more efficiently and effectively to drive innovation and improve health. Rapid growth of data also necessitates funding that will ensure long-term sustainability of these valuable information resources. NLM is unique because it stimulates and supports innovative research in data science and information management that transcends specific disease areas and data types.

NLM plays a critical role in NIH's data science and open science initiatives leading the development, maintenance and dissemination of key standards for health data interchange that are now required of certified electronic health records (EHRs). NLM builds, sustains, and augments a suite of almost 300 databases which provide information access to health professionals, researchers, educators, and the public. It supports the acquisition, organization, preservation, and dissemination of the world's biomedical literature. In FY 2019, NLM made genomic sequence data available in the cloud. NLM's Sequence Read Archive (SRA) is the world's largest publicly available repository of next-generation genome sequence data, with more than 9 million records comprising 25 petabytes of data. To improve access and utility of SRA data, NLM uploaded the public access SRA data to two commercial clouds that have agreements with NIH's Science and Technology Research Infrastructure for Discovery, Experimentation, and Sustainability (STRIDES) Initiative. This transition significantly expands the discovery potential of the data. Freed from the limitations of local storage and computational resources, users are empowered to compute across the full corpus of SRA data without having to download and store large volumes of data. Moving to cloud platforms also makes it possible to develop customized tools and methods for asking research questions of the data.

Growing Demand for NLM's Information Services

Each day, more than 6 million people use NLM websites and download 115 terabytes of data. Thousands of researchers and businesses upload a total of 15 terabytes of data daily. Annually, NLM information systems process more than six billion human requests and eight billion computer-to-computer interactions. NLM's information services help researchers advance scientific discovery and accelerate its translation into new therapies; provide health practitioners with information that improves medical care and lowers its costs; and give the public access to resources and tools that promote wellness and disease prevention. Every day, medical librarians across the nation use NLM's services to assist clinicians, students, researchers, and the public in accessing information to save lives and improve health. Without NLM, our nation's medical libraries would be unable to provide quality information services that our nation's health professionals, educators, researchers and patients increasingly need.

NLM's data repositories and online integrated services such as GenBank, dbGaP, Genetics Home Reference (GHR), PubMed, and PubMed Central (PMC) are revolutionizing medicine. GenBank is the definitive source of gene sequence information. Each month, 2.1 million users accessed consumer-level information about genetics from GHR, which contains more than 2,700 summaries of genetic conditions, genes, gene families, and chromosomes. PubMed, with more than 32 million references to the biomedical literature, is the world's most heavily used source of bibliographic information with almost 3.3 million users each day. NLM also launched a new PubMed platform for an improved user experience, including a new search algorithm with relevance rankings and better tools for citations. PubMed Central is NLM's digital archive which provides public access to the full-text versions of more than 6.8 million biomedical journal articles, including those produced by NIH-funded researchers. On a typical weekday more than 3.5 million users download articles from PubMed Central.

NLM continually expands biomedical information services to accommodate a growing volume of relevant data and information and enhances these services to support research and discovery. NLM ensures the availability of this information for future generations, making books, journals, technical reports, manuscripts, microfilms, photographs and images accessible to all Americans, irrespective of geography or ability to pay, and guaranteeing that citizens can make the best, most informed decisions about their healthcare.

Disseminating Clinical Trial Information

ClinicalTrials.gov, the world's largest clinical trials registry, now includes more than 370,000 registered studies and summary results in all 50 states and in 219 countries for more than 48,000 trials. More than 158,000 users access this vital information each day. As health sciences librarians who fulfill requests for information from clinicians, scientists, and patients, we applaud NIH and NLM for implementing requirements for clinical trials registration and results submission consistent with the FDA Amendments Act of 2007, and for applying them to all NIH-supported clinical trials. These efforts increase transparency of clinical trial results and provide patients and clinicians with information to guide health care decisions. They also ensure biomedical researchers have access to results that can inform future protocols and discoveries.

Partnerships Ensuring Outreach and Engagement in Communities Across the Nation

NLM's outreach programs are essential to the MLA and AAHSL membership and to the profession. The NLM coordinates an 8,000-member Network of the National Library of Medicine (NNLM), including 7 Regional Medical Libraries that receive NLM support, 125 resource libraries connected to medical schools, and more than 5,000 libraries located primarily in hospitals and clinics. Through the NNLM, NLM educates medical librarians, health professionals, and the general public about its services and provides training in their effective use. The NNLM serves the public by promoting educational outreach for public libraries, secondary schools, senior centers and other consumer settings, and its outreach to underserved populations helps reduce health disparities.

Since May 2018, the NNLM has partnered with the NIH All of Us Research Program to support community engagement efforts by United States public libraries and to raise awareness about the program. Together, NLM and NIH have built the NNLM All of Us Community Engagement Network (CEN). The CEN focuses on NNLM's mission to improve the public's access to health information and provide awareness of All of Us to communities that are Underrepresented in Biomedical Research by partnering with libraries across the United States. The CEN is designed to leverage the mission of the NNLM to help libraries in supporting the health information needs of their users.

NLM's MedlinePlus provides consumers with trusted, reliable health information on 1,000 topics in English and Spanish. It attracts more than 1 million visitors daily. NLM continues to enhance MedlinePlus and disseminate authoritative information via the website, a web service, and social media. MedlinePlus and MedlinePlus en Español have been optimized for easier use on mobile phones and tablets. NIH MedlinePlus Magazine and NIH MedlinePlus Salud are available in doctors' offices nationwide, and NLM's MedlinePlus Connect enables clinical care organizations to link from their EHR systems to relevant patient education materials.

Strengthening Data Science and Open Science Capacity

NLM is a leader in data science and open science, including the acquisition and analysis of data for discovery and the training of biomedical data scientists. The library aims to strengthen its position as a center of excellence for health data analytics and discovery, and to spearhead the application of advanced data science tools to biological, clinical and health data. NLM is building a workforce for data-driven research and health by funding PhD-level research training in biomedical informatics and data science. The library also partners with NIH to ensure inclusion of data science and open science core skills in all NIH training programs, and is expanding training for librarians, information science professionals, and other research facilitators. NLM is participating in NIH-wide efforts to foster a culture that advances science and ensures the development and retention of a diverse, safe, and respectful workforce for data-driven research and health well into the future.

Responding to the Novel Coronavirus (COVID–19)

The health sciences library community thanks Congress for providing NLM with the $10 million supplemental appropriations to prevent, prepare for, and respond to the Coronavirus. From the beginning, NLM has been at the forefront of providing people with information on COVID–19 . Our frontline health care providers use NLM's databases to access the latest research datasets, literature publications, and scientific information about Covid–19. NLM has responded to COVID–19's rapidly evolving situation through its suite of tools and deep well of expertise in managing large and complex datasets and making them accessible to the public. Our frontline healthcare providers use NLM's databases to access the latest research datasets, literature publications, and scientific information about COVID–19. For example, NLM has been:

—Making immediately available to the public in PubMed Central tens of thousands of coronavirus-related research publication and data contributed by major publishers
—Contributing to the COVID–19 Open Research Dataset (CORD–19), which represents the most extensive machine-readable coronavirus literature collection available for text mining to date, with more than 30,000 full-text scholarly articles from PMC as of mid-May 2020. The Text REtrieval Conference (TREC)-COVID Challenge makes use of the CORD–19 dataset to help search engine developers evaluate and optimize their systems in meeting the needs of the research and healthcare communities.
—Creating BI SARS–CoV–2 Resources, a portal of literature, gene sequence data, and clinical resources related to the virus that causes COVID–19.
—Providing the biomedical community free and easy access to genome sequences from the coronavirus through the GenBank sequence database.
—Providing information about US clinical trials related to COVID–19 via ClinicalTrials.gov, which is also now making available information about trials listed in the World Health Organization's international clinical trial registry.
—Extending standard terminologies to include terms related to COVID–19, including codes for laboratory tests, chemical entities, and indexing terms.
—Applying machine learning techniques to research conducted at NLM to assist in identifying COVID–19 in X-rays and to identify and categorize relevant published literature.

Supporting Biomedical Informatics Research and Health Information Technology Innovation

NLM conducts and supports informatics research, training and the application of advanced computing and informatics to biomedical research and healthcare delivery. NLM's National Center for Biotechnology Information (NCBI) focuses on genomics and biological data banks, and the Lister Hill National Center for Biomedical Communications (LHC), is a leader in clinical information analytics and standards. Many of today's biomedical informatics leaders are graduates of NLM-funded informatics research programs at universities nationwide. A number of the country's exemplary electronic and personal health record systems benefit from findings developed with NLM grant support. A leader in supporting the development, maintenance, and free, nationwide dissemination of standard clinical terminologies, NLM partners with the Office of the National Coordinator for Health Information Technology to support the interoperability of EHRs. NLM also develops tools to make it easier for EHR developers and users to implement accepted health data standards and link to relevant patient education materials. In FY 2019, NLM played a critical role in the development, usage, and utility of a data exchange standard to improve flow and availability of data, the Health Level Seven International (HL7) Fast Healthcare Interoperability Resources (FHIR(r)). NIH is encouraging funded investigators to use the FHIR standard to capture, integrate, and exchange clinical data for research purposes and to enhance capabilities to share research data. NIH has also announced to the small business communities its special interest in supporting applications that use FHIR in the development of health IT products and services. To support these efforts, NLM is managing the development and testing of FHIR tools that researchers can use to increase the availability of high-quality, standardized research datasets and phenotypic information for genomic research and genomic medicine.

Closing the Gap in Health Disparities

The National Library of Medicine supports NIH's efforts to close the gap in health disparities and improve the diversity of the biomedical information science workforce. Their work supports our mission and core values to make MLA and AAHSL more diverse and inclusive organizations. NLM accomplishes this by:

—Providing open access to scientific literature through PubMed and PubMed Central make scientific literature accessible, lading to biological discoveries and providing the foundation to developing clinical guidelines that inform health care. Resources include PubMed Special Query for Health Disparities and Minority Health Information Resources.
—Utilizing the Network of the National Library of Medicine to provide equal access to biomedical information and improves the public's access to information. NNLM supports events including the recent DEI webinar series "Nine Conversations that Matter to Health Sciences Librarians" as well as NNLM Reading Clubs on Disability Health, LGBTQ Health, Racism and Health and Diversity in Medicine.

—Funding grant programs that support research to advance health equity and grants to reduce health disparities research supplements to promote diversity in health research and leveraging health information technology to address minority health and health disparities.
—Raising awareness and sparking conversations about the intersection of society and ethical considerations in biomedical research and technology through the annual NLM Science, Technology, and Society lecture series.

We look forward to continuing this dialogue and thank you for your efforts to support funding of at least $475 million for NLM in FY22, with additional increases in future years.

PREPARED STATEMENT OF THE METAVIVOR RESEARCH AND SUPPORT, INC.

FISCAL YEAR 2021 APPROPRIATIONS RECOMMENDATIONS

—Please provide the National Institutes of Health (NIH) with an increase of at least a $3.2 billion for FY 2022 to bring total agency funding up to a minimum of $46.1 billion annually.
—Please support establishment and adequate funding for the new Advanced Research Projects Agency for Health (ARPA–H) at NIH as proposed in the Administration's Budget Request to Congress to facilitate robust scientific progress on cancers.
—Please continue to support additional investment for the cancer "moonshot" as outlined by the 21st Century Cures Act and otherwise ensure the National Cancer Institute (NCI) has adequate resources.
—Please continue to emphasize the importance of federal research activities focused on controlling and eliminating cancer that has already disseminated (Metastatic Cancer) through committee recommendations and timely oversight of ongoing activities.
—Please support emerging efforts to modernize the Surveillance, Epidemiology, and End Results Research Program (SEER) Registry to better capture the experience of metastatic cancer patients (as outlined by recommendations within the FY 2021 Senate LHHS Appropriations Bill).

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, thank you once again for considering the views of METAvivor and the stage IV metastatic cancer community as you work on FY 2022 appropriations for medical research and public health. The community is deeply grateful for the sustained investment in NIH, and emerging calls for a robust and comprehensive effort to enhance cancer research. Please maintain the commitment to supporting innovative medical research and providing adequate resources to public health programs moving forward, for FY 2022.

ABOUT METAVIVOR

My name is Jamil Rivers. I had a typical family before my diagnosis of "de novo" metastatic breast cancer. I was 39 years old, married, with three children and a full-time job. We were very active and always doing something. I have a big, tight-knit family and we love to travel. I had just changed jobs and we moved into a new house. I never missed a beat—and then my husband was diagnosed with stage-one colon cancer. I became his caregiver. It was in 2017, and everyone got sick in the wintertime like we always do. We had colds and were coughing, but my cold didn't go away. I also had this pain and this pinch, like I had pulled a muscle on my right side. When I went to the doctor about my cold and cough, they had prescribed me antibiotics. I also asked for an ultrasound because appendicitis runs in my family. The results showed that I had lesions in my liver. I had no other symptoms and no other pain, but further testing showed I had stage IV "de novo" metastatic breast cancer. It was the most shocking news ever.

The breast cancer had spread to my liver, my spleen, lymph nodes, lungs, bones, my abdomen and my chest wall. I was devastated. I'm blessed with this beautiful family and my kids are really young. At the time they were only 5, 6 and 16 years old. Why would God bless me with this beautiful family and then strip me from them? I couldn't wrap my brain around the fact that my husband and I could both have a serious health issue. It just wasn't a possibility.

"Who is going to take care of our kids?" That was the first thing I thought about in the midst of my devastation. But after that, I realized I had to survive for them;

I have to be here for them. I wanted my kids to know that I did everything I could possibly do in my power to be here for them. I had to process my diagnosis so I could focus on my health. You never think this could happen to you but it did. It happened to me.

I'm the type of person who, when a challenge is brought to me, I figure out how to execute it and get it done. I basically had to figure out. I empowered myself and armed myself with as much knowledge, information, resources and support as possible. My mission was survival.

I'm my kids' mom and no one else can be. I'm the breadwinner in my family and everyone is also on my benefits. It was imperative that I keep my job and do well at my job so I could continue to take care of them. I started chemotherapy right away because, on paper, I was literally dying. The kids had to see me lose all of my hair and be really tired. That's when I started researching what else I could do in terms of integrative therapy to help me manage the side effects of the chemo in order to still work, be active and take care of my kids the same way I always had.

Now, my husband is in recovery and after 1 year of chemotherapy, my tumors have shrunk to the point where they're a microscopic size so you can't see them on a scan... also known as "no evidence of disease". I'm still working, taking care of the kids and involved in their school activities. I want to soak in every waking second with my family.

I'm not giving up anytime soon.

Through my advocacy, I have tried to help bring more attention to metastatic breast cancer, the need for more research funding and investment towards metastatic breast cancer. I now serve as Board President of METAvivor and work alongside others to push this important work forward. I hope the lives of the more than 600,000 people with stage IV metastatic cancer is considered when making decisions about the future of cancer research and especially funding the stage IV metastatic cancer research. METAvivor has worked hard to fund research. Since 2009, we have funded over $18 million but we need more...stage IV metastatic cancer needs more research.

THE FACTS ABOUT METASTATIC STAGE IV CANCER

Roughly 600,000 Americans die annually from cancer. Ninety percent of these deaths are caused by a metastasis. If we wish to lower the death rate, we must tackle metastasis. For more than 20 years, the primary focus has been on preventing cancer altogether and if that fails, catching it early. But aside from convincing people to stop smoking, forbidding smoke in common areas and removing colon polyps prior to malignancy, little progress has been made. For most cancers, it is believed there are multiple causes, few if any of which are known, making prevention a formidable goal. Improved equipment has allowed some cancers to be diagnosed as early as stage 0; however, stage 0 patients are also metastasizing. And although we are slowly adding drugs to the treatment repertoire, a treatment's effectiveness often runs out in 2–3 months. Thus, we empty our toolbox of drugs far too quickly and we, metastatic patients, die. Saving lives is an achievable goal but tragically is not being realized because the focus continues to be prevent and early detect. Those goals have been maximized. Backs have been turned to the metastatic community long enough. It is high time to include metastasis as a major focus area.

Sarah, Oregon

My name is Sarah Wald. I live in Eugene, Oregon. I am a professor at the University of Oregon and a parent. I'm also living with metastatic breast cancer. I was diagnosed with metastatic breast cancer just over two years ago. It was a denovo diagnosis. This means I was Stage IV at diagnosis. It was not a recurrence. I have no family history of breast cancer. I saw my doctor annually for breast exams and planned to start mammograms at forty. I had no symptoms at diagnosis. I felt healthy. I biked 50 miles the weekend after I found what felt like an immobile small grape in my breast. I called my doctor the morning after I found the lump and took the first available appointment. She got me in for a mammogram and ultrasound the day I saw her. It was already too late. There were breast cancer cells in my bones.

I don't know how to explain to you what it is like to find out you are dying of a terminal disease in your thirties. I don't know how to explain to you what is like to feel healthy and be looking forward to the future with your family and then to be told that you will almost certainly be dead in the next few years. There is nothing I want more than to live. I want every day of life that I can have. I want every extra week I can spend with my family. I want to see the flowers come in and bloom every spring. We need money for research. I was shocked to find out how little money actually goes to metastatic breast cancer research when it is metastatic

breast cancer that kills. For those of us living with the disease, it is a race against time to find new treatments that will give us those extra months and those extra days. New research and new treatments make a difference. For the past two years, my cancer has been controlled by a treatment that first received FDA approval in 2015. My second line of treatment will contain a drug that received FDA approval after my diagnosis in 2019. The research you fund today might be the research that lets me see another birthday, mine or my child's. We need to find out how to stop breast cancer from metastasizing and treat it when it does. I don't want anyone else to go through what I am enduring. Please support funding more research for stage IV metastatic breast cancer.

[This statement was submitted by Jamil Rivers, Board Chair, METAvivor Research and Support, Inc.]

PREPARED STATEMENT OF THE MICHELSON CENTER FOR PUBLIC POLICY

The Michelson Center for Public Policy (MCPP) thanks the Subcommittee for its long-standing bipartisan leadership in support of the National Institutes of Health (NIH). Robust support for science and innovation is critical if we are to advance public health, sustain U.S. leadership in medical research, and remain competitive in today's innovation economy.

It is now estimated that the COVID–19 pandemic will cost the U.S. economy more than $16 trillion.[1] The NIH's fiscal year (FY) 2021 budget was just 0.25 percent of that. The NIH is the world's largest funder of medical research and the basic, clinical, and translational research that it funds is the very fuel that feeds the American engine of discovery and drives innovation in pharmaceuticals and biotechnology. More importantly, NIH research saves lives and improves wellbeing for millions worldwide. Now is the time to vaccinate the economy and bolster our ability to respond to the emerging public health threats of tomorrow by continuing to invest heavily in biomedical research with transformative potential. MCPP urges the Subcommittee to provide $100 billion for NIH in FY 2022.

MCPP is a 501(c)(4) social welfare organization that propels legislative change through meaningful collaboration with elected officials, government agencies, and civic leaders to achieve positive outcomes in medical research, education, equity, and animal welfare. The Michelson Center for Public Policy is an affiliated but separate organization from the Michelson Philanthropies network of foundations (Michelson 20MM Foundation, Michelson Found Animals Foundation, and Michelson Medical Research Foundation) and complements the Michelson Philanthropies' thought leadership and expertise with bold and effective advocacy.

MCPP's founder and co-chair is physician, inventor, and philanthropist Gary Michelson, M.D. He is committed to using his platform to advocate for robust investment in biomedical research, disruptive innovation that can deliver more treatments and cures, and support for the next generation of researchers.

Through the Michelson Medical Research Foundation, Dr. Michelson makes grants to support high-quality, cutting-edge medical research because a single breakthrough could benefit the lives and health of hundreds of millions. But philanthropy cannot do it alone. Truly transformative medical advances are seeded by robust investment in the NIH and these investments have exponential returns for the economy, jobs, tax revenues and—most importantly-humankind.

MCPP is thankful for the strong bipartisan support that the Subcommittee leaders, Chairwoman Rosa DeLauro and Ranking Member Tom Cole, have shown in providing the NIH with six consecutive funding increases during this time of constrained budgets. These increases have helped the NIH regain ground from the years of largely flat funding in inflation-adjusted dollars. However, we must do more.

The Biden Administration has proposed to fund the NIH at $51 billion in 2022, which is a good start, but not nearly enough. This is precisely the right time to be bold and go bigger. For the NIH to invest adequately in risky research with the most promise for transformative advances—the very type of research that enabled the unprecedented COVID–19 vaccine development we saw over the past year-it needs twice that.

We cannot afford to be modest in our efforts. No one deserves to fall ill and die, or to helplessly watch as their child, parent or spouse suffers because we failed to do the work right now to save them. We must dramatically increase the NIH's budg-

[1] https://news.harvard.edu/gazette/story/2020/11/what-might-covid-cost-the-u-s-experts-eye-16-trillion/.

et, so that a lack of funding is not the reason why patients go untreated and diseases remain a threat to public health.

The COVID–19 pandemic has shown that the NIH cannot only rely on incremental annual increases to its base budget to meet the next public health challenge. A fraction of the resources put into combating the pandemic should have been invested in the NIH years ago. With impacts like $16 trillion from one pandemic, we need more than inflationary increases to NIH each year to keep pace and inoculate the country against the next public health crisis.

Investing in the NIH is an investment in our national security. The investments that protect our nation's health and wellbeing should be protected in the same manner as investments in our national defense.

Not only is NIH research essential to advancing health and national security, it also plays a key economic role. Funds provided to NIH are not costs, but instead generate remarkable rates of economic return and even greater returns on our health and wellbeing. In FY 2020, NIH invested $34.65 billion, or almost 80 percent of its budget, in the biomedical research industry across the country. This investment supported more than 536,338 jobs nationwide and generated nearly $91.35 billion in economic activity across the U.S.[2] Just one NIH-funded medical research program, The Human Genome Project, directly generated more than a trillion dollars for the US economy—a 178-fold return on investment—and has paid for itself many times over in industry tax revenues returned to the government.[3]

MCPP is enthusiastic about the Biden Administration's proposal to establish a new Advanced Research Projects Agency for Health (ARPA–H). As proposed, ARPA–H could drive innovation and accelerate the development of innovative therapeutics, treatments, and cures for chronic conditions such as cancer, diabetes, and Alzheimer's Disease. Too often, research supported by the NIH results in incremental advancements and not the transformative scientific breakthroughs that only come from robust investment in high-risk high-reward research. MCPP is committed to supporting innovative ideas that can accelerate the pathway to cures. Standing up an entity like ARPA–H that is focused on high-risk high-reward research and accelerating the timeline from idea to clinical application is the exact thing our nation needs to leverage the lessons learned from the COVID–19 pandemic and apply them to other pressing public health challenges.

A crucial component of ensuring that the NIH is equipped to meet the health challenges of the future is supporting the next generation of scientists. Early career researchers in the biomedical sciences face many struggles as they move toward independence. Lack of independent funding opportunities and tenure-track faculty positions place many early career researchers in a cycle of training positions that may hinder growth, innovation, and scientific independence. In addition, the NIH funding ecosystem is harmfully "hypercompetitive." In 2020, only one out of every five applicants was ultimately awarded NIH funding, and the resulting grant was almost always less than the amount requested to effectively perform the research. This system especially disadvantages early career investigators, squandering the potential of scientists with groundbreaking and innovative ideas.[4] Furthermore, among early career researchers, women, parents, and those from underrepresented backgrounds in STEM bear a disproportionate amount of this burden. MCPP urges the Subcommittee to build NIH's ability to devote more of its annual budget to programs that support early career researchers, with the goal of attaining ten percent of the agency's overall budget invested in the most promising young investigators conducting highly innovative research with truly transformative potential.

MCPP thanks the Subcommittee for its important work dedicated to ensuring the health and security of the nation, and we appreciate this opportunity to urge the Subcommittee to continue the success of NIH by providing at least $100 billion in FY 2022. This is the minimum amount needed to transform our nation's investment in life-saving medical research, enhance NIH's ability to support highly innovative and groundbreaking research, and expand support for young investigators.

We have a once-in-a-lifetime opportunity to pave the way for future medical advances to benefit humankind. Let's seize it.

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[2] NIH's funding information and economic impact data comes from United for Medical Research's 2021 State-By-State Update, https://www.unitedformedicalresearch.org/wp-content/uploads/2021/03/NIHs-Role-in-Sustaining-the-U.S.-Economy-FINAL-3.23.21.pdf.

[3] https://www.nih.gov/about-nih/what-we-do/impact-nih-research/our-society.

[4] https://nexus.od.nih.gov/all/2018/05/04/the-issue-that-keeps-us-awake-at-night/.

PREPARED STATEMENT OF THE MIDWEST URBAN STRATEGIES

Dear Chairman Murray and Ranking Member Blunt:

Midwest Urban Strategies (MUS) represents a coordinated effort on behalf of 13 Department of Labor urban workforce development boards to connect traditional workforce development practices with economic development. Our member organizations are directly involved in the implementation of the bipartisan Workforce Innovation and Opportunity Act (WIOA) of 2014, specifically promoting the successful execution by local workforce boards of the law to serve businesses, employers, and job—and career-seekers. The economic recession and recovery caused by COVID–19 is unlike any other period is our nation's history. MUS members, along with local workforce development boards across the country, immediately adapted to continue to provide critical supports and services to job seekers and businesses throughout the pandemic. Our methods may have changed given the circumstances, but the impact of our work persisted, no matter the obstacle.

As the Senate Appropriations Committee considers the Fiscal Year (FY) 2022 Labor-HHS Appropriations Bill, we urge you to support further federal investment into WIOA and fully fund the law beyond its FY2020 authorized levels. We strongly support the proposed funding levels in President Biden's FY 2022 Budget as it recognizes that appropriated levels have fallen short of authorized levels specifically in Title I accounts at the Department of Labor (Adult Employment and Training Services, Youth Workforce Investment Activities, and Dislocated Worker Employment and Training Services).

Additional federal resources for WIOA programs lead to more job training, education, skills development and innovative, proven practices like industry-based sector partnerships, career pathways, and apprenticeships. MUS works collaboratively in our region and across the country to advance these best practices. Workers and entire industries have been severely disrupted as a result of COVID–19 and these strategies will need to be implemented seamlessly to respond. The established local workforce system is well-positioned to enhance efforts for an equitable recovery; low wage, low skill workers and minority populations were hit hardest by COVID–19. The federal funding structure, which allows these funds to be invested locally, provides for intentional investments to help those most in need.

Local workforce development leaders engage directly with businesses to keep individuals employed and design training/education programs to prepare the workforce for the future. We continue to work with unemployed individuals to re-connect them to the workforce and identify and evaluate other opportunities; recent BLS data suggests nearly 41% of those unemployed have been unemployed for at least 27 weeks (long-term unemployed).[1] Business services, especially for small and medium-sized enterprises, have been critical during the COVID–19 pandemic as employers sought to maintain payrolls and find workers as businesses began to re-open. Increased federal appropriations are greatly needed to address this unprecedented health, economic, and social destabilization.

The Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill must fully fund all Titles—I, II, III, and IV—at a minimum to the level authorized by the Workforce Innovation and Opportunity Act (WIOA).

The funding levels we are requesting in the FY2022 Labor, HHS, Education Appropriations Bill are listed below:

Title I—Department of Labor

—At least $899.987 million for Adult Employment and Training Services,
—At least $963.837 million for Youth Workforce Investment Activities, and
—At least $1.436 billion for Dislocated Worker Employment and Training Services

Title II—Department of Education

—$678.640 million for Adult Education

Title III—Department of Labor

—$692,370,000 for Wagner-Peyser (FY2021 Enacted)

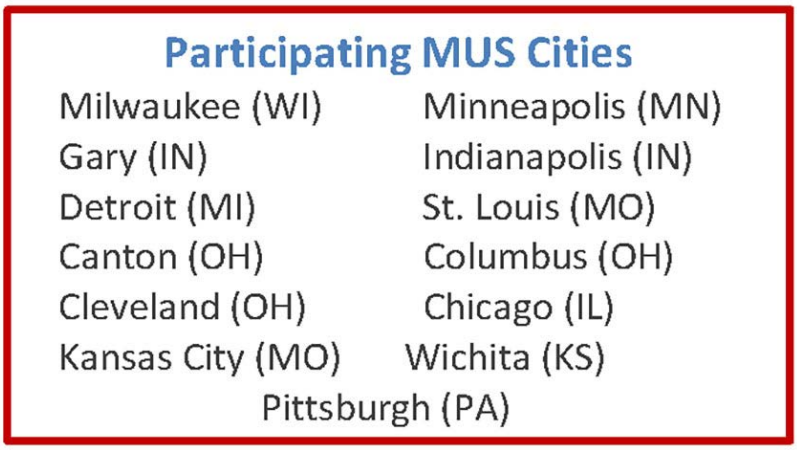
Title IV—Department of Education

—$3,675,021,000 for Vocational Rehabilitation Services (FY2021 Enacted)

This training, support and business partnership is vital to our country's economic prosperity. For further information, please contact Tracey Carey.

[1] https://www.bls.gov/charts/employment-situation/unemployed-27-weeks-or-longer-as-a-percent-of-total-unemployed.htm.

Sincerely.



[This statement was submitted by Tracey Carey, Executive Director, Midwest Urban Strategies.]

PREPARED STATEMENT OF THE MOORE CENTER FOR THE PREVENTION OF CHILD SEXUAL ABUSE

The Moore Center for the Prevention of Child Sexual Abuse at the Johns Hopkins Bloomberg School of Public Health (Moore Center) welcomes the opportunity to submit this statement for the record about the importance of federal investment in child sexual abuse prevention research. The Moore Center was founded in 2012 on the premise that child sexual abuse is a preventable, not inevitable public health problem. Our mission is to create, through rigorous science, a public health approach to preventing child sexual abuse. Together with many stakeholders in the child welfare community, the Moore Center requests that Congress appropriate $10 million for child sexual abuse prevention research at the Centers of Disease Control and Prevention's National Center for Injury and Violence Prevention, Division of Violence Prevention in FY 2022.

Child sexual abuse and the damage it causes to children, adults, families, and communities too often makes headlines. Astoundingly, approximately 13 percent of all children will become victims of the crime. Child sexual abuse is associated with serious mental and physical health problems that shorten the lifespan and reduce its quality. Effects include increased risk for post-traumatic stress system disorder, substance use disorders (including opioid abuse), HIV, heart disease, and suicide. Given this, it is no surprise that our 2018 study found that the economic burden of child sexual abuse was $9.3 billion in 2015, and costs each victim more than $280,000 in earning and other losses over their lifetime.[1]

The COVID–19 pandemic has further underscored the need for effective prevention programming. The National Center for Missing and Exploited Children reported an almost 100 percent increase in online enticement reports and a 63 percent increase in CyberTipline reports between January and September 2020, compared to the same months in 2019. Additionally, the International Criminal Police Organization reported increased consumption of child sexual exploitation and abuse materials among several member countries during the pandemic. In addition to increased online offending, data from US and UK Stop it Now! helplines and websites indicate a surge in requests for help by people concerned about their own sexual thoughts and behaviors, particularly stepfathers with sexual thoughts about their stepdaughters. These increases are likely due to steep pandemic-related job losses and work-from-home/learn-from-home policies that leave at-risk men who were previously managing their urges with too much time, too much access to children, and

[1] Letourneau, Elizabeth J., et al. "The Economic Burden of Child Sexual Abuse in the United States." Child Abuse & Neglect, vol. 79, 2018, pp. 413–422., doi:10.1016/j.chiabu.2018.02.020.

too little structure. We expect risk for online and intra-familial offending will remain high until pre-pandemic employment and in-school education levels are regained.

The federal government rightly funds treatment and other services for crime victims, including victims of child sexual abuse, and funds criminal justice efforts to detect, prosecute and hold accountable those who commit child sexual abuse. Indeed, the federal government annual spends approximately $529,000,000 solely to incarcerate people with sex crimes against children in federal facilities. Yet 95 percent of all sex crimes are committed by people with no prior sex crime convictions. As important as victim and criminal justice efforts are, they do little if anything to prevent harm from occurring in the first place. An inadequate focus on preventing child sexual abuse stands in stark contrast to robust federal efforts that address all other forms of child victimization as preventable public health problems and not solely criminal justice programs. For decades, we have supported the development, validation, and dissemination of programs such as home visitation that effectively prevent child physical abuse and neglect, as well as school-based programs that effectively prevent peer-on-peer bullying, teen dating violence, and suicide. The lack of similar strategies to prevent child sexual abuse is primarily due to the failure to fund similar research in this space.

In the absence of validated prevention efforts, organizations and individuals that work with children have had to develop and implement idiosyncratic and untested prevention efforts. Youth serving organizations, schools, religious groups, sports clubs, after-school programs, child care settings, hospitals, and other youth-focused organization have to create and recreate their untested prevention strategies. Indeed, most states mandate that child sexual abuse curricula be implemented in K–12 schools, yet few such programs have been tested for their effectiveness. There is no way to tell if any given prevention effort might be effective, ineffective, or even harmful to children in the absence of evaluation.

The FY 2019 appropriations bill directed the CDC to release a report on the current state of child sexual abuse prevention research. The report, released in December 2019, outlines significant gaps in existing research efforts, which include the need to: improve surveillance systems and data collection; increase the understanding of risk and protective factors; and, strengthen, develop and disseminate evidence-based prevention policies, programs and practices.

In FY 2020 $1 million was allocated to the CDC's Division of Violence Prevention, which funded two grants to study adult child sexual abuse perpetration prevention. The Moore Center was a recipient of one of these grants, which is being used to conduct research to validate our Help Wanted intervention, an online prevention program designed to provide individuals with sexual interest in younger children with the support and resources to maintain their commitment to non-offending. Virginia Commonwealth University was the recipient of the other grant, which will be used to evaluate Praesidium's Armatus(r) Learn to Protect program, a program focused on the prevention of school employee-perpetrated child sexual abuse, misconduct, and exploitation of students.

In FY 2021 child sexual abuse prevention research received a $500,000 increase. In response, the CDC published a funding opportunity announcement for proposals to evaluate approaches on primary prevention of child sexual abuse perpetrated by youth or adults. The Moore Center was very appreciative for this increase and recognizes the difficulty that the budget caps created for giving programs funding increases; however, it is critical that additional funding is allocated in FY 2022 to address the aforementioned research gaps identified by the CDC. We believe that a $10 million appropriation would allow for meaningful advances to be made in the successful prevention of child sexual abuse.

We want all American children to grow up free from abuse; federal investment in child sexual abuse prevention research is needed to make this wish a reality. The foundation and philanthropic community currently supporting prevention research and evaluation cannot continue to fund it alone. We urge you to include $10 million for research on the primary prevention of child sexual abuse at the CDC as funding priority for FY 22.

We look forward to working with the committee on efforts to protect our children from child sexual abuse and hope that you will consider the Moore Center a resource in the future. Thank you in advance for your time and consideration.

[This statement was submitted by Elizabeth J. Letourneau, Ph.D., Director, Moore Center for the Prevention of Child Sexual Abuse.]

PREPARED STATEMENT OF NAF

NAF is a national network of education, business, and community leaders who work together to ensure high school students are college, career, and future ready. NAF appreciates the opportunity to submit testimony to the Senate Labor, Health and Human Services, Education, and Related Agencies (LHHS) Appropriations Subcommittee regarding our request for Fiscal Year 2022 report language for a Work-based Learning Coordinators Demonstration Program funded at $5,000,000 at the Department of Labor's Employment and Training Administration.

NAF's educational design promotes open enrollment in our career academies and allows students of all backgrounds and capabilities to participate. The design is replicable, sustainable, and cost-effective, and because it integrates within public schools, supports lasting systemic reform and equity nationwide. NAF transforms the learning environment to include STEM-infused, industry-specific curricula and work-based learning experiences. NAF serves more than 117,000 students in 34 states, Washington D.C., Puerto Rico, and the U.S. Virgin Islands. NAF is focused on helping to eliminate systemic, educational, and professional barriers faced by students of color.

Economic upheaval from the pandemic will negatively affect the young people entering the workforce at a time when communities need talented workforce to aid in the recovery. It is even more challenging for students of color and from low-income communities with systemic inequities who will face lower earnings, less overall wealth, and greater economic consequences.

Public secondary education institutions play a critical role in preparing youth for future success through initiatives like career and technical education programs, access to local colleges, and work-based learning opportunities with employers. As a principal public institution that young adults go through before becoming adults, the secondary education system plays a significant role in setting up the next generation for success in the workforce. Work-based learning programs ensure a connection between schools and the working world, whether it's preparing students to enter existing jobs, encouraging entrepreneurial endeavors, or serving as a foundation for career opportunities after post-secondary education.

Work-based learning is the continuum of activities both in classroom learning and the actual workplace setting that leads students to gain real world experience. It also has proven economic benefits for Black and Latinx students and young people from families with low incomes. Through work-based learning, virtual and in-person, students can better identify their career interests and aptitudes, understand the education and training they need to achieve their aspirations, and build their professional and support networks.

The most effective work-based learning experiences provide sustained and meaningful interaction between a student and employer partner. This would include career preparation activities such as internships, apprenticeships, and mentorship programs. While less intensive activities—such as guest speakers, mock interviews, and worksite tours—are important to help students with career awareness and exploration and to introduce employers to the concept of work-based learning, the more time—and resource-intensive activities like internships are where students gain the most insight into the working world and are able to hone their professional skills.

When created with intentional student learning outcomes and ownership by all stakeholders, work-based learning can shape students' aspirational opportunities by helping them explore potential careers of interest; build student skills; and help level the playing field by exposing students to networking opportunities to build a diverse professional network, which research indicates is particularly transformative for students of color and those from low-income households.

Further, 80% of jobs are filled through personal and professional connections. Work-based learning helps students build these relationships and expand their networks beyond their immediate communities. The relationships with adults nurtured through work-based learning opportunities are also shown to be long-lasting, positively benefiting students up to a decade later. Young people deserve an education that builds workforce-ready skills, helps them create social capital, and connects them to opportunity. This is true in "normal" economic times and even more critical during a downturn.

Engaging high school students in work-based learning experiences ensures these students graduate college, career, and future ready, which is essential, especially for students who fail to see the connection between high school academics and future careers. In a recent study, students enrolled in a NAF program in grade 9 and were identified as at-risk of not graduating were 5 percentage points more likely to grad-

uate from high school than their non-NAF counterparts. NAF academy students have a 99% graduation rate.

Educators often have the challenge of finding time to plan and implement work-based learning due to their lack of staffing capability to this particular initiative. With so many demands on school staff, work-based learning is seen as supplementary and not a priority. Administrators and teachers who have accountability testing requirements also push back on the amount of time this strategy requires outside of the classroom. These educators may lack the capacity to meaningfully engage employers and develop sustainable relationships.

Work-based learning coordinators can bridge the divide between school and community employers. The coordinators support work-based learning programs by assisting schools and districts with strategic program planning, coordinating work-based learning activities, and building relationships with employer partners to increase access to internships and other career-focused activities.

NAF encourages schools and communities to have work-based learning coordinators as we have seen it make a difference in the quality and quantity of experiences for students. NAF urges the subcommittee to support and advocate for the inclusion of the following report language in the Fiscal Year 2022 Appropriations bill.

Research shows that participation in work-based learning during high school has a positive impact on students, including completing high school, and helps them secure higher-quality jobs, boosting equity and economic opportunity. To build upon Congress' request of the Department in Fiscal Year 2021 to encourage local secondary education authorities be included on local workforce development boards, the Committee recommends $5,000,000 in Fiscal Year 2022 for the first year of a five-year demonstration program to provide full-time, work-based learning coordinators in underserved communities with an already proven track record for secondary career and technical education. Work-based learning coordinators to conduct outreach, engagement, recruitment and coordination of work-based learning activities, including, but not limited, to paid internships or pre-apprenticeships for high school students, with local community employers, especially with in-demand industries of information technology, health sciences, and engineering. The work-based learning coordinators may be employed by the local education agency, local workforce development board or local workforce development agency, a group of employers, or a consortium of eligible entities. In making grant awards, the Committee directs the Secretary to ensure to require a plan for evaluations in each individual grant proposal, including types of work-based learning opportunities completed, demographics of participating students, and students' post-secondary career plan, as well as to conduct a national assessment of all grantee proposals once complete.

CONCLUSION

Though our world is changing rapidly, and we face unprecedented challenges; we have an opportunity to pave the way for a stronger and more equitable economy. Work-based learning, including paid internships, is a proven, effective way to ensure high school students are college, career, and future ready and prepared to meet the demands of an evolving economy. NAF appreciates the opportunity to share its expertise; and thanks you for your consideration of this important request.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR CAREGIVING

Chair Murray and Ranking Member Blunt, and members of the Subcommittee, thank you for your tireless efforts during the COVID–19 pandemic to ensure that older adults, people with disabilities, and their caregivers across the nation could access the supports and services that they needed to survive. As you know, during our historic collective crisis, Older Americans Act programs that provide community-based care and services to millions of older adults, caregivers, and people with disabilities each year, became part of the lifeline that empowered many to stay safely in their homes. Other vital federal programs provided critical support for caregivers, who became increasingly isolated during one of our nation's most challenging periods. Your Subcommittee's work saved lives and helped to ensure quality care for millions of people. We are grateful to you and your staff for all you have done.

As we move into the next phase of the pandemic and recovery, we submit our funding requests for FY 2022 with the sincere hope that programs supporting family caregivers will again emerge as a priority for the Subcommittee. The needs of caregivers in your states and across the nation, including mid-career Americans who are juggling children and aging parents, have only become more pronounced. Many have left the workforce altogether because they needed more support. In the wake of emergency investments that responded to a historic increase in the needs of older

adults and caregivers during the pandemic, federal investments cannot simply return to normal.

We urge congressional appropriators to embrace, at a minimum, many of the recommendations included in the FY 2022 Biden Administration budget. However, for key, national caregiver support programs, we ask that you consider going above the Administration's request and fund these programs at levels that sufficiently recognize the immense challenges that caregivers of all ages and demographics faced during the global crisis. Therefore, we ask that you consider the following appropriations requests which fall under the Administration for Community Living (ACL) and the Administration on Aging (AoA):

—$334,000,000—Older Americans Act Title III E, National Family Caregiver Support Program (NFSCP), including $400,000 for the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Council

—$21,600,000—Older Americans Act Title VI, Native American Caregiver Support Services

—$14,200,000—Lifespan Respite Care Program

—$5,000,000—Care Corps Community Care Corps Grants

—$35,000,000 Alzheimer's Disease Program Initiatives (ADPI):

In addition, we ask that you provide $20,000,000 for the BOLD Infrastructure for Alzheimer's Act initiatives under the Centers for Disease Control and Prevention. These funding requests align with those of national coalitions that focus on caregiving, including. the Leadership Council of Aging Organizations (LCAO), Leaders Engaged in Alzheimer's Disease (LEAD), and the Eldercare Workforce Alliance (EWA).

I submit these requests and this testimony as the President and Chief Executive Officer of the National Alliance for Caregiving (NAC). NAC's mission is to build partnerships in research, advocacy, and innovation to make life better for family caregivers. Our work aims to support a society which values, supports, and empowers family caregivers to thrive at home, work, and life. As a 501(c)(3) charitable nonprofit organization based in Washington, D.C., we represent a coalition of more than 60 non-profit, corporate, and academic organizations; nearly 40 family support researchers with expertise in pediatric to adult care to geriatric care; advocates who work on national, state, and local platforms to support caregivers across over 30 states. In addition to our national work, NAC leads and works closely with peer organizations in countries such as Australia, Canada, Denmark, Finland, France, Hong Kong, India and Nepal, Ireland, Israel, Japan, New Zealand, Sweden, Taiwan, and the United Kingdom. You can learn more about NAC and our work at www.caregiving.org.

Background: For the purposes of this testimony, the term "caregiver" is defined as it is in the RAISE Family Caregivers Act. A caregiver is "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[1] Many on this committee have been personally impacted by family caregiving. We appreciate your leadership and that of your colleagues in the Senate and House who have spoken openly, and candidly, about the realities of caregiving.[2] Those experiences, along with 53 million other Americans who support a friend or family member, form the backbone of our long-term care systems.

Family caregiving is a public health issue. In a nationally representative research study NAC conducted with AARP and released last year, we identified some of the common issues facing caregivers today.[3] Just in the last five years, 9.5 million more people have taken on caregiving, and we anticipate additional caregivers because of the coronavirus pandemic. Compared to 2015, family caregivers have faced more confusing care pathways and face a "ripple effect" on their mental health, physical health, and financial health. About 1 in 5 (18%) of caregivers feel financial strain due to caregiving. Caregivers often must work less, spend more money out-of-pocket, and save less for retirement. More people are caring for someone for up to five years when compared to five years ago—and these caregivers are more likely to care for

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[1] From P.L. No: 115–119, available at https://www.congress.gov/bill/115th-congress/house-bill/3759. In research and in advocacy, "caregiver" may be described as: informal caregiver, care partner, caretaker, and related terminology. In an international context, the term "carer" is often used. It should be noted that an estimated 1.4 million children in the U.S. are unpaid caregivers (NAC and United Hospital Fund, Young Caregivers in the U.S. (2005) at https://www.caregiving.org/data/youngcaregivers.pdf).

[2] See Congressional Stories of Family Caregiving (November 2017), https://www.caregiving.org/wp-content/uploads/2018/02/GSA-Congressional-Stories-of-Caregiving-briefing-paper.pdf.

[3] National Alliance for Caregiving and AARP Public Policy Institute, Caregiving in the U.S. 2020 (May 2020), Caregiving in the U.S. 2020—NAC/AARP Research Report

someone with multiple care needs. Yet we know from economic analysis that when supported, family caregivers can improve health outcomes for individuals, reduce health care costs, and improve population health.

Investing in supports and services for caregivers makes sense. Even modest investments could add an additional $1.7 trillion to the U.S. GDP by 2030.[4] New analysis from BlueCross BlueShield[5] likewise anticipates that supporting caregivers can improve population health and reduce costs. Without support, caregivers who were also commercially insured beneficiaries faced worse overall health, and a higher prevalence of cost-driving health conditions including anxiety, major depression, adjustment disorder, behavioral health disorders, and hypertension. Given the macroeconomic impact of investing in family caregivers, we respectfully request that this committee prioritize the following FY 2022 federal investments in this essential population.

OAA Title III E-National Family Caregiver Support Program:

We request $334,000,000 for the Older Americans Act's (OAA) Title III(e), National Family Caregiver Support Program (NFCSP), which is a critical cornerstone to supporting the dignity and independence of older adults, adults with disabilities, and the friends or family who provide care to them. NFCSP offers an entry point for identifying caregiver needs and can help to address the need for caregiver education, respite, and support. Since 2000, the program has provided grants to states and territories to help older adults and people with disabilities stay in the home as long as possible. The NFCSP offers five core services including information about available services to caregivers; assistance to gain access to services; individual counseling, organizational of support groups, and caregiver education; respite care, to allow caregivers to take a break; and other important supplemental services. The NFCSP remains the only nationally administered program to provide supports and services to caregivers of older adults and people with disabilities.

Within the National Family Caregiver Support Program, we ask you to continue—at a minimum—funding the important and groundbreaking work of the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Council. The Administration requested $400,000 for this ongoing work in their FY 2022 budget request, which would allow the RAISE Family Caregivers Council to work toward fulfilling its mission to develop a national strategy to address the needs of family caregivers of all ages and circumstances.

OAA Title VI C-Native American Caregiver Support Services:

Title VI of the OAA provides grants to eligible Tribal organizations to promote the delivery of home and community-based supportive services (HCBS), including nutrition services and support for family and informal caregivers, to Native American, Alaskan Native, and Native Hawaiian elders. During the COVID–19 crisis, we witnessed tragic devastation among tribal elders and their families. Therefore, we ask you to fund vital caregiver support programs at $21,600,000, which would fully double the investment in these programs and continue important support for tribal caregiving communities still recovering from the ravages of the pandemic.

Lifespan Respite Care Program:

The Lifespan Respite Care Program, administered through the Administration for Community Living, provides short-term care that offers individuals or family members temporary relief from the daily routine and stress of providing care. The program strengthens family stability and maintains family caregiver health and well-being by providing often desperately needed respite to exhausted and at-risk caregivers. Additionally, respite care proved through this program can save additional federal dollars by helping to delay, or altogether avoid, out-of-home placements or hospitalizations. Only 14 percent of family caregivers report having used respite care service, despite nearly 38 percent feeling respite would be helpful. We urge your Subcommittee to adopt the President's budget request of $14,200,000 for this vital program.

Community Care Corps Grants:

Within ACL's program portfolio, we urge you to continue to fund the important work of the Community Care Corps Grant program at $5,000,000. The Community

[4] AARP. The Economic Impact of Supporting Working Family Caregivers (2021), available at https://www.aarp.org/content/dam/aarp/research/surveys__statistics/econ/2021/longevity-economy-working-caregivers.doi.10.26419-2Fint.00042.006.pdf, https://doi.org/10.26419/int.00042.006.

[5] See, BlueCross BlueShield. The Impact of Caregiving on Mental and Physical Health (9/9/20), last accessed 5/25/21, https://www.bcbs.com/the-health-of-america/reports/the-impact-of-caregiving-on-mental-and-physical-health.

Care Corps supports innovative local models in which trained volunteers assist family caregivers or directly assist older adults or adults with disabilities in maintaining their independence. These volunteers provide critical non-medical support and companionship to supplement their other caregiving options and relieve over-burdened family caregivers and help meet the growing demand for services from a large and growing aging and disability population.

Alzheimer's Disease Program Initiatives (ADPI) and BOLD Act Initiatives:

Within both the Administration for Community Living and the Centers for Disease Control and Prevention, there are two important programs that support those caring for Alzheimer's disease and related dementias (ADRDs). ADPI supports HCBS for people living with ADRD and their caregivers through grants to states, communities, and Tribal entities. To support the important work of ADPI, we hope your committee will support a $35,000,000 FY 2022 funding request. Within CDC, the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act Initiatives establish an effort within the Centers of Excellence in Public Health Practice dedicated to promoting Alzheimer's disease management and caregiving interventions. We encourage your Subcommittee to include $20,000,000 to support the BOLD Initiatives.

In closing, these vital federal efforts and programs that support millions of family caregivers across the country have a profound impact on the quality of life. They can reduce caregiver depression, anxiety, and stress, enabling caregivers to provide care longer and thereby avoiding or delaying the need for costly hospital and institutional care. On behalf of myself, the National Alliance for Caregiving, other national aging and disability advocates, and countless caregivers across the country, I implore you and your Subcommittee to support FY 2022 funding levels for these programs that recognize and respect the immense contribution of caregivers to society. Thank you again for all you have done and will do for older adults and individuals with disabilities and their caregivers.

[This statement was submitted by C. Grace Whiting, J.D., President and CEO, National Alliance for Caregiving.]

Prepared Statement of the National Alliance for Eye and Vision Research

EXECUTIVE SUMMARY

NAEVR, which serves as the "Friends of the National Eye Institute," is a 501(c)4 non-profit advocacy coalition comprised of 50 organizations involved in eye and vision research, including ophthalmic/optometric professional societies, patient and consumer groups, private funding foundations, and industry. NAEVR is immensely grateful to Congress, especially the House and Senate Appropriations Subcommittees on Labor, Health and Human Services, and Education (LHHS), for the strong bipartisan support for National Institutes of Health (NIH) funding increases from Fiscal Years (FY) 2016 through FY2021. The $12.85 billion NIH increase in that timeframe has helped the agency regain ground lost after a decade of effectively flat budgets.

This past investment in NIH has not only improved our understanding of fundamental life and health sciences but also prepared the nation to combat unprecedented health threats, including the COVID–19 pandemic, and promoted ever-evolving medical advances. To maintain this momentum in FY2022, NAEVR strongly supports the NIH program funding level of $51.95 billion as proposed by President Biden, including no less than $46.1 billion for NIH's base program level budget [absent proposed funding for the Advanced Research Projects Agency-Health (ARPA–H)], an increase of at least $3.177 billion or 7.4 percent (as compared to the Administration's proposed $45.45 billion NIH base funding level, which is a $2.51 billion or 5.9 percent increase), to enable NIH's base budget to keep pace with the Biomedical Research and Development Price Index (BRDPI) and allow for 5 percent growth. This increase is necessary to support promising science across all Institutes and Centers (ICs), ensure continued Innovation Account funding established through the 21st Century Cures Act for special initiatives, and support early-stage investigators.

NAEVR also urges one-time emergency funding for federal research agency "research recovery" investment to enable NIH to mitigate the pandemic-related disruptions without foregoing promising new science. NAEVR supports the bipartisan Research Investment to Spark the Economy (RISE) Act (H.R. 869/S. 289) which includes $10 billion for NIH (although at the Subcommittee's May 26, 2021, hearing NIH Director Francis Collins, MD, PhD estimated that the pandemic shutdown re-

sulted in a $16 billion loss to its biomedical enterprise). Though pandemic-related lab closures impacted all researchers, the situation was especially acute for early-stage investigators. NAEVR's educational foundation Alliance for Eye and Vision Research (AEVR) documented this impact in a September 2020 video discussion engaging 22 Emerging Vision Scientists who described the chilling effect on their research, collaborations, training, and overall career pathway (a journal article version of this discussion will be published on July 1, 2021, in JAMA Ophthalmology),

NAEVR also urges Congress to fund the National Eye Institute (NEI) at $900 million, a $64.3 million or 7.7 percent increase over FY2021 that reflects both biomedical inflation and growth as compared to the Administration's $858.4 million funding level, a $22.83 million or 2.7 percent increase. Despite NEI's total $160 million funding increases in the FY2016–2020 timeframe, its enacted FY2021 budget of $835.7 million is just 19 percent greater than the pre-sequester FY2021 funding of $702 million. Averaged over those nine fiscal years, the 2.1 percent annual growth rate is still less than the average annual biomedical inflation rate of 2.7 percent, thereby eroding purchasing power. In fact, NEI's FY2021 purchasing power is less than that in FY2012.

The NEI currently faces an increasing burden of vision impairment and eye disease due to an aging population, the disproportionate risk/incidence of eye disease in fast-growing minority populations, and the impact on vision from numerous chronic diseases (such as diabetes) and their treatments/therapies. Especially with the COVID–19 pandemic, the NEI faces additional challenges, as both the working age population and students have relied almost exclusively on electronic communications devices and e-learning platforms which can increase the rates of myopia, dry eye, eye strain, and other vision disorders.

Maintaining the momentum of vision research is vital to vision health, as well as to overall health and quality of life. Since the US is the world leader in vision research and training the next generation of vision scientists, the health of the global vision research community is also at stake.

NEI-FUNDED RESEARCH SAVES SIGHT AND RESTORES VISION

The past federal investment in vision research has led to major advances in the prevention of vision loss as well as the restoration of vision.

Audacious Goals Initiative: The NEI has been at the forefront of regenerative medicine with its Audacious Goals Initiative (AGI), which launched in 2013 with the goal of restoring vision. Engaging a broad constituency of scientists from the vision community and numerous other disciplines, the AGI currently funds major research consortia that are developing innovative ways to image the visual system. Researchers can now look at individual nerve cells in the eyes of patients in an examination room and learn directly whether new treatments are successful. Another consortium is identifying biological factors that allow neurons to regenerate in the retina. And the AGI is gathering considerable momentum with current proposals to develop disease models that may result in clinical trials for therapies within the next decade.

Retinal Diseases: The NEI has been at the forefront of research into retinal diseases. NEI-funded researchers helped show that a protein called Vascular Endothelial Growth Factor (VEGF) stimulates abnormal blood vessel growth that occurs in the advanced stages of the "wet" form of Age-related Macular Degeneration (AMD) and Diabetic Retinopathy. Food and Drug Administration (FDA)-approved anti-VEGF drug therapies that slow the development of blood vessels in the eye delay vision loss and may improve vision for patients. The NEI has funded comparison trials of anti-VEGF drugs to provide eye care professionals and patients with the information they need to choose the best treatment options.

With respect to the "dry" form of AMD, known as geographic atrophy and the leading cause of vision loss among individuals age 65 and older, in late 2019 NEI began a first-in-human clinical trial that tests a stem cell-based therapy from induced pluripotent stem cells (iPSC) to treat geographic atrophy. This trial converts a patient's own blood cells to iPS cells which are then programmed to become retinal pigment epithelial (RPE) cells, which nurture the photoreceptors necessary for vision and which die in geographic atrophy. Bolstering remaining photoreceptors, the therapy replaces dying RPE with iPSC-derived RPE.

Genetics/Genomics: The NEI has been at the forefront of genetics/genomics and gene therapy approaches to various vision disorders—both common and rare. The causes of AMD and glaucoma remain elusive—although most cases are not inherited, genetics does play a role. While NEI-funded researchers have identified many genetic risk factors for AMD and glaucoma, further study of these genes is helping to elucidate the biology of these disease and holds promise for improved therapies.

NEI-funded research has also made discoveries of dozens of rare eye disease genes possible, including the discovery of RPE65, which causes congenital blindness called Leber congenital amaurosis (LCA). As of late 2017, NEI's initial efforts led to a commercialized, Food and Drug Administration (FDA)-approved gene therapy for this condition. These gene-based discoveries are forming the basis of new therapies that treat the disease and potentially prevent it entirely.

Front-of-Eye Research: The NEI has launched an Anterior Segment Initiative (ASI) in order to capitalize on research opportunities at the front of the eye. The ASI is addressing clinically significant, quality-of-life problems such as ocular pain and Dry Eye Disease (DED), especially in terms of pain and discomfort sensations, as well as disruptions in the tearing process. Using multi-disciplinary approaches, the ASI plans to elucidate relevant anterior segment innervation pathways that contribute to normal or abnormal functioning of the neural circuits related to the ocular surface.

CONGRESS MUST ROBUSTLY FUND THE NEI AS IT ADDRESSES THE INCREASING BURDEN OF VISION IMPAIRMENT AND EYE DISEASE

NEI's FY2021 enacted budget of $835.7 million is less than 0.5 percent of the $177 billion annual cost (inclusive of direct and indirect costs) of vision impairment and eye disease, which was projected in a 2014 Prevent Blindness study to grow to $317 billion—or $717 billion in inflation-adjusted dollars—by year 2050. Of the $717 billion annual cost of vision impairment by year 2050, 41 percent will be borne by the federal government as the Baby-Boom generation ages into the Medicare program. A 2013 Prevent Blindness study reported that direct medical costs associated with vision disorders are the fifth highest—only less than heart disease, cancers, emotional disorders, and pulmonary conditions. The U.S. is spending only $2.53 per-person, per-year for vision research, while the cost of treating low vision and blindness is at least $6,680 per-person, per-year. [http://costofvision.preventblindness.org/]

A May 2021 JAMA Ophthalmology article reported that more than 7 million people in the U.S. are living with uncorrectable vision loss, including more than 1 million with blindness. Of those living with vision loss and blindness, nearly 1 in 4 are under the age of 40, while 20 percent of all people aged 85 and older experience permanent vision loss. More females than males experience permanent vision loss or blindness, and the Hispanic and African American populations experience a higher risk of vision loss. This study's research methods allowed for a broader analysis of populations in the U.S. (including individuals under age 40) than that used in previous national estimates of vision loss and blindness. [doi:10.1001/ jamaophthalmol.2021.0527]

In an August 2016 JAMA Ophthalmology article, AEVR reported from a national attitudinal survey that a majority of Americans across all racial and ethnic lines describe losing vision as having the greatest impact on their day-to-day life. Other studies have reported that patients with diabetes who are experiencing vision loss or going blind would be willing to trade years of remaining life to regain perfect vision, since they are concerned about their quality of life. [doi:10.1001/ jamaophthalmol.2016.2627]

Investing in vision health is an investment in overall health. NEI's breakthrough research is a cost-effective investment, since it leads to treatments and therapies that may delay, save, and prevent health expenditures. It can also increase productivity, help individuals to maintain their independence, and generally improve the quality of life—as vision loss is associated with increased depression/accelerated mortality.

In summary, NAEVR supports the President's request for $51.95 billion in NIH funding but urges the Subcommittee to appropriate no less than $46.1 billion for NIH's base program level and $900 million for the NEI. NAEVR also supports one-time emergency "research recovery" investment to mitigate the pandemic-related disruptions without foregoing promising new science.

NAEVR thanks the Subcommittee for the opportunity to submit this written testimony, especially as it continues to grapple with the long-term challenges from the COVID–19 pandemic.

For more information, visit NAEVR's Web site at www.eyeresearch.org.

[This statement was submitted by James Jorkasky, Executive Director, National Alliance for Eye and Vision Research.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR PUBLIC CHARTER SCHOOLS

Madam Chair and Members of the Subcommittee, I am pleased to present the views of the National Alliance for Public Charter Schools on the fiscal year (FY) 2022 appropriation for the Charter Schools Program (CSP), which is administered by the U.S. Department of Education. I thank the Subcommittee for maintaining strong support for the CSP, including by providing $440 million for FY 2021. The CSP plays a critical role in expanding educational opportunities for families and in improving educational outcomes nationwide. As the Subcommittee considers the FY 2022 Labor, Health and Human Services, Education and Related Agencies appropriation, we request an increase in funding for the CSP to at least $500 million.

We support the Administration's proposed investments in programs that will benefit all public school students, including the Title I program and the Individuals with Disabilities Education Act. These increases, along with the other COVID relief funds, will help charter schools, like other public schools, address the many challenges they face after the pandemic-related shutdowns. At the same time, we were disappointed to see that the Administration's budget proposal called for flat funding of the CSP. The CSP is the only source of federal funding to support the growth of high-quality charter schools in the communities that need them most. Given charter schools' history of educating students with disadvantages in diverse situations, a $60 million increase for the CSP will deliver outsized returns.

THE OPERATION OF CHARTER SCHOOLS DURING THE PANDEMIC

The COVID–19 pandemic has been extremely challenging for charter schools, just as for all other public schools. Most had to pivot quickly from on-site instruction to distance learning, ensure that teachers had the skills and knowledge to deliver online instruction effectively, overcome disparities in student access to technology, and address many other challenges. Fortunately, charter schools are used to innovating and adapting to meet changing needs, and in this time of crisis they were able to leverage their autonomy effectively. A recent report released in partnership with Public Impact found that small charter networks and single-site charter schools (which together account for 65 percent of all charter schools) were more likely than district schools to set expectations that teachers would engage in real-time synchronous instruction, check in regularly with students, and monitor attendance. Parents have responded accordingly: an April 2021 survey of more than 2,700 parents nationwide found that 65 percent believe that choices like charter schools and learning pods would be "extremely or very effective" in helping students in their state. Parents want more opportunities for their kids, and charter schools are one critical way of providing them.

UNDERSTANDING CHARTER SCHOOLS AND THEIR ACCOMPLISHMENTS

In recent years, and notwithstanding charter schools' achievements and significant efforts to meet the needs of students during the pandemic, we have seen a number of misconceptions emerge about charter schools. To be clear, charter schools are public schools, supported by taxpayers, and open to all students, without entrance requirements. The CSP is the only federal K–12 program that requires its recipients to be open enrollment. Each State decides who may authorize charter schools and how schools will be held accountable for meeting the goals laid out in their charters. And charter schools, as public schools of choice, are ultimately accountable to parents: if a charter school is not delivering for families, it will not remain open. Moreover, while charter schools typically have more flexibility than district schools—such as to set curriculum, hire teachers and staff, and adapt to meet the needs of their students—they are required to meet the same academic testing and Title I accountability requirements as other public schools.

Most importantly, although there is some variety in charter school performance, in the main they are delivering. The 2015 Urban Charter School Study, from the Center for Research on Education Outcomes (CREDO) at Stanford University, found that students in urban charter schools gained an average of 40 additional days of learning per year in math and 18 days in reading, compared to their non-charter-school peers. Moreover, the study found that the longer a student attends an urban charter school, the greater the gains: four or more years of enrollment in such a school led to 108 additional learning days in math and 72 in reading.

More recently, a 2020 study from the Program on Education Policy and Governance at Harvard University found greater academic gains for students in charter schools than for students in traditional public schools who took the reading and math assessments administered by the National Assessment of Educational Progress (NAEP) in fourth and eighth grade between 2005 and 2017. African Amer-

ican and low-income students attending charter schools were almost 6 months ahead of their peers in reading and math compared with students in traditional public schools over the 12-year span of the study. This was the first nationwide study to compare student achievement trends over time between sectors rather than effectiveness at a single point in time.

THE IMPORTANCE OF THE FEDERAL CHARTER SCHOOLS PROGRAM

First authorized in 1994 through the bipartisan efforts of President Bill Clinton and Congressional leaders, the CSP was originally created to support the start-up costs of new schools. Since then, the program has enjoyed strong support from Presidents and Members of Congress from both parties, and has expanded to address the changing needs of the movement.

Since its inception, Congress has appropriated some $6.3 billion for the CSP. To put that number in context, it amounts to less than 2 percent of the appropriation for ESEA Title I LEA Grants over that same time period. This modest investment has helped the number of charter schools grow from only a handful in the early 1990s to around 7,500 schools and campuses today that serve around 3.3 million public school students. CSP has made many of those schools possible by supporting non-sustained start-up costs not covered by per-pupil funding-such as planning, staff training, equipment and materials, renovations, recruitment, and other necessary start-up activities. In addition, State appropriations have often not given charter schools the same level of per-pupil support as non-charter schools, and often have not addressed their facilities needs. The majority of all charter schools, therefore, have needed CSP grants to open.

The CSP makes it possible for new charter schools to open to address changing community needs. One such school—Lumen High School in Spokane, WA—received a 2020 subgrant from the Washington State Charter Schools Association, a 2019 State Entity CSP grant recipient. Lumen is a dual-generational school designed to meet the layered need of teen parents. It offers childcare and early childhood education, incorporates parenting skills in the curriculum, and offers critical wrap-around services to eliminate barriers that might keep parenting teens from accessing education. When the COVID–19 pandemic struck, Lumen's founding Executive Director was offered the chance to delay opening for a year but chose to put the needs of her community first and open in the midst of the pandemic because, as she explained, "our students need school now." Increased CSP funding makes it possible for schools like Lumen to open in the communities that need them most.

Charter school enrollment has grown rapidly, but it has not kept up with family demand. Surveys indicate that some 3.3 to 3.5 million additional students would attend a charter school if space were available to them. Many of those are students who currently attend schools identified as in need of support and improvement under Title I, that is, schools that are not meeting State performance targets. The increase we recommend would enable the creation of charter schools to serve more of the students and families who want them.

FISCAL YEAR 2022 REQUEST

As previously noted, our request for FY 2022 is $500 million-a $60 million increase that would be a wise investment. Within the account, funds should be allocated to programs with floors and ceilings so that the Department can shift funds according to the needs of the field from one year to the next. $500 million would provide sufficient funding for new grants to States and CMOs and thus enable those entities to support the creation of new charter schools. This would reduce wait lists and provide high-quality educational options to more families, particularly those in communities that have been hit hard by the pandemic and where the learning needs are greatest. It will also help ensure funds are available for states that have recently strengthened their charter school laws, including Iowa, Wyoming, and West Virginia.

Finally, our request would help charter schools access appropriate facilities. Charter schools generally have not had the same access to funding sources that support the facilities needs of other public schools, such as municipal bonds, property tax revenues, and State school facilities programs. This forces schools to scrape by in buildings not designed for learning, use funds that should have been available for instruction to cover facility needs, or simply not open at all. The two small facilities programs included in the CSP—Credit Enhancement for Charter School Facilities and the State Facilities Incentive Grants—help fill some of this unmet need.

CONCLUSION

The National Alliance for Public Charter Schools takes great pride in the growth and accomplishments of public charter schools over the last quarter century. Our schools' enrollments continue to climb, and more and more studies have found that charter schools are succeeding: they increase achievement and meet the other needs of a diverse and often historically underserved student population. This success could not have been achieved without the CSP. We ask that you continue that support and accept our recommendation for $500 million for FY 2022.

[This statement was submitted by Nina Rees, President and CEO, National Alliance for Public Charter Schools.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS

Chairwoman Murray, Ranking Member Blunt and Members of the Subcommittee, on behalf of the National Alliance on Mental Illness, thank you for the federal investments in mental health crisis response that you have supported and made possible so far. I appreciate the opportunity to discuss NAMI's priorities, many of which we share, as evidenced by the hearing this Subcommittee held last week on building a robust crisis response system. Without personnel who are trained to handle mental health emergencies, and without the infrastructure in place, the default response to many people in crisis is a law enforcement response, which often ends in trauma or tragedy. In fact, one in four fatal police shootings are of people with mental illness, with one in three being people of color. The lack of effective crisis response also burdens emergency departments (EDs) that are ill-equipped for mental health crises, despite the fact that one of every eight ED visits is related to a mental health or substance use disorder. But as you said in your statement, Madame Chairwoman, there is something we can do about it. Thank you for your leadership.

NAMI is grateful that Congress passed the bipartisan National Suicide Hotline Designation Act of 2020, which created 988 as a three-digit mental health and suicide crisis line that will go live nationwide by July 16, 2022. This alternative to 911 gives communities the opportunity to transform care by developing 988 crisis response systems with the core elements described in SAMHSA's National Guidelines for Crisis Care: 1) crisis call centers, 2) mobile crisis teams, and 3) crisis receiving and stabilization programs. Crisis call center hubs, staffed by people well-trained in crisis response, can assist the vast majority of people calling with a behavioral health crisis. For those who need more, mobile crisis teams provide an in-person response and are able to effectively de-escalate the majority of behavioral health crises and connect people to follow-up services. In situations where needs are more acute, crisis receiving and stabilization services provide safe, therapeutic settings that reduce reliance on ED visits and can avoid the need for hospitalization.

While there is a clear vision for successful 988 crisis response systems, few systems meet the standards needed to realize this vision. Currently, National Suicide Prevention Lifeline (Lifeline) call centers rely on a patchwork of inadequate funding, leaving insufficient capacity to meet current needs, let alone the increased demand that will be spurred by the adoption of 988. There is growing availability of mobile crisis teams, but demand still far outstrips supply, particularly for children and adolescents. There is a dearth of crisis stabilization programs nationwide, and widespread shortages of behavioral health professionals to staff crisis response systems.

Robust federal investment is required to realize the promise of 988 to deliver a mental health response to mental health crises. Some states are adopting 988 user fees, but those fees are minimal and will support only a portion of 988 crisis system costs. Medicaid rarely covers the full costs of the core services—and it does not cover services for people who are not Medicaid-eligible. Without federal support, communities will be unable to develop and sustain a crisis infrastructure that ensures a mental health response will be available for mental health crises.

To help communities develop capacity for the critical first element of a 988 crisis system, crisis call center response, NAMI strongly recommends including $240 million in FY2022 for the National Suicide Prevention Lifeline. This recommendation is based on an initial analysis from Vibrant Emotional Health, the current administrator of the Lifeline. This will provide needed funding to expand capacity for 988 calls, chats, and texts, including implementing technology, enhancing standards and training, and providing nationwide back-up for local call centers.

In FY2021, this Subcommittee included an additional $35 million in the Mental Health Block Grant to fund a 5% set-aside for Crisis Care Services. While this was a valuable start and we are grateful for this investment that is helping states develop crisis services, especially mobile crisis teams, the need is substantial. That is

why NAMI is requesting a 10% set-aside for crisis services in FY2022 to provide critical funds to both start up crisis services and to support the many costs of crisis care that are not covered by Medicaid or insurance plans.

NAMI is also requesting $12.5 million for the SAMHSA Strengthening Community Crisis Response Systems program. When someone experiences a mental health crisis, they often wind up in hospital emergency departments (EDs) where they frequently end up waiting in hallways, sometimes for days, before being admitted to an inpatient or residential facility. This practice, referred to as "ED boarding," is harmful to patients and strains already-burdened EDs. The $12.5 million we are requesting will help communities reduce the traumatic practice of ED boarding by providing intensive crisis services, such as crisis receiving and stabilization programs, and by implementing databases of beds at inpatient and residential behavioral health facilities that help reduce the wait for intensive treatment.

These three programs, while important, are only part of realizing the promise of a successful crisis response system. And while some of the needed investments fall outside this Subcommittee's jurisdiction, I believe it is important to give you the full picture of what is required to effectively implement a comprehensive 988 crisis response system over the next several years.

Whether through the annual appropriations process, broader efforts to upgrade our country's infrastructure, or other means, Congress must invest $10 billion over the next 10 years in 988 infrastructure in three key areas: 1) Supporting capital projects and operations, 2) Increasing the behavioral health workforce, and 3) Ensuring Medicare, Medicaid, and TRICARE coverage. I would like to give you a quick overview of what is needed in each area.

First, supporting 988 capital projects and operations. To build a mental health crisis system that relies on well-equipped 988 call centers as the first point of contact, federal support of the national Lifeline should be supplemented by federal authorization and funding, based on SAMHSA's projections, to support operations at 180+ local Lifeline call centers across the country. This will ensure that people get connected to services when and where they need them.

In addition, communities need support for capital expenses to expand crisis services, such as mobile crisis team vans, facilities for crisis receiving and stabilization and peer respite programs, and call center infrastructure. Congress should expand funding and broaden the uses of the Health Resources and Services Administration's (HRSA) current Capital Development Grants to include crisis system infrastructure.

Second, increasing the behavioral health workforce. As the Subcommittee knows, behavioral health workforce shortages pose challenges for health systems, including crisis response. Congress can help by significantly expanding behavioral health workforce training programs, including HRSA's Behavioral Health Workforce Education and Training (BHWET) and Graduate Psychology Education (GPE) programs, as well as SAMHSA's Minority Fellowship Program (MFP). In addition, to help recruit and retain skilled staff, HRSA's National Health Service Corps Loan Repayment Program criteria must be expanded to include crisis call centers, mobile crisis teams, crisis receiving and stabilization programs, and Certified Community Behavioral Health Clinics.

Third, ensuring Medicare, Medicaid, and TRICARE coverage of crisis services. It is also vital that Medicare, Medicaid, and TRICARE cover mobile crisis and crisis stabilization services. Together, these programs cover tens of millions of people, many of whom will experience mental health and suicidal crises and deserve an appropriate response. Peer support specialists in particular play critical roles in crisis services yet are not covered providers under Medicare. That must change. Finally, to maximize access to behavioral health crisis services, Congress should make permanent the current flexibilities for Medicare coverage of telehealth behavioral health services.

It is NAMI's priority to ensure that an effective 988 crisis response system infrastructure is developed across the country and we are grateful for this Subcommittee's support. We recognize that it is also important to invest in research and a wide range of prevention, intervention, and recovery programs at SAMHSA, including Certified Community Behavioral Health Clinics, that help people get on a path of recovery. To that end, we urge your consideration of the Mental Health Liaison Group (MHLG) recommendations for FY2022 appropriations. NAMI also offers our strong support for the President's FY2022 proposed budget of $1.6 billion for the community mental health block grant and $1 billion to increase mental health professionals in schools.

Thank you for this opportunity and for the leadership you have demonstrated in advancing mental health care. I look forward to working with you to put in place the infrastructure to support a 988 crisis response system and transforming mental health care in America.

[This statement was submitted by Angela Kimball, National Director of Advocacy & Public Policy, National Alliance on Mental Illness.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE TO END SEXUAL VIOLENCE

The National Alliance to End Sexual Violence (NAESV) is the voice in Washington for the 56 state and territorial sexual assault coalitions and 1500 local programs working to end sexual violence and support survivors. The programs included in the Violence Against Women Act (VAWA) are a vital part of local programs' work to support survivors and end sexual violence. This testimony focuses specifically on the Rape Prevention & Education Program (RPE), a VAWA program located at the Centers for Disease Control, Injury Center, and the need to increase funding for the program from $51.75 million to $100 million in FY 22 as recommended by the President's budget and include report language requiring the collaboration with state sexual assault coalitions in the program. We are grateful to the committee for the $1 million increase for RPE in FY 21, however, increased funding is desperately needed.

RPE formula grants, administered by the CDC Injury Center, provide essential funding to states and territories to support rape prevention and education programs conducted by rape crisis centers, state sexual assault coalitions, and other public and private nonprofit entities. In the past few years, demand for programs funded by RPE have skyrocketed, the evidence base has progressed significantly, the current appropriation is very nearly the authorized level, and further investment in the program is desperately needed. The #MeToo movement, the national focus on campus sexual assault, and high-profile cases of sexual violence in the media have increased the need for comprehensive community responses to sexual violence but have also increased the demand for prevention programs beyond providers' capacity.

According to the National Intimate Partner and Sexual Violence Survey (CDC, 2015 national data):

—21% of women and 3% of men reported completed or attempted rape ever in their lifetime.

—Among victims of rape, 43% (11 million) of females and 51% (1.5 million) of males reported it occurred for the first time between the ages of 11–17.

If our children are to face a future free from sexual violence, RPE must be increased. The RPE program prepares everyday people to become heroes, getting involved in the fight against sexual violence and creating safer communities by engaging boys and men as partners; supporting multidisciplinary research collaborations; fostering cross-cultural approaches to prevention; and promoting healthy, non-violent social norms, attitudes, beliefs, policies, and practices.

We know RPE is working.

A 2016 study conducted in 26 Kentucky high schools over 5 years and published in American Journal of Preventive Medicine found that an RPE-funded bystander intervention program decreased not only sexual violence perpetration but also other forms of interpersonal violence and victimization.

"The idea that, due to the effectiveness of Green Dot, ... there will be many fewer young people suffering the pain and devastation of sexual violence: This is priceless." Eileen Recktenwald, Kentucky Association of Sexual Assault Programs

Across the country, states and communities are engaged in cutting-edge prevention projects:

—Connecticut's Women & Families Center developed a multi-session curriculum addressing issues of violence and injury targeting middle school youth.

—Oklahoma is working with domestic violence and sexual violence service agencies, public and private schools, colleges and other community-based organizations to prevent sexual violence.

—Alaska's Talk Now Talk Often campaign is a statewide effort developed in collaboration with Alaskan parents, using conversation cards, to help increase conversations with teens about the importance of having healthy relationships.

—Kansas is looking closely at the links between sexual violence and chronic disease to prevent both.

—Maryland's Gate Keepers for Kids program provides training to youth-serving organizations to safeguard against child sexual abuse.

—Missouri is implementing "Green Dot" bystander education statewide to reduce the rates of sexual violence victimization and perpetration.

—North Carolina was able to ensure sustainability of its consent-based curriculum by partnering with the public-school system to implement their sexual violence prevention curriculum in every 8th grade class.

—Washington is implementing innovative skill building projects that amplify the voices of historically marginalized communities, such as LGBTQ youth, teens with developmental disabilities, Asian American & Pacific Islander teens, & Latino parents & children.

Why increase funding for RPE?

The societal costs of sexual violence are incredibly high including medical & mental health care, law enforcement response, & lost productivity. 2017 research sets the lifetime economic burden of rape at $122 million per victim and also reveals a strong link between sexual violence and chronic disease.

The national focus on campus and military sexual assault as well as high profile cases of sexual violence in the media have increased the need for comprehensive community responses to sexual violence but has also increased the demand for prevention programs beyond providers' capacity.

A Missouri program reported: "The demand for our services has increased about 18% both in 2014 and in 2015. Increased awareness and increased need (crime) are most likely contributors to this trend. There are limited resources available for prevention education. In addition, new government requirements/laws, such as with Title IX and PREA, have contributed to referrals to our organization. Our organization always works to increase support from local resources, but funding is extremely competitive and limited."

A Massachusetts program reported: "With Title IX in the news, requests for prevention education have increased...We are saying no to many requests for education because of capacity issues. We are unable to build and sustain relationships with other underserved communities because of a lack of capacity."

A Nebraska program reported: "I am hugely dismayed at the lack of funding for prevention...It's noble to provide direct services to victims of sexual violence, but if we don't provide prevention monies, then we are just a band-aid. It's terribly frustrating."

Funded involvement of state sexual assault coalitions is imperative for the success of RPE.

RPE was first authorized in the original 1994 version of the Violence Against Women Act (VAWA) and has been reauthorized subsequently with each iteration of VAWA. RPE was the brainchild of National Alliance to End Sexual Violence (NAESV) founder, Gail Burns-Smith, as a coordinated federal response to the prevention of sexual violence. While funding goes to state health departments, the original intent of the RPE program was to fully involve state sexual assault coalitions and rape crisis centers as leaders in this work because of their vast experience in addressing sexual violence. Over the years, the level of involvement of state coalitions has varied between states and has ebbed and flowed. At the same time, there are states in which the state sexual assault coalition has never been meaningfully involved in RPE.

During 2019, NAESV met with state sexual assault coalitions and conducted two membership surveys. While some state coalitions continue to have good and strong working relationships with their state health departments and feel positively about how RPE is being administered, based on our research, over half of the state sexual assault coalitions are dissatisfied or very dissatisfied with how RPE is being administered. This past year, there have been changes in some states that have resulted in both concerns about state approaches to RPE and elimination of some state sexual assault coalitions involvement in RPE-funded prevention work. Our research also found that:

1. One in four coalitions expressed a concern about lack of sexual violence expertise in the administration of RPE at the state level.
2. 30% of coalitions have concerns about lack of collaboration and leadership.
3. Over 60% of coalitions thought there was too little involvement of community based sexual assault programs in the work of RPE.

NAESV has concluded, with the complete consensus of state sexual assault coalitions, that enough states are having a problem to warrant a legislative solution. Communities deserve the best, most well-informed prevention efforts especially in this era where demand and interest in sexual violence prevention is so high. We know, with the funded involvement of state sexual assault coalitions and increased funding, RPE can be an even more powerful tool in ending sexual violence. The field looked to other successful national formula grants designed to address violence against women as a guide in developing a legislative proposal. The STOP and Sexual Assault Services (SASP) Programs at the Department of Justice Office on Violence Against Women (OVW), designed to provide a criminal justice and survivor services response respectively, both include language to require meaningful collabo-

ration as well as funding to state sexual assault coalitions. We suggest following the success of these grant programs to also ensure the meaningful, funded involvement of state sexual assault coalitions in the prevention of sexual violence.

We recommend the following report language:

"The Committee believes significant involvement of state sexual assault coalitions and underserved communities is critical to ensure rape prevention education dollars are spent on the most impactful programs. So in granting funds to states, the Director of the National Center for Injury Prevention and Control shall set forth procedures designed to ensure meaningful involvement of the State or territorial sexual assault coalitions and representatives from underserved communities in the application for and implementation of funding."

Funding History: In the 2013 reauthorization of Violence Against Women Act, Congress cut authorization for RPE from $80 to $50 million. In FY 17, the program was funded at $44.4 million, a $5 million increase from FY 16. In FY 18 & FY 10, RPE was funded in the omnibus at $49.4 million. In FY 20, RPE was funded at $50.75 million. In FY 21, RPE was funded at $51.75 million.

Please increase funding for RPE to $100 million and include report language requiring the funded collaboration of state sexual assault coalitions in the RPE program.

Please feel free to contact me with any additional questions at terri@endsexualviolence.org.

[This statement was submitted by Terri Poore, Policy Director, National Alliance to End Sexual Violence.]

PREPARED STATEMENT OF THE NATIONAL ALOPECIA AREATA FOUNDATION

THE FOUNDATION'S FISCAL YEAR 2022 L–HHS APPROPRIATIONS RECOMMENDATIONS

—At least $46.1 billion for the National Institutes of Health (NIH).

—Proportional funding increases for National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute of Allergy and Infectious Diseases (NIAID) and the National Center for Advancing Translational Science (NCATS)

—Please provide $10 billion for the Centers for Disease Control and Prevention (CDC).

—Please provide $5 million for the Chronic Disease Education and Awareness Program.

Chairwoman Murray, Ranking Member Blunt and distinguished members of the Subcommittee, thank you for your time and your consideration of the priorities of the alopecia areata community as you work to craft the FY2022 L–HHS Appropriations Bill.

ABOUT ALOPECIA AREATA

Alopecia areata is a prevalent autoimmune skin disease resulting in the loss of hair on the scalp and elsewhere on the body. It usually starts with one or more small, round, smooth patches on the scalp and can progress to total scalp hair loss (alopecia totalis) or complete body hair loss (alopecia universalis).

Alopecia areata affects approximately 2.1 percent of the population, including more than 6.9 million people in the United States alone. The disease disproportionately strikes children and onset often occurs at an early age. This common skin disease is highly unpredictable and cyclical. Hair can grow back in or fall out again at any time, and the disease course is different for each person. In recent years, scientific advancements have been made, but there remains no cure or indicated treatment options.

The true impact of alopecia areata is more easily understood anecdotally than empirically. Affected individuals often experience significant psychological and social challenges in addition to the biological impact of the disease. Depression, anxiety, and suicidal ideation are health issues that can accompany alopecia areata. The knowledge that medical interventions are extremely limited and of minor effectiveness in this area further exacerbates the emotional stresses patients typically experience.

ABOUT THE FOUNDATION

NAAF, headquartered in San Rafael, California, supports research to find a cure or acceptable treatment for alopecia areata, supports those with the disease, and educates the public about alopecia areata. NAAF is governed by a volunteer Board of Directors and a prestigious Scientific Advisory Council. Founded in 1981, NAAF is widely regarded as the largest, most influential, and most representative foundation associated with alopecia areata. NAAF is connected to patients through local support groups and also holds an important, well-attended annual conference that reaches many children and families.

NAAF initiated the Alopecia Areata Treatment Development Program (TDP) dedicated to advancing research and identifying innovative treatment options. TDP builds on advances in immunological and genetic research and is making use of the Alopecia Areata Clinical Trials Registry which was established in 2000 with funding support from the National Institute of Arthritis and Musculoskeletal and Skin Diseases; NAAF took over financial and administrative responsibility for the Registry in 2012 and continues to add patients to it. NAAF is engaging scientists in active review of both basic and applied science in a variety of ways, including the November 2012 Alopecia Areata Research Summit featuring presentations from the Food and Drug Administration (FDA) and NIAMS.

NAAF is also supporting legislation to provide coverage for cranial prosthetics under Medicare. This bill will grant increased access to cranial prosthetics and therapies for patients with alopecia areata and other forms of medical hair loss. Many patients living with medical hair loss suffer from a variety of diseases, including cancer. With no known cause or cure, alopecia areata is an autoimmune skin disease affecting approximately 6.9 million Americans, many of whom are children.

NATIONAL INSTITUTES OF HEALTH

NIH hosts a modest alopecia areata research portfolio, and the Foundation works closely with NIH to advance critical activities. NIH projects, in coordination with the Foundation, have the potential to identify biomarkers and develop therapeutic targets. In fact, researchers at Columbia University Medical Center (CUMC) have identified the immune cells responsible for destroying hair follicles in people with alopecia areata and have tested an FDA-approved drug that eliminated these immune cells and restored hair growth in a small number of patients. This huge breakthrough has led to NIAMS providing a research grant to the researchers at Columbia to continue this work. In this regard, please provide NIH with meaningful funding increases to facilitate growth in the alopecia areata research portfolio.

PATIENT PERSPECTIVE

"There is a chance you could lose all your hair." That was the last thing anyone ever wants to hear. I will never forget standing in the shower in November 2015 with my hands full of hair and in complete disbelief. Was this really happening to me? I felt as though my identity was being ripped away from me as every strand of hair fell out of my head. My hair was my identity. Who would I be without it? How was I going to live like this for the rest of my life?

I lost all of my hair on my entire body including eyebrows and eyelashes within four weeks and I was diagnosed with the autoimmune disease called alopecia areata. For the next year, I did everything in my power to grow my hair back from every topical cream to medicines that compromised my immune system to weekly steroid injections into my scalp. This was the worst pain I had ever experienced in my life but I would do anything to grow my hair back.

Nothing was working. I had to stop as my mind, body, and soul couldn't take it anymore.

I don't know what was worse, the treatments or the stares I would receive out in public as everyone thought I was going through treatment for cancer. I wanted to blend in with society so badly, but wigs were so expensive. I refused to look at myself in the mirror because I hated the reflection. I wore a hat everywhere I went even to bed until the lights were turned off to take it off and I wouldn't take any pictures, especially during the holidays because I was ashamed of my appearance. I wanted my life back so I could be a good mom to my daughters and just enjoy life. Alopecia areata is not just cosmetic, it takes an emotional toll as it caused severe anxiety and depression that I continue to deal with years later. I was very fortunate to have the unconditional support of my parents who helped me to purchase wigs so I could feel somewhat normal again; however, there are too many people with alopecia areata who do not have the luxury of support that I was blessed with. Your support would impact people's lives immensely.

Thank you for the opportunity to testify before you today. NAAF looks forward to working with you all to advance medical research and public health activities that will improve patient outcomes for the members of our community suffering from alopecia.

[This statement was submitted by Jeanne Rappoport, Acting Chief Executive Officer, National Alopecia Areata.] Foundation.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR STATE COMMUNITY SERVICES PROGRAMS

As Board President of the National Association for State Community Services Programs (NASCSP), I am pleased to submit testimony in support of the Department of Health and Human Services' (HHS) Community Services Block Grant (CSBG). We are seeking a Fiscal Year 2022 appropriation level of $800 million for CSBG and an increase in client eligibility to 200% of the Federal Poverty Level. The current 200% eligibility established under the Coronavirus Aid, Relief, and Economic Security (CARES) Act will expire at the end of Fiscal Year 2021, creating a steep drop-off of services for many vulnerable families during a critical time of recovery. These funding and eligibility levels will empower States and local communities with the resources they need to lead the fight against poverty through innovative, effective, and locally tailored anti-poverty programs that help individuals, families, and communities achieve economic security.

NASCSP is the member organization representing the State CSBG Directors in all 50 states, the District of Columbia, and three U.S. territories on issues related to CSBG and economic opportunity. NASCSP provides training and technical assistance to empower State Offices in implementing program management best practices and in developing evidence-based policy. The State Offices represented by our organization would like to thank the members of this committee for their support of CSBG over the years, particularly for the supplemental funding through the CARES Act and the increase to CSBG in the FY 2021 Labor-HHS Bill.

CSBG is a model example of a successful Federal-State-Local partnership, a fact I can personally attest to having worked for more than 15 years in the Arkansas State CSBG office. I worked closely with the local Community Action Agencies and with federal OCS and ACF staff. The CSBG network leverages federal and non-federal funds to support a range of essential services and activities that improve the lives and communities of Americans. These activities are incredibly important to vulnerable individuals and families, especially during times of crisis. CSBG is in every state and county, from the most urban counties to the most rural ones, where CSBG furthers the critical goals of economic security, social mobility, and racial justice. I will highlight three main points in my testimony:

1. The structure of CSBG empowers States and local communities to take the lead on poverty, giving States wide discretion to tailor funding to their unique economic and social conditions.
2. CSBG creates impact in communities across the country by leveraging additional private, local, state, and federal investments to fight poverty, serving as the national human services infrastructure by weaving together and coordinating private and public antipoverty efforts.
3. The robust local, state, and federal accountability measures of the CSBG Performance Management Framework are uniquely comprehensive when compared to other federal programs, preventing service duplication and fostering continuous improvement.

Structure

Proponents of state and local anti-poverty efforts often highlight their ability to tailor services, asserting that state and local leaders are best equipped to tackle the challenges facing their communities. CSBG is a block grant administered and managed by states, who administer and distribute funds to a nationwide network of more than 1,000 local CSBG Eligible Entities, also known as Community Action Agencies or CAAs. The CSBG network forms the bedrock of the human services infrastructure that uplifts urban, rural, and suburban communities across the United States. In some rural counties, the CAA is the only human services organization addressing poverty and uplifting low-income families in the community.

State offices distribute funds to Community Action Agencies, who utilize CSBG funds to address their specific local needs, often in one or more of these core domains: employment, education and cognitive development, income, infrastructure and asset building, housing, health and social behavioral development, and civic engagement and community involvement. The CSBG Act requires that these services

are shaped by a community needs assessment performed at least every three years, ensuring programs are tailored and responsive to unique community needs, rather than a one-size-fits-all solution. The needs assessment prevents service duplication and incorporates community feedback in the strategic planning process.

Furthermore, the CSBG Act requires at least one-third of a Community Action Agency's board to be composed of people with low-incomes or their representatives, ensuring that local needs and viewpoints are accurately reflected in organizational priorities. In addition to low-income representation, Community Action boards are also comprised of local elected officials or their representatives and community stakeholders including local businesses, other assistance organizations, professional groups, and community organizations. This unique tripartite structure assures the needs of a community are identified and met with the available resources necessary to maximize outcomes and impact. The tripartite structure of Community Action boards calls on all sectors of society to join in the shared fight against poverty.

State Offices are charged with providing the oversight and support necessary for effective administration of CSBG at the local and state levels. States provide training and technical assistance to build the capacity of local CAAs; ensure compliance with federal and state requirements; and serve as important partners in the development of statewide linkages and coordination to combat state causes and conditions of poverty. The structure of CSBG empowers states and locals to work collaboratively, maximizing impact for America's communities.

Impact

CSBG is a positive federal investment in a national system to address poverty that produces concrete results. Federal CSBG dollars are used to build, coordinate, support, and strengthen anti-poverty infrastructure across our communities. In Fiscal Year 2018,[1] for every $1 of CSBG, CAAs leveraged $8.27 from non-federal sources. Leveraging funds allowed CAAs to expand highly successful and impactful programs. Including all federal sources, non-federal sources, and volunteer hours valued at the federal minimum wage, the CSBG Network leveraged $21.97 of non-CSBG dollars per $1 of CSBG. Without CSBG, many rural communities across America would not be able to implement critical programs that address poverty for low-income families and their communities. The CSBG network served more than 10.2 million people with low incomes in Fiscal Year 2018. A robust appropriation will expand impact and foster innovation within the network Below is a snapshot of some quantitative impacts of CSBG:

—915,230 households improved their energy efficiency and/or energy burden in their homes.
—594,718 low-income seniors (65+) achieved or maintained an independent living situation.
—253,422 children and youth who are achieving at a basic grade level (academic, social and other school success skills.
—78,713 adults who improved their education levels.
—55,684 unemployed adults who obtained employment up to a living wage.
—18,090 unemployed adults who obtained employment with a living wage or higher.

Looking beyond the data, we see that the CSBG Network is delivering innovative, comprehensive, and effective programs across the country that uplift individuals, families, and their communities:

—*Disaster Response and Recovery in Oregon:* In September of 2020, Oregon residents in Douglas and Josephine counties already experiencing a surge in COVID–19 cases were faced with the additional threat of unprecedented wildfires. Evacuating families struggled to find adequate shelter and consistent access to food as the fires raged across multiple impacted counties. Already familiar with serving local low-income communities, the United Community Action Network (UCAN) immediately began providing disaster relief. UCAN partnered with FEMA, local public health departments, and emergency response centers to help homeless or unsheltered individuals and families find safety. Unable to cook while evacuating, families utilizing food assistance relied on expensive prepared meals which quickly drained their resources. Despite the extreme circumstances, UCAN continued to provide food, hygiene products, and social services wherever space was available, including parking lots and outside gas stations. While the wildfires stoked confusion and separated families, UCAN connected those who were displaced and supplied cellphones so those affected could contact loved ones. UCAN was instrumental in organizing the

[1] FY 2018 data is the latest publicly available from the Office of Community Services (OCS) within the Department of Health and Human Services (HHS).

emergency response, providing critical resources, and reconnecting those separated by disaster.

—*Vaccination Coordination & Education in Wisconsin:* In coordination with Wisconsin's Vaccination Task Force, the Wisconsin Department of Children and Families and the Wisconsin Community Action Program Association (WISCAP) are training case managers to help Wisconsin residents to navigate the COVID–19 vaccination process. Trainings cover vaccine scheduling through the 2–1–1 Wisconsin phone service, a framework for discussing vaccine confidence, and a review of wrap-around services available to compliment vaccination. Through this coordination, Wisconsin is leveraging the 2–1–1 service as a referral source for hyper-local, trusted community member-driven vaccination education. Wisconsin's CSBG network also applied for a COVID–19 Outreach Grant to better assist BIPOC and rural, low-income people with vaccine hesitance or barriers to access like transportation. This coordinated effort helped all programs leverage vaccine rollout funding to create a broader reach within local communities, increase access to vaccines, and ultimately save lives.

—*Flexible & Bundled Services in Michigan:* Michigan's Bureau of Community Action and Economic Opportunity (BCAEO) began organized discussions around new services as soon as the CARES Act was first introduced. Working regionally with local CAAs as well as with Governor Whitmer's taskforce, BCAEO developed contracts and procedures to expand services as soon as CARES funding was available. Expanding their nutrition programs, local agencies created online grocery stores so families with medical, religious, or cultural dietary restrictions could choose foods for delivery. CAAs also delivered quarantine-boxes, packages of food and hygiene supplies that allowed residents to shelter in place before making long-term preparations. Agencies partnered with struggling local farmers to provide fresh produce while also fully retaining their staff during lockdowns by moving them to food warehouse & delivery positions. At the same time, Michigan CAAs utilized supplemental funding to provide more than 2,200 people with internet-connected devices to access remote education, employment opportunities, telehealth, and other critical online resources.

Accountability

CSBG is bolstered by a Performance Management Framework to ensure accountability at all levels of the network. This federally established Performance Management Framework includes state and federal accountability measures, organizational standards for Community Action Agencies, and a Results Oriented Management and Accountability (ROMA) system. Under the Performance Management Framework, CSBG state offices gather and document outcomes for the CSBG Annual Report. Within this reporting mechanism, National Performance Indicators are used across the network to track and manage progress, empowering CAAs have the data they need to improve services and innovate delivery. The ROMA system engages local communities to strengthen their impact and achieve robust results through continuous learning, improvement, and innovation. Furthermore, CSBG State Offices monitor local agency performance and adherence to organizational standards, providing training and technical assistance to ensure continuously high-quality delivery of programs and services.

In closing, we ask the committee to fund CSBG at no less than $800 million for FY 2022 and to increase client eligibility to 200% of the Federal Poverty Level, ensuring that this nationwide network with a nearly 60-year record of success continues to positively impact the lives of vulnerable Americans. The structure of CSBG empowers States and local agencies to address poverty in their communities, while prioritizing the voices of people with low incomes in determining solutions. CSBG is committed to the comprehensive accountability mechanisms of the Performance Management Framework, ensuring effective and responsible stewardship of funds at the Federal, State, and local level. CSBG is producing tangible results, serving millions of vulnerable Americans each year and empowering communities, families, and individuals to achieve economic security, social mobility, and racial justice. NASCSP looks forward to working with Committee members to ensure CSBG continues to help families achieve these outcomes, strengthening our communities and providing our most vulnerable neighbors with security, dignity, and justice. Thank you.

Respectfully submitted.

[This statement was submitted by Beverly Buchanan, Board President, National Association for State Community Services Programs.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNCILS ON DEVELOPMENTAL DISABILITIES

The National Association of Councils on Developmental Disabilities (NACDD), a national membership organization for the State Councils on Developmental Disabilities (DD Councils), appreciates the opportunity to present this testimony. NACDD respectfully requests $89 million, the level included in the President's FY22 budget request, for the DD Councils within the Administration for Community Living (ACL) in the Labor-HHS-Education appropriations bill for Fiscal Year (FY) 2022. We also respectfully request that the following report language be included in the Fiscal Year 2022 Labor, Health and Human Services, Education Appropriations bill:

> *Technical Assistance*.—The Committee provides not less than $700,000 for technical assistance and training for the State Councils on Developmental Disabilities. Such technical assistance should be provided by an organization with long-standing experience providing technical assistance to the national network of state developmental disabilities councils or similar Developmental Assistance and Bill of Rights Act national programs. In addition, the agreement encourages ACL to consult with the appropriate Developmental Disabilities Act stakeholders prior to announcing opportunities for new technical assistance projects and to notify the Committees prior to releasing new funding opportunity announcements, grants, or contract awards with technical assistance funding.

Funding for the DD Councils has obtained broad bicameral support from members of Congress. This funding request also has broad support from the disability community. The Consortium for Citizens with Disabilities, the largest coalition of national organizations working together to advocate for people with disabilities, submitted a support letter to this committee dated April 26, 2021.

Authorized by the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), DD Councils work collaboratively with the University Centers for Excellence in Developmental Disabilities, and the Protection and Advocacy program for Developmental Disabilities, to "assure that individuals with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life, through culturally competent programs."[1] Appointed by Governors, and consisting of at least 60 percent of people with DD and their families, DD Councils assess problems or gaps in the I/DD system and design innovative solutions that make real changes to social systems such as employment, transportation, education, healthcare, housing and more, to fully integrate people with I/DD into society.

The request for an increase in funding for FY2022 is informed by the tragedy and lessons learned from last year's COVID–19 pandemic and the spotlight it placed on circumstances of everyday living for people living with intellectual or developmental disabilities (I/DD) that present obstacles. For decades since the passage of the DD Act and later the Americans with Disabilities Act, the whispered concerns about the dangers of living with I/DD in isolation and stripped of critical supports were realized when the pandemic hit. Several studies showed a link between having an I/DD and a greater risk of contracting and dying from COVID–19, with one study finding having an intellectual disability was the strongest independent risk factor for presenting with a Covid–19 diagnosis and the strongest independent risk factor other than age for Covid–19 mortality. The Centers for Disease Control and Prevention identified social factors which increased the risk of COVID–19 transmission including: relying on direct support workers and families, difficulties understanding information and preventative measures, and difficulty communicating symptoms of the illness. The circumstances of simply living with I/DD means that people are struggling to simply live, not only during pandemics but every day of their lives. For example, it is true that relying on direct support workers and families is an obstacle to surviving COVID, but it is also an obstacle to obtaining employment, accessing transportation, and most activities people without disabilities take for granted.

The DD Councils support innovative programs to promote self-determination and create systemic pathways to independent living to keep people with I/DD safe during public health emergencies and to help them live their fullest lives in the community long after the pandemic. DD Councils direct resources through partnerships with local non-profits, businesses, and state and local governments, to overcome obstacles to community living for people with I/DD. States and territories rely on DD Councils to turn fragmented approaches into innovative and cost-effective strategies

[1] 42 U.S.C. 15001(b).

to increase the percentage of individuals with I/DD who become independent, self-sufficient and integrated into the community. Examples of DD Council projects include: partnerships to increase competitive and integrated employment, campaigns promoting access to qualified direct support workers, programs for successfully transitioning to independent living, advocacy for access to affordable housing, training to build leadership and advocacy skills, and more. DD Council members also provide a critical and unique role in educating state and local policymakers by directly participating in the design of state and local government-funded supports and services affecting their lives.

DD Councils promote community living in the states through narrowly tailored, state-specific initiatives for emerging issues. Every DD Council pivoted during COVID–19 to meet immediate and critical needs. For example, in response to the hardship that COVID–19 has placed on people's ability to stay connected and engaged, the Washington State Developmental Disability Council invested in grants including: providing laptops and prepaid data cards for internet access for those without technology; promoting healthy living during COVID; and combating social isolation. At the same time, their longer-term plans were implemented. For example, as part of their five-year plan, the Missouri Developmental Disabilities Council identified affordable and accessible housing is an essential need for people with I/DD. The council supported community initiatives that resulted in persons with developmental disabilities having opportunities for housing including the Missouri Inclusive Housing Development Corporation (MoHousing).

Thank you for consideration of our request.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, I am honored to have the opportunity to submit my testimony on behalf of this nation's nearly 4,000 treatment court programs and the 150,000 people the programs will connect to lifesaving addiction and mental health treatment this year alone. Given the overlapping crises of substance use and the COVID–19 pandemic, I am requesting that Congress provide funding of $105 million for the Drug Treatment Court Program at the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for fiscal year 2022.

I serve as a superior court judge in Lewis County, Washington, where, for the entirety of my tenure as judge, I have presided over our county's treatment court programs, including drug courts. I have never participated in a more effective approach to promoting public health while also remaining steadfast to the promise of the justice system to protect public safety. Strong empirical evidence shows time after time that treatment courts not only reduce crime, but also save lives and families by connecting participants to evidence-based treatment services and recovery support.

Participants like Brant. Before coming to our program, he spent much of his life cycling in and out of the justice system because of an addiction that began in his early twenties. By the time he came to our program, he had been to jail seven times, with more on the horizon unless something changed. Our treatment court program provided the accountability and treatment that Brant needed to change.

In our program, Brant, like the rest of our participants, was assessed and given an individualized treatment plan designed by substance use treatment professionals using evidence-based methods, including medication-assisted treatment where appropriate. Together, in concert with the multidisciplinary treatment court team who ensured Brant received the services and accountability he needed to succeed, we set a goal of recovery for him, not another costly and ineffective stint behind bars.

Today, Brant is not only living that goal, he's doing what he can to help others achieve the same. He works for an organization that conducts outreach to vulnerable populations with substance use disorders and helps them get their lives back on track, with a special focus on homeless veterans. He also serves as the president of the nonprofit organization that helps support the Lewis County Drug Court, ensuring the lifesaving work of our program continues well into the future.

I have worked in treatment courts since 2004, when I helped launch Lewis County's adult drug court as chief criminal deputy in the prosecutor's office. Subsequently, as the chief criminal deputy of neighboring Thurston County, I supervised our adult drug court, mental health court, and veterans court units. Since then, I have watched many of the most helpless individuals in our justice system overcome their substance use or mental health disorder, regained their lives, and became productive citizens. Most go on to raise families, begin growing careers, and help others

in the similar difficult positions they once found themselves in. Without hesitation, I credit the treatment court model for the health and safety of these individuals.

Lewis County is a rural, relatively quiet part of southwestern Washington. But we are not immune from the grips of the twin crises currently gripping the nation from coast to coast: the substance use epidemic and the ongoing effects of COVID–19, including isolation and economic devastation. Treatment courts, such as adult drug courts, veterans treatment courts, family treatment courts, and others, offer a public health and public safety response to these crises by expanding and enhancing substance use treatment capacity to serve more individuals in their communities.

With overwhelming empirical evidence showing their effectiveness, it is easy to see that treatment court programs across the country merit continued funding. The Government Accountability Office finds the drug court model reduces crime by up to 58%. Further, the Multi-Site Adult Drug Court Evaluation conducted by the Department of Justice confirmed drug treatment courts significantly reduce both drug use and crime, as well as finding a cost savings averaging $6,000 for every individual served. Additional benefits include improved employment, housing, financial stability, and reduced foster care placements.

Brant is not alone in his success. Treatment courts in this country have connected 1.5 million people who have lifesaving mental health and substance use disorders with treatment options best suited to them. Together, the court team offers the tools to overcome substance use disorder and past trauma to create meaningful, healthy relationships.

Continued support from the Drug Treatment Court Program at the Department of Health and Human Services ensures the nearly 4,000 treatment courts in the United States today provide critical treatment services to save lives and reunite families. But we know there are many more who still need this opportunity. I strongly urge this committee to recommend funding of $105 million to the Drug Treatment Court Program in fiscal year 2022, so treatment courts in Washington and beyond can continue providing lifesaving substance use treatment services.

[This statement was submitted by Hon. Andrew Toynbee, Judge, Superior Court of Lewis County, Washington, Chehalis, Washington.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF EMERGENCY MEDICAL TECHNICIANS

Thank you, Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee. My name is Bruce Evans, and I am the President of the National Association of Emergency Medical Technicians (NAEMT). I am also a fire chief leading a fire-based EMS organization in a super rural area of Southwest Colorado—12,000 residents in 264 square miles.

Founded in 1975 and over 70,000 members strong, NAEMT represents our nation's frontline EMS practitioners, who provide critical, lifesaving services to communities nationwide, especially in rural, frontier, and other hard-to-reach areas. On behalf of our organization, thank you for your ongoing support of EMS professionals. NAEMT would like to offer our views on the Subcommittee's FY 2022 bill. At the outset, we write to ask the subcommittee to provide robust funding for the SIREN Rural EMS Equipment and Training Assistance (REMSTEA) program within the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA).

This testimony is submitted just a few weeks after the 46th Annual EMS Week, which occurred from May 16—May 22, 2021. The goal of EMS Week is to thank paramedics, EMTs, and the entire EMS workforce for their services and sacrifices. However, EMS professionals do not just want a pat on the back—like the rest of our members, I am writing to continue to raise public awareness about the critical funding shortfall of EMS in the communities we serve. This urgent request aligns with the spirit of EMS Week.

Passed in the 2018 Farm Bill, the SIREN/REMSTEA grant program supports rural public and nonprofit EMS agencies in their efforts to complete their mandate to provide critical emergency medical care to all of the residents in the communities they serve. The grants help rural EMS agencies train and retain staff and purchase equipment, among filling other needs. Community demands keep growing: each year, fire departments and EMS agencies respond to more than 20 million calls for emergency services. While the COVID–19 pandemic exacerbated the plight of these agencies, EMS practitioners and agencies were facing severe challenges before the virus' outbreak. This can be attributed, in part, to greater distances between health care facilities and low reimbursement rates. The most pressing impact is the decline

of available medical care in rural communities, which has heightened the need for already-stretched EMS agencies to perform these lifesaving services. Again, this foreboding and bleak landscape existed even before the onset of the pandemic, which has strained the social safety net that EMS professionals provide.

COVID–19 made an already growing problem much worse. In FY2020 and FY2021, your Committee provided $5 million and $5.5 million for SIREN grants, respectively. However, the program requires a substantial increase in funds to make sure our personnel have the equipment and training they need. Social distancing and "stay-at-home" protocols because of the pandemic complicated income streams for these agencies. Many rural EMS agencies rely heavily on community fundraising efforts, such as bingo, raffles, and community barbeques. At the same time, support from localities whose tax revenue base has dramatically declined, further hindering EMS agencies' ability to fill their coffers. Beyond smaller revenue streams, costs have gone up, especially as EMS agencies have been paying higher prices for personal protection equipment (PPE) throughout the pandemic.

Rural EMS organizations, like mine in Colorado, have disproportionately suffered from shrinking revenue streams and increased demand before the pandemic and now, especially as it relates to synthetic opioid overdoses, which have skyrocketed and do not seem to be slowing down. Ambulance crews that support the most far-flung areas of our country are running out of money and personnel. Because of the especially demanding work that rural EMS organizations shoulder, they are struggling to stay afloat at a much higher rate than their more urban counterparts. This challenge is not limited to one region of the country; rather, rural EMS organizations across the board are more likely to shut their doors, leaving their residents without reliable access to local ambulance service. Ultimately, without the support this grant program provides, many more local EMS operations will likely have to close their doors.

The result is, unfortunately, predictable: increasing workforce shortages as EMS personnel become increasingly burnt out, face shrinking compensation, and are constantly exposed to unpredictable and dangerous environments. In short, more money is needed to bring more people aboard to ensure that our professionals are provided a safe, healthy, and respectful work environment, and that their EMS agency can effectively serve their communities. The enhanced funding for the SIREN/REMSTEA program will go to good use, especially as our country and economy recover from the economic and health care crisis brought on by the pandemic.

Beyond the demonstrated need, EMS personnel made good use of the funds allocated under the FY2020 and FY2021 spending bills. For FY2020, SAMHSA awarded REMSTEA grants ranging from $92,000 to $200,000 to approximately 27 EMS agencies across the country for recruitment and training purposes. In December 2020, SAMHSA announced the potential to grant awards to another 27 rural EMS applicants. Rural EMS agencies are in dire need for additional support—we can assure you that our organization's members will not leave money allocated by Congress on the table.

On behalf of our 70,000 members who live and work in every state across our country, thank you again for supporting our brave men and women who provide important roles in the health care ecosystem. SIREN/REMSTEA grants will certainly help them do their jobs to their fullest ability.

[This statement was submitted by Bruce Evans, MPA, NRP, CFO, SPO, President, National Association of Emergency Medical Technicians.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS

Our ask for FY 2022 is for a minimum total of $1.9 billion for the three Older Americans Act (OAA) Title III–C Nutrition Programs, divided approximately as follows:

—Congregate Nutrition Services (Title III C–1)—$965 million
—Home-Delivered Nutrition Services (Title III C–2)—$726 million
—Nutrition Services Incentive Program (NSIP) (Title III)—$211 million

We can more than justify the need for this funding level. It is important to understand the reality of how the pandemic impacted these programs. The OAA nutrition programs endured a wholescale conversion of the operations because of the COVID–19 pandemic. Before the pandemic, according to the Administration for Community Living's AGID database, more than twice as many older adults were served in the congregate program as in the home-delivered nutrition program. The pandemic caused the transition of almost all congregate program participants to the home-delivered nutrition program.

This conversion resulted in programs encountering immediate increases in costs for food, transportation and personnel, since many relied on older volunteers who were unable to continue their work. Price increases have been particularly felt in those transportation costs, including gasoline prices. Programs went from serving hundreds of participants per day in one location to getting meals to hundreds of individual locations. Gasoline prices have shown a 49.6 percent increase over the last year, including a 9.1 percent increase between just April and May.

Further, in addition to providing additional funding during the pandemic, Congress also has approved some needed flexibilities to allow these programs to seamlessly convert. The most impactful of these was an updated definition of "homebound," allowing any older adult forced to shelter in place to be eligible for a home-delivered meal, overriding any previous state restrictions. This has led to tremendous increases in demand. In fact, a survey conducted by Meals on Wheels America showed an average of 95 percent increase in demand in the early months of the pandemic, including 80 percent of surveyed programs reporting doubling of requests for home-delivered meals. While demand has stabilized to some extent, it remains at a national average of a 60 percent increase over pre-pandemic levels. Local programs also reported that operating costs will likely remain high for the foreseeable future, and nine in 10 home-delivered meals programs reported continued unmet need for home-delivered meals in their community. Nearly a third of these programs said they would need to nearly double or more than double their home-delivered efforts in the future to serve this unmet need.

This is perhaps the greatest justification for this funding. We do not want to see older adults crashing into and falling over this "cliff" of funding running out while the need for service continues. We do not want to have our dedicated personnel in the field be forced to remove older adults in need from their programs, knowing what the health consequences would be.

This funding request is premised on the fact that while the pandemic may be easing, it is not over by any means. Without question, the emergency funding provided to this nutrition network has been used. These funds we request will absolutely also be used.

It should also be noted that nutrition programs were creative and innovative in their use of emergency funds, establishing partnerships with restaurants, food delivery services, drop-ship services and the like in order to stretch their funding as far as it would go. But public-private partnerships do involve resources from both sides. Supporting our funding request for FY 2022 will allow these innovations and partnerships to continue and expand.

Another justification for this funding request must be what it can do to help alleviate the three evils of hunger, food insecurity, and malnutrition in older adults. We have documented information on major increases in food insecurity during the pandemic. We were also acutely aware that even before the pandemic, one in two older adults were at risk of or were already malnourished. The provision of a daily meal to an older adult in a homebound setting can often be the main source of their nutrition for that given day. Said another way, if you remove that meal, that older adult simply may not eat at all.

A continued investment in the OAA nutrition programs allows us an important intervention for those older adults who are socially isolated. Funding provided during the pandemic went well beyond just providing a meal. Our nutrition network responded by developing critically important programs to maintain contact with older adults who suddenly found themselves not being able to have their normal daily socialization at their congregate program. They provided telephone reassurance calls as well as higher-tech approaches to maintaining contact such as virtual book clubs, exercise classes, and nutrition education. These services, like the food provided, need to be continued in the year ahead.

We were also especially pleased that the American Rescue Plan Act included funding to allow the aging network to assist in the effort to get older adults vaccinated. At the time FY 2022 begins, we will be entering flu and pneumonia season. We need to ensure that we continue to provide the aging network with resources to aid older adults in getting the vaccines they need to prevent these illnesses.

In addition, we are all striving for the day when congregate nutrition sites, senior centers and adult day centers that provide meals can reopen. Of course, this can only be done with proper regard for health and safety rules and ordinances. NANASP and our colleagues at the National Council on Aging are surveying our members to find out what costs facilities will incur both to open and remain open. The results are concerning—many programs are reporting $15,000 in costs or more per facility—and these expected costs go outside of most budgets. We hope that this funding can be significant and flexible enough to allow some to be used to facilitate

reopening and/or that funding for these facilities be included in any major infrastructure bill Congress may produce with the President.

Finally, we implore this Subcommittee to think about what has unfolded in the past year with respect to different funding sources. Aging network programs must report their spending of regular FY 2021 funding as well as four streams of emergency funding and expected FY 2022 funding. We strongly request that you communicate through this legislation that while accurate reporting is necessary and important, steps should be taken by the Administration to ensure that the reporting process is as simplified as possible to ensure that programs are not spending much of their limited staff hours and resources on this onerous task.

Next year, this wonderful Older Americans Act nutrition program will celebrate its 50th anniversary. Without question, its 49th year has likely been its toughest. Yet the fact that the OAA nutrition program went seamlessly through an unexpected full-scale conversion speaks volumes about the dedication of nutrition service providers, who deserve our sincere thanks. They pivoted and persevered despite their personal struggles and fears about the virus. While not technically first responders, they were first to respond to one critical need for older adults—nutrition. In short, they always have the best interest of the older adults they serve front and center, as has this Subcommittee. We ask for you to keep this interest in mind again in this incredibly challenging time so we can be prepared for the final phases of the pandemic and all the related downstream issues there may be.

In closing, in the words of a program director from a recently-published *New York Times* article on OAA nutrition programs:

> "[Program administrators] worry that if Congress doesn't sustain this higher level of appropriations, the relief money will be spent and waiting lists will reappear.
> 'There's going to be a cliff,' Mary Beals-Luedtka [director of the area agency on aging serving northern Arizona] said. 'What's going to happen next time? I don't want to have to call people and say, 'We're done with you now.' These are our grandparents.'"

Prepared Statement of the National Association of Secondary School Principals

The National Association of Secondary School Principals (NASSP) appreciates the opportunity to submit the following testimony for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. As the premier national organization and voice for middle level and high school principals, assistant principals, and other school leaders, NASSP seeks to transform education through school leadership, recognizing that the fulfillment of each student's potential relies on great leaders in every school committed to the success of each student.

As you develop the fiscal year (FY) 2022 appropriations bill for the U.S. Departments of Labor, Health and Human Services, Education, and Related Agencies, NASSP encourages you to help every American student achieve success and be ready for college, career, and life by prioritizing funding for Supporting Effective Instruction State Grants, the School Leader Recruitment and Support program, the Literacy for All, Results for the Nation (LEARN) program, and Student Support and Academic Enrichment grants.

NASSP urges the subcommittee to allocate $3.00 billion for the Supporting Effective Instruction State Grants program, Title II, Part A (Title II–A) of the Every Student Succeeds Act (ESSA). This program provides states and school districts with formula funding that ensures that educators, principals, and school leaders receive the professional learning and leadership skills needed to support every student.

Research continues to show that Title II–A's investments in educators pays significant dividends in terms of improving educational practice and increasing student achievement. School districts use Title II–A funding to implement ESSA's rigorous definition of professional development that embodies the important transition from scattershot, one-off professional development workshops and sessions to collaborative, ongoing, job-embedded professional learning such as coaching, mentoring, and professional learning communities (PLCs). Research supports the positive effect of the kinds of professional development defined in ESSA. For example, key studies show that coaching helps teachers improve their practice faster. A 2018 meta-analysis, which examined 60 rigorous studies of coaching, found large positive effects of coaching on teachers' instructional practices. Across 43 studies, researchers found that coaching accelerates the growth that typically occurs as one moves from novice to veteran status. Additionally, multiple researchers have documented that teachers

who collaborate in PLCs to continuously improve their practice and their students' learning experiences have a measurable positive impact in schools. A 2009 study that took place in New York City documented student achievement gains across grade levels when teachers engaged in purposeful, content-focused interactions.

Title II–A's support for principal and school leader professional learning is also critical, as research shows a strong correlation between high-quality principals and student achievement and teacher retention. A March 2021 Wallace Foundation paper stated that a review of two decades of evidence—including six quantitative, longitudinal studies involving 22,000 principals—found that "principals have large effects on student learning, comparable even to the effects of individual teachers. A separate 2016 review of 18 studies meeting ESSA's Tiers I–III evidence standards concluded that "school leadership can be a powerful driver of improved education outcomes." This research buttresses earlier studies that concluded that principals are second only to teachers as the most important school-level determinant of student achievement. Other research suggests that schools led by high-quality principals have lower teacher turnover rates.

While the federal government's investment in Title II–A has proven to be much needed and welcome, the COVID–19 pandemic laid bare the need for higher levels of support for our nation's educators. A significant increase to $3.00 billion for Title II–A will provide schools and districts with crucial funds to address new and existing challenges induced or exacerbated by the pandemic. A larger investment in Title II–A will help accelerate student learning, curb teacher and principal shortages by recruiting new individuals into the educator workforce, provide supports to keep educators in the profession, keep class sizes low, and provide mental health and wellness support to our nation's educators as they reenter classrooms full time for the upcoming school year.

NASSP urges the subcommittee to support our nation's school leaders through renewed funding for the School Leader Recruitment and Support Program (SLRSP). Authorized under ESSA and funded at $14.5 million in FY 2017, SLRSP is the only federal program specifically focused on investing in evidence-based, locally-driven strategies to strengthen school leadership in high-need schools. Unfortunately, this program has received no funding in the last several fiscal years. Recently though, President Joe Biden released his FY 2022 budget, where he called for the program to receive $30 million, a number that NASSP requests this committee support.

SLRSP empowers states and school districts, individually or in partnership with nonprofits or institutions of higher education, to accelerate the recruitment, preparation, support, and retention of dynamic school leaders who have a measurable, positive effect on student achievement in high-need schools. Through this program, aspiring principals gain access to high-quality preparation programs, sitting principals receive critical professional development supports, and thousands of teachers—along with hundreds of thousands of students—have the opportunity to work and learn in schools where school leaders have the tools to help them maximize their potential. Funding SLRSP at $30 million will allow proven programs to train more principals to lead during this critical time, provide additional support to current principals, and ultimately lead to better support for teachers and students.

As we continue working with states, districts, and schools on how best to serve students and teachers as schools begin close out the current school year and look toward the next, it is important we recognize that investments in school leadership are critical to addressing learning loss and meeting students' social and emotional learning needs. Additionally, investments in leadership are extremely cost effective when you consider that investing in one principal is actually an investment in the 25 teachers and 500 students they, on average, support. A recent report from The Wallace Foundation states, "Principals really matter. Indeed, it is difficult to envision an investment with a higher ceiling on its potential return than a successful effort to improve principal leadership."

While investments in school leadership will have a significant impact on addressing lost instructional time for students, additional investments in critical programs will also be necessary to help student achievement. That is why NASSP also calls for the subcommittee to provide $500 million for the LEARN program, which builds on the success of the Striving Readers Comprehensive Literacy (SRCL) program.

Research has already started to highlight the pandemic's impact on students' literacy skills. McKinsey & Company found that students taking formative assessments in 2020 learned only 87% of the reading that grade-level peers would typically have learned by the fall. Students lost the equivalent of one-and-a-half months of learning in reading on average, but in schools that predominantly serve students of color, the learning loss was especially acute. The LEARN program builds on the success of the SRCL program where states implementing comprehensive literacy

plans have seen significant improvements in English language arts achievement in districts and schools serving disadvantaged students.

Eleven states (Georgia, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Montana, North Dakota, New Mexico, Ohio, and Oklahoma), the Bureau of Indian Education, and four territories received SRCL grants in 2017, and an additional 13 states (Alaska, Arkansas, California, Georgia, Hawaii, Kentucky, Louisiana, Minnesota, New Mexico, Ohio, Rhode Island, and South Dakota) received grants in 2019 under the now-named Comprehensive Literacy State Development program. With these grants, states are able to support high-quality professional development for teachers, principals, and specialized instructional support personnel to improve literacy instruction for struggling readers and writers, including English-language learners and students with disabilities.

The literacy skills our students need today are much more complex than they were 50 years ago. Creating a globally competent workforce depends on students using their reading and writing skills to develop important abilities in areas such as math, science, technology, and manufacturing. Yet despite the fundamental importance of reading and writing, only 35% of fourth-grade students and 34% of eighth-grade students performed at or above the proficient level in the reading assessment of the National Assessment of Educational Progress—the Nation's Report Card.

Of the more than 523,000 students who leave U.S. high schools each year without a diploma, many have low literacy skills. Research clearly demonstrates that a high-quality, literacy-rich environment beginning in early childhood is one of the most important factors in determining school readiness and success, high school graduation, college access and success, and workforce readiness.

A strong federal commitment to literacy is imperative. LEARN supports states in a comprehensive, systemic approach to strengthen evidenced-based literacy and early literacy instruction for children from early learning through high school and supports district capacity to accelerate reading and writing achievement for all students.

Lastly, NASSP urges the subcommittee to allocate $2.00 billion for the Student Support and Academic Enrichment (SSAE) grant program authorized by Title IV–A of ESSA for FY 2022. This would be a $780 million increase over the FY 2021 enacted level. Title IV–A is a flexible grant that supports state and district efforts to: 1) support safe and healthy students by providing comprehensive mental and behavioral health services and implementing violence prevention programs, trauma informed care, school safety trainings, and other evidenced-based initiatives; 2) increase student access to a well-rounded education, such as STEM, computer science and accelerated learning courses, career and technical education, physical education, music, the arts, foreign languages, college and career counseling, effective school library programs, and social and emotional learning; and 3) provide students with access to technology and digital learning materials and educators with professional development and coaching opportunities necessary to effectively use those resources.

Over the last four fiscal years, on a bipartisan basis, Congress has provided a $4 billion investment for Title IV–A, which has allowed districts to meaningfully invest in programs that provide direct educational services and equitable supports to students. Its flexibility has allowed districts to provide funding for critical programs that support educators, school leaders, and students. As district leaders continue to leverage the flexibility of the SSAE grants, they are eager to plan for the continuance and/or expansion of existing programs and services, and to create new programs.

To address unprecedented interruptions to learning caused by COVID–19, we call on Congress now to go beyond what was authorized in ESSA by providing $2 billion for the SSAE block grant. This will allow additional school districts, especially in rural areas, to make investments in not just one, but all three areas that this grant supports. Right now—more than ever—districts need the continued investments in the Title IV–A program. This pandemic has made clear that districts face a wide range of unique challenges, whether it's ensuring all children have access to technology for remote or blended learning or the ability to provide mental health supports from afar. As school systems prepare for the return to classrooms next school year, they will need the flexibility of Title IV–A funds to provide social and emotional learning programs, engaging well-rounded classes like music and physical education, and active learning opportunities enabled through technology.

NASSP thanks you again for the opportunity to share these thoughts and information with you, and also thanks you for your continued work to support our nation's students and educators. To discuss this testimony further or if you have any questions, please contact NASSP's senior director of federal engagement and outreach, Zach Scott, at scottz@nassp.org.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF STATE HEAD INJURY ADMINISTRATORS

On behalf of the National Association of State Head Injury Administrators (NASHIA), thank you for the opportunity to submit testimony regarding the fiscal year 2022 appropriations for federal programs that impact approximately 2.87 million Americans who are treated annually in emergency department visits and hospitals for a traumatic brain injury (CDC, 2014). To address their needs, NASHIA is requesting increased funding for programs authorized by the Traumatic Brain Injury (TBI) Program Reauthorization Act of 2018 and administered by the U.S. Department of Health and Human Services' (HHS) Administration for Community Living (ACL) and the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control (NCIPC). We also support additional funding for the ACL's National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) program authorized by the Workforce Innovation and Opportunity Act (WIOA) of 2014, and which funds TBI Model Systems and TBI research. NASHIA is requesting:

—$12 million additional funding for the ACL TBI State Partnership Grant Program to provide funding to all states, territories and District of Columbia;
—$6 million additional funding for the ACL TBI Protection & Advocacy Grant Program to increase the amount of the awards; and
—$5M additional funding for the CDC's NCIPC to establish and oversee a National Concussion Surveillance System as authorized by the TBI Program Reauthorization Act of 2018.

NASHIA is also requesting a funding increase of $6.6 million to expand the NIDILRR TBI research capacity through the TBI Model Systems (TBIMS):

—To increase the number of TBIMS from 16 to 18 ($1 million each), while increasing per center support by $200,000;
—$1 million to expand TBIMIS collaborative research projects from 1 to 3; and
—$100,000 to increase funding for the National Data and Statistical Center in order to gain information for valuable research.

Each year, a substantial number of Americans are injured due to motor vehicle crashes, falls, military-related injuries, violence, industrial injuries, sports-related injuries and other injuries that cause cognitive, emotional, physical, sensory and health-related problems resulting in unemployment and loss income; homelessness; incarceration; and institutional and nursing home placement due to lack of community alternatives. While recent trends have noted the increasing number of Americans with TBI-related disabilities among older adults due to falls, the COVID–19 pandemic is raising alarms regarding those who are infected who may experience hypoxia due to the deprivation of oxygen, resulting in brain damage that may necessitate the need for rehabilitation to regain functioning and ongoing supports should functioning not be restored. In addition, the increased risk of domestic and intimate partner violence during the time of the "stay at home" orders put people at risk for sustaining a brain injury from the abuser hitting the head, slamming the head against the wall or from near strangulation. As we emerge from the pandemic, the impact on both those at risk for a brain injury and for those with a brain injury will certainly become more apparent.

This year has been especially challenging for individuals with brain injury and their families. States have reported that brain injury program participants have cancelled services due to the fear and anxiety that COVID–19 has caused them. At the same time, providers have experienced loss of income as the result of not being able to perform contractual duties due to the restrictions. As a result, states have witnessed increased anxiety and self-isolation among individuals with brain injury. Thus, the federal funding requested is critical to assist states with issues that emanate from the pandemic, as well as to address the increased number of brain injuries due to an aging population and other factors.

ADMINISTRATION FOR COMMUNITY LIVING—TBI ACT PROGRAMS

The ACL TBI State Partnership Grant Program is the only program that assists states in building and expanding service capacity to address the complex needs associated with brain injury that generally require the coordination of multiple systems (e.g., medical, rehabilitation, education, vocational, behavioral health, Medicaid) and payers (e.g., insurance, Workers' Comp, state and federal programs). Twenty seven states are ending their grant activities. We are requesting additional funding so that all states, territories and District of Columbia may receive funding to address gaps in services within their states.

These grants also help to carry out the ACL priorities to increase direct services, including home and community-based services; accelerating COVID–19 recovery; supporting caregivers; and advancing equity.

ACL TBI STATE PROTECTION & ADVOCACY (PATBI) PROGRAM

The ACL Federal Protection and Advocacy TBI (PATBI) program is a formula grant that provides $4 million total in funding for the 57 P&As in the United States, its territories and the Native American Protection and Advocacy Project in order to provide: (1) information, referrals, and advice; (2) Individual and family advocacy; (3) legal representation; and (4) specific assistance in self-advocacy. The requested amount will increase the amount awarded to state and PATBI grantees.

CENTERS FOR DISEASE CONTROL AND PREVENTION—NATIONAL CENTER ON INJURY PREVENTION AND CONTROL

CDC's National Injury Center initiated a pilot study as a first step in implementing a national surveillance system to determine the extent of mild brain injury or concussions in this country. Most individuals with a concussion are treated in an emergency department or physician's office and may not be reported in other data systems that capture the number of Americans who are hospitalized with moderate to severe TBI. Subsequently, Congress included $5 million authorization to implement the National Concussion Surveillance System within the TBI Program Reauthorization Act of 2018.

Last year, the Government Accountability Office (GAO) issued a Report to Congress that found that data on the overall prevalence of brain injuries resulting from intimate partner violence are limited and that such data is needed to better understand the problem to ensure that resources are targeted appropriately to address these issues. In 2013, the Institute of Medicine (IOM) and the National Research Council released an extensive report on sports-related concussions in children and teens and also examined sports-related concussions among military dependents, as well as concussions in military personnel ages 18 to 21 that result from sports and physical training at military service academies or during recruit training. The report noted that limited data is available and recommended that CDC oversee a national surveillance system to accurately determine the incidence of sports-related concussions.

We strongly support funding to implement a national surveillance system to help states, federal and national partners with needed data to address prevention, identification, and treatment for concussions.

ACL'S NATIONAL INSTITUTE ON DISABILITY, INDEPENDENT LIVING, AND REHABILITATION RESEARCH (NIDILRR)

NIDILRR supports innovative projects and research in the delivery, demonstration, and evaluation of medical, rehabilitation, vocational, and other services designed to meet the needs of individuals with TBI through TBI Model Systems grants. Each TBI Model System contributes to the TBI Model Systems National Data and Statistical Center (TBINDSC), participates in independent and collaborative research, and provides valuable information and resources. This research is critical to help TBI providers to better deliver services that result in good outcomes.

In closing, NASHIA, as a nonprofit organization, works on behalf of states to promote partnerships and build systems to meet the needs of individuals with TBI with the goal of all states having resources to assist individuals with TBI to return to home, community, work and school after sustaining a brain injury. Federal funding is critical to help states in that endeavor, including data and research to support an effective delivery system. We urge you to consider increasing funding for the ACL TBI Program (state and protection & advocacy grant programs), for the ACL NIDILRR program to expand TBI research, for CDC to establish a National Concussion Surveillance system.

Thank you for your continued support. Should you wish additional information, please do not hesitate to contact: Susan L. Vaughn, Director of Public Policy at svaughn@nashia.org, or Becky Corby, NASHIA Government Relations at rcorby@ridgepolicygroup.com.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS

Chairman Murray and Ranking Member Blunt, I present this testimony on behalf of the nearly 74,000 residents in Washington State's long-term care facilities and

in collaboration with the National Association of State Long-Term Care Ombudsman Programs (NASOP). Thank you for your past support of State Long-Term Care Ombudsman Programs (SLTCOPs) and the at-risk individuals that they serve, particularly in the CARES Act. As you know, our work to serve the residents of long-term care facilities under the terrible cloud of the COVID–19 pandemic has been extremely challenging. We are emerging from this period facing many crises in facilities across the nation, but we are determined to protect the rights of residents, resolve their complaints and service problems, and work with facilities to improve the quality of care, the roles in which we ombudsmen have been entrusted.

I submit this statement and the funding recommendations for the Fiscal Year 2022 for SLTCOPs administered through the Administration for Community Living, Department of Health and Human Services, to include:

—$65 million to support our work with residents of assisted living, board and care, and similar community-based long-term care settings as these are less regulated and residents often need greater advocacy;

—$70 million for our current core obligation to respond to tremendous need, ensuring residents have regular and timely access to our program; and

—$20 million under the Elder Justice Act for training and services to address increasing abuse, neglect, and exploitation, including related to staff that are part of the opioid crisis.

Let me explain why our program is requesting this funding. I will start by letting you know why we ombudsmen are so passionate about our work. Our mission is to protect the health, safety, welfare, and rights of our nation's older adults and individuals with disabilities living in nursing homes and assisted living facilities. We protect the residents' rights to be treated as individuals with autonomy, choice, independence, and access to quality health care. We believe that in a just society, all people would have their needs met. LTC Ombudsmen are paid professionals who recruit, train, and oversee teams of local volunteers who want to give back to their communities. The advocacy we provide is the first line of protection for thousands of elders living in licensed long-term care facilities. Increased consistent funding is needed for the SLTCOP to support the critical role ombudsmen play in the care infrastructure, specifically the long-term care and community-based care infrastructure funded in part by Medicaid and Medicare.

Two years ago, volunteers in Washington donated approximately 32,860 hours of their time and skill to resolve complaints made to the program with a success rate of nearly 90 percent. We save the state resources by resolving complaints at the lowest level keeping them out of the expensive regulatory and legal systems. However, like our sister programs across the nation, we are not able to keep up with consumer needs and growing costs. One of the key areas of need right now is the direct result of the covid–19 pandemic. The advocacy and protections our programs provide are necessary to address the trauma and impact that residents, family members, and staff have experienced during the pandemic. Many ombudsman programs, due to the risks, have lost paid staff and volunteers who need to be replaced.

The pandemic put all ombudsmen on high alert. The Washington State LTCOP responded swiftly to the needs of residents and their families by adapting our methods, and developing ways to reach into facilities that were in "lockdown". We distributed nearly 70,000 post cards and notes to long-term care residents and their families informing them about the program, and Residents Rights. Through private donors and a grant from Washington State, we delivered approximately 800 Amazon Fire Tablets to adult family homes to help residents "stay connected" with their family, friends, and communities. We advocated on behalf of residents and their families through participation in multiple stakeholder meetings, educating and informing journalists, providing testimony, and working with our state legislature to pass meaningful legislation (HB1218). The State LTCOP created a mental health and spiritual counselor referral list to address the loss and grief, and the trauma experienced by long-term care residents. We organized a new resident-only advisory council to the State LTC Ombuds, giving voice to the thousands of long-term care residents who were voiceless during the pandemic. These are just a few examples of the work conducted during the COVID–19 crisis which is not yet over.

To alleviate the effects of diminished budgets and expanding long-term care populations, we respectfully request the following funding to support all SLTCOPs.

First, we request $65,000,000 to support SLTCOP work with residents of assisted living, board and care, and similar community-based long-term care settings. While the mandate to serve residents in assisted living facilities was added to our mission Act, there have been no appropriations for this function. Assisted living and similar businesses have boomed, but SLTCOP funding has not increased to meet the demand and respond to the industry boom. We rarely are able to get to the growing number of assisted living facilities, which depending on the state are called board

and care and other names. Nationally, for example, while assisted living beds have grown to more than 57,000 in the years 2013 to 2018, we have about 2,000 fewer volunteers and only 71 more paid ombudsmen over that five-year period.

Home and Community based service options continue to grow in number, but there is no expansion in ombuds services. Increases in long-term care residents is a key factor and challenge to providing our cost saving advocacy services. Washington State has demonstrated leadership by reducing Medicaid costs, while excelling in consumer options outside of expensive nursing homes. Assisted living residents have complex medical needs, very much like the nursing home residents of 20 years ago. Growth in the number of assisted living facilities, in conjunction with complex needs of consumers and diminished funding threaten the health and wellbeing of people in our care. These challenges hinder our ability to meet program requirements to provide regular and timely access to all residents wanting long-term care ombudsman services. Current funding levels preclude SLTCOPs from quickly responding to complaints and monitoring facilities. Without our eyes and ears in these buildings, residents are at risk of abuse, neglect, and serious financial exploitation, and any number of violations of their rights.

Our second request is for $70,000.000, which is needed to provide core program funding for the program under Title VII of the Older Americans Act. These funds must be allocated to all fifty states. In addition to improving the quality of life and care for our family members and neighbors in long-term care, our work saves Medicare and Medicaid funds by avoiding costs associated with poor quality care, unnecessary hospitalizations and expensive procedures and treatments. Furthermore, nationally in 2019, more than 5,947 volunteers donated their time. Ombudsman staff and volunteers investigated 198,502 complaints made by residents, relatives, friends, and volunteers. Ombudsmen were able to resolve or partially resolve 71.5 percent—or an ombudsman resolved nearly three out of every four complaints investigated.

In 2018, Washington State had 3,818 long-term care facilities with approximately 71,000 residents. Our state program includes me, and two other full-time staff, which has not changed much since 1989. Thankfully, we have great partnerships with other not-for-profits to operate local ombudsman programs, extending our reach into the most isolated of nursing home residents in our rural communities. These partners include seven Area Agency on Aging entities and three Community Action Programs and in total, we employ 17.51 full-time staff. Two national studies about the effectiveness of the LTC Ombudsman Program (the Institute of Medicine, and the Bader Report) have recommended that best practice be to employ one full-time paid ombudsman for every 2,000 long-term care residents or licensed beds. Washington State falls short of that goal at having only 49 percent of the needed paid staff.

Although we have a great team of paid and volunteer ombudsmen, our program suffered a significant loss of volunteers during the pandemic. We weren't able to cover every facility before the pandemic and things are worse now. Nearly half of the facilities in our state never receive routine visits by an ombuds, and visitations are the hallmark activity of the Program—vital to building trust and effectiveness. We are so busy responding to complaints that we are not able to conduct regular outreach or build presence in all facilities. We are overwhelmed with complaints about involuntary, and unlawful discharges, also known as, "resident dumping" which is harmful to residents, and costly. Long-term care providers recognize the value and benefit of the LTC Ombudsman program trainings, and consultation services, which often address problems before they escalate.

Third, we request $20,000,000 to support the work of SLTCOPs under the Elder Justice Act (EJC). This appropriation would allow states to hire and train staff and recruit more volunteers to prevent abuse, neglect, and exploitation of residents and investigate complaints. However, the funds have been authorized since 2010, to date no EJC funds have been appropriated for SLTCOPs, except for $4 million in the Coronavirus Response and Relief Supplemental Appropriations Act of 2021. Currently, federal Older Americans Act funding comprises about a third of the total funding required to maintain the Washington Long-Term Care Ombudsman Program, at its current level, with the majority of funding coming from our State General Funds.

Demand for our services is growing. The number of complex and very troubling cases that ombudsmen investigate has been steadily increasing. As more residents are vaccinated and facilities "re-open" ombudsmen are returning to in-person visits. What we see is concerning and disturbing when it comes to poorer staffing levels and the impacts of social isolation. In addition, there continues to be a disturbing increase in the frequency and severity of citations for egregious regulatory violations by long-term care providers that put residents in immediate jeopardy of harm. Om-

budsmen are needed now more than ever in nursing homes, assisted living, and similar care facilities.

In order to improve advocacy and services available to residents, our office and NASOP respectfully request the aforementioned funding levels. Just think how much more we could accomplish if we had the resources to meet the demand.

We appreciate that the Leadership Council of Aging Organizations has written in support of these requests.

Thank you for your ongoing support.

[This statement was submitted by Patricia L. Hunter, MSW, Washington State Long-Term Care Ombudsman.]

PREPARED STATEMENT OF THE NATIONAL COLLEGE ATTAINMENT NETWORK

Dear Chair Murray and Ranking Member Blunt,

Thank you for your continued leadership in past funding cycles to reinforce investments in the federal programs that support students in their pursuit of higher education. Today, we write to respectfully request that federal student aid funding be a high priority for the Subcommittee. Without the statutory discretionary spending caps for Fiscal Year 2022, we hope that total discretionary funding can rise to provide strong support for our nation's higher education system and students.

With this goal in mind for FY22, NCAN recommends these specific funding levels for the U.S. Department of Education programs:

—NCAN recommends the requisite funding in FY22 so that the maximum Pell Grant award can be increased to $12,990, double the current maximum award.
—Supplementary Educational Opportunity Grant funding of $1.061 billion.
—Federal Work-Study funding of $1.48 billion.
—TRIO program funding of $1.316 billion.
—GEAR UP funding of $435 million.
—$200 million increase in administrative funding for federal student aid management.

Additionally, we request that the Corporation for National and Community Service receive $1.21 billion in funding for FY22—and that the AmeriCorps program, that allows some college access programs to provide near-peer mentors for their students, receive $501 million in funding.

The National College Attainment Network (NCAN), founded in 1995, represents more than 600 members across the country that all work toward NCAN's mission to build, strengthen, and empower communities and stakeholders to close equity gaps in postsecondary attainment for all students. Collectively, we are committed to college access and success so that all students, especially those underrepresented in postsecondary education, can achieve their educational dreams. NCAN's members span a broad range of the education, nonprofit, government, and civic sectors, including national and community-based nonprofit organizations, federally funded TRIO and GEAR UP programs, school districts, colleges and universities, foundations, and corporations.

Drawing on the expertise of our hundreds of organizational members in every U.S. state, NCAN is dedicated to improving the quality and quantity of support that underrepresented students receive to apply to, enter, and succeed in postsecondary education. Students of color, students from low-income backgrounds, and those who are the first in their family to attend college experience disproportionately lower rates of postsecondary success. For example, a low-income student is 29% less likely to enroll in postsecondary education directly after high school than a high-income student. Ultimately, only 35% of low-income high school students obtain a postsecondary credential by age 26, compared to 72% of high-income students.

The federal investments that would most bolster the goal of closing attainment gaps include the following:

PELL GRANT INVESTMENTS

NCAN recommends that the maximum Pell Grant award be increased to $12,990, double the current maximum award. The Pell Grant has served as the cornerstone of financial aid for students from low-income backgrounds pursuing higher education since its creation in 1972. This need-based grant provides crucial support for around 7 million students each year, or about one-third of undergraduates. Without this need-based grant funding, an even smaller portion of students from low-income backgrounds would be able to access higher education. Congress has recognized the importance of the Pell Grant over the past five years by investing in annual increases of, on average, about $140 to the maximum award.

Given that the previously required automatic inflationary increases have expired, these annual investments by Congress have been essential for the nation's students who do not have the means to pay for college from falling farther behind in their pursuit of higher education. Even with these investments, the purchasing power of the Pell Grant for a four-year college degree from a public institution is holding at a historic low of 29% of the cost of attendance. At its peak in 1975–76, the maximum Pell Grant award covered more than three-fourths of the average cost of attendance—tuition, fees, and living expenses—for a four-year public university.

To address the long-term purchasing power of the Pell Grant, and to have the Pell Grant be increased so that it covers at least half of the cost of a four-year public higher education, the maximum award should be doubled.

In President Biden's budget for FY22, the administration has requested that Congress consider a Pell Grant increase of $1,875, through discretionary and mandatory funding, to bring the maximum award to $8,370 for the 2022–23 award year. If Congress adopted the President's request, raising the maximum Pell Grant to $8,370, its purchasing power would significantly increase to 36%. NCAN applauds this historic investment, referred to in the budget as a "down payment on the President's commitment to doubling the grant in future years." NCAN encourages Congress to consider a plan for future increases that would achieve a doubling of the Pell Grant, such as is outlined in the bicameral Pell Grant Preservation and Expansion Act of 2021—which would achieve this goal, over a five-year timeframe.

To reach this goal, NCAN requests the requisite funding in FY22 so that the maximum individual Pell Grant award can be increased to $12,990, double the current maximum award.

FAFSA SIMPLIFICATION

In President Biden's budget for FY22, the administration requests a $200 million increase in administrative funding for federal student aid management. These funds are necessary to help with the implementation of the FAFSA Simplification Act and FUTURE Act—two laws that will achieve the goal of simplifying the Free Application for Federal Student Aid (FAFSA) process, a top priority for NCAN. With the Office of Federal Student Aid announcing a phased implementation plan for FAFSA simplification, to take full effect one year later than originally anticipated, NCAN supports this funding request to ensure that the timeline is not further delayed. The urgency for students to access need-based aid has only grown since passage of the legislation.

CAMPUS-BASED AID

As low-income students piece together resources from a variety of sources to support their postsecondary education pursuits, every dollar and type of aid is significant. For most low-income students, the Supplemental Educational Opportunity Grant (SEOG) and Federal Work-Study help to fill unmet need in their financial aid packages.

The SEOG program should be increased for FY22 so that institutions of higher education to support a greater percentage of the country's lowest-income students. For FY22, NCAN respectfully requests that Congress fund the SEOG program at a total of $1.061 billion.

Sixty-four percent of today's students work while enrolled in school. The Federal Work-Study (FWS) program allows students to work in a flexible environment, learn important skills, and minimize the amount of time they spend commuting between work and campus. For FY22, NCAN respectfully requests that Congress increase the FWS program budget for a total of $1.48 billion.

Federally Funded College Access Programs—TRIO and GEAR UP

Annually, approximately 1.8 million high school seniors are defined as students from low-income backgrounds. A variety of programs are needed to meet all their needs as they pursue their options for education beyond high school. The NCAN community serves approximately 2 million students annually from middle school through college graduation. To reach all the students needing services nationwide, our members build important partnerships both with TRIO and GEAR UP programs. NCAN respectfully requests that Congress continue its investment in federally funded college access programs at the amounts requested by their communities: $1.316 billion for TRIO and $435 million for GEAR UP.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE (CNCS)

For every dollar spent on national service, the country sees a return on investment that is almost fourfold. Service also plays an important role in the college access movement. Many of NCAN's largest members can maximize their impact on

underrepresented students by participating in the AmeriCorps public-private partnership. Continuing support for CNCS, and specifically the AmeriCorps program, will enable additional volunteers to work with low-income students, students of color, and students who are first in their family to attend college. NCAN respectfully requests of that the Corporation for National and Community Service and the AmeriCorps program receive $1.21 billion and $501 million, respectively, for FY22.

Thank you for this opportunity to provide our funding priorities for the fiscal year 2022. Through continued supports—both financial and programmatic—our country can work together to close gaps in attainment, where a low-income student is about half as likely to complete a postsecondary degree or credential as a high-income student. Thank you for your support of this important goal.

Sincerely.

[This statement was submitted by Kim Cook, Executive Director, National College Attainment Network.]

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR DIVERSITY IN THE HEALTH PROFESSIONS

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to submit this statement for the record on behalf of the National Council for Diversity in the Health Professions (NCDHP). I am Dr. Wanda Lipscomb and I serve as President of the NCDHP and Director of the Center of Excellence for Culture Diversity in Medical Education at Michigan State University. NCDHP was established in 2006 and is composed of institutions that are either currently or formerly distinguished as a "Center of Excellence" through the Health Resources and Services Administration's (HRSA)'s Centers of Excellence (COE) program or are a current or former recipient of the Health Careers Opportunities Program (HCOP) grant, now known as the National HCOP Academies program. Every member institution within the council is committed to advancing pipeline programs and programmatic activity that leads to diversity in the health professions.

The National Council for Diversity in Health Professions (NCDHP) is comprised of institutions with Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP) grants funded by the Health Resources and Services Administration under the Title VII Health Professions Training Programs. COE/HCOP grantees are in health professions education and other institutions which excel in the development of educational pipeline programs for individuals from minority and disadvantaged backgrounds, and in the improvement of the quality of health care delivery to medically underserved communities. I am proud to put forth the following recommendations for the fiscal year (FY) 2022 appropriations process:

Minority health professional development is a cost-effective and long-term mechanism of improving health care and decreasing health disparities in minority and underserved communities. 50–80% of Under-Represented Minority (URM) physicians and other health professionals practice in shortage areas serving minority patients. Minority health professionals possess the cultural, experiential and linguistic skills needed to provide cost-effective health care to minority communities. Minority students identified, recruited, supported, admitted, and trained in the health professions in this decade will provide services into the 2060s and 2070s.

HRSA CENTERS OF EXCELLENCE (COE) RECOMMENDATION

COE award recipients serve as innovative resource and education centers to recruit, train, retain and graduate URM students and faculty at health professions schools. Programs improve information resources, clinical education, curricula, and cultural competence as they relate to minority health issues and social determinants of health. These award recipients also focus on facilitating faculty and student research on health issues particularly affecting URM groups. The goal of the program is to effectively deliver health care to underserved communities.

NCDHP recommends $47.42 million for the COE program in Fiscal Year 2022

HRSA HEALTH CAREER OPPORTUNITIES PROGRAM (HCOP) RECOMMENDATION

HCOP provides opportunities for colleges and community-based health professions training and promotes the recruitment of qualified students and non-traditional students like veterans from disadvantaged backgrounds into health and allied health professions programs. As a major federal pipeline program into the health professions, HCOP improves the acceptance, retention and matriculation rates of partici-

pating students by implementing tailored enrichment programs designed to address their academic and social needs.

The NCDHP recommends $47.95 million for the HCOP program in Fiscal Year 2022.

FUNDING JUSTIFICATION AND APPROPRIATIONS HISTORY FOR HRSA'S HCOP AND COE PROGRAMS

—The Association of American Medical Colleges projects that in the U.S. there will be a shortage of nearly 120,000 primary care physicians by the year 2030. Looming workforce shortages exist not only in medicine, but also in dentistry, public health, physician assistants and other health professions. If not adequately addressed, our nation will continue to fall short in addressing the needs of medically underserved communities as most recently exposed by the COVID–19 pandemic.

—We are seeking to restore COE and HCOP funding to FY 2005 levels. For FY 2006 the COE appropriation was cut by 65% from $33M to only $12M. Similarly HCOP was cut by 89% to only $4M. Adjusting for inflation COEs $33M in 2005 dollars would be $45M in 2021 dollars. HCOPs $35M in 2005 would now be $47M.

—The number of COE grantees dropped from 34 (in 2005) to 19 (in 2020), and the number of HCOP grantees dropped from 74 (in 2005) to 22 (in 2020). These programs have not fully recovered. Presently there is not enough funding in either program to support a new competition-only to maintain existing programs. A significant increase is needed in COE and HCOP to increase the number of Latino, Black, American Indian and disadvantaged students recruited, admitted and graduated as culturally competent physicians and other health professionals who have a high likelihood of practicing in underserved minority communities. For example, with increased funding, COE could launch an initiative to increase the number of post-baccalaureate slots and programs that enroll previously rejected applicants in one-year programs, with 90% being accepted to medical school, of which >95% will graduate as physicians.

As you begin the FY 2022 process, NCDHP asks that you further prioritize Title VII health professions training programs. Chairwoman DeLauro, Ranking Member Cole, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, NCDHP member institutions are keeping course to overcome health workforce and health disparities. Thank you for your time and consideration of these requests. We look forward to working with the Subcommittee to prioritize the health professions programs in FY 2022 and the future.

[This statement was submitted by Wanda Lipscomb, PH.D., President, National Council for Diversity in the Health Professions.]

PREPARED STATEMENT OF THE NATIONAL ECZEMA ASSOCIATION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—Please provide the National Institutes of Health (NIH) with at least $46.1 billion to expand and advance critical research activities, and provide individual NIH institutes and centers, such as the National Institute of Allergy and Infectious Diseases (NIAID) and the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) with proportional funding increases.

—While NIH has received notable funding over recent years, funding for the eczema portfolio has stayed relatively flat and additional resources are needed.

—Please provide the Centers for Disease Control and Prevention (CDC) with at least $10 billion to facilitate timely public health efforts on a variety of conditions, including skin disease. Additionally, please provide individual CDC centers, such as the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) with proportional funding increases.

—Please provide $5 million for the new Chronic Disease Education and Awareness Program at CDC.

Thank you for the opportunity to submit testimony on behalf of the National Eczema Association and the over 31 million eczema patients of all ages across the country. Chairwoman Murray, Ranking Blunt, and distinguished members of the

subcommittee, thank you for the ongoing investment in medical research that has facilitated breakthroughs and scientific progress for the eczema community. As you and your colleagues work on appropriations for FY 2022, please continue this investment in medical research and similarly provide robust funding for public health programs. Thank you for your time and for your consideration of these requests.

ABOUT THE NATIONAL ECZEMA ASSOCIATION (NEA)

NEA is the driving force for an eczema community fueled by knowledge, strengthened through collective action and propelled by the promise for a better future.

Reflecting back and looking ahead led us to appreciate how central the concept of "community" has become to NEA's identity and its existence, as is now captured in our aforementioned mission statement. We also recognize that what we mean by the term "eczema community" has expanded over the years to reflect a multitude of personal and professional interests committed to making life better for those who live with eczema. Many people seek out NEA to connect with others who understand and share the experience of living with eczema. Each individual's unique perspective, based on their own experience, is a source of strength and vibrancy for the diversity of our community. Through our dedicated advocates, we will share some of those stories and perspectives with you today.

ABOUT ECZEMA

Eczema is the name for a group of conditions that cause the skin to become itchy, inflamed and red in lighter skin tones or brown, purple, gray or ashen in darker skin tones. Eczema is very common in both children and adults and affects all races and ethnicities. In fact, more than 31 million Americans have some form of eczema-with up to 40% of affected individuals experiencing more severe disease symptoms and chronic disease burden.

Eczema is not contagious. You cannot "catch it" from someone else. While the exact cause of eczema is unknown, researchers do know that people who develop eczema do so because of a combination of genes and environmental triggers.

When an irritant or an allergen from outside or inside the body "switches on" the immune system, it produces inflammation. It is this inflammation that causes the symptoms common to most types of eczema.

There are seven different types of eczema:

—Atopic dermatitis
—Contact dermatitis
—Neurodermatitis
—Dyshidrotic eczema
—Nummular eczema
—Seborrheic dermatitis
—Stasis dermatitis

It is possible to have more than one type of eczema on your body at the same time. Each form of eczema has its own set of triggers and treatment requirements, which is why it is so important to consult with a healthcare provider who is knowledgeable in treating eczema. Many healthcare providers can be involved in the diagnosis and treatment of eczema including primary care providers, pediatricians, dermatologists, and allergists. Recent years of scientific progress have led to the emergence of new therapies, but much more work needs to be done in research and public health to improve care for patients and address areas of continued unmet treatment and quality of life needs.

RECENT ADVANCEMENTS AND EMERGING RESEARCH OPPORTUNITIES

NEA's research priorities, including grants that we fund on an annual basis, focus on improving health outcomes for the community and translating breakthroughs in basic science to diagnostic tools, innovative therapies, and improved healthcare information:

—Cutting-Edge Basic & Translational Science- Innovative investigations of targets, pathways or technologies that will advance understanding of the pathophysiology or natural history of eczema, and potentially lead to novel or enhanced therapeutic/preventative areas of exploration or application.
—Eczema Heterogeneity: Novel Insights- Projects aimed at advancing understanding of the underlying factors contributing to the diversity of eczema clinical presentation, treatment response and comorbidities.
—Innovations in Clinical Practice & Care-Studies addressing approaches to facilitate optimal identification and treatment of eczema and associated comorbidities in all health care settings to enhance patient-reported and patient-centric outcomes.

—Understanding & Alleviating Disease Burden-Insightful proposals that identify, quantify or aim to reduce aspects of eczema burden that negatively affect patient or family/caregiver quality of life (including lifestyle, academic/occupational, or economic impacts) based on patient population, treatment approach, etc.
—Eczema Prevention-Novel investigations into the potential risk factors and strategies of primary eczema prevention at all ages.

Our research efforts overlap with NIH-supported research activities, which currently total a modest-but-meaningful $35 million annually.

PATIENT STORIES

People with eczema and their loved ones are the true experts, which is why we call upon our community regularly to share their stories.

Lindsay is one of our Illinois advocates. She was diagnosed at six years old with eczema. Now, in her 40s, she wants to ensure that policymakers understand that eczema is more than just a rash. While getting access to a biologic has been a challenge (to the point where she had to miss doses), the medicine has changed the way eczema presents on her skin. It still gets angry and red, but it no longer weeps. It will just dry up and flake off. Her body is about 75% clear on a good day, but she can still get bad flares primarily on her face and neck.

Andrea is one of our Connecticut advocates. She has had eczema for 15 years and her youngest child was diagnosed with eczema on the back of her knees two years ago. She advocates that all patients should have access to specialty care because to help heal eczema you need the right support and right care to know the underlying cause.

Traciee is one of our Oregon advocates. She advocates on behalf of herself and all the eczema warriors and their families. She feels strongly that patients should have access to quality healthcare and that fellow eczema warriors should not have to suffer in silence with an uncontrollable itch. The solution is that treatment decisions should be made by the provider who has received extensive training in this disease.

[This statement was submitted by Michele Guadalupe, MPH, Associate Director, Advocacy and Access.]

PREPARED STATEMENT OF THE NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION

Dear Chairwoman Murray and Ranking Member Blunt:

As President & CEO of the National Family Planning & Reproductive Health Association (NFPRHA), I thank you for this opportunity to provide testimony in support of a fiscal year (FY) 2022 appropriation of $737 million for the Title X family planning program (Office of Population Affairs, funded within the Health Resources and Services Administration account). We are grateful for Chairwoman Murray's longtime leadership in advocating for family planning and urge you to take this substantial step forward in this year's bill.

NFPRHA is a non-partisan, non-profit membership association whose mission is to advance and elevate the importance of family planning in the nation's health care system; NFPRHA membership includes close to 1,000 members that operate or fund more than 3,500 health centers that deliver high-quality family planning education and preventive care to millions of people every year in the United States. These members cover the broad spectrum of publicly funded family planning providers, including state and local health departments, hospitals, family planning councils, federally qualified health centers, Planned Parenthood affiliates, and other private nonprofit agencies. NFPRHA represents three-quarters of all current Title X grantees as well as the majority of grantees that withdrew from the program in 2019 rather than comply with the Trump administration's program rule.

Title X is the nation's only federal program dedicated to providing family planning services for people with low incomes across the United States. In 2018, prior to the implementation of the Trump administration's devastating regulations, nearly 4,000 health centers in the network served nearly 4 million patients.[1] Title X-funded health centers are lifelines for their communities, providing high-quality reproductive and sexual health care, including cancer screenings, testing and treatment for

[1] Christina Fowler et al, "Family Planning Annual Report: 2018 National Summary," RTI International (August 2019). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2018-national-summary.pdf.

sexually transmitted infections, HIV/AIDS education and testing, contraceptive services and supplies, pregnancy testing, and other vital health care services. These centers disproportionately serve people from communities that face systemic barriers to accessing quality health care, including people with low incomes, people who are uninsured or underinsured, people of color, people who live and work in rural areas, LGBTQ people, and young people. In fact, 60% of women who received contraceptive services from a Title X-funded health center in 2016 had no other source of medical care in the prior year,[2] and almost two-thirds of patients at these sites have incomes at or below the federal poverty level.[3]

Unfortunately, the current funding level is woefully below what is required to meet the family planning and sexual health needs of people living with low incomes. Title X has been cut or flat-funded every year for the past decade, and the program's FY2021 allocation is just $286.5 million, the same allocation the program has received for seven fiscal years, and significantly below the allocation from a decade ago. Other important public health programs, such as the Title V Maternal-Child Health Block Grant and the Ryan White HIV/AIDS Program, have seen significant increases in the same period, and people who rely on publicly funded family planning care deserve that same investment in their health care needs. The current allocation is also well below the $737 million estimate that researchers from the Centers for Disease Control and Prevention, the Office of Population Affairs (OPA), and the George Washington University determined in 2016 would be needed annually just to provide family planning care to low-income women without insurance.[4] We urge you to take a substantial step forward for family planning access and appropriate that $737 million for the program in FY2022.

This funding increase is particularly vital given the harms the Trump administration inflicted on the program, the providers funded by it, and, most importantly, the people who seek family planning and sexual health care. On July 15, 2019, that administration's regulations for Title X went into effect, and the impact was felt almost immediately: by fall 2019, approximately 1,000 health centers across 33 states had withdrawn from the program. In 2018, those health centers had provided 1.6 million patients with high-quality Title X-supported family planning and sexual health services.[5] In September 2020, OPA released the first federal data showing the impact of the rule, and the results were devastating: relative to 2018, Title X-funded health centers provided family planning services to 844,083 fewer patients in 2019, a staggering 21% decrease, and that was after just five months of having the rule in effect. In addition, fourteen states lost more than one-third of their patient volume. This drastic decrease translated to hundreds of thousands of fewer contraceptive services provided, more than 1 million fewer STD tests administered, and more than 250,000 fewer life-saving breast and cervical cancer screenings performed with Title X funds.[6] The numbers for 2020—no doubt exacerbated by the impact of COVID–19 on health care access—are even worse, with preliminary data showing that only 1.5 million people were able to receive Title X-supported services in 2020, a drop of 60% from just two years earlier.[7] Six states—Hawaii, Maine, Oregon, Utah, Vermont, and the chairwoman's home state of Washington—have had no Title X-funded services for almost two years.

Compounding these harms, a 2020 study shows that COVID–19 has led many women to want to delay or prevent pregnancy while it has simultaneously made it more difficult for people to access family planning and sexual health care, including contraception. Women of color and women with low incomes are more likely to re-

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[2] Meghan Kavanaugh, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016," Guttmacher Institute (June 2018). https://www.guttmacher.org/journals/psrh/2018/06/use-health-insuranceamong-clients-seeking-contraceptive-services-title-x.

[3] Christina Fowler et al, "Family Planning Annual Report: 2019 National Summary," RTI International (September 2020). https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

[4] Euna August, et al, "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," American Journal of Public Health (February 2016): 334–341.

[5] Mia Zolna Sean Finn, and Jennifer Frost, "Estimating the impact of changes in the Title X network on patient capacity," Guttmacher Institute (February 2020). https://www.guttmacher.org/article/2020/02/estimating-impact-changes-title-x-network-patient-capacity.

[6] Christina Fowler et al, "Family Planning Annual Report: 2019 National Summary," RTI International (September 2020). https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

[7] Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, 86 Federal Register 19812 (proposed April 15, 2021) (to be codified at 42 CFR 59).

port both findings.[8] The confluence of the Trump administration's rule and a global pandemic means that a significant influx of funds is desperately needed to begin to rebuild the network and restore Title X services to communities across the country as quickly as possible.

These funds will be particularly significant given the Biden administration's commitment to restore the Title X program's commitment to high-quality, client-centered, evidence-based care by fall 2021.[9] That process is moving quickly: on April 15, HHS published a notice of proposed rulemaking, and comments were due on May 17.[10] NFPRHA continues to urge HHS to complete the rulemaking process as quickly as possible and to subsequently make funds available to communities that have been without services as soon as the new rule is in effect.

We thank you for your consideration of this request.

Sincerely.

[This statement was submitted by Clare Coleman, President & CEO, National Family Planning & Reproductive Health Association.]

PREPARED STATEMENT OF THE NATIONAL INSTITUTES OF HEALTH

Good morning, Chairwoman Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee. I am Francis S. Collins, M.D., Ph.D., and I have served as the Director of the National Institutes of Health (NIH) since 2009. It is an honor to appear before you today.

First, I want to thank this Subcommittee for your commitment to NIH, which allowed the biomedical research enterprise to respond quickly to the greatest public health crisis in our generation over the past year. We mounted vigorous research efforts to understand the viral biology and pathogenesis of the coronavirus disease 2019 (COVID–19), develop vaccines in record time, support and commercialize diagnostics at the point of care, and test therapeutics for both outpatient and inpatient settings. This work is far from finished.

The President's Discretionary Request proposes budget authority of $51 billion for NIH in fiscal year (FY) 2022. The Biden Administration places great emphasis on research and development in general. At NIH in particular, the Request proposes to build on the successes of pandemic era research and to put the research enterprise to work on some of our Nation's most persistent and perplexing health challenges, including cancer, Alzheimer's disease, opioid use disorder, health disparities, maternal mortality, HIV/AIDS, gun violence, climate change, and other areas with major implications for our Nation's health.

First and foremost, the President's Request proposes $6.5 billion to establish the Advanced Research Projects Agency for Health—ARPA–H to drive transformational innovation in health research and speed application and implementation of health breakthroughs. ARPA–H will tackle bold challenges requiring large scale, cross-sector coordination, employing a non-traditional and nimble approach to high risk research, modeled after DARPA in the Department of Defense. To achieve this, ARPA–H will invest in emergent opportunities by conducting advanced systematic horizon scans of academic and industry efforts, leveraging novel public-private partnerships, recruiting visionary program managers, and using directive approaches that provide quick funding decisions to support projects that are results-driven and time-limited. Potential areas of transformative research driven by ARPA–H include: the use of the mRNA vaccines to teach the immune system to recognize any of the 50 common genetic mutations that drive cancer; development of a universal vaccine that protects against the 10 most common infectious diseases in a single shot; development of wearable sensors to measure blood pressure accurately 24/7; and leveraging of artificial intelligence technology to advance care for individual patients and improve detection of early predictors of disease.

ARPA–H represents the kind of transformative idea for biomedical research that only comes along once in a long while. Our confidence that NIH is ready has been greatly advanced by our experience in addressing the COVID–19 pandemic—devel-

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[8] Lindberg LD et al, "Early Impacts of the COVID–19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences," Guttmacher Institute (June 2020). https://www.guttmacher.org/report/early-impacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health.

[9] Office of Population Affairs, "Title X Statutes, Regulations, and Legislative Mandates," US Department of Health and Human Services (March 2021). https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates.

[10] Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, 86 Federal Register 19812 (proposed April 15, 2021) (to be codified at 42 CFR 59).

oping vaccines in record time, establishing an unprecedented public-private partnership on therapeutics that has made it possible to test more than a dozen possible therapeutics in rigorous trials, and building a venture capital model for assessing SARS–CoV–2 diagnostic technologies that has yielded millions of daily tests in just months.

But while we begin to imagine a life after COVID–19, we must acknowledge that there are COVID-related impacts that we have yet to understand and address, including the full impact of the pandemic on children. Children were largely spared from COVID–19 but for some children, exposure to the COVID–19 virus led to Multisystem Inflammatory Syndrome in Children (MIS–C), a severe and sometimes fatal inflammation of organs and tissues. The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) is leading a multi-institute initiative known as the Collaboration to Assess Risk and Identify loNG-term outcomes for Children with COVID (CARING for Children with COVID), which will assess both short-term and long-term effects of MIS–C and other severe illness related to COVID–19 in children, including cardiovascular and neurodevelopmental complications.

For many Americans, this pandemic and its related socioeconomic effects have had an overwhelming impact on their mental health. Prior research on disasters and epidemics has shown that in the immediate wake of a traumatic experience, large numbers of affected people report distress, including new or worsening symptoms of depression, anxiety, and insomnia. To aid in mental health recovery from the COVID–19 pandemic, NIH will continue to focus on research in this area. This will be done, in part, by utilizing participants in existing cohort studies, who will be surveyed on the effect of the pandemic and various mitigation measures on their physical and mental health.

The COVID–19 pandemic has brought into sharp focus the dramatic health disparities that exist across the American population. In addition, the Nation has been shaken by the killing of George Floyd and other attacks on people of color, forcing a recognition that our country is still suffering the consequences of centuries of racism. NIH will continue to address these disparities, specifically through research managed by the National Institute on Minority Health and Health Disparities (NIMHD), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute of Nursing Research (NINR) and the Fogarty International Center (Fogarty).

NIMHD looks to better understand the human biological and behavioral mechanisms and pathways that affect disparity populations, better understand the long-term effects of disasters on health care systems caring for populations with health disparities and research focusing on the societal-level mechanisms and pathways that influence disease risk, resilience, morbidity and mortality. NINR and Fogarty both look to better understand and reduce rural health disparities in low-income counties in the southern United States, support nursing science focused on racial, ethnic, and socioeconomic health disparities, with the goal of closing the gap in health inequities and increase health disparity research in low and middle income countries.

In addition to the core health disparities research, the President's Request puts an additional specific focus on maternal morbidity and mortality (MMM), which disproportionately affect specific racial and ethnic minority populations. Black and American Indian/Alaska Native individuals are two to four times more likely to die from pregnancy-related or pregnancy-associated causes compared to white individuals. Furthermore, Black, Hispanic and Latina Americans, Asian, Pacific Islander, and American Indian/Alaska Native individuals all have higher incidence of severe maternal morbidity (SMM) compared to white individuals. The Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) initiative supports research on how to mitigate preventable MMM, decrease SMM, and promote health equity in maternal health in the United States.

As the climate continues to change, the risks to human health will grow, exacerbating existing health threats and creating new public health challenges. Major scientific assessments document a wide range of human health outcomes associated with climate change. While all Americans will be affected by climate change, underserved populations are disproportionately vulnerable. These populations of concern include children, the elderly, outdoor workers, and those living in disadvantaged communities. NIH is poised to lead new research efforts to investigate the impact of climate on human health, with the goal to understand all aspects of health-related climate vulnerability. Therefore, the President's Request includes a $100 million increase for research on the human health impacts of climate change.

The FY 2022 President's Discretionary Request makes a major additional investment to address the opioid crisis. The crisis of opioid misuse, addiction, and overdose in the United States is a rapidly evolving and urgent public health emergency

that has been exacerbated by the coronavirus pandemic. Since the declaration of a public health emergency for COVID, illicit fentanyl use and heroin use have increased, and overdoses in May 2020 were 42 percent higher than in May 2019.

The use of opioids together with stimulants, such as methamphetamine, is increasing; and deaths attributed to using these combinations are likewise increasing. Taking note of these trends, FY 2021 appropriation language expanded allowable use of Helping to End Addiction Long-term (HEAL) funds to include research related to stimulant misuse and addiction. Identifying how opioids and stimulants interact in combination to produce increased toxicity will enhance our ability to develop medications to prevent and treat comorbid opioid and stimulant use disorders and overdoses associated with this combination of drugs.

Finally, I'd like to take a moment to thank this Subcommittee for its recognition over the last two years that America's continuing leadership in biomedical research requires infrastructure and facilities that are conducive to cutting-edge research. With your support, we will break ground in the near future on a new Surgical, Radiological, and Laboratory Medicine division of our Clinical Center, which will replace severely outdated and deteriorating operating suites and lab space with state-of-the-art facilities. NIH continuously works to ensure that the buildings and infrastructure on its campuses are safe and reliable and that these real property assets evolve in support of science—but NIH's backlog of maintenance and repair is now nearly $2.5 billion. The President's FY 2022 Discretionary Request includes $250 million to make progress on reducing this backlog and requests flexibility for Institutes and Centers to fund construction, repair, and improvement projects.

COVID–19 compelled us to perform a stress test on biomedical research enterprise. The enterprise performed nobly. We found what worked, and also identified barriers we hadn't fully appreciated before, and invented new ways around them. The President's FY 2022 Discretionary Request is a roadmap for how to build on the successes of research, address our gaps, and apply our insights to the most important problems we face as a nation. With your support, the future is filled with opportunity. My colleagues and I look forward to answering your questions.

[This statement was submitted by Francis S. Collins, M.D., Ph.D., Director, National Institutes of Health.]

PREPARED STATEMENT OF THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation (NKF) is pleased to submit testimony to highlight the significant burden that chronic kidney disease (CKD), including irreversible kidney failure, places on patients, families, and our nation's health care system. We urge the subcommittee to increase funding for programs and activities as a bold step to help transform CKD awareness, prevention, detection, and management. Specifically, NKF requests $15 million for CKD activities at the Centers for Disease Control and Prevention and a substantive increase, commensurate with or exceeding the increase for NIH as a whole, for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) for kidney research activities. We also urge greater collaboration between NIDDK and other Institutes studying related comorbidities and conditions, such as hypertension, cardiovascular disease, immunology, disparities, and genomics.

ABOUT CKD

CKD impacts an estimated 37 million American adults and was the nation's 8th leading cause of death in 2020. Although it can be detected through simple blood and urine tests, an estimated 90% of CKD patients are undiagnosed, often until advanced stages when it is too late for interventions to slow disease progression. Alarmingly, some patients are not diagnosed until they have progressed to irreversible kidney failure (end stage kidney failure, or ESKD) and undergo urgent start dialysis. More than 750,000 Americans have irreversible kidney failure, requiring kidney dialysis at least 3 times per week at a dialysis center; daily home dialysis, or a kidney transplant to survive. Medicare spends $130 billion on the care of people with a CKD diagnosis. Individuals with kidney failure represent 1% of Medicare beneficiaries but comprise 7% of Medicare fee-for-service expenditures. The need for a substantially increased federal commitment to address the societal and economic burdens of CKD is undeniable.

CKD is a disease multiplier, with many patients experiencing cardiovascular disease, bone disease, cognitive challenges, depression, and increased hospitalization. CKD also is an independent risk predictor for heart attack and stroke. Early-stage intervention can improve outcomes and lower costs, yet fewer than half of patients

with high blood pressure or diabetes (which together are responsible for three-fourths of all cases of ESKD) receive CKD testing. To improve awareness, early identification, and early-stage intervention, NKF calls on Congress to invest in kidney health programs throughout HHS.

DISPARITIES

CKD is characterized by racial, ethnic, and socioeconomic disparities. Blacks or African Americans, Hispanics, Asian Americans and Pacific Islanders, and Native Americans or Alaska Natives are at higher risk for CKD and ESKD. A common reason is the disproportionate incidence of chronic comorbidities such as diabetes and hypertension in many of these groups. While Blacks or African Americans make up 13 percent of the U.S. population, they account for 35 percent of Americans with kidney failure, and are almost four times more likely than Whites to progress to kidney failure. Hispanic Americans are 1.3 times more likely than Whites to have kidney failure. Blacks or African Americans and Hispanics experience more rapid decline of kidney function than Whites and are less likely to have had a visit with a nephrologist prior to starting dialysis. Disparities are present in kidney transplant as well. Blacks have less access to the kidney wait list and experience a longer wait once listed. As of May 6, 2021, Black patients were 31.5% of the kidney wait list candidates, but in 2020 they received only 27% of kidney transplants. Hispanics represent 21% of the wait list and received 18.4% of kidney transplants.

COVID–19

COVID–19 has amplified the CKD and ESKD disparities discussed above, as kidney patients (including transplant recipients) are at risk for severe COVID–19 infection and mortality. In October 2020, COVID–19 hospitalizations were 2,194 per 100,000 Medicare ESKD beneficiaries, compared to 320 per 100,000 Medicare aged beneficiaries. In data reported by CDC, from February 1–August 31, 2020, a comparison of observed and predicted monthly deaths among ESKD patients showed an estimated 8.7–12.9 excess deaths per 1,000 ESKD patients, or a total of 6,953–10,316 excess deaths. The increased vulnerability is due to a series of factors, including compromised immune systems, multiple comorbidities, and exposure through the in-center dialysis care environment that necessitates close contact with others. Transplant recipients in particular face higher COVID–19 mortality risk. In addition, patients experiencing severe COVID–19 are at an increased risk of developing acute kidney injury (AKI), often requiring the need for acute dialysis and sometimes resulting in CKD or irreversible kidney failure.

KIDNEY PUBLIC AWARENESS INITIATIVE

A key aspect of the Department of Health and Human Services's 2019 Advancing American Kidney Health (AAKH) Initiative is increased awareness of CKD among the public and health care practitioners to improve early detection, provide early intervention and improve outcomes. Early intervention can slow the CKD progression and, in some instances, prevent kidney failure, reduce the impact of comorbidities, and reduce hospitalizations and readmissions. A sustained Kidney Public Awareness Initiative under the guidance of CDC will educate at-risk individuals to enhance awareness of the causes, consequences, and comorbidities of kidney disease, and educate clinical professionals on early detection and opportunities for intervention.

CDC CHRONIC KIDNEY DISEASE INITIATIVE

The CDC Chronic Kidney Disease Initiative comprehensive public health strategy was created at the urging of Congress and NKF 15 years ago. Annual funding has fluctuated between $1.6 million and $2.6 million. This funding level has supported activities including the development of a web site for patients, surveillance and epidemiology activities, and assistance to the National Center for Health Statistics for CKD data collection. However, a more robust effort is needed to increase awareness and reduce incidence of CKD. The National Kidney Foundation requests additional funds to establish a CKD screening program to detect people at high risk and examine the benefits screening this population; determine changes in provider behavior and care, and monitor patients' health outcomes. Additional funding would also expand capacity for national CKD prevalence surveillance to allow for repeated laboratory measures in the National Health and Nutrition Examination Survey (NHANES). Current national estimates of CKD prevalence using NHANES rely on single measurements of both serum creatinine and urinary albumin, preventing re-

searchers from estimating CKD persistence. NKF requests $15 million to the CDC for these enhanced activities.

NIH NIDDK

Despite the high prevalence of CKD and its impact on patients and Medicare, NIH funding for kidney disease research is only about $700 million annually. NIH invests only $18 per CKD patient, a fraction of what it spends on other major diseases. Fiscal Year 2021 funding for NIDDK increased by less than 1%, the smallest percentage increase of any disease Institute under NIH. From FY 2015–2020, NIH monetary support for kidney research increased at half the rate of NIH funding increases overall. America's scientists are at the cusp of many potential breakthroughs in improving our understanding of CKD, including genetic kidney disease. Further advances can lead to new therapies to delay and treat kidney diseases, which has the potential to provide cost savings to the government like that of no other chronic disease.

In December 2020, NKF established Research Roundtables comprised of nephrology leaders from prominent academic institutions, the pharmaceutical industry, and key bodies with expertise in the multiple areas of pre-clinical and clinical research, including pediatric nephrology, genetics, epidemiology, drug development, public health, and health equity. In addition, kidney disease patients as well as family members of children with kidney disease and living kidney donors were recruited to share patient priorities and viewpoints on research needs.

The Roundtables were charged with identifying pre-clinical and clinical areas of research in which additional funding could help bridge existing deficits in kidney disease treatments and reduce kidney disease incidence, reduce health disparities, and lower healthcare costs. Their final recommendations are expected in June 2021, which NKF will share with policy makers.

As the first step towards expanding kidney research opportunities, NKF requests a substantive funding increase for NIDDK in FY 2022 that is at least commensurate with if not exceeding the percentage increase to NIH as a whole. We also request additional support from other Institutes on kidney activities. Opportunities include NHLBI support for cardiorenal syndromes in CKD patients; NIAID initiatives to study CKD effects on the immune system; and NCI activities to study decreased kidney function in cancer patients. Thank you for your consideration of the National Kidney Foundation's requests for Fiscal Year 2022.

[This statement was submitted by Sharon Pearce, Senior Vice President, Government Relations.]

PREPARED STATEMENT OF THE NATIONAL MARROW DONOR PROGRAM/BE THE MATCH

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, my name is Kristin Akin from Chesterfield, Missouri. On behalf of the patients, family members, donors, couriers, volunteers, and staff of the National Marrow Donor Program (NMDP)/Be The Match, I want to express my most sincere gratitude to the members of the Committee for your work last year, continuing the full funding of the C.W. Bill Young Cell Transplantation Program (Program) within the Health Resources and Services Administration (HRSA), Health Care Systems account. In Fiscal Year 2022, we respectfully request that the subcommittee increase funding for the Program to the amount of $56,000,000 to eliminate financial and socioeconomic barriers that reduce access to cellular therapies for thousands of primarily traditionally underserved patients.

By establishing a national bone marrow donor registry in the mid-1980s, Congress promised patients with blood cancers, like leukemia and lymphoma, that they would have a way to find a life-saving donor match. While bone marrow transplant started as a cure for a single disease, we now provide cures for over 70 diseases, everything from cancers, blood disorders, immune deficiencies and Sickle Cell. In 2019, the Program completed its milestone 100,000th transplant between a matched, unrelated donor and a patient. This has been a true public/private partnership for more than 30 years and it is obvious that the funding is saving lives.

My son, Andrew Preston Akin, was born on June 5, 2007. At ten weeks old, what initially started as severe jaundice quickly landed us in the Pediatric Intensive Care Unit (PICU) at our local hospital. After months of tests, on September 7, 2007, our world was officially turned upside down when we were informed that Andrew had a rare immune deficiency called Hemophagocytic Lymphohistiocytosis (HLH), and the only cure was a bone marrow transplant.

Our then six-month-old son underwent his first bone marrow transplant in an effort to save his life. He was started on the standard protocol for HLH (HLH 2004) and initially responded very positively. But, suddenly, his HLH came roaring back and not only did we have to move up his transplant, we used umbilical cord cells, as there was not a suitable bone marrow match on the registry at the time. Grateful and optimistic that this was the end of HLH and the beginning of a new and healthy Andrew, we were devastated to learn that two months after his transplant, it did not work, and he would need another one.

In the meantime, we continued with steroids, chemotherapy and a host of other drugs, all the while keeping him in a bubble away from any germs. The search began again to find Andrew the best possible unrelated, matched bone marrow donor. Excited that marrow was going to be the answer to our prayer, Andrew underwent his second bone marrow transplant right before his first birthday. Sadly, almost a year to the day of his diagnosis, we learned that again, for various reasons, his transplant was not a success.

Through this process, we learned several things about Andrew's disease: the cause of his HLH was among the newest genetic mutations—X-Linked Lymphoproliferative Disorder #2 (XLP–2). Because it is X-linked, the doctors immediately tested me and our other son Matthew. On my 34th birthday, I received among the worst news in my life: not only was I the carrier, but my healthy 4-year old son also carried the mutation, meaning it was only a matter of time before he, too, would get HLH.

After countless discussions with the team of experts, we weighed the pros and cons of taking Matthew into transplant while he was healthy or waiting until the disease struck.

We did another preliminary search on the bone marrow registry and found one perfect match. Not knowing if that match would be there down the road, we made the extremely difficult decision to transplant Matthew prophylactically.

At the same time, we prepared Andrew for his third bone marrow transplant in less than two years.

We were fighting for the lives of our two sons.

Andrew, only 27 months old, developed severe pulmonary complications that ultimately took his life on September 5, 2009, in the PICU.

Matthew was just two weeks post-transplant, we thought life could not get any worse, but somehow, eight short months later, it did. Our first-born son, Matthew Austin Akin passed away in the same PICU on May 1, 2010. He was only 5 and a half years old.

My husband and I have experienced every parent's worst nightmare, twice, but we both agreed we would not allow our son's deaths to be the last thing people remembered about them. It's why my husband and I started the Matthew and Andrew Akin Foundation in their memory: to raise awareness and critical funds for HLH, NMDP, and the American Red Cross, and to advocate for other parents and children.

However, I would be remiss if I did not share that a very large part of what drives us to continue to help others is the fact that we were blessed with the opportunity to be parents again, twice, through adoption. William and Christopher are the reason we have love in our hearts and can fight for the memory of their brothers Matthew and Andrew.

While Matthew and Andrew ultimately lost their lives due to disease complications, NMDP was our line of hope that we held onto from day one when learned that a successful bone marrow transplant was the only cure. With each transplant my boys received, we were reminded of the kindness of strangers, the feeling of indebtedness to NMDP and Congress for establishing the registry and the power of a worldwide network. It has been and will continue to be my honor to volunteer my time with NMDP.

The C.W. Bill Young Cell Transplantation Program, authorized by Congress, has been funded by the Committee and fulfills three important missions. The first is the nation's registry, which includes more than 39 million selfless volunteers worldwide, like my sons' donors, who stand ready to be a life-saving bone marrow donor. It also includes more than 806,000 cord blood units through Be The Match and international partnerships, 106,000 of which are in the National Cord Blood Inventory, which is also funded by your Committee. When we couldn't find a matching donor for Andrew right away, a cord blood transplant was our only hope for his first transplant.

While Matthew and Andrew were able to proceed to transplant thanks to their selfless matching donors, there are still many patients who cannot find a match on the registry. This is why the funding you provided in Fiscal Year 2021, and which we are asking for in Fiscal Year 2022, is so critically important. From the moment

doctors search the registry for a donor, to the safe delivery of the life-saving cells to the bedsides of patients for transplant—NMDP is there every step of the way. NMDP ensures that the global network, technology, and logistical support are in place to facilitate a transplant.

The Program's second mission is to support patients and families through its Office of Patient Advocacy. NMDP works tirelessly to improve the lives of patients and provide one-on-one support to these individuals and their families. They offer the resources and guidance patients need throughout the transplant process—from deciding if transplant is right for them to adjust to life after transplant.

Finally, the Stem Cell Therapeutic Outcomes Database is a third program component that helps doctors significantly impact/improve survival for blood cancer and other diseases while also improving the quality of life for thousands of transplant patients. NMDP is relentless in its search to find answers that will lead to better donor matching, more timely transplants, and treatment of even more blood diseases through transplant.

Thank you for the opportunity to share my story and most importantly thank you for learning a little bit about my beautiful sons Matthew and Andrew. Your longstanding support for this Program is the hope that people hold onto after receiving their life-threatening diagnosis. On behalf of those who are alive today, those who are currently searching the national registry for their potentially life-saving donor, and for those who will need to look to the Program for help in the future, I urge you to fund the C.W. Bill Young Cell Transplantation Program at $56 million to immediately provide access to therapy at the point of diagnosis for all patients.

Our bold request this year builds upon the full funding you provided in Fiscal Year 2021 to clear a pathway for more patients, especially those from minority and rural communities, to be able to access transplant services. More than any other Committee in Congress, the programs you support save lives every day. The increase we are asking for this year will immediately increase the number of patients who enter the pipeline to receive a bone marrow transplant for a lifesaving cure.

[This statement was submitted by Kristin Akin on behalf of National Marrow Donor Program/Be The Match.]

PREPARED STATEMENT OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

Madam Chairwoman and Members of the Subcommittee, the National Multiple Sclerosis Society (Society) thanks you for this opportunity to provide testimony regarding fiscal year 2022 (FY22) funding for the federal agencies under the jurisdiction of the Labor, Health and Human Services, Education and Related Agencies (LHHS) subcommittee. Nearly one million people who live with multiple sclerosis (MS) rely on these agencies and as the U.S. recovers from the COVID–19 pandemic, the federal agencies and programs under the jurisdiction of this Committee are more important than ever.

The Society is supportive of the President's FY22 proposed budget request. We believe this request would support the ability of people with MS to receive the coverage and services they need and fund critical research toward a cure for MS. We urge the Subcommittee to provide the following funding in Fiscal Year 2022 (FY22):

—$500 million for the Agency for Healthcare Research and Quality (AHRQ)
—$10 billion for the Centers for Disease Control and Prevention (CDC) inclusive of $5 million for the National Neurological Conditions Surveillance Program authorized in the 21st Century Cures Act;
—$14.2 million for the Lifespan Respite Care Program;
—Robust support for Medicare and Medicaid and protection of Medicaid's current financing structure; and
—At least $46.1 billion for the National Institute of Health (NIH),
—Fully fund the Patient Centered Outcomes Research Institute (PCORI); and
—At least $13.5 billion for the Social Security Administration's administrative budget.

MS is an unpredictable, often disabling disease of the central nervous system that interrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity, and specific symptoms of MS in any one person cannot yet be predicted. The Society is a fundamental partner to the federal agencies under the LHHS jurisdiction, and is focused on curing MS while ensuring that people affected by the disease have what they need to live their best lives.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ is a small agency that is revolutionizing the healthcare system based on health care costs and quality. It provides evidence-based reports for health care providers to use in making health care safer, higher quality, more accessible, equitable, and affordable. These reports are vital to patients and the health care community, which needs high-quality science and evidence-based

information to aid in consultations on treatment decisions. The Society recommends Congress provide $500 million for AHRQ in FY22.

CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC is tasked with protecting public health and safety through the control and prevention of disease, injury, and disability. COVID–19 demonstrated how years of consistent underfunding impacted the Agency's ability to fulfill its mission. Part of that mission that is often overlooked involves data collection for diseases and conditions. The 21st Century Cures Act authorized the creation of the National Neurological Conditions Surveillance System (NNCSS) at CDC, and Congress has funded it since 2018. Although COVID–19 has delayed its efforts, CDC has set up pilot projects in MS and Parkinson's disease to determine the best method to collected incidence and prevalence data. These methods would then be expanded to use in other neurologic areas. Having strong and reliable prevalence data is critical to protecting the public health and funding new and novel research to treat neurologic conditions. The Society recommends that Congress increase funding for the CDC to $10 billion in FY22, inclusive of the $5 million for the NNCSS.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Approximately 25–30 percent of the MS population relies on Medicare as their primary insurer. Many of these individuals are under the age of 65 and are eligible for Medicare due to disability. The Society urges Congress to ensure appropriate reimbursement levels for Medicare providers. These reimbursement levels allow Medicare beneficiaries to maintain affordable access to prescription drugs, diagnostics, durable medical equipment, medically necessary speech, physical and occupational therapy services, and allows the program to update coverage determinations to keep pace with advances in care.

Up to 15 percent of people with MS are thought to qualify for Medicaid benefits for all or part of their health and/or long-term care needs. The Society urges Congress to ensure robust funding for Medicaid that allows for its enrollees to access benefits that are affordable and adequate to their needs. Additionally, we advise Congress to oppose proposals to cap or block grant the program or that impose unreasonable utilization review practices that can result in disruptions in MS care, putting patients at risk of disease exacerbations and irreversible disability. Ensuing that lower income individuals have access to health coverage and care is vital to the continued health and economic recovery of the country and we oppose any policy shift that would limit or cut services for people with MS.

LIFESPAN RESPITE CARE PROGRAM

The Lifespan Respite Care Program provides competitive grants to states to establish or enhance statewide lifespan respite programs that better coordinate and increase access to quality respite care. Approximately one quarter of individuals living with MS require long-term care services at some point during their lifetime. Often, a family member steps into the role of primary caregiver. Family caregivers allow the person living with MS to remain home for as long as possible and avoid premature admission to costlier institutional facilities but can also become overwhelming. Respite offers professional short-term help to give caregivers a break from the stress of providing care and has been shown to provide family caregivers the relief necessary to maintain their own health and bolster family stability. Many existing respite care programs have age eligibility requirements, but the Lifespan Respite Care Program serves families regardless of special need or age. MS is typically diagnosed between the ages of 20 and 50, and Lifespan Respite programs are often the only open door to needed respite services. For these reasons, the Society asks that Congress provide $14.2 million for the Lifespan Respite Care Program in FY22.

NATIONAL INSTITUTES OF HEALTH

The importance of the NIH cannot be overstated. It is the nation's premiere biomedical research institution and drives innovation while supporting jobs in all 50 states. The NIH is a fundamental partner in the Society's mission to cure MS while

empowering people affected by the disease to live their best lives. To date, the Society has invested over $1 billion in MS research; but we rely on Congress to provide consistent and sustained investments to the NIH to cultivate an environment that is optimal for scientific discovery and innovation. As evident by the NIH funding that paved the way to the development of the mRNA COVID–19 vaccines, NIH continues to provide the basic research necessary to facilitate the development of novel therapies. In fact, the NIH has provided the basic research that has led to every MS treatment that is available today. The Society urges Congress to provide at least $46.1 billion for the NIH in FY22. This funding level would allow for meaningful growth of 5% in the NIH base budget, and we urge the Agency to continue its efforts to diversify its workforce and grantees and to support the careers of early-career investigators.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

PCORI serves a vital role in ensuring that the public and private health care sectors have valid and trustworthy data on health outcomes, clinical effectiveness, and appropriateness of different medical treatments by both conducting research and evaluating existing studies. Its research addresses the need for real-world evidence and patient-focused outcomes data that will improve healthcare quality and help shift healthcare payment models toward value-based care. To date, PCORI has invested over $69 million in comparative effectiveness studies in MS. These studies will provide important evidence for the best ways to address questions surrounding what care approaches work best for whom in various care settings and can inform conversations about value that truly considers the patient perspective. This information is important to aid in shared decision-making conversations between people with MS and their healthcare providers in consultations on treatment decisions. To complete this important work, we urge Congress to fully fund PCORI in FY22.

SOCIAL SECURITY ADMINISTRATION (SSA)

Due to the unpredictable nature and sometimes disabling impairments caused by the disease, SSA recognizes MS as a chronic illness or "impairment" that can cause disability severe enough to prevent an individual from working. During such periods, people living with MS are entitled to and rely on Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits to survive. The National MS Society urges Congress to provide robust funding of at least $13.5 billion for the Social Security Administration's administrative budget in FY22.

The Society thanks the Committee for the opportunity to provide written testimony on our recommendations for the base funding for federal agencies programs under the jurisdiction of the FY22 LHHS appropriations bill. The above agencies are of vital importance to people affected by MS and all Americans. Please do not hesitate to contact the Society with any questions that you may have, and we look forward to continuing to work with the Committee to help move us closer to a world free of MS.

[This statement was submitted by Leslie Ritter, Associate Vice President, Federal Government Relations, National Multiple Sclerosis Society.]

PREPARED STATEMENT OF THE NATIONAL PANCREAS FOUNDATION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—The Foundation joins the broader research community in requesting $46.1 billion in discretionary funding for the National Institutes of Health (NIH), an increase of $3.2 billion over FY 2021. Further, please provide proportional increases for the National Cancer Institute (NCI), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and other NIH Institutes and Centers.

—Please support adequate funding to establish the new Advanced Research Projects Agency for Health (ARPA–H) at NIH as proposed in the Administration's Budget Request to Congress to facilitate robust and tangible scientific progress on a variety of conditions, particularly cancers.

—The Foundation joins the broader public health community in requesting $10 billion in overall funding for the Centers for Disease Control and Prevention (CDC) to reinvigorate meaningful professional education, public awareness, and public health activities.

—Please provide the new CDC Chronic Disease Education and Awareness Program with $5 million, an increase of $3.5 million over FY 2021, to further advance and expand timely public health efforts with community stakeholders.

Chairwoman Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee, thank you for the opportunity to submit testimony on behalf of the National Pancreas Foundation (NPF) and the patient community that we serve. We deeply appreciate the investments in the National Institutes of Health (NIH) that have occurred over the past five fiscal years and the research advancements that additional resources have facilitated, most notably in potential treatments for pancreatitis. Moreover, we thank you for establishing the new Chronic Disease Education & Awareness Program at CDC with an initial investment of $1.5 million in FY 2021. The COVID–19 pandemic has highlighted the importance of robust investment in public health and with an infusion of much-needed resources for CDC for FY 2022, please also enhance this important new initiative. Thank you again.

ABOUT THE FOUNDATION

The National Pancreas Foundation is a patient-driven, non-profit organization that provides hope for those suffering from pancreatitis and pancreatic cancer by funding cutting edge research, advocating for new and better therapies, and providing support and education for patients, caregivers, and health care professionals.

CONDITIONS OF THE PANCREAS

Pancreatitis can be acute or chronic. It is characterized by inflammation of the pancreas, and chronic pancreatitis does not heal or improve-it gets worse over time and leads to permanent damage. Chronic pancreatitis eventually impairs a patient's ability to digest food and make pancreatic hormones. Chronic pancreatitis can strike at any age, but often develops in patients between the ages of 30 and 40, and is more common in men than women. The annual incidence rate is 5–12 per 100,000 and the prevalence is 50 per 100,000. Pancreatitis can be managed with proper information and healthy practices.

Pancreatic cancer is currently the third leading cause of cancer deaths in the United States. One of the major challenges associated with pancreatic cancer is that the condition often goes undetected for a long period of time because signs and symptoms seldom occur until advanced stages. By the time symptoms occur, cancer cells are likely to have spread (metastasized) to other parts of the body, often preventing surgical removal of tumors. Research indicates an emerging link between pancreatitis and the onset of pancreatic cancer.

NIH RESEARCH: PROGRESS AND OPPORTUNITIES

NIDDK has been a leader on pancreatitis research while NCI has facilitated key breakthroughs for pancreatic cancer. More work needs to be done though as translation and clinical research are necessary to ensure innovative treatment options and diagnostic tools can be deployed to the benefit of affected patients.

In this regard, NIDDK recently hosted an effort with the community to capitalize on progress for pancreatitis and ensure promising ideas move into the FDA pipeline for review. The need remains great as pancreatitis patients currently have extremely limited treatment options despite the severity of the illness. The advancements in the pancreatitis research portfolio have now led to treatment review activities at FDA and a critical Patient-Focused Drug Development Initiative meeting with the community.

Moreover, the Cancer Moonshot has been extremely meaningful for scientific efforts focused on pancreatic cancer. Similar to pancreatitis though, treatment options remain extremely limited despite the severity of the disease. In fact, due to improvements in other areas and an overall lack of progress in outcomes, pancreatic cancer is now the third leading cause of cancer deaths in America. While the details in the budget request remain sparse our hope is the new ARPA–H initiative will greatly enhance cancer research activities at NIH.

Over recent years, key Committee Recommendations have been included that have moved the pancreas and pancreatitis research portfolios forward, and it is our hope that the Subcommittee will continue to demonstrate an interest in this area during the FY 2022 process.

CDC CHRONIC DISEASE EDUCATION & AWARENESS PROGRAM

Thank you again for establishing the CDC Chronic Disease Education & Awareness Program in FY 2021 and providing an initial investment of $1.5 million. For

many years, CDC has lacked public health initiatives in a variety of conditions where simple interventions can save lives and lower healthcare costs. Conditions of the pancreas are no exception and access to simple health information can prevent the progress of many conditions and in some cases lower the rate of pancreatic cancer. Many patient organizations are seeking timely collaborations with CDC that can directly impact patients and improve public health using this new mechanism. It is important that this emerging program receives annual funding increases to ensure it can grow and facilitate new projects. While CDC has the ability to fund meritorious proposals, there will be no shortage of opportunities and the current investment of $1.5 million will only go so far. Please increase funding for this program to $5 million for FY 2022.

Adam Barbosa—Rhode Island

I am a 21 year-old resident of Rhode Island. I had my first pancreatic episode at age 15. It wasn't until after my third attack, and many medical tests later, that the Drs. told me I had two genetic mutations (SPINK1 & CFTR) and a physical anomoly (pancreas divisum) that were causing my attacks. I was officially diagnosed with chronic pancreatitis. Since my first attack, my condition went on a downward spiral. I went from a 3-day hospital stay every 5–6 months to a 7-day stay every 2 months, then eventually every 2 weeks. At that point, my case was so severe that the only option I had was to have the TPIAT surgery at the University of Minnesota. The surgery lasted 14 hours, required the removal of 4 organs [pancreas and spleen included], and left me with post-operative cognitive dysfunction. A condition that has crippled my college studies and hope for a "normal" future. Also, without a pancreas, I became an instant Type-1 diabetic. I now have to count carbs, dose myself with insulin and slug down a fistful of pills [pancreatic enzymes] before anything I eat/drink . I suffer with significant digestive issues and have lost 40 lbs. since surgery. Every day is an intense physical, mental, and emotional struggle. I suffer from depression, anxiety and panic attacks. Things I have come to find patients with a chronic illness have to deal with on a daily basis. There is no real "Recovery" from this surgery. My life is simply an agonizing waiting game for medical advancements.

Jenny Jones—Illinois

I am 36 and live in Chicago, Illinois. I was 9 or 10 years old when I experienced my first pancreatitis attack; my pediatrician at the time ran blood work and immediately said I would need a liver transplant. She also recommended we get a second opinion and see a GI pediatrician specialist at another local hospital. After a full battery of tests, the physician came to the conclusion that I probably had chronic pancreatitis. I am glad that we went for the second opinion. I battled this disease throughout my life, but it ceased after my ERCP from the ages of 17–24. But, when I was 24 the pancreatitis had returned and by then my sister was also diagnosed with pancreatitis. Life was ever more challenging, the pain intolerable, and I could not imagine living another 5–10 years this way. At this point, I had already become a Type 2 diabetic along with dealing with CP. In 2019, I had my 13-hour Total Pancreatectomy Auto Islet Cell Transplant at the University of Chicago Medicine on the South Side of Chicago where they removed my pancreas and transferred any working islets from the pancreas into my liver, removed half my stomach, small intestine, and duodenum. I am almost one-year post op and although I am now Type 3C diabetic, I am glad I choose to have the surgery. I am totally insulin-dependent and rely on an insulin pump as my islets have not awakened yet. My life post-op has been very challenging and I still deal with a measure of pain, and digestive issues. Despite all the surgeries and debilitating illnesses I have learned to become an advocate for others dealing with any chronic debilitating illness.

Cecilia Petricone—Connecticut

My story with pancreatitis started at the age of 12-years-old. Just a few weeks before I was supposed to start middle school I suddenly woke up with excruciating abdominal pain. After the first hospitalization, I started seeing lots of doctors including pancreatic specialists, my official diagnosis became Idiopathic Recurrent Acute Pancreatitis. During the first couple of years, I had genetic testing done which showed I have a SPINK1 mutation, which made me more prone to pancreatitis.

Doctors spent years trying to manage my symptoms. We tried changes to my diet, getting more rest, staying extra hydrated, taking precautions when I got onto airplanes, going on an anti-anxiety and getting multiple pancreatic stents—nothing worked. In fact, my condition worsened! My freshman year at Boston College was when things really escalated. My yearly hospitalizations had become 2–3 a year and my diagnosis transitioned from acute pancreatitis to chronic. My sophomore year of college I made a visit to the ER, unaware that it was the beginning of back-to-back

pancreatitis attacks that left me living in a hospital for the majority of time between October 2017 and February 2018. I left school, finishing the fall semester partially from a hospital bed 3 months later than my classmates. I lost a significant amount of weight, was malnourished, and began losing my hair.

That was until March, when my pancreatic specialist recommended I consider getting a Total Pancreatectomy and Islet Auto Transplant (TPIAT). In April of 2018, I had the surgery. Fast forward three years later, I am in no pain and realize I am one of the lucky ones as having the TPIAT does not guarantee a life of being pain-free. I have Type 3C diabetes which I monitor and manage on a daily basis. While I am pain-free, there are mental and emotional hurdles that come with medical experiences as all-encompassing as this. I am deeply grateful to be healthy and to no longer suffer from pancreatitis and I believe that mental health is an incredibly important component of medical issues that needs to be addressed.

Jane Holt—Rhode Island

My name is Jane Holt and I am a patient with chronic pancreatitis from Rhode Island. My journey began in early January, 1988. I was at home, asleep, with my husband and four young children. I woke up in the middle of the night in excruciating pain. It felt as though my insides were exploding. I knew immediately there was something terribly wrong and I needed to go to the hospital. Ten days later my gall bladder was removed, after the surgery, I told the surgeon that the original pain was still there. I was able to get an appointment with a gastroenterologist at BI Deaconess Hospital in Boston in October, 1988. After doing a medical history and blood work my doctor said he thought I had pancreatitis. I had an ERCP that confirmed this diagnosis. Finally, a cause for the pain and it only took several months instead of years for some patients. In November I had major surgery on my pancreas to open the ducts to my pancreas and the journey continued.

Since then, I've had a few ERCPs, many MRCPs, CAT scans, Ultrasound, and thousands and thousands of blood tests. I have travelled to Mayo Clinic, Lahey Clinic, George Washington Hospital for second opinions. My doctor has brought my records to many medical meetings for input from other physicians. Over the last 32 years I have done everything I can to try and fix this disease or at least find out more about it. For most patients treatment hasn't changed. The only treatment for patients is hospitalization and I would be hospitalized 3 or 4 times a year, sometimes for as long as a month. It is now even getting harder to get the one thing that can help, pain medication. We can't ignore patients like me. We have to do something to make a difference for all of our patients.

[This statement was submitted by David Bakelman, Chief Executive Officer, National Pancreas Foundation.]

PREPARED STATEMENT OF THE NATIONAL RESPITE COALITION

Mr. Chairman, I am Jill Kagan, Chair, National Respite Coalition (NRC), a network of state respite coalitions, providers, caregivers, and national, state and local organizations. We are requesting $14.2 million in the FY 2022 Labor, HHS, and Education Appropriations bill for the Lifespan Respite Care Program administered by the Administration for Community Living, Department of Health and Human Services. The request is consistent with the Administration's request to double funding for the program and will allow all States to receive a Lifespan Respite Grant to help family caregivers, regardless of care recipient's age or disability, access affordable respite. Additional funding will help states improve respite quality; expand the respite workforce; and use person and family-centered approaches that provide family caregivers tailored information on how to find, use and pay for respite services.

The pandemic cast a harsh light on the lack of supports for the nation's family caregivers. When congregate and group settings became too risky for older adults and people with disabilities, the importance of family caregivers to providing care at home was greatly amplified. At the same time, the availability of services, such as respite, became harder to access. The Lifespan Respite network responded with flexible respite and support options for family caregivers. During this challenging time, this may have been the only support they received.

Respite Care Saves Money and Benefits Families. Now, more importantly than ever, delaying a nursing home placement for individuals with Alzheimer's or avoiding hospitalization for children with autism can save Medicaid billions of dollars. Researchers at the University of Pennsylvania studied records of 28,000 children with autism enrolled in Medicaid and concluded that for every $1,000 states spent on respite, there was an 8% drop in the odds of hospitalization (Mandell, et al.,

2012). Respite may help delay or avoid facility-based placements (Gresham, 2018; Avison, et al., 2018), improve maternal employment (Caldwell, 2007), strengthen marriages (Harper, 2013), and reduce caregiver depression, stress and burden linked to caregiver health (Broady and Aggar, 2017; Lopez-Hartmann, et al., 2012; Zarit, et al., 2014).

With at least two-thirds (66%) of family caregivers in the workforce (Mantos, 2015), U.S. businesses lose from $17.1 to $33.6 billion per year in lost productivity of employed caregivers (MetLife Mature Market Institute, 2006). Higher absenteeism among working caregivers costs the U.S. economy an estimated $25.2 billion annually (Witters, 2011). The University of NE Medical Center conducted a survey of caregivers receiving respite through the NE Lifespan Respite Program and found that 36% of family caregivers reported not having enough money at the end of the month to make ends meet, but families overall reported a better financial situation when receiving respite (Johnson, J., et al., 2018).

Who Needs Respite? About 53 million unpaid family caregivers of adults provide care worth $470 billion annually (National Alliance for Caregiving and AARP, 2020; Reinhard, SC, et al., 2019). Eighty percent of those needing long-term services and supports (LTSS) are living at home. Two-thirds of older people with disabilities receiving LTSS at home receive care exclusively from family caregivers (Congressional Budget Office, 2013).

Concerns about providing care for a growing aging population are paramount. However, caregiving is a lifespan issue. The majority (54%) of family caregivers care for someone between the ages of 18 and 75 (NAC and AARP, 2020). In addition, nearly 14 million children with special health care needs require specialized care from parents and guardians (Child and Adolescent Health Measurement Initiative, 2021). Families caring for children with special health care needs provide nearly $36 billion worth of care annually (Romley, et al., 2016).

National, State and local surveys have shown respite to be among the most frequently requested services by family caregivers (Anderson, L, et al., 2018; Maryland Caregivers Support Coordinating Council, 2015). Yet, 86% of family caregivers of adults did not receive respite services at all in 2019 (NAC and AARP, 2020). Nearly half of family caregivers of adults (44%) identified in the National Study of Caregiving were providing substantial help with health care tasks, yet, fewer than 17% used respite (Wolff, 2016). The percentage is similar for parents of children with disabilities. The Elizabeth Dole Foundation continues to recommend that respite should be more widely available to military and Veteran caregivers.

Respite Barriers and the Effect on Family Caregivers. While most families want to care for family members at home, research shows that family caregivers are at risk for emotional, mental, and physical health problems (American Psychological Association, 2012; Spillman, J., et al., 2014). When caregivers lack effective coping styles or are depressed, care recipients may be at risk for falling, developing preventable secondary health conditions or limitations in functional abilities. The risk of care recipient abuse increases when caregivers are depressed or in poor health (American Psychological Association, nd). Parents of children with special health care needs report poorer general health, more physical health problems, worse sleep, and increased depressive symptoms compared to parents of typically developing children (McBean, A, et al., 2013).

Respite, that has been shown to ease family caregiver stress, is too often out of reach or completely unavailable. In a survey of more than 3000 caregivers of individuals with intellectual and developmental disabilities (ID/DD), nine in ten reported that they were stressed. Nearly half (49%) reported that finding time to meet their personal needs was a major problem. Yet, more than half of the caregivers of individuals with ID or Autism Spectrum Disorder reported that it was difficult or very difficult to find respite care (Anderson, L., et al., 2018). Respite may not exist at all for those with Alzheimer's, ALS, MS, spinal cord or traumatic brain injuries, or children with serious emotional conditions.

Barriers to accessing respite include fragmented and narrowly targeted services, cost, and the lack of information about respite or how to find or choose a provider. Moreover, a critically short supply of well-trained respite providers or meaningful service options may prohibit a family from making use of a service they so desperately need.

Lifespan Respite Care Program Helps. The Lifespan Respite Care Program, designed to address these barriers to respite quality, affordability and accessibility, is a competitive grant program to states administered by ACL in the Administration on Aging. The premise behind the program is both care relief and cost effectiveness. Lifespan Respite provides funding to states to expand and enhance local respite services across the country, coordinate services to reduce duplication and fragmentation, and improve respite access and quality.

Since 2009, 37 states and DC have received Lifespan Respite grants. The program received $4.1 million in FY 18 and FY 19, and $6.1 million in FY 2020. We are grateful for the increase to $7.1 million in FY 2021; however, the program received no emergency Congressional supplemental funding during the pandemic, despite the elevated need. With these funds, States are required to establish statewide coordinated Lifespan Respite care systems to serve families regardless of age or special need; provide planned and emergency respite care; train and recruit respite workers and volunteers; and assist caregivers in accessing respite. Lifespan Respite helps states maximize use of limited resources and deliver services more efficiently to those most in need. Increasing funding could allow funding for all states and help current grantees complete their ground-breaking work in serving the unserved, and ensuring sustainability by integrating services into statewide No Wrong Door systems for long-term services and supports.

During the current pandemic, when family caregiver social isolation is escalating, grantees and their primary partners continue to provide respite safely in states where they are permitted to do so. They are the frontline workers who may be the only outside contact and support these families are receiving. If they cannot provide in-person respite, the network has expanded support services to include regular phone call check ins, delivery of care packages, online support groups, virtual training and other educational services via Facebook and other social media outlets.

How is Lifespan Respite Program Making a Difference? Key accomplishments of State Lifespan Respite grantees are highlighted in a new ARCH National Respite Network report, In Support of Caregivers [archrespite.org/key-accomplishments]. State Lifespan Respite programs are engaged in the following innovative activities:

—AL, AR, AZ, CO, DE, MD, MT, ND, NE, NV, NC, OK, RI, SC, TN, VA, WA, and WI, administer successful self-directed respite vouchers for underserved populations, such as individuals with Alzheimer's disease, traumatic brain injury, MS or ALS, adults with intellectual or developmental disabilities (I/DD), rural caregivers, or those on waiting lists for services. When families were willing and states allowed it, these programs continued to operate with enhance flexibilities during the pandemic.

—AL's respite voucher program found a substantial decrease in the percentage of caregivers reporting how often they felt overwhelmed with daily routines after receiving respite. Caregivers in NE's Lifespan Respite program reported significant decreases in stress levels, fewer physical and emotional health issues, and reductions in anger and anxiety.

—Innovative and sustainable respite services, funded in AL, CO, MA, NC, and NY through mini-grants to community-based agencies, also have documented benefits to family caregivers.

—AL, MD, ND and NE offer emergency respite and AL, AR, CO, NE, NY, PA, RI, SC and TN implemented new volunteer or faith-based respite services.

—Respite provider recruitment and training are priorities in NE, NY, SC, SD, VA, and WI.

State agency partnerships are changing the landscape. Lifespan Respite WA, housed in Aging & Long-Term Support Administration, partnered with WA's Children with Special Health Care Needs Program, Tribal entities and the state's Traumatic Brain Injury program to provide respite vouchers to families across ages and disabilities. The OK Lifespan Respite program partnered with the state's Transit Administration to develop mobile respite in isolated rural areas. States, including NC, NY and NV, are building "no wrong door systems" in partnership with Aging and Disability Resource Centers to improve respite access. States are developing long-term sustainability plans, but without continued federal support, many grantees will be cut off before these initiatives achieve their full impact.

During the pandemic, social isolation and severe mental health issues among family caregivers intensified. The CDC found that "unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation." The Lifespan Respite network responded with flexible and innovative respite options. For countless caregivers, respite became their only lifeline to supports, services, and vital human connection. OK, ND, NV, WA, VA, and WI were some of the states that introduced flexibility to their respite voucher programs to encourage use, such as expanded eligibility and timeframes, increased flexibility in who could provide respite to include other family members in the home, and increased voucher amounts. Other Lifespan Respite grantees met the needs of family caregivers through new and creative approaches:

Alabama: Alabama Lifespan Respite, in order to increase targeted support to caregivers during the pandemic, offered Care Chats (one-on-one support by phone or video conferencing) with their social worker staff, monthly support groups, and caregiver mental health education opportunities to help increase overall caregiver

wellness. Alabama Lifespan Respite also introduced a Caregiver Wellness Initiative that increases Emergency Respite reimbursement funds and designates funds specifically for mental health counseling to caregivers currently enrolled with their reimbursement (voucher) program. The intended impacts of the Caregiver Wellness Initiative include decreases in caregiver stress, anxiety, fatigue, and burnout after receiving Emergency Respite and/or mental health counseling.

Tennessee: The TN Respite Coalition awarded mini-grants for caregiver-selected items, such as personal protective equipment, tablets enabling internet access to online support groups, home exercise equipment, and movie or magazine subscriptions. Expanding ideas of traditional respite services, the Tennessee Respite Voucher Program provided respite in innovative ways that allowed for safe social distancing but maintained caregiver-provider contact that kept caregivers socially connected during times of increased stress and isolation.

No other federal program has respite as its sole focus, helps ensure respite quality or choice, and supports respite start-up, training or coordination. We urge you to include $14.2 million in the FY 2022 Labor, HHS, and Education appropriations bill. Families will be able to keep loved ones at home safely and ensure their own well-being, saving Medicaid and other federal programs billions of dollars.

For more information, please contact Jill Kagan, National Respite Coalition at jkagan@archrespite.org. Complete references available on request.

[This statement was submitted by Jill Kagan, Chair, National Respite Coalition.]

PREPARED STATEMENT OF THE NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Mr. Chairman and Members of the Committee:

I respectfully submit the FY 2022 budget request for NTID, one of nine colleges of RIT, in Rochester, New York. Created by Congress by Public Law 89–36 in 1965, NTID provides a university-level technical and professional education for students who are deaf and hard of hearing, leading to successful careers in high-demand fields for a sub-population of individuals historically facing high rates of unemployment and under-employment. NTID students study at the associate, baccalaureate, master's and doctoral levels as part of a university (RIT) that includes more than 17,000 hearing students. NTID also provides baccalaureate and graduate-level education for hearing students in professions serving deaf and hard-of-hearing individuals.

BUDGET REQUEST

On behalf of NTID, for FY 2022 I would like to request $89,700,000 for Operations. NTID has worked hard to manage its resources carefully and responsibly. NTID actively seeks alternative sources of public and private support, with approximately 24% of NTID's Operations budget coming from non-federal funds, up from 9% in 1970. Since FY 2006, NTID raised more than $26 million in support from individuals and organizations.

NTID's FY 2022 request of $89,700,000 includes $3,400,000 for establishing a national hub of innovation for deaf scientists in Rochester, New York. The "Hub" will be a collaborative partnership with the University of Rochester and Rochester Regional Health that will enhance the access of deaf and hard-of-hearing persons to career opportunities as scientists, biomedical researchers and health professionals. Hub programs will include a summer research program, a pre-career training pipeline for deaf and hard-of-hearing scientists, mentoring programs, a postdoc-to-faculty program, and guidance for biomedical research institutions and medical schools on best practices for training deaf and hard-of-hearing scientists and health professionals. The coronavirus has also demonstrated the national need for timely, accurate and official information in ASL about pandemics and health care concerns—a service the Hub could provide.

NTID's FY 2022 request also includes an additional $2,000,000 to expand the NTID Regional STEM Center (NRSC) partnership, which serves deaf and hard-of-hearing students in 12 southeastern states by promoting training and postsecondary participation in STEM fields, providing professional development for teachers, and developing partnerships with business and industry to promote employment opportunities. Via the NRSC, deaf and hard-of-hearing middle school students are introduced to STEM programs and careers that will help inform their academic and career decisions. Deaf and hard-of-hearing high school students can take NTID STEM dual-credit courses and participate in career exploration and college preparation programs that will help them transition from high school to college. In FY 2020, up to 2,023 educators, 1,685 students, 590 employers, 379 interpreters, 241 parents,

and 190 vocational rehabilitation staff enrolled in NRSC programs (some may have enrolled in multiple programs).

NTID's FY 2022 operations request also provides $700,000 to establish a Computer Science and Cybersecurity Training Center for deaf and hard-of-hearing students based at RIT's new Global Cybersecurity Institute (GCI), a 52,000-square-feet facility providing students, researchers and industry professionals with the most advanced technology tools and education offerings to help further digital security across the world. The Cybersecurity Training Center would allow NTID to build on its new partnership with the GCI, which is currently offering a boot camp to deaf and hard-of-hearing students that results in an RIT GCI Cybersecurity Bootcamp Certificate and preparation for industry-standard certifications, including CompTIA Security+ and Cybersecurity First Responder. Finally, the requested increase in operations will also provide $2,100,000 for NTID to manage inflationary costs.

ENROLLMENT

Truly a national program, NTID has enrolled students from all 50 states. In Fall 2020 (FY 2021), NTID's enrollment was 1,101 students. NTID also serves students nationwide through Project Fast Forward, a project that builds a pathway for deaf and hard-of-hearing students to transition from high school to college in selected STEM disciplines by allowing deaf and hard-of-hearing high school students to take dual-credit courses, earning RIT/NTID college credit while they are still in high school. In FY 2021, 185 deaf and hard-of-hearing high school students enrolled in dual-credit courses at partner high schools.

NTID ACADEMIC PROGRAMS

NTID offers high quality, career-focused associate degree programs preparing students for specific well-paying technical careers. NTID also provides transfer associate degree programs to better serve our student population seeking bachelor's, master's, and doctoral degrees. These transfer programs provide seamless transition to baccalaureate and graduate studies in the other colleges of RIT.

A cooperative education (co-op) component is an integral part of academic programming at NTID and prepares students for success in the job market. A co-op assignment gives students the opportunity to experience a real-life job situation and focus their career choice. Students develop technical skills and enhance vital personal skills such as teamwork and communication, which will make them better candidates for full-time employment after graduation. Last year, 181 students participated in 10-week co-op experiences that augment their academic studies, refine their social skills, and prepare them for the competitive working world.

STUDENT ACCOMPLISHMENTS

NTID deaf and hard-of-hearing students persist and graduate at rates higher than or on par with national persistence and graduation rates for all students at two-year and four-year colleges. For NTID deaf and hard-of-hearing graduates, over the past five years, an average of 95% have found jobs commensurate with their education level. Of our FY 2019 graduates (the most recent class for which numbers are available), 95% were employed one year later, with 77% employed in business and industry, 16% in education and non-profits, and 7% in government.

Graduation from NTID has a demonstrably positive effect on students' earnings over a lifetime, and results in a notable reduction in dependence on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In FY 2012, NTID, the Social Security Administration (SSA), and Cornell University examined earnings and federal program participation data for more than 16,000 deaf and hard-of-hearing individuals who applied to NTID over our entire history. The study showed that NTID graduates, over their lifetimes, are employed at a higher rate and earn more (therefore paying more in taxes) than students who withdraw from NTID or attend other universities. NTID graduates also participate at a lower rate in SSI programs than students who withdrew from NTID.

Using SSA data, at age 50, 78% of NTID deaf and hard-of-hearing graduates with bachelor degrees and 73% with associate degrees report earnings, compared to 58% of NTID deaf and hard-of-hearing students who withdrew from NTID and 69% of deaf and hard-of-hearing graduates from other universities. Equally important is the demonstrated impact of an NTID education on graduates' earnings. At age 50, $58,000 is the median salary for NTID deaf and hard-of-hearing graduates with bachelor degrees and $41,000 for those with associate degrees, compared to $34,000 for deaf and hard-of-hearing students who withdrew from NTID and $21,000 for deaf and hard-of-hearing graduates from other universities.

An NTID education also translates into reduced dependency on federal transfer programs, such as SSI and SSDI. At age 40, less than 2% of NTID deaf and hard-of-hearing associate and bachelor degree graduates participated in the SSI program compared to 8% of deaf and hard-of-hearing students who withdrew from NTID. Similarly, at age 50, only 18% of NTID deaf and hard-of-hearing bachelor degree graduates and 28% of associate degree graduates participated in the SSDI program, compared to 35% of deaf and hard-of-hearing students who withdrew from NTID.

ACCESS SERVICES

Access services include sign language interpreting, real-time captioning, classroom notetaking services, captioned classroom video materials, and assistive listening services. NTID provides an access services system to meet the needs of a large number of deaf and hard-of-hearing students enrolled in baccalaureate and graduate degree programs in RIT's other colleges as well as students enrolled in NTID programs who take courses in the other colleges of RIT. Access services also are provided for events and activities throughout the RIT community. Historically, NTID has followed a direct instruction model for its associate-level classes, with limited need for sign language interpreters, captionists, or other access services. However, the demand for access services has grown recently as associate-level students request communication based on their preferences.

During FY 2020, 118,240 hours of interpreting and 21,856 hours of real-time captioning were provided to students.

SUMMARY

NTID's FY 2022 funding request ensures that we continue our mission to prepare deaf and hard-of-hearing people to excel in the workplace and expand our outreach to better prepare deaf and hard-of-hearing students to excel in college. NTID students persist and graduate at rates higher than or on par with national rates for all students. NTID graduates have higher salaries, pay more taxes, and are less reliant on federal SSI programs. NTID's employment rate is 95% over the past five years. Therefore, I ask that you please consider funding our FY 2022 request of $89,700,000 for Operations.

We are hopeful that the members of the Committee will agree that NTID, with its long history of successful stewardship of federal funds and an outstanding educational record of service to people who are deaf and hard of hearing, remains deserving of your support and confidence. Likewise, we will continue to demonstrate to Congress and the American people that NTID is a proven economic investment in the future of young deaf and hard-of-hearing citizens. Quite simply, NTID is a federal program that works.

[This statement was submitted by Dr. Gerard J. Buckley, President, National Technical Institute for the Deaf and Vice President and Dean, Rochester Institute of Technology.]

PREPARED STATEMENT OF THE NATIONAL VIRAL HEPATITIS ROUNDTABLE

Dear Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee,

I am writing on behalf of the National Viral Hepatitis Roundtable (NVHR), a coalition of patients, health care providers, community-based organizations, and public health partners fighting for an equitable world free of viral hepatitis. We are respectfully requesting an increase in funding to CDC's Division of Viral Hepatitis (DVH), to no less than $134 million in FY 2022 from its current level of $39.5 million for FY 2021.

According to data released by the CDC last month, cases of acute hepatitis A increased by a staggering 1300% between 2015 and 2019, representing outbreaks of person-to-person transmission of this vaccine-preventable infection linked to substance use and homelessness. While reported rates of new hepatitis B infections generally remained stable over this period, the overwhelming majority occurred among unvaccinated adults between the ages of 30 and 59, with a substantial number of cases linked to injection drug use. Over this time period, acute hepatitis C cases surged by 63%, with estimated new infections now exceeding annual rates of new HIV infections in the United States. Specifically, CDC estimates 57,500 new hepatitis C infections for 2019, while noting that the true number could be as high as 196,000.

The tragedy of our viral hepatitis response is that these cases reflect failures in prevention, exacerbations in health disparities, and gaps in our public health sys-

tem. We have strong tools—including vaccination for hepatitis A and B, alongside syringe services programs and medication-assisted treatment for opioid use disorder for hepatitis C—proven effective and well-established in preventing new infections, when implemented comprehensively and at scale. Chronic hepatitis B is treatable and chronic hepatitis C is curable, and indeed CDC's surveillance data and 2021 National Viral Hepatitis Progress Report show promising momentum in decreasing mortality from hepatitis B and hepatitis C, including among communities burdened with substantial racial/ethnic health disparities (Asian and Pacific Islander communities for hepatitis B, and American Indian/Alaskan Native persons and African Americans for hepatitis C).

The Department of Health and Human Services released a new National Viral Hepatitis Strategic Plan at the beginning of 2021, committing the nation to eliminate viral hepatitis as a public health threat by 2030 and outlining a comprehensive and credible set of strategies and priorities to achieve this goal. However, we cannot meet this challenge without reckoning with the persistent underfunding of viral hepatitis within the CDC budget, a chronic shortfall that cascades down to states and local communities struggling to keep pace with shifting trends and increased new cases as a downstream consequence of the broader opioid and stimulant health crisis. CDC's Division of Viral Hepatitis plays an essential role in leading our public health efforts towards viral hepatitis elimination, but can only fulfill that promise with adequate resources. We strongly urge the subcommittee to strengthen our public health infrastructure by investing at least $134 million in CDC's Division of Viral Hepatitis for FY 2022.

In tandem with this investment, we respectfully request that the subcommittee increases CDC's funding for eliminating opioid-related infectious diseases to $120 million in FY 2022, to accelerate urgent efforts to support building out programmatic infrastructure—particularly syringe services programs (SSPs)—capable of prevention and linkage to care for not only HIV and viral hepatitis but other infectious diseases such as endocarditis which disproportionately affect people who inject drugs. These programs continue to serve on the frontlines of both the COVID–19 pandemic and the overdose epidemic, uniquely effective at engaging a highly vulnerable and marginalized population that other systems—including health care—struggle to engage, serve, and retain in a timely and effective manner. In keeping with the vital importance of resourcing these programs, we similarly urge the subcommittee to remove restrictions on the use of federal funds to purchase sterile syringes in order to maximize the impact and benefits of these programs.

In conclusion, we thank the subcommittee for their commitment to public health and attention to viral hepatitis, and would be eager to respond to questions or provide additional information and context to support your work.

[This statement was submitted by Daniel Raymond, Director of Policy, National Viral Hepatitis Roundtable.]

PREPARED STATEMENT OF THE NEPHCURE KIDNEY INTERNATIONAL

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2022

—Provide $46.1 billion for the National Institutes of Health (NIH)
—Provide a proportional increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the National Institute on Minority Health and Health Disparities (NIMHD) and support the expansion of the FSGS/NS research portfolio at NIDDK and NIMHD by funding more research into primary glomerular disease.
—Provide $10 billion for the Centers for Disease Control and Prevention (CDC) and $5 million for the Chronic Disease Education and Awareness Program.

Chairwoman Murray and Ranking Member Blunt, thank you for the opportunity to present the views of NephCure Kidney International regarding research on focal segmental glomerulosclerosis (FSGS) and nephrotic syndrome (NS). NephCure is the only non-profit organization exclusively devoted to finding a cure and supporting patients with FSGS and the NS disease group. Driven by a panel of respected medical experts and a dedicated band of patients and families, NephCure works tirelessly to support kidney disease research and awareness.

NS is a collection of signs and symptoms caused by diseases that attack the kidney's filtering system. These diseases include FSGS, Minimal Change Disease and Membranous Nephropathy and others. When affected, the kidney filters leak protein

from the blood into the urine and often cause kidney failure, which requires dialysis or kidney transplantation. According to a Harvard University report, 73,000 people in the United States have lost their kidneys as a result of FSGS. Unfortunately, the causes of FSGS and other 'filter related' diseases are poorly understood.

FSGS is the second leading cause of NS and is especially difficult to treat. There is no known cure for FSGS and current treatments are difficult for patients to endure. These treatments include the use of steroids and other dangerous substances which lower the immune system and contribute to severe bacterial infections, high blood pressure and other problems in patients, particularly child patients. In addition, children with NS often experience growth retardation and heart disease. Finally, NS that is caused by FSGS, MCD or MN is idiopathic and can often reoccur, even after a kidney transplant.

FSGS disproportionately affects minority populations and is five times more prevalent in the African American community. In a groundbreaking study funded by NIH, researchers found that FSGS is associated with two aggressive APOL1 gene variants. 75% of Black Americans with FSGS possess this gene. These variants developed as an evolutionary response to African sleeping sickness and are common in the African American patient population with FSGS/NS. Researchers continue to study the pathogenesis of these variants.

FSGS has a large social impact in the United States. FSGS leads to end-stage renal disease (ESRD) which is one of the most costly chronic diseases to manage. In 2008, the Medicare program alone spent $26.8 billion, 7.9% of its entire budget, on ESRD. In 2005, FSGS accounted for 12% of ESRD cases in the U.S., at an annual cost of $3 billion. It is estimated that there are currently approximately 20,000 Americans living with ESRD due to FSGS.

Research on FSGS and other forms of NS could achieve tremendous savings in federal health care costs and reduce health status disparities.

ENCOURAGE FSGS/NS RESEARCH AT NIH

There is no known cause or cure for FSGS and scientists tell us that much more research needs to be done on the basic science behind FSGS/NS. More research could lead to fewer patients undergoing ESRD and tremendous savings in health care costs in the United States. NephCure works closely with NIH and has partnered with NIH on two large studies that will advance the pace of clinical research and support precision medicine. These studies are the Nephrotic Syndrome Study Network (NEPTUNE) and the Cure Glomerulonephropathy Network (CureGN).

With collaboration from other Institutes and Centers, ORDR established the Rare Disease Clinical Research Network. This network provided an opportunity for NephCure Kidney International, the University of Michigan, and other university research health centers to come together to form the NEPTUNE. Now in its second 5-year funding cycle, NEPTUNE has recruited over 450 NS research participants, and has supported pilot and ancillary studies utilizing the NEPTUNE data resources. NephCure urges the subcommittee to continue its support for RDCRN and NEPTUNE, which has tremendous potential to facilitate advancements in NS and FSGS research.

NIDDK houses the Cure GN, a multicenter five-year cohort study of glomerular disease patients. Participants will be followed longitudinally to better understand the causes of disease, response to therapy, and disease progression, with the ultimate objective to cure glomerulonephropathy. NephCure recommends that the subcommittee continues to support the work that the CureGN initiative has accomplished towards further understanding rare forms of kidney diseases. It is estimated that annually there are 20 new cases of ESRD per million African Americans due to FSGS, and 5 new cases per million Caucasians. This disparity is largely due to variants of the APOL1 gene. Unfortunately, the incidence of FSGS is rising and there are no known strategies to prevent or treat kidney disease in individuals with the APOL1 genotype. NIMHD began supporting research on the APOL1 gene in FY13. Due to the disproportionate burden of FSGS on minority populations, it remains appropriate for NIMHD to continue to advance this research. NephCure asks the subcommittee to recognize the work that NIMHD and NIDDK are doing to address the connection between the APOL1 gene and the onset of FSGS and encourage NIMHD to work with community stakeholders to identify areas of collaboration.

As a result of the important research done through NIH we have been able to work with FDA to establish new endpoints for clinical trial leading to more trials than ever before. This has led to the creation of the Kidney Health Gateway Clinical that will connect patients with breakthrough clinical trials and access top Nephrotic

Syndrome doctors all in one place. These crucial trials will hopefully lead to more treatment options for our patients.

CHRONIC DISEASE EDUCATION AND AWARENESS

We thank the Subcommittee for the creation of the Chronic Disease Education and Awareness Program in FY2021 and encourage continued support by providing $5 million for this critical program in FY2022.

Patient Perspective

Meet 13-year-old Macy! She was diagnosed with Nephrotic Syndrome and later FSGS when she was three. Her 10-year journey with kidney disease has been long and hard. Macy did not respond to treatments for her kidney disease and within two years of diagnosis, her native kidneys were damaged beyond repair and she was in kidney failure and on dialysis. At the age of five, she received a living donor kidney transplant, but her disease, FSGS came back and attacked her new to her kidney. It took a full year of aggressive treatments to get Macy's FSGS into remission post-transplant. For the past 10 years, Macy has taken 18 to 26 medications a day. Those medications and her kidney disease have led to multiple co-morbidities. She is currently followed by 7 specialties, has endured 30+ surgeries & been hospitalized over 100 times. Macy participates in the Beads of Courage program in which she earns different beads for each procedure, appointment etc. The strand of beads you see in this photo are just the beads she earned in 2018! Those black beads are for pokes (lab draws, IV's, Shots) and Macy earned over 400 last year. As you can see kidney disease is tough! Although Macy continues to struggle with kidney disease and will need another transplant sooner than later, she doesn't let that stop her from living life! Macy loves dancing and musical theater, art, and hanging out with her dog Bentley!

Thank you for the opportunity to present the views of the FSGS/NS community.

[This statement was submitted by Irving Smokler, PH.D., Board Chairman, Acting President and Founder, NephCure Kidney International.]

PREPARED STATEMENT OF THE NEUROFIBROMATOSIS NETWORK

Thank you for the opportunity to submit testimony to the Subcommittee on the importance of funding for the National Institutes of Health (NIH), and specifically for continued research on Neurofibromatosis (NF), a genetic disorder closely linked to many common diseases widespread among the American population. My name is Kim Bischoff and I am the Executive Director of the Neurofibromatosis (NF) Network, a national organization of NF advocacy groups. We respectfully request that you include the following report language on NF research at the National Institutes of Health within the Office of the Director account in the Fiscal Year 2022 Labor, Health and Human Services, Education Appropriations bill.

Neurofibromatosis [NF].—The Committee supports efforts to increase funding and resources for NF research and treatment at multiple Institutes, including NCI, NINDS, NIDCD, NHLBI, NICHD, NIMH, NCATS, and NEI. Children and adults with NF are at elevated risk for the development of many forms of cancer, as well as deafness, blindness, developmental delays and autism; the Committee encourages NCI to increase its NF research portfolio in fundamental laboratory science, patient-directed research, and clinical trials focused on NF-associated benign and malignant cancers. The Committee also encourages NCI to support clinical and preclinical trials consortia. Because NF can cause blindness, pain, and hearing loss, the Committee urges NINDS to continue to aggressively fund fundamental basic science research on NF relevant to restoring normal nerve function. Based on emerging findings from numerous researchers worldwide demonstrating that children with NF are at significant risk for autism, learning disabilities, motor delays, and attention deficits, the Committee encourages NINDS, NIMH, and NICHD to increase their investments in laboratory-based and patient-directed research investigations in these areas. Since NF2 accounts for approximately 5 percent of genetic forms of deafness, the Committee encourages NIDCD to expand its investment in NF2-related research. NFl can cause vision loss due to optic gliomas. The Committee encourages NEI to expand its investment in NF1-focused research on optic gliomas and vision restoration.

On behalf of the Neurofibromatosis (NF) Network, I speak on behalf of the over 100,000 Americans who suffer from NF as well as the millions of Americans who suffer from diseases and conditions linked to NF such as cancer, brain tumors, heart disease, memory loss, and learning disabilities. Thanks in large part to this Subcommittee's strong support, scientists have made enormous progress since the discovery of the NF1 gene in 1990 resulting in clinical trials now being undertaken at NIH with broad implications for the general population.

NF is a genetic disorder involving the uncontrolled growth of tumors along the nervous system which can result in terrible disfigurement, deformity, deafness, pain, blindness, brain tumors, cancer, and even death. In addition, approximately one-half of children with NF suffer from learning disabilities. NF is the most common neurological disorder caused by a single gene and is more common than Cystic Fibrosis, hereditary Muscular Dystrophy, Huntington's disease and Tay Sachs combined. There are three types of NF: NF1, which is more common, NF2, which initially involves tumors causing deafness and balance problems, and Schwannomatosis, the hallmark of which is severe pain. While not all NF patients suffer from the most severe symptoms, all NF patients and their families live with the uncertainty of not knowing whether they will be seriously affected because NF is a highly variable and progressive disease.

Researchers have determined that NF is closely linked to heart disease, learning disabilities, memory loss, cancer, brain tumors, and other disorders including deafness, blindness and orthopedic disorders, primarily because NF regulates important pathways common to these disorders such as the RAS, cAMP and PAK pathways. Research on NF therefore stands to benefit millions of Americans.

Learning Disabilities/Behavioral and Brain Function

Learning disabilities affect one-half of people with NF1. They range from mild to severe and can impact the quality of life for those with NF1. In recent years, research has revealed common threads between NF1 learning disabilities, autism, and other related disabilities. New drug interventions for learning disabilities are being developed and will be beneficial to the general population. Research being done in this area includes working to identify drugs that target Cyclic AMP, so they can be paired with existing drugs targeting RAS. Identification of new drug combinations may benefit people with multiple types of learning disabilities.

Bone Repair

At least a quarter of children with NF1 have abnormal bone growth in any part of the skeleton. In the legs, the long bones are weak, prone to fracture and unable to heal properly; this can require amputation at a young age. Adults with NF1 also have low bone mineral density, placing them at risk of skeletal weakness and injury. Research currently being done to understand bone biology and repair will pave the way for new strategies to enhancing bone health and facilitating repair.

Pain Management

Severe pain is a central feature of Schwannomatosis, and significantly impacts quality of life. Understanding what causes pain, and how it could be treated, has been a fast-moving area of NF research over the past few years. Pain management is a challenging area of research and new approaches are highly sought after.

Nerve Regeneration

NF often requires surgical removal of nerve tumors, which can lead to nerve paralysis and loss of function. Understanding the changes that occur in a nerve after surgery, and how it might be regenerated and functionally restored, will have significant quality of life value for affected individuals. Light-based therapy is being tested to dissect nerves in surgery of tumor removal. If successful it could have applications for treating nerve damage and scarring after injury, thereby aiding repair and functional restoration.

Cancer

NF can cause a variety of tumors to grow, which includes tumors in the brain, spinal cord and nerves. NF affects the RAS pathway which is implicated in 70% of all human cancers. Some of these tumor types are benign and some are malignant, hard to treat and often fatal. Previous studies have found a high incidence of intracranial glioblastomas and malignant peripheral nerve sheath tumors (MPNSTs), as well as a six-fold incidents of breast cancer compared to the general population. One of these tumor types, malignant peripheral nerve sheath tumor (MPNST), is a very aggressive, hard to treat and often fatal cancer. MPNSTs are fast growing, and because the cells change as the tumor grows, they often become resistant to individual drugs. Clinical trials are underway to identify a drug treatment that can be widely used in MPNSTs and other hard-to-treat tumors.

The enormous promise of NF research, and its potential to benefit over 175 million Americans who suffer from diseases and conditions linked to NF, has gained increased recognition from Congress and the NIH. This is evidenced by the fact that numerous institutes are currently supporting NF research, and NIH's total NF research portfolio has increased from $3 million in FY1990 to an estimated $36 million in FY2021. Given the potential offered by NF research for progress against a

range of diseases, we are hopeful that the NIH will continue to build on the successes of this program by funding this promising research and thereby continuing the enormous return on the taxpayers' investment.

We appreciate the Subcommittee's strong support for the National Institutes of Health and will continue to work with you to ensure that opportunities for major advances in NF research at the NIH are aggressively pursued. Thank you.

[This statement was submitted by Kim Bischoff, Executive Director, Neurofibromatosis Network.]

PREPARED STATEMENT OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Greetings Chair Murray, Ranking Member Blunt, and Members of the Subcommittee, for the opportunity to share the Northwest Portland Area Indian Health Board's funding priorities for the Department of Health and Human Services (HHS) in FY 2022. My name is Nickolaus Lewis, and I serve as Council on the Lummi Indian Business Council, and as Chair of the Northwest Portland Area Indian Health Board (NPAIHB or Board). I thank the Subcommittee for the opportunity to provide testimony on FY 2022 HHS appropriations.

The NPAIHB is a tribal organization, established in 1972, under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638 that advocates on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. The Board's mission is to eliminate health disparities and improve the quality of life of American Indian and Alaska Native (AI/AN) people by supporting Northwest Tribes in the delivery of culturally appropriate, high quality health programs and services. "Wellness for the seventh generation" is the Board's vision. In order to achieve this vision, NPAIHB delegates respectfully ask that this Subcommittee consider tribal sovereignty, traditional knowledge, and culture in all policy initiatives and funding opportunities.

Last year, COVID–19 dramatically impacted Northwest Tribes. We are grateful for the diligent work of our Congressional representatives in ensuring that Tribal Nations were provided with resources, including vaccines, to battle this pandemic. We know that working together improved our ability take care of our people despite the long standing systemic and funding shortfalls to the Indian health care system. As we emerge from the pandemic, I make recommendations that will help rebuild and repair the foundational necessities for the Indian health care system.

HHS AND ITS AGENCIES

This Committee must honor tribal sovereignty and trust and treaty obligations as to HHS funding to Tribal Nations. For FY 2022, we ask this Committee to make the legislative changes needed across all HHS agencies to move away from grants and allocate funding to tribes through Indian Self-Determination and Education Assistance Act (ISDEAA) compacts and contracts. We also request Tribal set-asides and direct funding to tribes—not through state block grants.

We also request that this Committee consider the important role that Tribal Epidemiology Centers play in the Indian health system and support funding to TECs. TECs should be funded across HHS agencies to provide support to tribes in their area for any type of data or evaluation component, surveillance support and/or training and technical assistance. TECs know the tribes in their area and should be given the opportunity to support tribes in their roles as public health authorities.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Tribal Opioid Response. Through Tribal Opioid Response (TOR) funding, NPAIHB coordinated a TOR consortium of 28 Northwest Tribes. Our tribes have developed innovative opioid programs with positive outcomes reflecting the resilience in our area. For example, the Lummi Nation brought on success coaches (peers) for those using or in recovery and 18 of the 28 TOR consortium tribes have made medication-assisted treatment (MAT) available. However, a funding increase is needed for a more robust opioid response in tribal communities. In FY 2022, we request an increase in TOR funding to $75 million; and an increase in the Tribal MAT funding to $20 million.

Other Grant Programs. Thank you for the increases to the AI/AN Zero Suicide Initiative funding, and Tribal Behavioral Health Grants in FY 2021. For FY 2022, we request the following amounts for Tribal Specific Programs: fund the Tribal Behavioral Health Grant program at least $50 million—$25 million for mental health and $25 million for substance use disorder; fund the Garrett Lee Smith Suicide Preven-

tion Tribal Set Aside at $3.5 million; fund Zero Suicide Initiative at $3 million; and fund the National Child Traumatic Stress Initiative Tribal Set Aside at $1.5 million.

Designated Resources for Youth Behavioral Health Programs. In order to comprehensively address the need for whole person mental health and substance use disorder services for AI/AN youth, there must be dedicated funding streams for culturally-centered prevention, intervention, treatment, aftercare and transitional living support. Funding for Youth Residential Treatment Centers that provide aftercare and transitional living for both substance use disorder and mental health are a priority for Portland Area Tribes and current facilities in the area do not meet demand. For FY 2022, we request $25 million in funding for youth-specific outpatient and inpatient mental health and substance use programs.

OFFICE OF THE SECRETARY

Minority HIV/AIDS Fund. The Minority HIV/AIDS Fund is a significant funding source for communities of color that have not traditionally been supported by mainstream opportunities, and includes important funding to IHS for HIV and hepatitis C (HCV) prevention, treatment, outreach and education. Tribes in the Portland Area appreciated the $1.5 million MHAF Tribal set-aside in FY 2021. For FY 2022, we request that funding for Minority HIV/AIDS Fund be increased to $80 million with a $15 million Tribal set-aside. This is a step toward addressing the impact that HIV has in Indian Country.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Public Health Infrastructure & Environmental Impacts. COVID–19 has demonstrated the under-investment made by the federal government in public health and medical care infrastructure in the Indian, Tribal, and Urban (I/T/U) health system. The I/T/U system is underfunded, and lacks capacity to respond effectively to public health emergencies like COVID–19. We can no longer allow population density as the primary consideration in the allocation of emergency preparedness resources. In FY 2022, we request at least $1 billion for a Tribal Public Health Emergency Fund established through the Secretary of HHS that tribes can access directly for tribally-declared public health emergencies.

Include Tribes in HIV/HCV Funding Opportunities. HIV/HCV prevention and education generally flows to states via block grants. This leaves many tribes with limited or no resources and forces tribes to compete with states for funding. For FY 2022, we recommend that the Committee set-aside at least $25 million for HIV and HCV prevention for Tribal communities.

Fund Good Health and Wellness in Indian Country (GHWIC). The GHWIC initiative supports AI/AN communities in the implementation of holistic and culturally adapted approaches to reduce and prevent chronic disease through policy, system and environment changes. With COVID–19, tribal communities are more focused than ever on the importance of traditional foods and the nutritional and healing qualities of these food in a time of crisis. Additional funding is needed to address food access issues, food insecurity, and support traditional food and local food system initiatives beyond COVID–19. NPAIHB recommends that the Committee allocate at least $32 million in FY 2022 to the Good Health and Wellness in Indian Country.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid Legislative Initiative. HHS must work with Congress to pass legislation that creates the authority for states to extend Medicaid eligibility to all AI/AN people with household incomes up to 138% of the federal poverty level; authorizes Indian Health Care Providers (IHCP) in all states to receive Medicaid reimbursement for health care services delivered to AI/AN people under IHCIA; extends 100% FMAP to states for Medicaid services furnished by urban Indian providers permanently; excludes Indian-specific Medicaid provisions in federal law from state waiver authority; and removes the limitation on billing by IHCP for services provided outside the four walls of a tribal clinic.

Medicare Telehealth Reimbursement. Medicare telehealth expansion is set to expire at the end of the current public health emergency. Telehealth provided a way to care for our people during the pandemic and should be made permanent to increase access. We request that this Committee support legislation to make Medicare telehealth flexibilities permanent at the OMB encounter rate at I/T/U facilities, expand telephone-only telehealth visits, direct physician supervision of non-physician providers be provided remotely via telephone, and expand "originating site" locations from which telehealth services can be received, and support inclusion of multiple platforms including FaceTime, Zoom, and Skype.

Dental Health Aide Therapists Reimbursement. In Washington, tribes have faced barriers to get the state plan amendment in Washington approved to include dental health aide therapists (DHATs) working in tribal health programs in the Medicaid program. The state and the Swinomish Indian Tribal Community have petitioned the Ninth Circuit Court of Appeals to hear an appeal on the rejection of the Washington State Plan Amendment. Medicaid reimbursement for DHATs is critical to supporting and expanding dental services in tribal communities. We trust that this matter is resolved soon so tribal health programs in Washington can be reimbursed at the OMB encounter rate for these critical services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Provider Relief Fund Uninsured Program. The COVID–19 relief legislation packages exclude Indian Health Care Providers from receiving reimbursement from the Provider Relief Fund Uninsured Programs for uninsured American Indian/Alaska Native people. This exclusion is inconsistent with national Indian policy to elevate the health status of AI/AN people by making all resources available to the Indian health system. We request that the Subcommittee support the following legislative language to address this issue:

SEC. XXX. CLARIFICATION REGARDING INDIANS AND UNINSURED INDIVIDUALS.

Subsection (ss) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as added by section 6004(a)(3)(C) of the Families First Coronavirus Response Act, is amended—(ss) in paragraph (2), by inserting "(except Indians (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) who receive health services funded by the Indian Health Service, shall not be treated as enrolled in a Federal health care program for purposes of this paragraph)" before the period at the end.

Provider Shortages and Needs. The Broken Promises Report, National Tribal Behavioral Health Agenda, National Tribal Budget Formulation Workgroup Recommendations for 2021, and the IHS Strategic Plan all detail how culturally responsive care is critical for the health and well-being of AI/AN people. There are significant vacancy rates and challenges in filling vacancies at I/T/U facilities. Some of these challenges include: the rural location of tribal facilities, lower salaries, lack of incentives, and insufficient housing for providers.

For these reasons, we strongly recommend that the Committee support funding for HRSA, as follows:

—*Increase Tribal Set-Aside for Loan Forgiveness Program.* Increase tribal set-asides for loan forgiveness and include mid-level health care professionals such as Community Health Aide Program providers in the program.

—*Support Community Health Aide Program Expansion.* As IHS is expanding the CHAP program in the lower 48, HRSA must create new funding opportunities that support national CHAP expansion. We recommend $60 million to support CHAP education programs and other implementation activities.

NATIONAL INSTITUTES OF HEALTH

The Native American Research Centers for Health (NARCH) national program has catalyzed multiple tribal-academic partnerships that have resulted in many successful research projects and training opportunities for AI/AN people interested in science and health of AI/AN people. The NPAIHB's NARCH programs have supported and developed countless Native researchers through this program. We request that NARCH be a congressionally mandated funding priority as it supports tribal health research with the development of tribal health leaders to design and implement research that is responsive to tribal needs. In FY 2022, we recommend increased funding for the NARCH program to $20 million and request that 30% of the funding be directed to enhance AI/AN workforce development in parity with priorities of NIH institutes and centers.

Thank you for this opportunity to provide recommendations to the Committee on FY 2022 funding for HHS. We invite you to visit Portland Area Tribes to learn more about the communities, utilization of HHS funding, and health care needs in our Area. We look forward to working with the Subcommittee on our requests.[1]

[1] For more information, please contact Candice Jimenez, cjimenez@npaihb.org.

PREPARED STATEMENT OF THE NURSING COMMUNITY COALITION

As the nation continues to address COVID–19, we recognize how crucial federal investments for the nursing workforce and the nursing pipeline are to our patients and the health of our nation. Given these realities, the Nursing Community Coalition (NCC) respectfully requests that Congress continues robust and bold investment in nursing workforce, education, and research in Fiscal Year (FY) 2022 by supporting at least $530 million for the Nursing Workforce Development programs (authorized under Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] and administered by HRSA), a doubling of Title VIII funding, and at least $199.755 million for the National Institute of Nursing Research (NINR), which aligns with the President's FY 2022 budget and is one of the 27 Institutes and Centers within NIH.

The Nursing Community Coalition is comprised of 63 national nursing organizations who work together to advance health care issues that impact education, research, practice, and regulation. Collectively, the NCC represents Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs),[1] nurse leaders, students, faculty, and researchers, as well as other nurses with advanced degrees. With more than four million nurses throughout the country, the NCC is committed to advancing the health of our nation through the nursing lens.[2] The nursing workforce is involved at every point of care, which is exemplified by nurses' heroic work during the COVID–19 pandemic. Together, we reiterate the bold request for increased funding for Title VIII Nursing Workforce Development programs and NINR, especially during these unprecedented times.

Providing Care to All Americans Through the Nursing Lens

As we continue to confront today's health care challenges and plan for tomorrow, increased federal resources for our nation's current and future nurses are even more imperative. Title VIII programs are instrumental in bolstering and sustaining the nation's diverse nursing pipeline by addressing all aspects of nursing workforce demand. In fact, the Bureau of Labor Statistics projected that by 2029 demand for RNs would increase 7%, illustrating an employment change of 221,900 nurses.[3] Further, the demand for most APRNs is expected to grow by 45%.[4] This is just one example on why continued and elevated investments in Title VIII Nursing Workforce Development Programs in FY 2022 is essential and will help nurses and nursing students have the resources to tackle our nation's health care needs, remain on the frontlines of the COVID–19 pandemic, assist with the distribution and administration of the vaccine, and be prepared for the public health challenges of the future.

Funding for Title VIII is essential, but especially crucial during public health emergencies as these programs connect patients with high-quality nursing care in community health centers, hospitals, long-term care facilities, local and state health departments, schools, workplaces, and patients' homes. A prime example of this is the Title VIII Advanced Nursing Education (ANE) programs. ANE programs support APRN students and nurses to practice on the frontlines and in rural and underserved areas throughout the country. In Academic Year 2019–2020, ANE programs supported more than 8,200 students.[5] Of these students directly supported by the Advanced Nursing Education Workforce (ANEW) program, 75 percent had clinical training sites in primary care settings, while 73 percent of Nurse Anesthetist Trainee (NAT) recipients were trained in medically underserved areas.[6]

Together, Title VIII Nursing Workforce Development programs serve a vital need and help to ensure that we have a robust nursing workforce that is prepared to respond to public health threats and ensure the health and safety of all Americans.

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[1] APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).

[2] National Council of State Boards of Nursing. (2021). Active RN Licenses: A profile of nursing licensure in the U.S. as of February 9, 2021. Retrieved from: https://www.ncsbn.org/6161.htm.

[3] U.S. Bureau of Labor Statistics. (20). Occupational Outlook Handbook-Registered Nurses. Retrieved from: https://www.bls.gov/ooh/healthcare/registered-nurses.htm.

[4] U.S. Bureau of Labor Statistics. (2021). Occupational Outlook Handbook-Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm.

[5] Department of Health and Human Services Fiscal Year 2022 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. Pages 153–158. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf.

[6] Department of Health and Human Services Fiscal Year 2022 Health Resources and Services Administration Justification of Estimates for Appropriations Committees. Pages 153–155. Retrieved from: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf.

The Nursing Community Coalition respectfully requests at least $530 million for the Title VIII Nursing Workforce Development programs in FY 2022.

Improving Patient Care Through Scientific Research and Innovation

For more than thirty years, scientific endeavors funded at the National Institute of Nursing Research (NINR) have been essential to advancing the health of individuals, families, and communities. Rigorous inquiry and research are indispensable when responding to the ever-changing healthcare landscape and healthcare emergencies, such as COVID–19. From precision genomics to palliative care and wellness research to patient self-management, NINR has been at the forefront of evidence driven research to improve care.[7] It is imperative that we continue to support this necessary scientific research, which is why the Nursing Community Coalition respectfully requests at least $199.755 million for the NINR in FY 2022.

Now, more than ever, it is vital that we have the resources to meet today's public health challenges, such as COVID–19. Investing in Title VIII Nursing Workforce Development programs and NINR are essential to meeting that need. By providing bold funding for Title VIII and NINR, Congress can continue to reinforce and strengthen the foundational care nurses provide daily in communities across the country. Thank you for your support of these crucial programs.

60 Members of the Nursing Community Coalition Submitting this Testimony

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
Academy of Neonatal Nursing
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Heart Failure Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Association of Post-Acute Care Nursing
American College of Nurse-Midwives
American Nephrology Nurses Association
American Nurses Association
American Nursing Informatics Association
American Organization for Nursing Leadership
American Pediatric Surgical Nurses Association, Inc.
American Public Health Association, Public Health Nursing Section
American Psychiatric Nurses Association
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses
Association for Radiologic and Imaging Nursing
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of Pediatric Hematology/Oncology Nurses
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Rehabilitation Nurses
Association of Veterans Affairs Nurse Anesthetists
Association of Women's Health, Obstetric and Neonatal Nurses
Chi Eta Phi Sorority, Incorporated
Commissioned Officers Association of the U.S. Public Health Service
Dermatology Nurses' Association
Emergency Nurses Association
Friends of the National Institute of Nursing Research
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
International Association of Forensic Nurses
International Society of Psychiatric-Mental Health Nurses
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses

[7] National Institutes of Health, National Institute of Nursing Research. The NINR Strategic Plan: Advancing Science, Improving Lives. Pages 4, 10 Retrieved from https://www.ninr.nih.gov/sites/www.ninr.nih.gov/files/NINR__StratPlan2016__reduced.pdf.

National Association of Neonatal Nurse Practitioners
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Black Nurses Association
National Council of State Boards of Nursing
National League for Nursing
National Nurse-Led Care Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Oncology Nursing Society
Organization for Associate Degree Nursing
Pediatric Endocrinology Nursing Society
Preventive Cardiovascular Nurses Association
Society of Pediatric Nurses
Society of Urologic Nurses and Associates
Wound, Ostomy, and Continence Nurses Society

[This statement was submitted by Rachel Stevenson, Executive Director, Nursing Community Coalition.]

PREPARED STATEMENT OF THE NUTRITION & MEDICAL FOODS COALITION

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—NMFC joins the research and patient advocacy community in requesting $46.1 billion in discretionary funding for the National Institutes of Health (NIH), an increase of $3.2 billion over FY 2021.
—Further, NMFC requests proportionate increases for all NIH Institutes and Centers, including the Office of the Director (which now houses the Office of Nutrition Research), to reflect the vast array of applications for medical foods and nutrition to address a variety of health conditions through ongoing scientific inquiry and advancement.
—The Coalition joins the broader public health community in requesting $10 billion in overall funding for the Centers for Disease Control and Prevention (CDC) to reinvigorate meaningful professional education, public awareness, and public health activities.
—The community encourages ongoing outreach through the annual appropriations process to address systemic (and often arbitrary) barriers that obstruct proper patient access to medical foods including directing HHS and FDA to administer public health programs and regulations where medical foods are classified as prescription medical products intended for the dietary management of unmet needs.

Chairwoman Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee: thank you for the opportunity to submit testimony on behalf of the Nutrition and Medical Foods Coalition (NMFC). We strongly support emerging efforts to modernize the medical foods category and enhance patient access, such as establishing the Office of Nutrition Research within the Office of the NIH Director, and the 2018 National Academies workshop on distinct nutritional requirements. As you work with your colleagues on appropriations for FY 2022, please continue to invest in medical research and public health programs to improve coverage and access for patients in need of medical foods. Medical foods provide important clinical product alternatives when drugs are not effective or well tolerated. Consistent with the establishment of the medical foods regulatory category in the Orphan Drug Act amendments of 1988, increasing medical research and expanding the reimbursement of medical food products from the hospital-only environment to retail pharmacies through Medicare, Medicaid, TRICARE, and medical insurance for federal employees, would enable the use of medical foods to address unmet medical needs and support scientific innovation providing clinical options to physicians as they work to manage national public health issues such as the Opioid Crisis, genetic disorders, and the increasing incidences of chronic diseases and conditions associated with aging like depression, osteoarthritis, IBS, and Alzheimer's. This could, in-turn, manage disease progression and lower national healthcare costs. Thank you for your time and please consider the Coalition a resource.

ABOUT THE COALITION

NMFC is a collaborative, multi-stakeholder effort to promote and advance proper use of safe and effective medical foods. Medical foods occupy a unique niche in healthcare and are used to manage many rare and chronic conditions for patients with unmet medical needs. NMFC is committed to educating policymakers and the general public about the role of medical foods in the healthcare ecosystem, while advancing an agenda focused on increasing medical research, improving regulation and oversight, and increasing access through appropriate insurance coverage and reimbursement.

The Coalition actively supports legislative efforts to address coverage and access, such as the Patient Access to Medical Foods Act (H.R. 56), Medical Nutrition Equity Act, and similar legislation. In this regard, NMFC calls on legislators to ensure that any updates to medical foods coverage:

—Maintains the integrity of the current (aforementioned) definition for the category.

—Does not arbitrarily carve out specific patient communities for coverage while leaving other communities (including patients without digestive or metabolic disorders) behind.

—Provides comprehensive coverage and adequate access to facilitate reasonable outpatient access to medical foods so there is health insurance pharmacy reimbursement in addition to historical access that exists through hospitals.

Moving forward, federal medical research and public health programs can play a key role in informing coverage and access updates while educating patients and providers about innovative (often cost-effective) healthcare options.

ABOUT MEDICAL FOODS

As defined by the Orphan Drug Act of 1988, a medical food is, "a food which is formulated to be consumed or administered enterally under the supervision of a physician, and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation."

Currently, patients in need of medical foods face significant coverage and access barriers often stemming from a lack of awareness of these products and their unique role in the healthcare system. Reimbursement access is grounded in federal and private insurance pharmacy benefit plans often categorically denying coverage of medical foods through pharmacies as a policy matter while they generally reimburse under medical benefits in hospitals. This often results in patients being denied access to nutritional therapies which are necessary alternatives to drugs that are ineffective or not well tolerated. The Food and Drug Administration (FDA) regularly intervenes to provide guidance on medical foods, including through a recent episode where products were mislabeled as Over-The-Counter on massive level, but these interventions are inconsistent at best and often do not resolve underlying coverage issues.

PERSPECTIVE OF CINDY STEINBERG, US PAIN FOUNDATION

One example of important innovation in medical foods is in the area of chronic pain, a highly prevalent yet challenging condition to treat. The CDC has reported that 19.6 million Americans live with high-impact chronic pain resulting from a multitude of serious diseases, conditions and injuries that affects their ability to function on a daily basis. Indeed, chronic pain is the number one cause of disability in the US and globally.

There are few truly effective treatment options and most of these come with difficult side effects, safety concerns or other risks. Opioids do help some with severe pain but carry significant risks when diverted to those with substance abuse disorder. Non-steroidal anti-inflammatory (NSAIDs) medications are widely prescribed but, due to risks of heart attack, stroke and gastrointestinal bleeding are contraindicated for many, especially those with multiple chronic conditions. Acetaminophen has limitations due to insufficient pain relief and liver damage at doses high enough to alleviate serious pain for some. Moreover, federal agencies and the broader stakeholder community have been actively working over recent years to identify non-opioid options for pain management.

Medical foods have been found to fill a need for pain relief for individuals with certain chronic conditions such as osteoarthritis. Medical foods are generally safe products that can address conditions such as pain without causing other side effects. Distinct from both drugs and supplements, medical foods must be used under the supervision of a medical professional. Lack of awareness about medical foods as an

emerging, cost-effective treatment option for certain pain conditions amongst healthcare providers and insurers have limited their use. Improving research and coverage for medical foods would offer patients another option, particularly those with multiple chronic conditions and unmet medical needs.

Recommendation:

Please include timely committee recommendations on medical foods research at NIH, like the example below, to sustain progress in this area. Please also work with your colleagues to engage HHS in a productive dialogue and otherwise seek out opportunities to improve coverage and access for patients in need of reliable access to medical foods. Thank you for your time and for your consideration of our request.

RECOMMENDED REPORT LANGUAGE

NATIONAL INSTITUTES OF HEALTH

OFFICE OF THE DIRECTOR

Office of Nutrition Research [ONR].—The Committee applauds NIH for recent efforts to move the Office of Nutrition Research to the Office of the Director in recognition of the fact that scientific progress in nutrition and medical foods now has applications to a variety of health topics and conditions beyond diet and metabolism. NIH is encouraged to continue to advance cross-cutting research through ONR, including timely applications for a variety of conditions, such as innovative strategies and alternative therapeutic products for pain management.

[This statement was submitted by P. Keith Daigle, Acting Director, Nutrition & Medical Foods Coalition.]

PREPARED STATEMENT OF ONE VOICE AGAINST CANCER

One Voice Against Cancer (OVAC) is a broad coalition of public interest groups representing millions of cancer patients, researchers, providers, survivors, and their families, delivering a unified message to Congress and the White House on the need for increased funding for cancer research and prevention priorities.

2021 is the 50th Anniversary of the National Cancer Act and it provides a unique opportunity to renew the country's commitment and bring new urgency to the fight against cancer. Although we have made much progress against cancer in the past half-century, more funding is needed to meet the overwhelming demand for research grants at the National Cancer Institute (NCI), address cancer health disparities, and mitigate the impacts of COVID–19 on cancer research, clinical trials, and patient screenings and treatment. For fiscal year (FY) 2022, we are asking that Congress fund the National Institutes of Health (NIH) at $46.111 billion, including $7.6 billion for the NCI. We are also asking that the Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC) receive $559 million.

There is much to celebrate in the fight against the hundreds of diseases we call "cancer." The cancer death rate rose during most of the 20th century, but federal investments in cancer research and prevention have resulted in a continuous decline in the cancer death rate since its peak in 1991. From 1991 to 2018, the cancer death rate fell 31 percent. However, cancer is still the second most common cause of death in men and women in the U.S. In 2021, almost 1.9 million new cancer cases will be diagnosed, and more than 600,000 people will die from cancer. Approximately $183 billion was spent in the U.S. on cancer related health care in 2015, and this amount is projected to grow to $246 billion by 2030-an increase of 34 percent.

Cancer is a disease that affects everyone, but it doesn't affect everyone equally. A close look at cancer incidence and mortality statistics reveals that certain groups, such as African Americans, Asian Americans, Hispanics/Latinos, Native Americans, Alaska Natives, Native Hawaiians/Pacific Islanders, and rural populations are more likely than the general population to suffer from cancer and its associated effects, including premature death. For instance, the death rate for Black men with prostate cancer is more than double that of men in every other population. Black women have a 40 percent higher breast cancer death rate than white women, even though their diagnosis rates are slightly lower.

There are still some cancers for which survival rates are dismally low with few, if any, effective treatments. In 2021, approximately 44 percent of patients will be diagnosed with a cancer that has a five-year survival rate below 50 percent. Research is critical so we can develop additional treatments and tools to ensure more Americans survive a cancer diagnosis.

Additionally, the NCI reports that we may see a rise in cancer mortality rates for the first time in almost 30 years because of the impacts from COVID–19. The COVID–19 pandemic has led to reduced access to care for cancer patients, including delays in cancer screening, diagnosis, and treatment. These delays will likely lead to a rise in late-stage diagnoses and cancer deaths in the years to come.

For the last 50 years, every major medical breakthrough in cancer can be traced back to the NIH and NCI. We know that investment in research at the NIH and NCI leads to lives saved. Additionally, more than 80 percent of federal funding for the NIH and NCI is spent on biomedical research projects at research facilities across the country. In FY 2020, the NIH provided over $34.6 billion in extramural research to scientists in all 50 states and the District of Columbia. NIH research funding also supported more than 536,000 jobs and more than $91 billion in economic activity last year.

COVID–19 and Cancer Research and Clinical Trials:

The Committee should be aware of the ongoing impact of COVID–19 on the cancer research ecosystem, including clinical trials. Thousands of researchers working on new discoveries that may one day alter the way we treat cancer had their projects disrupted, leading to increased costs and in some cases, having to restart research projects, losing data and productivity in the process.

COVID–19 has had serious consequences for cancer clinical trials, which play a pivotal role in advancing cancer care and treatment. The results of clinical trials and the broader drug development process can take years to realize, meaning that without aggressive measures to mitigate the impact, the full effect of these disruptions on therapeutic innovation in cancer care is likely to be felt for years to come. Not only are cancer clinical trials critical in the over-all research and progress against the disease, for individual cancer patients, clinical trials often provide the best, and sometimes only, treatment option available.

We therefore urge Congress to provide the NIH with at least $10 billion to restore the research ecosystem so we can continue to make progress in the fight against cancer and other diseases. We hope that members of the Subcommittee can work with their colleagues to ensure this issue is addressed outside the usual appropriations process.

ARPA–H:

We understand that President Biden has called for the creation of an Advanced Research Projects Agency-Health (ARPA–H) as a key component to "drive transformational innovation in health research" to deliver cures for cancer and other diseases. Based upon available information, the initiative is likely to have twin focus areas: transformation of research and speeding application and implementation of breakthroughs in health care, where the current model has failed to deliver medical advancements. The President has spoken about the initiative and has included a $6.5 billion proposal in the his FY2022 budget, but few other details have emerged.

We in the cancer community are excited by a new initiative that focuses separate and additional resources on the development of new diagnostics, treatments, and even cures for cancer. However, we also know that clinical advances for patients have to be built on a broad foundation of basic scientific understanding.

Therefore, OVAC recommends that funding for ARPA–H remain separate from the established research enterprise and that Congress works to ensure that base funding for cancer research at the NCI is increased at a sustained, appropriate rate that ensures the pace of discovery is maintained.

OVAC Priorities for Fiscal Year 2022:

The NCI is currently experiencing a demand for research funding that is far beyond that of any other Institute or Center (IC). Between FY 2013 and FY 2019, the most recent year for which data are available, the number of Research Project Grant (R01) applications to NCI rose by 50.6 percent. For all other ICs during that time, the number of R01 applications rose by just 5.6 percent.

As a result of this extraordinary demand from the scientific community, the RPG success rate at NCI dropped from 13.7 percent in FY 2013 to 11.6 percent in FY 2019. This is a situation unique to NCI, at a time when cancer researchers are making historic advances in new treatments and therapies. The overall success rate for NIH during that same period rose from 16.8 percent to 21.2 percent.

Thanks to bipartisan, bicameral leadership, Congress has increased funding for NIH by $12.9 billion over the past six years. We are especially grateful that Congress has highlighted the need for dedicated funding to address the precipitous decline in the success rate for R01 applications at NCI. Significant, sustained funding increases for NCI are essential to raising the R01 success rate and ensuring progress in the fight against cancer continues.

Therefore, OVAC recommends at least $46.111 billion for NIH in FY 2022, a $3.177 billion increase over the comparable FY 2021 funding level, which would allow the NIH's base budget to keep pace with the biomedical research and development price index and provide meaningful growth of 5 percent. For NCI, we recommend $7.609 billion, the amount proposed by NCI in its FY 2022 professional judgment budget.

Preventing cancer is also critically important. About half of the over 600,000 cancer deaths that will occur this year could be averted through the application of existing cancer control interventions. The CDC's DCPC provides key resources to states and communities to prevent cancer by ensuring that at-risk, low-income communities have access to vital cancer prevention programs.

COVID–19's impact on screening and the early-detection of cancer will exacerbate current barriers to cancer prevention and early detection strategies, potentially increasing disparities in overall cancer outcomes. Additionally, addressing the backlog of cancer screenings for those without adequate health coverage will place a new burden on existing cancer screening programs, which have long been underfunded. CDC's programs help ensure that Americans have options for cancer screening regardless of income or insurance status. Increased investment in the equitable application of existing cancer control interventions as spearheaded by CDC's DCPC will accelerate progress in the fight against cancer. For this reason, OVAC recommends $559 million overall for DCPC, an increase of $173.1 million over the FY 2021 level.

Once again, thank you for your continued leadership on funding issues important in the fight against cancer. Funding for cancer research and prevention, survivorship, and must continue to be top budget priorities in order to increase the pace of progress in the fight against cancer.

Below please find an overview of OVAC's program level requests in the Labor-HHS bill:

National Institutes of Health (NIH)—$46.111 billion, including:
—National Cancer Institute (NCI): $7.609 billion
—National Institute on Minority Health and Health Disparities (NIMHD): $419.8 million
—National Institute on Nursing Research (NINR): $187.9 million

Centers for Disease Control and Prevention (CDC) Cancer Programs—$559 million, including:
—National Comprehensive Cancer Control Program: $50 million
—National Program of Cancer Registries: $70 million
—National Breast and Cervical Cancer Early Detection Program: $275 million
—Colorectal Cancer Control Program: $70 million
—National Skin Cancer Prevention Education Program: $5 million
—Prostate Cancer Awareness Campaign: $35 million
—Ovarian Cancer Control Initiative: $13 million
—Gynecologic Cancer and Education and Awareness (Johanna's Law): $15 million
—Cancer Survivorship Resource Center: $900,000

Health Resources and Services Administration (HRSA)
—Title VIII Nursing Programs: $270 million

Prepared Statement of the Pandemic Action Network

On behalf of the Pandemic Action Network—a network of over 100 organizations that work together to drive collective action to help bring an end to COVID–19 and ensure the world is prepared for the next pandemic—I am pleased to offer testimony for Fiscal Year 2022 Labor, Health, and Human Services Appropriations.

To ensure the United States heeds the lessons learned from COVID–19 and helps ensure the world sustainably prioritizes and invests in pandemic preparedness, we respectfully urge you to increase funding to the U.S. Centers for Disease Control and Prevention (CDC) overall and bolster its critical role in promoting global health security; support permanent, dedicated funding for the Biological Advanced Research and Development Authority's (BARDA) work in emerging infectious diseases; and ensure the U.S. government contributes to global R&D efforts by strengthening the Coalition for Preparedness Innovations (CEPI). Specifically, Pandemic Action Network calls on the Committee to prioritize the following investments for FY22:
—No less than $456.4m for CDC's Center for Global Health Division of Global Public Health Protection and $226m for the Global Immunization Division;
—No less than $10m for CDC's Global Water, Sanitation & Hygiene program;
—No less than $735m for CDC's Center for Emerging Zoonotic and Infectious Diseases;

—No less than $300m in CDC's Infectious Disease Rapid Response Fund
—No less than $300m for BARDA's work on Emerging Infectious Diseases
—No less than $200 million support US investment in and partnership with the Coalition for Epidemic Preparedness Innovation (CEPI), in collaboration with BARDA

The COVID–19 pandemic has laid bare the grave health and socio-economic consequences of repeated failures to prioritize and invest in health security and pandemic preparedness both at home and abroad. The pandemic has already cost over 580,000 lives in the United States and 3.4 million around the world. The International Monetary Fund projects it will cost the global economy at least $22 trillion. While vaccination efforts have begun to dramatically reduce COVID–19 transmission in the U.S., the pandemic continues to spread globally as a majority of the world's population still lacks access to vaccines and other lifesaving tools and new variants of the virus continue to emerge. Until the virus is controlled around the world, Americans will not be safe and our domestic recovery will continue to stall.

The COVID–19 pandemic was an avoidable disaster. Partners in our network and infectious disease experts had been warning for decades of the threat of a fast-moving respiratory virus pandemic. Yet a persistent culture of panic and neglect, has prevented forward-looking and long-term investments in global health security. U.S. leadership and international cooperation is essential both to end this pandemic and to prepare for the next one. CDC, BARDA, and other agencies across the Department of Health and Human Services have a critical role to play to keep both Americans and the world safe—but they must be appropriately, and sustainably, resourced. The Pandemic Action Network urges this committee and Congress to break this dangerous cycle once and for all and commit to increased—and sustained—investments in pandemic preparedness in Fiscal Year 2022 and beyond.

CDC:

The CDC comprises an essential piece of the U.S. and global health security architecture—by serving as the steward of U.S. public health and by partnering with countries to build and maintain their capacities to detect, prevent, and respond to emerging disease threats.

The Division of Global Public Health Protection (DGHP) works to protect Americans from dangerous health threats around the world and has been vital in the global fight against COVID–19. Graduates of its Field Epidemiology Training Program, a program to train disease detectives around the world, have been supporting COVID–19 responses in their countries through disease detection and rapid response, as well as data analysis, contact tracing, and community outreach. DGHP's Global Rapid Response Team has deployed more than 500 deployments for a total of nearly 16,000 person-days, to assist with COVID–19 emergency response at home and abroad. In a world where pandemic threats are growing in frequency, this critical work needs to be resourced and upscaled.

Many other divisions and programs within CDC are also critical to fighting deadly outbreaks and strengthening global health security, including the Global Immunization Division of the Center for Global Health, the Global Water, Sanitation & Hygiene program, the Center for Emerging Zoonotic and Infectious Diseases, and the Infectious Disease Rapid Response Fund. All have been routinely underfunded relative to their vital roles in protecting American and global health and deserve funding commensurate with their increasing demand and value.

BARDA:

BARDA has been playing an important and unmatched role in accelerating the development of medical countermeasures for emerging infectious diseases, including for Ebola, Zika, and pandemic influenza. The authority partners with industry on late-stage research and development, bridging the "valley of death" between clinical research and product development to translate basic science into urgently needed medical tools and technologies—where few entities operate.

Yet BARDA's work to combat COVID–19 and advance innovations for other emerging and neglected infectious diseases has largely been financed through emergency supplemental funding. This means that only when a disease crisis strikes does BARDA get the go-ahead and funding to advance countermeasures. Decades of research in health R&D laid the groundwork for the accelerated COVID–19 vaccine development—and humanity was lucky that we could build on progress in SARS and mRNA platforms. Emergency, surge funding is not a viable solution for pandemic prevention or preparedness: in many cases it is not even a solution for pandemic response. Annual, targeted funding for emerging infectious disease R&D will enable BARDA to work proactively to counter infectious disease threats so that

we are prepared, and not caught flat footed when the next dangerous outbreak happens.

CEPI:

This Committee should also prioritize BARDA's partnership with CEPI, which has played a critical role in the COVID–19 response. Scientific partnership, collaboration, and resource sharing between BARDA and CEPI is critical to leverage their respective strengths and resources, and to promote the development of infectious diseases tools that can be rapidly deployed in a diverse array of settings. The U.S. should be a leading partner in supporting CEPI's new five-year plan of action with an annual appropriation of at least $200 million.

Just as the U.S. military is routinely resourced and prepared to fight a current war while getting ready for the next one, so too should Congress ensure that our civilian health infrastructure is equipped to fight this pandemic and prepare for the next one. We should commit the funds necessary to deploy a robust global response to the evolving COVID–19 pandemic while simultaneously make strong, sustainable, and ultimately cost-effective investments in future pandemic preparedness and prevention—lest we risk repeating the cycle of panic and neglect that spawned this protracted global emergency. Additional and sustained investments in CDC, BARDA, and CEPI are vital to America's health and security and warrant Congress's strong and unwavering support.

PREPARED STATEMENT OF PATH

This testimony is submitted by Jenny Blair on behalf of PATH, an international nonprofit organization that drives transformative innovation to save lives and improve health in low- and middle-income countries. PATH is appreciative of the opportunity afforded by Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to submit written testimony regarding fiscal year (FY) 2022 funding for global health programs within the US Department of Health and Human Services (HHS). PATH acknowledges and appreciates the strong leadership the Committee has shown in supporting HHS' work in this area—especially given the current pandemic—and we recommend that support continue. Therefore, we respectfully request that this Subcommittee provide no less than the FY21 enacted level of $593 million to the Center for Global Heath (CGH) at the Center for Disease Control and Prevention (CDC) to sustain programming and replenish funds that have been diverted for the COVID–19 response that were intended for global immunization, malaria, global health security, and research and development (R&D). Within CGH, we specifically support increases for CDC's Division of Global Health Protection, which should be increased from $203.2 million to at least $456.4 million to bolster capacity to prevent, detect, and rapidly respond to emerging diseases—including the current COVID–19 pandemic—in low- and middle-income countries. We also support an additional $300 million for the Infectious Disease Rapid Response Fund, $30 million for CGH's Division of Parasitic Diseases and Malaria, and $271.1 million for the Global Immunization Division—of which $211.2 million should allocated to polio eradication and $60 million for measles. This funding allows CDC to save lives, reduce disease, prevent and detect future pandemics, and improve health around the world.

The Vital Role of HHS in Global Health and Security

PATH applauds Congressional appropriators for the global health funding that has been provided in four supplementals—the Coronavirus Preparedness and Response Supplemental, the CARES Act, the Coronavirus Response and Relief Supplemental Appropriations Act of 2021, and the American Rescue Plan Act of 2021—over the last year. COVID–19 has reached every country in the world, crippling economies, overwhelming health care systems, filling hospitals, dwindling supplies, and emptying public spaces. While we are beginning to see the end of the pandemic here in the United States, countries such as India and Brazil are still heavily impacted. With the potential for emergence of vaccine-evading strains, COVID–19 will continue to threaten global health security as long as it is uncontrolled anywhere in the world.

Investments that help contain diseases at the source are some of the most effective and important the US government can make. US investments through the CDC have been used to train epidemiologists, engage affected communities, improve disease detection and tracking systems, build Emergency Operations Centers (EOCs), and upgrade laboratories. Such efforts have allowed partner countries to greatly shorten their response times to outbreaks and epidemics—for example, enabling

Cameroon to shorten its response timeline from 8 weeks to 24 hours. Many of the US's partner countries have deployed these systems for their COVID–19 response.

The ongoing threat that COVID–19 and other infectious diseases pose to the health, economic security, and national security of the United States demands dedicated and steady funding for global health security. We must invest not only to end the current pandemic, but also to ensure that we are better prepared for the next one.

Protecting the US Through Leadership in Global Health Research and Development

The ongoing COVID–19 pandemic is a clear call for investment in America's capacity to rapidly develop and deploy new technologies that can prevent, detect, and treat emerging global health threats. The US leads the world in R&D for tools that solve some of humanity's most pressing health problems. The annual G-Finder report from Policy Cures Research estimates that in 2018, the US contributed $1.718 billion through the National Institutes of Health (NIH) and $30 million through CDC toward the development of global health products.

In the current pandemic, support through NIH and the Biomedical Advanced Research and Development Authority (BARDA) helped speed the development and manufacturing of vaccines to prevent COVID–19, including through partnerships Janssen Research & Development, part of Johnson & Johnson, as well as Moderna. Under Operation Warp Speed, BARDA pivoted existing programs for pandemic influenza and other threats to accelerate the development of new vaccines, therapeutics, and diagnostic tests.

However, as a nation we have failed to sustain investment in a suite of technologies that will help us respond to the disease threats most likely to impact Americans and populations around the globe. For example, development of a promising SARS vaccine was halted in 2016 due to lack of funding—only to be re-started after the spread of COVID–19. Congress must ensure that the US is making sustained smart investments for just-in-case development and just-in-time delivery of the tools we will need for the most likely threats to human health.

Today more than ever, the US is at the forefront of global health innovation because of long-term investment in NIH, CDC, and BARDA. To accelerate progress toward lifesaving tools for a range of health threats, we call for: maintaining robust funding for NIH and particularly for the National Institute of Allergy and Infectious Diseases (NIAID) and the Fogarty International Center; providing funding to match CDC's increased responsibilities in global health and security for the Center for Global Health and the National Center for Emerging Zoonotic and Infectious Diseases; and supporting BARDA's work in emerging infectious diseases.

As a complement to continued investment in BARDA and NIH, the US should invest in the Coalition for Epidemic Preparedness Innovations (CEPI) which is working to advance at least twelve COVID–19 vaccine candidates. Investment in CEPI would allow the US to leverage funding from other global donors and ensure the US can influence the impact and outcome of CEPI's efforts. A US contribution to CEPI would leverage the contributions of other donors to increase overall pandemic preparedness and response effectiveness, including the potential to help increase the effectiveness of vaccines already being used in the United States.

Successful implementation of these components requires urgent coordination across agencies and strategic investments. Congress should monitor progress on investments in emerging technologies and medical countermeasures, as well as the integration of R&D into federal planning including facilitating policies and incentives across interagency R&D efforts.

Immunization Programs During COVID–19 and Beyond

HHS is also achieving complementary global health and security goals through investment in immunization, with most vaccine delivery activities overseen by CDC's Global Immunization Division. Vaccines are among the most high-impact and cost-effective tools available today to combat infectious disease threats; many vaccine-preventable diseases were once global pandemics much like COVID–19. This pandemic is a stark reminder of how fast an outbreak can spread without a vaccine to protect us. Thanks to immunization, outbreaks of childhood diseases such as polio, measles, diphtheria, and pertussis are preventable, and communities are protected from some of the most infectious and lethal pathogens.

Immunization programs prevent an estimated 2.5 million deaths each year among children under the age of five worldwide; these programs also bolster local health systems and enable better disease detection. However, the COVID–19 pandemic has severely disrupted global immunization programs and continues to threaten achievement of critical global goals, such as polio eradication. Of the 129 countries able to report routine immunization data at the outset of the pandemic last year, over half

reported moderate to total disruption of immunization services. Of the 26 countries that were forced to suspend measles immunization campaigns due to the pandemic, 18 reported measles outbreaks by July of last year, according to data available in November 2020. Suspended campaigns put 94 million people at risk of missing measles vaccinations in 2020. The Global Measles and Rubella Laboratory Network (M&RI), for example, has been repurposed to provide laboratory space, equipment, staff, and reagents for COVID–19 diagnostic testing, and measles immunization staff supported by M&RI are being called on to support COVID–19 responses in many vulnerable countries. These same systems and infrastructure will be essential to ensuring COVID–19 vaccines are distributed equitably.

Even before the COVID–19 pandemic, vaccines for measles, polio, and other diseases were out of reach, on an annual basis, for 20 million children under the age of one. Worldwide, more than 10 million children below the age of one do not receive any vaccines at all, many of whom live in countries with weak health systems. Given these difficulties, the disruption to immunization programs caused by COVID–19 could leave pathways open to disastrous outbreaks in 2020 and future years and will increase imported cases of measles and other vaccine preventable diseases into the US. As health care continues to be disrupted globally, maintaining strong US support for global vaccination efforts—including key goals such as polio eradication, which we are on the brink of achieving—is critical to preventing needless deaths.

Fighting to Eliminate Malaria

The CDC plays a critical role in the fight against malaria, as co-implementer of the President's Malaria Initiative (PMI)—alongside the US Agency for International Development—as well as through its Parasitic Diseases and Malaria program. These programs provide crucial technical assistance, with a focus on monitoring, evaluation, and surveillance, as well as operational and implementation research, including serving as an evaluation partner in the large-scale pilot implementation of the RTS,S malaria vaccine in Kenya (one of three African countries involved). Malaria prevention and treatment programs have prevented more than seven million deaths globally since 2000. Sustained US commitment made this progress possible.

The World Health Organization estimates that nearly half the world's population lives in areas at risk of malaria-there were an estimated 229 million cases and 409,000 deaths from the disease in 2019 alone. Disruptions of essential health services due to the COVID–19 pandemic are having a catastrophic impact on the most vulnerable communities worldwide, threatening our progress against malaria. According to the Global Fund, in Africa malaria diagnosis and treatment has fallen roughly 15 percent during the pandemic and more than 20 percent of facilities have reported stockouts of medicines for treating children under five. In Asia, diagnosis and treatment has fallen almost 60 percent due to COVID–19, and 37 percent of facilities have reported COVID–19 infections amongst their health workers.

To reduce the pressure that COVID–19 is exerting on health systems, it is critical that we continue to deliver malaria interventions at the community level. As PMI has expanded, CDC's mandate has grown, but its budget for malaria has remained stagnant. In FY 2022, Congress should fully fund PMI and increase funding for the CDC Division of Parasitic Diseases and Malaria (DPDM) program from $26 million to $30 million, to better track, treat, and test for malaria, and to ensure these services continue in the midst of a global health crisis.

An Investment in Health, at Home and Around the World

With strong funding for global health programs within HHS, the department will be able to improve access to proven health interventions in the communities where they are needed most, as well as respond to the ongoing threat of COVID–19. By fully funding global health and BARDA accounts, the US can prevent the further spread of disease, protect the health of Americans, and minimize the impact of COVID–19 on vulnerable populations worldwide.

[This statement was submitted by Jenny Blair, Manager, US & Global Policy and Advocacy, PATH.]

PREPARED STATEMENT OF PATIENT SERVICES, INC.

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

PSI joins the broader patient advocacy community in requesting:

—$46.1 billion in discretionary funding for the National Institutes of Health (NIH), an increase of $3.2 billion over FY 2021.
  —Please provide proportional funding increases for the various NIH Institutes and Centers to expand and advance condition-specific research portfolios.
—$10 billion in overall funding for the Centers for Disease Control and Prevention (CDC) to bolster public health activities.
  —Please provide the new CDC Chronic Disease Education and Awareness Program with $5 million, an increase of $3.5 million over FY 2021, to further advance and expand timely public health efforts with community stakeholders.
—$9.2 billion for the Health Resources and Services Administration (HRSA) and $500 million for the Agency for Healthcare Research and Quality (AHRQ).
—PSI joins the broader patient advocacy community in requesting that the subcommittee continue to use the annual appropriations process, spending bills, and corresponding committee reports, to advance efforts that improve coverage and access for patients in need, including restoring equitable access to third party assistance offered by reputable charities.

Chairwoman Murray, Ranking Member Blunt, and distinguished member of the Subcommittee, thank you for your leadership on health funding and patient care issues. I am Gwen Cooper, and I look forward to working with you as the CEO of PSI. We share a goal of improving the lives of patients and families impacted by rare, chronic, and life-threatening illness. In this regard, thank you for your ongoing efforts to invest in medical research, public health, and patient care programs. For FY 2022, please maintain this investment while continuing to utilize the appropriations process to highlight systemic issues and resolve contemporary coverage and access issues facing patients.

ABOUT PSI

PSI is a national nonprofit charitable assistance program with over 30 years' experience assisting patients in obtaining healthcare coverage and needed care and therapies. Founded by a patient for patients, we know the challenges of chronic illness. We help pay for medications, health insurance premiums and copays, navigate health insurance plans, provide free legal services, and walk alongside patients and their families through every step of their healthcare journey. Over the last ten years, we have had the privilege of providing over $800 million in financial assistance to help people obtain the healthcare they so desperately need. In 2020 alone, nearly 15,000 patients from every state across the nation benefitted from $56 million in financial assistance from PSI. We are honored to do the important work of breaking down barriers to healthcare access and payment options so that patients with rare and chronic diseases can focus on living their best lives.

ABOUT CHARITABLE ASSISTANCE

Patient assistance charities, like PSI, primarily raise private donations to provide health insurance premium assistance; pharmacy and treatment costs, as well as travel, nursing and ancillary services. Our programs help patients who are uninsured and underinsured in the commercial market, and beneficiaries of public insurance coverage like Medicare, Medicaid and TRICARE. PSI bridges the gaps in health coverage for families by providing premium assistance for:

—Medicare beneficiaries for Medicare Part D plans,Medicare Advantage plans and Medigap Plans.
—Patients during the 24-month waiting period for Medicare when qualified for Social Security Disability.
—Patients who no longer qualify for the Medicaid program because of age or income.
—Those who lose employer sponsored coverage through COBRA plans and plans through the Marketplace. In 2020, over 16M Americans lost their employer sponsored healthcare. PSI helped patients secure new plans for coverage lifesaving treatments.

When a patient turns to PSI, they often already have a doctor, and health plan, and a course of therapy. PSI simply assists them with the costs to maintain cov-

erage and access, based on financial need and other factors. For patients with life-threatening conditions, who wish to continue working while managing their conditions, and those who do not qualify for disability or need-based federal programs, maintaining access to life-sustaining care is absolutely critical and few reliable options exist without compassionate charitable assistance. Most patients with rare and chronic diseases do not automatically quality for disability, nor do they want to. They wish to continue living their most productive lives through continued access to treatments required to manage their illness.

CONTEMPORARY EXAMPLES OF "BACKDOORS" TO PRE-EXISTING CONDITION DISCRIMINATION

Third Party Payer

Center for Medicare and Medicaid Services (CMS) has discouraged insurers from accepting payments from third party payers, including organizations like PSI and other nonprofit patient assistance programs (PAPs). This results in severe economic hardships for patients.

In November of 2013, CMS published a Frequently Asked Questions (FAQ) document which discouraged health insurers from accepting payments from third party payors on behalf of enrolled individuals. This FAQ document was CMS' response to reported concerns, by insurers, that accepting payments from someone other than the insured could skew the insurance risk pool and create an unlevel field in the Exchanges.

A subsequent 2014 CMS FAQ document clarified that CMS had not intended to discourage insurers from accepting third party premium and cost-sharing payments from state and federal government programs, Indian tribes, tribal organizations, and urban Indian organizations.

However, insurers were still discouraged from accepting third party payments from any other organizations, including PAPs and other charitable organizations, such as churches. This creates significant barriers to care for many patients who deal with recurring costs and chronic illnesses.

Copay Accumulators

CMS endorsed another tactic used by insurers to limit care for the most ill (and, thus, most expensive) patients—the copayment accumulator. A copay accumulator—or accumulator adjustment program—is a strategy insurance companies and Pharmacy benefit Managers (PBMs) use that stop manufacturer copay assistance coupons from counting towards a patient's deductible and out-of-pocket maximum spending. This is like saying a manufacturer's coupon would not lower your total grocery bill when you use the coupon at the grocery store. These coupons help lower the cost of medications in these scenarios: they can't afford the high cost of the medication; they have a high deductible plan and cannot t afford the copayment, and/or they qualify for PAP assistance but their insurer will not accept the payment due to the CMS rule.

Because CMS has endorsed the copay accumulator mechanism, patients often never reach their out-of-pocket maximum spending, putting other treatment for their diseases in jeopardy.

Specialty Claim Carve-Out or Alternative Funding Model

This prescription drug procurement model improperly uses for-profit drug manufacturers' free assistance programs to the detriment of patients who are forced to continually switch drugs because manufacturer assistance programs are time limited; diseases are not. Additionally, any costs for filling the prescriptions or are not counted toward the patient's out-of-pocket costs.

CONCLUSION

Over previous years, appropriators have asked HHS and CMS to explain the rationale and justifications for taking various coverage and access actions. It would be meaningful to have the new administration's perspective on these issues. The community would welcome the opportunity to share their experiences and collaboratively discuss challenges and opportunities with policymakers. In addition to including timely committee recommendations, please consider questions for the record and similar options to facilitate a productive discussion with the administration on enhancing coverage and access while Congress works on potential legislative solutions, as well. Thank you again and please consider PSI a resource for future conversations.

[This statement was submitted by Gwen Cooper, Chief Executive Officer, Patient Services, Inc.]

PREPARED STATEMENT OF THE PEDIATRIC POLICY COUNCIL

I write on behalf of the Pediatric Policy Council (PPC), a public policy collaborative of the Academic Pediatric Association, the American Pediatric Society, the Association of Medical School Pediatric Department Chairs, and the Society for Pediatric Research. We urge the subcommittee to provide robust investments in pediatric research and training to support the health and well-being of children, as outlined below. We are grateful for the investments Congress has made in these areas in recent years, as evidenced in particular through enhanced support for the National Institutes of Health (NIH) and other key pediatric research priorities, and hope you will support sustained increases in pediatric research and training priorities to enable the next generation of scientific discoveries to benefit child health.

Fiscal Year (FY) 2022 Funding Priorities:

—National Institutes of Health: $46.1 billion
—Eunice Kennedy Shriver National Institute of Child Health and Human Development: $1.7 billion
—Pediatric Subspecialty Loan Repayment Program: $50 million
—Gun Violence Prevention Research: $50 million split evenly between NIH and CDC
—Agency for Healthcare Research and Quality: $500 million
—Children's Hospital Graduate Medical Education: $485 million

National Institutes of Health (NIH):

Biomedical research is key to improving child health and well-being through new cures for pediatric conditions and a deeper understanding of children's unique biology. Research funded by the NIH has made significant strides toward treating and preventing chronic diseases, many of which have their roots in childhood. This work has led to new therapies, vaccines, and diagnostic tests that have improved the lives of millions of people worldwide. Pediatric research has yielded groundbreaking treatments for deadly chronic diseases, saved the lives of premature babies, and even cured some common childhood cancers. NIH funding also helps fund the development of physician scientists through loan repayment and research training awards. The COVID–19 pandemic has only further underscored the importance of the federal investment in biomedical research, which was crucial in developing the scientific knowledge and infrastructure to rapidly study the novel coronavirus in children and adults and to develop needed medical interventions like immunizations that will be key to ending the pandemic.

We urge a funding level for NIH of no less than $46.1 billion in FY 2022, a $3.2 billion increase over the agency's FY 2021 level. Within the overall FY 2022 funding for the NIH, we request $1.7 billion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)—the single largest funder of pediatric research within the NIH and a key leader in coordinating and advancing a pediatric research agenda NIH-wide. This amounts to a proportionate increase for NICHD of $117 million over FY 2021.

Pediatric Subspecialty Loan Repayment Program (PSLRP):

Across the country, there are significant shortages of pediatric subspecialists—pediatricians who pursue additional training to care for the most medically complex children—which lead to long travel distances and long appointment wait times for families. There is also a disparity in the geographic distribution of pediatric subspecialists, resulting in many children in underserved rural and urban areas not receiving timely health care. Shortages of pediatric subspecialists may also slow the development of the next generation of treatments and cures for young people, since many pediatric researchers are trained as subspecialists and dedicate their careers to research on complex health needs like Type 1 diabetes and autism spectrum disorder.

PSLRP is designed to address these shortages by providing qualifying child health professionals with up to $35,000 in loan repayment annually in exchange for practicing in an underserved area for at least two years, which would help address high medical school debt that serves as a barrier to pursuing training in a pediatric subspecialty. Congress reauthorized this program last year in the Coronavirus Aid, Relief, and Economic Security (CARES) Act in recognition of the need to support child access to pediatric medical and mental health care amid the COVID–19 pandemic. We urge you to begin addressing these shortages by providing $50 million in initial funding for PSLRP in FY 2022.

Gun Violence Prevention Research:

Gun violence is a public health crisis for citizens of all ages, genders, races, ethnicities, and socio-economic backgrounds—and this includes for children and youth. Firearms are now the leading cause of death for those 1–24 years old in the United States. Suicide accounts for 40% of these deaths. In the last decade, an increasing number of teenagers and young adults have died by suicide using a gun, which results in death more than 90 percent of the time. Funding to better elucidate risk and protective factors for gun violence in children and youth and their families is critical to decrease gun deaths and injuries. For the first time in 25 years, Congress provided a welcomed investment in this research in FY 2020 and again in FY 2021 at the NIH and the Centers for Disease Control and Prevention (CDC). After the absence of research funding for almost 3 generations of young investigators, additional funding is needed to rebuild the public health research infrastructure needed for gun violence. We therefore urge you to provide $50 million in funding for gun violence prevention research split evenly between the NIH and the CDC, a doubling of current funding in line with President Biden's FY 2022 budget request.

Agency for Healthcare Research and Quality (AHRQ):

The Agency for Healthcare Research and Quality (AHRQ) funds research into health care as it is practiced to improve care in the clinic and support quality improvement. For instance, AHRQ research has helped reduce unnecessary blood cultures in critically ill children and led to important insights about the health and economic benefits of increased physical activity in children. AHRQ has also played an important role in the development and evaluation of the Pediatric Quality Measures Program (PQMP), which is helping to improve quality of care for the 37.6 million children enrolled in Medicaid and the Children's Health Insurance Program. We urge you to provide $500 million in funding for AHRQ in FY 2022.

Children's Hospital Graduate Medical Education (CHGME):

The ability to produce top quality pediatric research is dependent on the availability of trained pediatrician scientists who choose to pursue a career in research. Many factors influence a physician's choice to pursue research, but a stable pipeline of trained clinicians is a critical prerequisite. Freestanding children's hospitals train half of all pediatricians and pediatric subspecialists despite representing less than one percent of hospitals. CHGME is necessary to maintain the number of pediatric residents and fellows in the United States and has allowed participating children's hospitals to improve their training experience for residents and fellows. A strong investment in pediatric training through freestanding children's hospitals is essential to ensuring that future pediatrician scientists are trained and have the opportunity to pursue pediatric research. We urge you to provide $485 million in funding for CHGME in FY 2022.

PREPARED STATEMENT OF ANN D. PEEL

Madam Chairwoman,

Amyloidosis is a rare and usually fatal disease. There is no known cure for amyloidosis, an abnormal folding protein disease that can destroy various major organs. The causes of the disease remain elusive. I ask that you include language in the Committee's report for fiscal year 2022 directing the National Institutes of Health (NIH), Office of the Director, Multi-Institute Research Issues to expand its research efforts into amyloidosis. I also ask the Committee to direct NIH to inform Congress on the steps taken to increase the understanding of the causes of amyloidosis and the measures taken to improve the diagnosis and treatment of this devastating group of diseases. The vaccines developed to combat COVID–19 illustrate the importance of the research necessary to overcome diseases. Only through more research can deaths from amyloidosis be prevented.

Over the years, your Committee has been instrumental in moving forward to finding the causes and a cure for amyloidosis. Efforts made by NIH and Amyloidosis Centers around the country are resulting in many more people being diagnosed and treated for amyloidosis than a decade ago.

I have endured two stem cell transplants in order to fight the deadly disease amyloidosis and have been one of the lucky ones to survive the disease for 18 years. This was due to the intensive, life-saving treatment that I have received through the Amyloidosis Center at Boston University School of Medicine and Boston Medical Center. I continue to participate in a clinical trial that looks for ways to diagnose and treat amyloidosis.

One of the major concerns is that current methods of treatment are risky and unsuitable for many patients. Even with successful initial treatment, amyloidosis remains a threat, since it can recur years later.

Due to research, there are new forms of treatment that are options for me and patients with recurring amyloidosis. These new treatment options were not available 18 years ago. They provide evidence that funding through Health and Human Services can make a difference.

I ask for your support in helping me turn what has been my life-threatening experience into hope for others.

WHAT IS AMYLOIDOSIS?

I have been treated for primary amyloidosis, which is immunoglobulin light chain (AL) amyloidosis. This type of amyloidosis occurs when cells in the bone marrow produce an abnormal amyloidogenic protein and these form amyloid fibrils that are deposited in major organs, such as the heart, kidney and liver. These misfolded proteins clog the organs until they are no longer able to function-sometimes at a very rapid pace.

In addition to AL amyloidosis, a blood or bone marrow disorder, there are also cases of inherited or familial amyloidosis and secondary or reactive amyloidosis. Familial amyloidosis may be present in a significant number of African Americans.

All three types of amyloidosis, left undiagnosed or untreated, are fatal. There is no explanation for how or why amyloidosis develops and there is no known reliable cure. Thousands of people die because they were diagnosed too late to obtain effective treatment. Thousands of others die never knowing they had amyloidosis. The small numbers of those with amyloidosis who are able to obtain treatment face challenges that can include high dose chemotherapy and stem cell replacement or organ transplantation.

Amyloidosis can cause heart, kidney, or liver dysfunction and failure and severe neurological problems. Left untreated, the average survival is just months from the time of diagnosis.

Researchers have not been able to determine the root cause of the disease or an effective low-risk treatment. Amyloidosis can literally kill people before they even know that they have the disease.

Older Americans are susceptible to heart disease due to amyloid formed from the non-mutated form of the same protein. Another type of amyloidosis, secondary or reactive amyloidosis, occurs in patients with chronic infections or inflammatory diseases.

All of these types of amyloidosis, left undiagnosed or untreated, are fatal.

HOW IS AMYLOIDOSIS TREATED?

Boston University School of Medicine and other centers for amyloidosis treatment have found that high dose intravenous chemotherapy followed by stem cell replacement, or rescue, is an effective treatment in selected patients with AL amyloidosis. Abnormal bone marrow cells are killed through high dose chemotherapy and the patient's own extracted blood stem cells are replaced in order to improve the recovery process. The high dose chemotherapy and stem cell rescue and other new drugs have increased the remission rate and long-term survival dramatically. However, this treatment can also be life threatening and more research needs to be done to provide less risky forms of treatment.

Timely diagnosis and treatment are of great importance. Early treatment is the key to success.

More needs to be done in this area to alert health professionals to identify this disease.

RESEARCH AND DIAGNOSIS

Researchers are moving forward with limited funding to develop targeted treatments that will specifically attack the amyloid proteins. Additional funding for research and equipment is needed to accomplish this task. Only through more research is there hope of further increasing the survival rate and finding treatments to help more patients.

Amyloidosis is vastly under-diagnosed. Thousands of people die because they were not diagnosed or diagnosed too late. More needs to be done to alert health professionals to identify this disease. Although I was diagnosed at a very early stage of the disease, many people are diagnosed after the point that they are physically able to undertake treatment.

I believe there are many more cases of amyloidosis than are known, as the disease can escape diagnosis and patients die of "heart failure," "liver failure," etc. In re-

ality, some of these people had amyloidosis. Perhaps amyloidosis is not as rare a disease as we think.

Through the leadership of this Committee and the further involvement of the U.S. Government, several positive developments have occurred. Research supported by the National Institute of Neurologic Disorders and Stroke at NIH and the Office of Orphan Products Development at the Food and Drug Administration led to successful repurposing of a generic drug that markedly slows progression of familial amyloidosis.

Basic and clinical research at the Boston University Amyloidosis Center has increased: models of light chain (AL) amyloid disease have been developed; serum chaperone proteins that cause amyloid precursor protein misfolding are being identified; imaging techniques for the diagnosis of amyloid disease are being investigated; and new clinical trials for primary and familial amyloidosis are underway. Federal funding for research, equipment and treatment has been an important element in progress to date. Further funding is essential to speed the pace of discovery for basic and clinical research.

Madam Chairwoman, the United States Congress and the Executive branch working together are key to finding a cure for and alerting people to this terrible disease.

I want to use my experience with this rare disease to help save the lives of others. With your support more can be done to help me achieve my dream.

PREPARED STATEMENT OF THE PERSONALIZED MEDICINE COALITION

Chairwoman Murray, Ranking Member Blunt and distinguished members of the subcommittee, the Personalized Medicine Coalition (PMC) appreciates the opportunity to submit testimony on the National Institutes of Health (NIH) fiscal year (FY) 2022 appropriations and the importance of the agency's research to personalized medicine. PMC is a nonprofit education and advocacy organization comprised of more than 220 institutions from across the health care spectrum who support this growing field. The tragically uneven effects of the COVID–19 pandemic have underlined the importance of developing more targeted health care interventions just as groundbreaking technologies are giving us an unprecedented ability to understand the biological and environmental factors that drive disease and influence patients' responses to various treatments. As the subcommittee begins work on the FY 2022 Labor, Health and Human Services, Education and Related Agencies appropriations bill, we strongly support the President's proposed increase in funding for NIH to $51 billion, and we request the agency receive no less than $46.1 billion for NIH's base program level budget, $3.2 billion above the comparable FY 2021 funding level.

Personalized medicine, also called precision or individualized medicine, is an evolving field in which physicians use diagnostic tests to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances and values, health care providers can develop targeted treatment and prevention plans with their patients. Personalized medicine promises to detect the onset of disease, pre-empt its progression, and improve the quality, accessibility, and affordability of health care.[1] By increasing government spending on science at this pivotal moment, Congress can help advance a new era of personalized medicine that promises a brighter future for patients and health systems.

I. THE ROLE OF NIH IN PERSONALIZED MEDICINE

Continued research on the genetic and biological underpinnings of disease has made it possible to develop new personalized medicine treatments for cancers as well as rare, common, and infectious diseases. This research has informed the development of more than 286 personalized treatments[2] and over 166,703 genetic testing products[3] available for patients in 2020. Foundational advances in genetic and genomic technologies have also paved the way for scientists' rapid response to COVID–19. The rapid progress we have seen, from mRNA vaccine development, diagnostic testing, and variant sequencing, to beginning to understand how human genomic variation influences infectivity, disease severity, vaccine efficacy, and treat-

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[1] http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC__The__Personalized__Medicine__Report__Opportunity__Challenges__and__the__Future.pdf.

[2] http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC__The__Personalized__Medicine__Report__Opportunity__Challenges__and__the__Future.pdf.

[3] https://doi.org/10.1002/ajmg.c.31881.

ment response, relies on years of personalized medicine research,[4,5]—as well as years of diligent funding from Congress to support this research.

The widely variable effects of COVID–19 have only highlighted the need for personalized medicine to move further and faster. A $3.2 billion increase would allow for NIH's base budget to keep pace with biomedical inflation and allow meaningful growth of 5 percent. This request also includes the full $496 million NIH is scheduled to receive in FY 2022 from the Innovation Account established in the 21st Century Cures Act (Cures Act).

II. SUSTAINING BASIC AND TRANSLATIONAL RESEARCH FOR PERSONALIZED MEDICINE

NIH is leading scientific discovery for personalized medicine, which begins with basic research that generates fundamental knowledge about the molecular basis of a disease and with translational research aimed at applying that knowledge to develop a treatment or cure. Many institutes and centers at the NIH are supporting research informing the development of personalized medicines, including the National Human Genome Research Institute (NHGRI), the National Cancer Institute (NCI), the National Institute on Aging (NIA), the National Heart, Lung and Blood Institute (NHLBI), and the National Center for Advancing Translational Sciences (NCATS). An increase for NIH in FY 2022 would protect its foundational role in the identification and development of treatments, technologies, and tools for personalized medicine.

The future of cancer care, for example, is expected to be profoundly influenced by personalized medicine approaches for detecting and treating early- and late-stage cancers. In 2020, for example, FDA approved the first comprehensive pan-tumor liquid biopsy test for patients with advanced cancer that allows physicians to detect actionable biomarkers in patients' blood through next-generation sequencing.[6] As soon as next year, NCI aims to launch large national trials for similar tests that are being developed to detect multiple early-stage cancers in patients' blood.[7] These tests would provide less invasive testing options that can detect cancers at early stages when treatment may be more effective and less costly.

Basic and translational research also offers opportunities for personalized medicine beyond oncology, especially for rare diseases. Although individually rare, rare diseases collectively affect an estimated 25 to 30 million Americans. With advances in genomics, the molecular causes of 6,500 rare diseases have been identified—but only about 5 percent have an FDA-approved treatment, and in 2019, the estimated economic cost of only 379 rare diseases reached nearly $1 trillion in the U.S.[8] Over the past decade, NIH has helped shift the scientific approach to researching rare diseases from one disease at a time to many diseases. Pooling patients, data, experiences, and resources promises to lead to more successful clinical trials sooner for rare disease patients who presently have few or no treatment options.

There are others living with highly prevalent diseases where personalized medicine can offer patients better treatments or a cure. The Alzheimer's Association estimates that 6.2 million Americans are living with Alzheimer's disease, for example.[9] Despite increasing numbers of Alzheimer's diagnoses and FDA's recent approval of the first new Alzheimer's drug in decades, researchers are still studying the genetic underpinnings of Alzheimer's disease to more fully understand its complexity. To shorten the time between the discovery of potential drug targets and the development of new drugs, the Accelerating Medicines Partnership for Alzheimer's disease led by NIH has identified over 500 drug targets, and in 2020 launched a second iteration of the partnership to enable a personalized medicine approach to researching new treatments.[10]

Still, ensuring that the scientific breakthroughs in personalized medicine are impactful to all patients will require the inclusive and equitable representation of patients with diverse characteristics and health needs in research. Improving research policies and incorporating diverse perspectives into solving complex scientific problems, such as through NIH's UNITE initiative and NHGRI's action agenda for a diverse genomics workforce, will play a key role in addressing these disparities,

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[4] https://doi.org/10.1016/j.cell.2021.01.015.

[5] https://doi.org/10.1038/s41586-020-2817-4.

[6] http://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PM__at__FDA__The__Scope__Significance__of__Progress__in__2020.pdf.

[7] https://www.precisiononcologynews.com/policy-legislation/nci-director-sharpless-outlines-ideas-aggressively-lower-cancer-deaths.

[8] https://everylifefoundation.org/burden-study/.

[9] https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf.

[10] https://www.nih.gov/research-training/accelerating-medicines-partnership-amp/alzheimers-

in addition to research on improving minority health and understanding factors contributing to health disparities.

III. ACCELERATING PERSONALIZED MEDICINE RESEARCH

Increasing the NIH's base budget will also ensure that the agency has the resources necessary to advance the longstanding aspects of its mission without deprioritizing supplemental initiatives in personalized medicine provided for by Congress in the Cures Act.

The first initiative, the All of Us™ Research Program, was launched in 2018 to begin collecting genetic and health information from one million volunteers as part of a decades-long research project. As of May 2021, over 382,000 individuals consented to participate and over 279,000 have fully enrolled.[11] More than 80 percent of those individuals are from groups historically underrepresented in research,[12] such as seniors, women, Hispanics and Latinos, African Americans, Asian Americans and members of the LGBTQ community. Last year, program officials met their targets to start returning individual genetic results to participants and inviting researchers to begin using the data collected.[13] The program also began analyzing data from its diverse participant cohort to look for patterns explaining individuals' different responses to COVID–19.[14] In the future, pooling health care data across large datasets will play a key role in advancing research for personalized medicine approaches to care.

The second initiative, the Beau Biden Cancer Moonshot, aims to transform the way cancer research is conducted by fostering collaboration and data sharing. Moonshot currently supports over 240 new research projects,[15] including the Partnership for Accelerating Cancer Therapies (PACT). Through PACT, the NIH is collaborating with 12 pharmaceutical companies, the Foundation for NIH, and FDA to identify, develop, and validate biomarkers to advance the discovery of new immunotherapy treatments. Over the past decade, personalized treatments harnessing the immune system have driven declines in mortality for lung cancer and melanoma.

IV. CONCLUSION

PMC appreciates the opportunity to highlight the NIH's importance to the continued success of personalized medicine. As the subcommittee considers the President's proposal, we encourage the subcommittee to support at least a $3.2 billion increase for existing centers and programs, in addition to funding Congress may provide for targeted initiatives such as establishing the President's proposed Advanced Research Projects Agency for Health (ARPA–H). PMC believes that diligently funding basic and translational research at the NIH is key to bringing us closer to a future in which every patient benefits from an individualized approach to health care.

[This statement was submitted by Cynthia A. Bens, Senior Vice President, Public Policy, Personalized Medicine Coalition.]

PREPARED STATEMENT OF THE PHYSICAL ACTIVITY ALLIANCE

Members of the subcommittee, thank you for the opportunity to testify today. My name is Mark Fenton. I am an adjunct associate professor at Tuft University and a nationally recognized public health, planning, and transportation consultant. I am representing the Physical Activity Alliance, the nation's broadest coalition dedicated to promoting physical activity for health. As such, I'm pleased to testify today on specific opportunities to improve Americans' health in the fiscal year (FY) 2022 Labor, Health and Human Services, Education and Related Agencies appropriations bill that address funding for the Centers for Disease Control and Prevention. I respectfully request you work over the next three years to triple the budget of the Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to $3.75 billion, including in this next budget at least $125 million for the Division of Nutrition, Physical Activity and Obesity (DNPAO), and $10 million for Active People Healthy Nation (APHN), an initiative to help 27 million Americans become more physically active by 2027.

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[11] https://www.joinallofus.org/newsletters/2021/may.
[12] https://doi.org/10.1016/j.cell.2021.01.015.
[13] https://www.joinallofus.org/newsletters/2020/december.
[14] https://www.nih.gov/news-events/news-releases/all-us-research-program-launches-covid-19-research-initiatives.
[15] https://doi.org/10.1016/j.ccell.2021.04.015.

The Active People Healthy Nation support would build on the increased capacity of the public health infrastructure from a 50-state DNPAO program funding commitment. The 50-state program, including the District of Columbia, would allow for each state to have resources for staff who are experts in:

—Promoting physical activity through community and state changes to increase safe and convenient access to physical activity, especially for those populations most at risk of physical inactivity, through activities such as master planning, access to parks, safe routes to school, and improvements for physically active (walking and bicycling) routes to everyday destinations.

—Promoting nutrition security especially for the youngest and most vulnerable populations

—Obesity prevention and management with linkages to health care systems

—Communication and policy

—Evaluation, quality improvement and accountability

—Equitable and inclusive community engagement

The specific resources for Active People Heathy Nation would allow states, municipalities and, local communities to leverage the expertise of the 50-state program to specifically address the populations who are the most disproportionately affected by risk of chronic diseases (including obesity, diabetes, cancer and heart disease) due to their lack of safe and convenient access to physical activity. This could include but is certainly not limited to:

—Implementing social support systems and networks to promote walking for older populations.

—Implementing low-cost "quick builds" to improve street designs to encourage safe walking and biking at the local level in specific neighborhoods where health disparities are the greatest.

—Convening local groups to develop action plans for promoting safe and convenient access to local parks and other key destinations.

—Promoting safe routes to schools with design changes (e.g., high visibility crosswalks, traffic calming near schools) to increase safety and to reduce hesitancy from parents.

—Taking steps to prioritize safety over speed in local and state policies and practices.

As a consultant to communities across the country, I have seen the positive impact of these funds in communities, especially for those that are historically underresourced. The pandemic has demonstrated that chronic diseases and infectious diseases are inextricably linked and inequity can be exacerbated. Addressing chronic diseases, their associated risk factors, as well as mental health and well-being are essential for improving our population health and productivity. And physical activity to improve cardiorespiratory fitness are integral interventions. Being physically active is one of the most important lifestyle behaviors people can engage in to maintain their physical health, improve their mental health, and optimize well-being.[1]

—Studies show that physical activity is associated with strong immune response, better outcomes from community-acquired infectious disease, reduced mortality and increased vaccine potency.[2,3,4,5]

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[1] US Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. 2018.

[2] Nieman DC, Wentz LM. The compelling link between physical activity and the body's defense system. J Sport Heal Sci. Published online 2019. doi:10.1016/j.jshs.2018.09.009.

[3] Hamer M, Kivimäki M, Gale CR, David Batty G. Lifestyle risk factors, inflammatory mechanisms, and COVID–19 hospitalization: A community-based cohort study of 387,109 adults in UK. Brain Behav Immun. Pblished online 2020.

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[5] Perico, L., Benigni, A., Casiraghi, F., Ng, LFP., Renia, L., Remuzzi, G. Immuity, endothelial injury and complement-induced coagulopathy in COVID–19. Nature Reviews Nephrology. October 2020.

—Physical activity also contributes to social connectedness,[6] quality of life,[7] and environmental sustainability.[8,9]

—Regular physical activity is both health-promoting and important for treatment and prevention of diseases such as cardiovascular disease and cancer that are the leading causes of death in the U.S., with numerous benefits that contribute to a disability-free lifespan.[10]

—There are racial, ethnic and socioeconomic status (SES) disparities that exist with regard to physical activity, access to recreational spaces and physical activity-related programs. These disparities differ with respect to occupation, transportation, community infrastructure, and leisure.[11,12,13]

—Low physical activity and fitness pose immediate and long-term threats to our nation's safety and security. Currently, 71 percent of Americans ages 17–24 fail to meet core eligibility requirements for entrance into the military, creating a serious recruiting deficit.[14] Among those who do meet basic requirements for service, musculoskeletal injuries associated with low fitness levels cost the Department of Defense hundreds of millions of dollars,[15] and have been identified as the most significant medical impediment to military readiness.[16]

Streets and downtowns that are designed to safely accommodate the physically active modes (walking, biking, and transit) along with motor vehicles are more economically robust,[17] have more resilient real estate values,[18] and are increasingly appealing to businesses because of enhanced employee recruitment and retention.[19]

Physical activity is integral to population health and well-being, educational achievement, effective health care delivery, emergency preparedness, and military readiness, and will be critical to our nation's recovery from the pandemic. If we can help more Americans to be physically active, we will save lives, contribute to lower vehicle emissions and health care costs, reduce racial, ethnic, gender, and socioeconomic health disparities, improve mental well-being, and make American employers and the U.S. overall much more productive and successful.

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[8] Global Advocacy Council for Physical Activity International Society for Physical Activity and Health. The Toronto Charter for Physical Activity: A Global Call for Action. J Phys Act Health. 2010;7 Suppl 3:S370–85.

[9] Safe routes to school: Steps to a greener future. How walking and bicycling to school reduce carbon emissions and air pollutants. Accessed online November 2020 at https://www.saferoutespartnership.org/sites/default/files/pdf/SRTS_GHG_lo_res.pdf.

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I thank you for the opportunity to offer my perspective today, and for your continued leadership.

PREPARED STATEMENT OF PLANNED PARENTHOOD

Dear Chairwoman Murray and Ranking Member Blunt,

Planned Parenthood is the nation's leading reproductive health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the U.S as well as the nation's largest provider of sex education. As experts in sexual and reproductive health care, we reach 2.4 million people in our health centers, 1.1 million people through educational programs, and see 198 million visits to our website every year. People come to Planned Parenthood for the accurate information and critical resources they need to stay healthy and reach their life goals. For many of our patients, Planned Parenthood is their only source of care—making our health centers an irreplaceable part of this country's health care system. Backed by more than 17 million supporters, Planned Parenthood Action Fund works every day to defend access to health care and advance reproductive rights at home and abroad. Through our international arm, Planned Parenthood Global, we provide financial and technical support to nearly 100 innovative partners in nine countries in Africa and Latin America for service delivery and advocacy to expand access to reproductive health care and empower people to lead healthier lives.

Longstanding progress towards addressing sexual and reproductive health both here in the United States and around the world has been undermined and is threatened to erode further—both deliberately and as a result of unprecedented challenges, most notably the COVID–19 pandemic. The Biden-Harris administration has taken welcome early actions to reverse the Trump-Pence administration's ideological and harmful policies—including the global gag rule and Title X domestic gag rule—and prioritize sexual and reproductive health and rights, but more action is needed from both the administration and congress to ground policies in science and equity and expand access to health care, including sexual and reproductive health, for millions, particularly for those who most often struggle to overcome the systemic barriers to care. Meanwhile the pandemic has exacerbated existing inequities in health care systems and created a growing need for timely services, including those to help with the growing number of households that have identified a need for affordable family planning and increasing rates of sexually-transmitted infections (STIs).

Through these extraordinary challenges, Planned Parenthood health centers continue to expand services and innovate new and better ways to deliver health care and information—through telehealth and in health centers across the country. We are breaking down structural barriers to accessing reproductive health care by making it more timely, relevant and equitable for all people.

However, there remain significant and unacceptable inequities in health outcomes that are the result of longstanding systems of oppression that deeply impact traditionally marginalized communities, including persons of color, those with low-incomes, those who identify as LGBTQ, and those who live at the intersection of structural racism, inequality, sexism, classism, xenophobia, and other systemic barriers to health care and other resources are among those most severely impacted. The ongoing COVID–19 pandemic has underscored the inequities in access to health care worldwide, both within and between countries, and is further exacerbating gender-based violence and the financial barriers to seeking care that is needed, including sexual and reproductive health services.

On behalf of Planned Parenthood Federation of America, I respectfully request that while assembling legislation to provide appropriations for fiscal year 2022 (FY22) you provide increased funding for key sexual and reproductive health funding priorities while also ending harmful and discriminatory policies that undermine access to care, including by:

1. Building Back the Title X Family Planning Program
2. Increasing Funding for STI Prevention
3. Increasing Funding for the Teen Pregnancy Prevention Program and the CDC's Division of Adolescent School Health, and Eliminate Harmful and Ineffective Abstinence-Only-Until-Marriage Programs
4. Eliminating Harmful Policy Riders that Limit Access to Abortion

1. Building Back the Title X Family Planning Program

Title X is the nation's only federal program dedicated to providing affordable birth control and other reproductive health care to people with low incomes. Despite mass outcry from the public health community and American people, in August 2019 the

Trump administration began enforcing a rule that made significant changes to Title X. The gag rule—a harmful regulation that prohibits Title X providers from giving their patients full and accurate information—dismantles the program and blocks people struggling to get by from getting free or low-cost birth control, STI services, cancer screenings, and other essential health care. The gag rule slashed the Title X network's patient capacity nearly in half, creating unacceptable barriers to affordable care. The gag rule resulted in family planning providers in 33 states leaving the program and at least 1.5 million people, many of whom are low-income, losing access to Title X-funded care at the site they had used in 2018. More than 1,000 sites (roughly 25 percent) have left the Title X network; six states (HI, ME, OR, UT, VT, and WA) currently have no Title X-funded services.

In the meantime the COVID–19 pandemic has further exacerbated the county's sexual and reproductive health care needs. In spring 2020, 33 percent of women faced delays or were unable to get contraception or other care because of the COVID–19 pandemic, while 34 percent wanted to get pregnant later or wanted fewer children because of the pandemic. Women belonging to groups already experiencing systemic health and social inequalities—such as Black and Latina women, queer women, and low income women—reported the greatest change in fertility preference and barriers to access.

In April 2021, the Biden administration issued a notice of proposed rulemaking and we applaud their proposal to rescind the gag rule and make several modifications aimed at "strengthen[ing] the program and ensur[ing] access to equitable, affordable, client-centered, quality family planning services for all clients, especially for low-income clients."[1] However, an increase in annual funding will be necessary to help rebuild the Title X network and provide much-needed care to qualifying participants.

The best analysis (conducted prior to the pandemic and without adjusting for inflation) estimates that the Title X program would need $737 million in annual funding to address the unmet family planning needs for low-income women. We urge Congress to provide the program with $512 million in FY22 funding—an increase halfway towards the unmet need of the program—to help rebuild the Title X network and restore access to critical health care services.

2. Increasing Funding for STI and HIV Prevention at the Centers for Disease Control and Prevention (CDC)

Sexually-transmitted infections (STIs) are a serious and growing public health problem. This month the latest annual CDC surveillance report announced that STD rates have reached an all-time high for the sixth consecutive year. In 2019, more than 2.5 million cases of syphilis, chlamydia, and gonorrhea diagnoses were identified in the United States.[2] Of particular concern were cases of congenital syphilis—syphilis passed from a mother to her baby during pregnancy—which have quadrupled between 2015. Congenital syphilis can result in miscarriage, stillbirth, newborn death, and severe lifelong physical and neurological problems. The report also identified that disparities in rates persist among racial and ethnic groups. For example, STD rates for Hispanic or Latino people ranging up to two times those of non-Hispanic White people. Rates for American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander people were 3–5 times as high while rates for African American or Black people were five to eight times those of non-Hispanic White people. All of this has likely been exacerbated by the COVID–19 pandemic which has reduced access to essential screening and treatment services and stretched public health resources thin.

Screening and treatment for STIs-including HIV/AIDS-are an essential part of planning for a healthy pregnancy and healthy communities. Despite the CDC recommendation that all pregnant women be tested for STIs, many women and other sexually active adults are not being adequately tested, in part because of limited resources for screening. The CDC's National Center for HIV/AIDS, Hepatitis, STIs and TB Prevention (NCHHSTP) conducts critical public health surveillance, but also funds screenings and other important activities. Increasing funding for the CDC's STI prevention programs is a cost-effective public health investment that will improve the lives of women and all Americans across the country. We ask that you fund CDC/NCHHSTP at $1.4 billion for FY22, including $252.91 million for the Division of STD Prevention.

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[1] https://www.hhs.gov/about/news/2021/04/14/fact-sheet-notice-of-proposed-rulemaking-ensuring-access-to-equitable-affordable-client-centered.html.

[2] Centers for Disease Control and Prevention (CDC). 2019 STD Surveillance Report. April 13, 2021. https://www.cdc.gov/nchhstp/newsroom/2021/2019-STD-surveillance-report.html.

3. Increasing Funding for the Teen Pregnancy Prevention Program and the CDC's Division of Adolescent School Health, Eliminate Harmful and Ineffective Abstinence-Only-Until-Marriage Programs

As the nation's leading provider of sex education, Planned Parenthood works in and with communities across the country to provide outstanding sex education programs. Our educators see daily how vital it is for young people to have access to sex education programs that give them knowledge and skills they need to lead fulfilling, safe, and healthy lives. However, less than 43 percent of all high schools and only 18 percent of middle schools across the country provide education on all of the CDC's identified topics that are critical to ensuring sexual health.[3] Congress should continue to make investments in programs that are proven to promote adolescent health by increasing young people's access to medically accurate and age-appropriate sexual health information that they need to make safe and healthy decisions.

Since fiscal year 2010 (FY10), the Teen Pregnancy Prevention Program (TPPP) has supported projects and programs that deliver community-driven, evidence-based or informed, medically accurate, and age-appropriate approaches that incorporate involvement from parents, educators, and health providers. Beginning in 2015, 84 organizations in 33 states, the District of Columbia, and the Marshall Islands were awarded TPPP funds to replicate evidence-based programs in communities with the greatest needs; conduct rigorous evaluation of new and innovative approaches to prevent unintended teen pregnancy; or build capacity to support implementation of evidence-based programs. The positive outcomes of the program have been well-documented. In September 2017, the bipartisan Commission on Evidence-Based Policymaking, established by then-House Speaker Paul Ryan and Senator Patty Murray, highlighted TPPP as a model example of a federal program that has developed evidence in support of good policy.

Planned Parenthood urges you to increase TPPP funding to $150 million. This $49 million funding increase from FY21 to FY22 is partially offset by eliminating $35 million for discretionary sexual risk avoidance (SRA) grants. Additionally we urge you to support $6.8 million for dedicated evaluation transfer authority, and ask that $900,000 of the $6.8 million in Public Health Service Act funding for "Evaluation of Teen Pregnancy Prevention Approaches" be allocated specifically to reactivate the Teen Pregnancy Prevention Evidence Review. Furthermore, urge you to eliminate funding for the abstinence-only-until-marriage "sexual risk avoidance" competitive grant program.

The CDC's Division of Adolescent and School Health (DASH) provides funding to local education agencies across the country to implement school-based programs and practices designed to prevent HIV and other STIs among young people, and also integrates approaches aimed at substance use and violence prevention. In addition, the program expands the research and evidence base of how to best meet the respective needs of young people, including LGBTQ youth and other adolescents. Currently, DASH provides funding to 28 school districts across the country. Providing a significant increase ($66 million over the FY21 enacted level) to DASH funding would considerably expand the number served through this important program. We ask that you provide CDC/DASH with $100 million in FY22.

4. Eliminating Harmful and Discriminatory Policy Riders That Undermine Access to Abortion and Reject Any New Anti-Sexual and Reproductive Health Provisions

Opponents of sexual and reproductive health and rights have long used the appropriations process to undermine access to comprehensive reproductive care, including access to abortion. Through policy riders in bills under the jurisdiction of multiple subcommittees, including the original Hyde Amendment in the Labor/HHS bill, opponents have limited access for women on Medicaid, women who work for the federal government, women in prison, and others, including women living in the District of Columbia, which is even prohibited from spending non-federal funds on these services. Separately, the Weldon Amendment has been used to interfere with policies that expand abortion coverage and access, emboldening health entities to refuse to provide, cover, pay for, or refer for abortion services.When elected officials deny certain categories of women insurance coverage for or access to abortion, they either are forced to carry the pregnancy to term or pay for care out of their own pockets or simply do not get the care they need. The result is unfair and discriminatory policy that further exacerbates poor public health outcomes for those who already face significant barriers to care, such as low-income women, immigrant

[3] Centers for Disease Control and Prevention. School Health Profiles 2018: Characteristics of Health Programs Among Secondary Schools. Atlanta: Centers for Disease Control and Prevention; 2019.

women, young women, and women of color. We urge the Committee to eliminate all such restrictions on access to abortion.

In addition, the Committee should reject any harmful new policy riders we have seen proposed in years past that would roll back progress, including proposals to "defund" Planned Parenthood.

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PPFA issues these requests in the hopes that we can protect and build upon federal investments to make quality reproductive health care affordable and accessible so that women and their families can lead healthier lives. We welcome the opportunity to discuss these requests with you or your staff. If you have questions about any of the above requests, please don't hesitate to contact me at (jacqueline.ayers@ppfa.org). For more information about domestic priorities, please contact Jack Rayburn, Director, Legislative Affairs at (jack.rayburn@ppfa.org).

Sincerely.

[This statement was submitted by Jacqueline Ayers, Vice President of Public Policy and Government Affairs, Planned Parenthood Federation of America.]

PREPARED STATEMENT OF THE POPULATION ASSOCIATION OF AMERICA/ ASSOCIATION OF POPULATION CENTERS

Thank you, Chair Murray and Ranking Member Blunt for this opportunity to express support for the National Institutes of Health (NIH), National Center for Health Statistics (NCHS), Institute of Education Sciences (IES), and Bureau of Labor Statistics (BLS). These agencies are important to the members of the Population Association of America (PAA) and Association of Population Centers (APC) because they provide direct and indirect support to population scientists and the field of population, or demographic, research overall. In FY 2022, we urge the Subcommittee to adopt the following funding recommendations: $46.1 billion, NIH; $200 million, NCHS; $700 million, IES; and $800 million, BLS. In addition, we urge the subcommittee to accept report language, previously submitted, regarding population research programs and surveys supported by the National Institutes of Health.

NATIONAL INSTITUTES OF HEALTH

Demography is the study of populations and how or why they change. The health of our population is fundamentally intertwined with the demography of our population. Recognizing the connection between health and demography, NIH supports population research programs primarily through the National Institute on Aging (NIA) and the National Institute of Child Health and Human Development (NICHD). PAA and APC thank Chair Murray and Ranking Member Blunt for their bipartisan leadership and for working together in recent years to provide the NIH with robust, sustained funding increases. As members of the Ad Hoc Group for Medical Research, PAA and APC recommend the Subcommittee continue to prioritize NIH funding by endorsing an appropriation of at least $46.1 billion for the NIH, a $3 billion increase over the NIH's program level funding in FY 2021. We urge that NIA and NICHD, as components of the NIH, receive commensurate funding increases in FY 2022.

NATIONAL INSTITUTE ON AGING

The NIA Division of Behavioral and Social Research (DBSR) is the primary source of federal support for basic population aging research. The NIA Division of Behavioral and Social Research (DBSR) supports a scientifically innovative population aging research portfolio that reflects some of the Institute's, and nation's, highest scientific priorities including Alzheimer's disease and social inequality in health and the aging process. With additional support in FY 2022, DBSR could expand its existing research portfolio to encourage more research on the short and long-term social, behavioral, and economic health consequences of COVID on older people and their families. The population research community is especially eager to see NIA use existing large-scale, longitudinal and panel surveys, such as the Health and Retirement Study, the National Health and Aging Trends Study, and Understanding America Study, to facilitate scientific research on the complex, multifaceted effects of the pandemic on older, diverse populations. Further, the field believes NIA should sustain its support for developing data infrastructure to promote research on racial, ethnic, gender and socioeconomic disparities in health and well-being in later life and the long-term effects of early life experiences. With additional funding in FY 2022, DBSR could support these activities as well as fully fund the NIA Centers on

the Demography and Economics of Aging, which are conducting research on the demographic, economic, social, and health consequences of U.S. and global aging at 12 universities nationwide.

EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE ON CHILD HEALTH AND HUMAN DEVELOPMENT

Since the Institute's inception in 1962, NICHD has had a clear mandate to support a robust research portfolio focusing on maternal and child health, the social determinants of health, and human development across the lifespan. The NICHD Population Dynamics Branch meets this mandate by supporting innovative and influential population science initiatives, including: (1) large-scale longitudinal surveys, with population representative samples, such as The National Longitudinal Study of Adolescent to Adult Health and Fragile Families and Child Well Being Study; (2) a nationwide network of population science research and training centers; and, (3) numerous scientific research initiatives that have advanced our understanding of specific diseases and conditions, including obesity, autism, and maternal mortality, and, further, how socioeconomic and biological factors jointly determine human health. Given the dearth of data being collected regarding the short and long-term social, economic, developmental, and health effects of the COVID pandemic on children and families, the field of population research urges NICHD to consider expanding data collection through existing surveys and the NICHD Population Dynamics Centers Research Infrastructure Program. Further, population scientists encourage NICHD to explore the use of existing and new mechanisms to enhance research regarding the effects of COVID on fertility trends and reproductive health overall. With additional funding in FY 2022, the Institute could sustain its existing population research activities as well as implement our field's recommended COVID related research expansions.

NATIONAL CENTER FOR HEALTH STATISTICS

NCHS is the nation's principal health statistics agency, providing data on the health of the U.S. population. Population scientists rely on large NCHS-supported health surveys, especially the National Health Interview Survey and National Health and Nutrition Examination Survey, to study demographic, socioeconomic, and behavioral differences in health and mortality outcomes. They also rely on the vital statistics data that NCHS releases to track trends in fertility, mortality, and disability. NCHS health data are an essential part of the nation's statistical and public health infrastructure. In order for NCHS to continue monitoring the health of the American people and to allow the agency to make much-needed investments in the next generation of its surveys and products, PAA and APC, as a member of the Friends of NCHS, recommends the agency receive $200 million in FY 2022. In addition, our organizations urge the Subcommittee to reiterate its support for the agency's participation in the Centers for Disease Control (CDC) Data Modernization Initiative (DMI). The CDC should be encouraged to provide NCHS with a greater share of the agency's DMI funding—especially given NCHS has received less than 4 percent of the $600 million that DMI has received since FY 2020. NCHS should be benefitting from DMI funds, as the Committee intended, and applying them to make long overdue and necessary systematic and technological upgrades as well as facilitating enhanced use of Electronic Health Records.

BUREAU OF LABOR STATISTICS

Population scientists who study and evaluate labor and related economic policies use BLS data extensively. The field also relies on unique BLS-supported surveys, such as the American Time Use Survey and National Longitudinal Surveys, to understand how work, unemployment, and retirement influence health and well-being outcomes across the lifespan. As members of the Friends of Labor Statistics, PAA and APC are very grateful for $40 million programmatic increase that BLS received in FY 2020 and for maintaining the agency's funding level in FY 2021. We are also pleased that BLS received $10 million in FY 2020, and report language in FY 2021, to plan for a new youth cohort for the National Longitudinal Survey of Youth (NLSY). As the Subcommittee knows, the current NLSY 1979 and 1997 cohorts cannot provide adequate information about teens and young adults entering the labor market. PAA and APC hope that this planning process will provoke a new, necessary NLSY cohort. We urge the Subcommittee to give the agency increased support in FY 2022 by providing BLS with $800 million and to adopt, once again, report language urging the agency to maintain its plans for a new NLSY cohort.

INSTITUTE OF EDUCATION SCIENCES

The Institute of Education Sciences (IES) plays a critical role in supporting research used in developing and examining the effectiveness of education programs and curricula. The National Center for Education Statistics (NCES), the statistical arm of IES, provides objective data, statistics, and reports on the condition of education in the U.S. Population scientists rely on NCES surveys to conduct research on topics, such as linkages between educational access/attainment to health outcomes of specific populations, economic well-being, and incarceration rates. The field is pleased NCES is ramping up a new School Pulse Survey (SPS), to begin in August, that will collect data on how schools are adapting during the recovery phase of the pandemic. PAA continues to be concerned, however, that NCES has inadequate staffing to effectively manage the agency's broad array of surveys and other data collection and evaluation programs, and to maintain data quality and program rigor—particularly as it takes on new initiatives such as SPS. Years of staff attrition combined with bureaucratic hurdles have hindered the agency's ability to replace key personnel and maintain an adequate staffing level. We urge the Committee to continue to exert careful oversight of this situation.

Thank you for considering our support for these agencies as the Subcommittee drafts the FY 2022 Labor, Health and Human Services and Education Appropriations bill.

PREPARED STATEMENT OF THE PORT GAMBLE S'KLALLAM TRIBE

Requests and Recommendations:

1. Increase in funding for the Tribal Opioid Response grant program to a minimum of $75 million;
2. Increase in funding for the Temporary Assistance for Needy Families Program to a minimum of $17.8 billion;
3. Increase in funding for the Child Support Program to a minimum of $4.424 billion;
4. Increase in funding for the Head Start Program to a minimum of $17.8 billion;
5. Increase in funding for the Child Care and Development Block Grant to a minimum of $7.3 billion; and
6. Increase in funding for the Low-Income Home Energy Assistance Program to a minimum of $3.85 billion and a tribal set-aside.[1]

INTRODUCTION

The Port Gamble S'Klallam Tribe is a sovereign Indian nation comprised of over 1,342 citizens located on the northern tip of the Kitsap Peninsula in Northwest Washington State. The 1855 Point No Point Treaty reserved hunting, fishing, and gathering rights for our Tribe, and the United States agreed to respect the sovereignty of our Tribe and to protect and provide for the well-being of our Tribe. The United States, therefore, has both treaty and trust obligations to protect our lands and resources and provide for the health and well-being of our citizens. The current COVID–19 pandemic has necessitated the need for more resources and services to provide for the health, safety, and welfare of our tribal citizens as well as American Indian and Alaska Native (AI/AN) people across the United States.

Overarching Comments. Thank you for your commitment to honor and uphold the United States' trust and treaty obligations, strengthen the government-to-government relationship between the United States and tribes, and empower tribes to govern their own communities and make their own decisions. As you know, federal programs and services are critical components of building strong tribal governments, economies, and communities. We look to the Subcommittee to help address the chronic underfunding of unmet federal obligations and duties owed to Indian Country. This includes providing funding and support for the delivery of reliable and quality health care to AI/AN people, ensuring tribal communities are safe and secure, and expanding economic opportunity and community development in tribal communities. We ask the Subcommittee to support increased funding for critical In-

[1] We also support the National Congress of American Indians' FY 2022 budget requests. See NCAI, Indian Country FY 2022 Budget Request: Restoring Promises, https://www.ncai.org/resources/ncaipublications/NCAI__IndianCountry__FY2022__BudgetRequest.pdf.

dian programs and the inclusion of helpful report language on many significant issues impacting Indian Country.

Funding for Tribal Health Care. Appropriations to support health care services are needed to, among other things, address the significant health disparities that persist among AI/AN people, treat chronic diseases that plague tribal communities, update and improve tribal health clinics, and modernize equipment and health information technology within Indian Country. Our Tribe has administered health services to its members for several years, and was one of the first tribes to join the Tribal Self-Governance Project in 1990. We are the only Indian health care provider of both primary and behavioral health services in Kitsap County. Our health programs aim to provide the highest quality medical care and treatment to individuals within our tribal community, but we still face significant challenges related to funding, facilities, and program administration. Due to the COVID–19 pandemic, our health programs have run short of resources and need additional funding to support the services we provide. To strengthen our health programs, we ask for the following in the FY 2022 appropriations:

Tribal Opioid Response. We appreciate the President's proposed funding of $75 million to the Tribal Opioid Response grant program, but more is needed. This program to critical to address the opioid substance use needs in tribal communities. Indian Country, including our Tribe's Reservation, has been severely affected by the opioid epidemic. Increased funding for the Tribal Opioid Response grant program will address increasing rates of opioid dependence, overdose, and other negative consequences stemming from opioid use. Funding is essential to combat the opioid crisis that imposes threats to Indian Country.

Temporary Assistance for Needy Families (TANF). We support the President's FY 2022 request of $17.8 billion to support the TANF Program, which would be an increase in $600 million over FY 2021. The TANF Program is a capped entitlement program that has continued to receive the same funding level since it was established. The Tribe strongly encourages reauthorization of the TANF Program with higher funding levels in order to provide temporary assistance and economic self-sufficiency for children and families. The Tribe currently receives $516,680 from the TANF Program to support its members and strongly encourages a continuation of at least this amount. However, there remains an unmet need to operate programs for the benefit of low-income families. These programs are necessary for the United States to fulfill its trust responsibility and contribute to the overall well-being of the Tribe's members.

Child Support Program. We reject the President's request to reduce funding for the Child Support Program by $233 million to a total of $4.16 billion. Instead, funding for the Program should be at $4.424 billion, the FY 2020 level. The Tribe operates a robust Child Support Program. The Tribe's Child Support Program has a need of $781,955 to enhance its services offered to children with need and to improve activities offered to children, including an increase of staff members, support staff training, child counseling, and ensuring that the physical environments of the Tribe's Head Start Program is conducive to providing effective program services, increased hours of operation, improved strategic planning for the program, and safe transportation of children in the program safely, An increase in funding for the Child Support Program would allow the Tribe to increase and enhance services to its members. Any decrease in the level of funding for the Child Support Program would cause hardship to the Tribe's members.

Head Start Program. We support the President's request of $11.9 billion for the Head Start Program-an increase of $1.2 billion over the FY 2021 enacted level. The Head Start Program promotes the school readiness of our tribal youth as well as early learning and development, health, and family well-being of children from low-income families. Funding from the Head Start Program greatly assists the Tribe in offering competitive wages to its employees in its Early Head Start Program. The Tribe needs additional funding over and above its current funding to pay its teachers to ensure equitable wages that support Head Start Performance Standard Regulations. Such funding will also help the Tribe recruit and maintain teachers and teaching assistants, which is critical to our education programs and the children the Tribe serves. The Tribe estimates that it needs at least $235,000 to be able to offer competitive wages to its program employees. In addition, the Tribe would like to invest $18,000 in an outdoor learning environment and $75,000 to support Head Start Program Performance Standards. Indigenous learning is based on outdoor environments that reflect tribal culture. The Tribe is in need of funds to plan and develop an outdoor learning environment to support exploration and discovery in forest/beach/wetland/stream. Lastly, the Tribe requests an increase in quality improvement funds to support our students, staff, and families based on community need.

Child Care and Development Block Grant. Our Tribe supports the President's request for providing $7.3 billion in discretionary funds for the Child Care and Development Block Grant. This program supports low-income, working families within our Tribe by providing access to affordable, high quality child care. Adequate child care is essential for our tribal members. The pot of child care money going to Tribal governments from this program needs to be bigger so that the portions of it that Tribes receive can meet their needs. The overall funding amount for the Child Care Development Fund needs to be increased and Tribes should get a 5% set-aside from it. Indian Country, including our Tribe, have a strong need to access the Fund for facility purposes. An increase in funding for the Child Care and Development Block Grant would allow the Tribe to increase and enhance services intended to serve its youth.

Low-Income Home Energy Assistance Program (LIHEAP). We appreciate the President's request to increase funding for the LIHEAP Program by $100 million for a total of $3.85 billion. The LIHEAP Program assists low-income households to pay a proportion of household income for home energy, primarily in meeting their immediate home energy needs. Currently, the Tribe receives $23,979 from LIHEAP to assist its members, but there continues to be an unmet need. The Tribe requests an increase in LIHEAP funding to assist our tribal members in paying their home energy bills. Any decrease or in the current level of funding in the LIHEAP Program would cause significant hardship to the Tribe's members. We also request that a tribal set-aside for the LIHEAP Program be established.

CONCLUSION

Thank you for the opportunity to share our interests regarding FY 2022 appropriations for programs and services that will greatly benefit us as well as other tribes across the United States. On behalf of the Port Gamble S'Klallam Tribe, we thank you and your dedication and continued hard work in protecting the tribal interests. We know that you will be fighting for Indian Country in the appropriations process.

[This statement was submitted by Jeromy Sullivan, Chairman, Port Gamble S'Klallam Tribe.]

PREPARED STATEMENT OF PUBLIC HEALTH-SEATTLE & KING COUNTY, WA

Chair Murray, Ranking Member Blunt, and members of the Subcommittee, my name is Brad Finegood and I work for King County (WA) as a Strategic Adviser for Public Health-Seattle & King County in Seattle, WA.

I am pleased to submit testimony on behalf of King County, WA to urge Congress to appropriate $120 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) at the Department of Health and Human Services (HHS) to save lives and address the overdose crisis by supporting and expanding access to syringe services programs (SSPs).

King County, WA is seeing an unprecedented surge in overdose deaths. In 2020, there were 510 confirmed overdoses in the county, which is more than the 422 experienced in 2019. There has been a year over year rise over the past decade when there were 245 overdose fatalities in 2011. The majority of the drug overdoses include opioids, although a rising number of overdoses also contain stimulants both alone and in polysubstance use overdoses. Our county is also besieged by fentanyl rising from 3 fentanyl related overdose deaths in 2015, to 172 in 2020 with 135 confirmed fentanyl overdoses already in 2021 (as of date authored). We know that access to sterile use equipment is one of the evidence-based interventions that keeps individuals engaged in health services, decreases the likelihood of transmissible diseases and keeps individuals alive.

The United States is experiencing an urgent and unprecedented drug overdose crisis, with more than 100,000 overdose deaths expected to be counted in 2020 and potentially more in 2021. Overdose deaths are expected to have increased by more than 40% than the previous record year of 2019. According to the Washington Department of Health, overdose deaths accelerated in Washington in 2020, increasing by 38% in the first half of 2020 compared to the first half of 2019. The infectious diseases associated with opioid and other drug use also have dramatically increased. Since 2010, the number of new hepatitis C infections has increased by 380%. Outbreaks of viral hepatitis and HIV among people who inject drugs continue to occur nationwide.

Overdose deaths have increased more dramatically among Black people and communities of color. From 2015 to 2018, overdose deaths among African Americans

more than doubled (by 2.2 times) and among Hispanic people increased by 1.7 times while increasing among white, non-Hispanic people by 1.3 times. In Washington, the increase in overdose deaths was highest among groups already dealing with inequitable health outcomes: American Indian/Alaska Natives, Hispanic/Latinx, and Black people.

SSPs are an essential component of preventing overdose deaths. Tacoma Needle Exchange proudly services clients, who can exchange their used injection supplies for sterile syringes, which helps prevent the spread of blood-borne pathogens like HIV. Other services include safe injection supplies, naloxone training and distribution, safer sex supplies, and referrals for medication assisted treatment and other medical services. Our outreach staff attempts to meet people where they are at, and to help them address their needs in the safest and healthiest way possible, free of judgement and stigma.

Congress must respond to the overdose crisis, as well as work to prevent and reduce infectious diseases related to drug use, such as HIV and hepatitis C by supporting and expanding access to syringe services programs (SSPs). The CDC has documented over 30 years of studies that show that SSPs reduce overdose deaths and infectious diseases transmission rates as well as increase the number of individuals entering substance use disorder treatment. These studies also confirm that SSPs do not increase illicit drug use or crime and save money.

SSPs are among the only health care services trusted and used by people who use drugs and so can effectively engage this highly stigmatized population. SSPs help protect the community (including first responders) by ensuring safe disposal of syringes, reducing rates of infectious diseases, and can help providing a pathway to effective mental health and alcohol and other drug treatment and to other medical care.

SSPs are the most effective way to get naloxone—a drug which reverses an opioid overdose—into the hands of people who use drugs, who are most likely to be at the scene of an overdose. People who use drugs are an essential partner in preventing overdose fatalities and are best reached by SSPs. With additional resources, SSPs can reach more people with naloxone, which would help reduce the dramatically increasing number of overdose deaths.

Unfortunately, the nation has insufficient access to SSPs and the COVID–19 pandemic has decreased access to these life-saving services during a time when the need for services has increased dramatically. In January 2021, Drug Policy Alliance conducted a survey of SSPs that showed that 91% of respondents experienced an increase in clients in 2020, many as a result of the COVID–19 pandemic. During this time of skyrocketing need, 42% of respondents experienced funding cuts in 2020 and expect such shortfalls to continue in 2021. As a response to funding shortfalls, many SSPs have been forced to lay off staff and reduce services. In King County service availability has been limited so individuals experienced limited access to life saving interventions like needle exchange and naloxone. Consequently, because of these decreased and limited resources, SSPs cannot reach the millions of people who may benefit from their life-saving services.

Federal funding would expand access to these critical and effective programs. Tacoma, WA's NASEN's statistics show that there are only approximately 400 SSPs operating nationwide. Experts estimate that to sufficiently expand access to SSP programs, the U.S. would require at least 2,000 programs—5 times the number in existence now.

A recent study that assessed the startup costs of an individual program estimated that it would cost (in 2020 dollars) $490,000 for a small rural program and $2.1 million for a large urban program, resulting in an average start-up cost of $1.3 million per program. Based on these numbers the requested funding would provide an 10% increase to currently operating SSPs to help address funding shortfalls and also expand the number of SSPs nationwide.

Finally, expanding access to SSPs will reduce health care costs, including for infectious diseases treatment. Hepatitis C treatment can cost more than $30,000 per person, while HIV treatment can cost upwards of $560,000 per person. Averting even a small number of cases would save millions of dollars in treatment costs in a single year.

The Infectious Diseases and Opioid Epidemic Program at CDC helps to eliminate infections related to injection drug-use and improve their prevention, surveillance, and treatment. It also strengthens and expands access to syringe services programs. In FY2019, CDC began several projects to expand capacity of SSPs nationwide through technical assistance to ensure high-quality, comprehensive services and best practices. With additional FY22 funding, CDC could significantly expand SSPs at this critical time to help prevent overdose deaths, the spread of HIV and viral hepatitis and connect people to life-saving medical care.

On a personal note—in addition to leading the overdose prevention work for King County, I am the brother of overdose victim. Every single person who counts as a fatal overdose is a family member to someone and an individual that could have been saved. We have the tools; we just need the funding to help implement.

I want to thank the Subcommittee for its past funding of the CDC Infectious Diseases and Opioid Epidemic program and urge Congress to provide $120 million for the program in FY22. Thank you also for your time and consideration of my testimony, and please do not hesitate to contact me at brad.finegood@kingcounty.gov if you have questions or need additional information.

Sincerely.

[This statement was submitted by Brad Finegood, MA, LMHC, Strategic Adviser, Public Health-Seattle & King Co., King County, WA.]

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION

PHA'S FISCAL YEAR 2022 L-HHS APPROPRIATIONS RECOMMENDATIONS

—At least $46.1 billion in program level funding for the National Institutes of Health (NIH).

—Proportional funding increases for NIH's National Heart, Lung, and Blood Institute (NHLBI); the National Institute of Child Health and Human Development (NICHD), and the National Center for Advancing Translational Sciences (NCATS).

Chairwoman Murray, Ranking Member Blunt and distinguished members of the Subcommittee, thank you for your time and your consideration of the priorities of the pulmonary hypertension (PH) community as you work to craft the FY2022 L-HHS Appropriations bill.

ABOUT PULMONARY HYPERTENSION

Pulmonary hypertension (PH) is high blood pressure that occurs in the arteries of the lungs. It reflects the pressure the heart must apply to pump blood from the heart through the arteries of the lungs. As with a tangled hose, pressure builds up and backs up forcing the heart to work harder and less oxygen to reach the body. PH symptoms generally include fatigue, dizziness and shortness of breath with the severity of the disease correlating with its progression. If left undiagnosed or untreated it can lead to heart failure and death. In recent years, innovative treatment options have been developed and approved for PH. The effectiveness of current treatment options depends on accurate diagnosis and early intervention.

ABOUT PHA

Headquartered in Silver Spring, Md., the Pulmonary Hypertension Association (PHA) is the country's leading PH organization. PHA's mission is to extend and improve the lives of those affected by PH. PHA achieves this by connecting and working together with the entire PH community of patients, families, health care professionals and researchers. The organization supports more than 200 patient support groups; a robust national continuing medical education program; a PH clinical program accreditation initiative; and a national observational patient registry.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Due to the serious and life-threatening nature of PH, it is common for patients to face drastic health interventions, including heart-lung transplantation. To ensure HRSA can continue to make improvements in donor lists and donor-matching please provide HRSA with an increase in discretionary budget authority in FY2022.

NATIONAL INSTITUTES OF HEALTH

Please provide NIH with meaningful increases—including at least $46.1 billion in program funding in FY2022—to facilitate expansion of the PH research portfolio and continued improvement in diagnosis and treatment. NHLBI and PHA have partnered on a groundbreaking clinical study, the Redefining Pulmonary Hypertension through Pulmonary Vascular Disease Phenomics (PVDOMICS) program (RFA–HL–14–027 and RFA–HL–14–030). By collecting information from nearly 1,200 participants with various types of PH, subjects at risk for PH, and healthy controls, PVDOMICS hopes to find new similarities and differences between the cur-

rent WHO classifications of PH. This research is intended to lead to identification of both endophenotypes of lung vascular disease and biomarkers of disease that may be useful for early diagnosis or for assessment of interventions to prevent or treat PH.

Data from the original cohort is currently being prepared for publication and the rich resources of PVDOMICS have spurred many presentations at national and international meetings. With its novel approach to enrollment and data analysis, PVDOMICS is poised to change our thinking about pulmonary hypertension and its classification in the upcoming years.

PROPER HEALTH COVERAGE AND ACCESS

The PH community is concerned that the Centers for Medicare and Medicaid Services (CMS) is allowing insurance payers to refuse to accept charitable copay and premium assistance on behalf of patients with complex, chronic and life-threatening conditions like PH. Because of breakthroughs in research, PH patients are able to utilize life-sustaining treatments that allow them to manage this potential fatal condition and lead relatively normal lives. When patients are denied access to financial assistance they are forced to choose between necessities: between dramatically shortening their lives by giving up medication in order to afford housing and food or continuing medication while starting their families on the road to bankruptcy. We aware of the Subcommittee's continued requests for an explanation of this practice targeting rare disease patients. We ask that this Subcommittee once again ask CMS to explain this decisions and encourage them to fix this problem that is greatly affecting the rare disease community.

PHA also asks the Subcommittee to urge CMS to increase incentives for the supply of oxygen that affects all oxygen modalities including both liquid and portable supplies. This increased flexibility will increase patient's quality of life at home and in their communities.

PATIENT PERSPECTIVES

Chandani's three-year-old son was diagnosed with severe PH in July 2020 at the age of two. Chandani is a physician herself and so she understands all too well the seriousness of her son's prognosis. Since his diagnosis last year, her son's medical care team has tried progressively increasing therapies in a stepwise fashion, which is often required by insurance companies but is known to lead to worse outcomes than when patients are allowed to immediately begin the treatment prescribed by their doctor.

Currently, Chandani's toddler is receiving three oral drugs in addition to a subcutaneous infusion, all for PH. As of the end of April, he has not been responsive to these therapies which unfortunately indicates a poor prognosis. Currently, without a transplant, her son has a 60% chance of survival over the next five years, and if he were to receive a double-lung transplant, it would statistically add 2.7 years to his life. Studies show that self-reported quality of life for patients with pulmonary hypertension ranks worse than cancer patients. Research and treatment are vitally needed for this disease that has such a fatal prognosis and a poor quality of life.

Denise has a health insurance plan with a $3,000 deductible. She uses a manufacturer copay card to pay for the first of her life-sustaining pulmonary hypertension (PH) medications. However, Denise's health insurance plan will not apply the copay card to her deductible, so when Denise fills the prescription for her second medication, she is responsible for her entire deductible out-of-pocket. When Denise was renewing her health insurance coverage for the year, this information was hidden from her. She was told about other changes to the plan, but the shift to a copay accumulator was never mentioned, nor could Denise find the relevant information online.

Barbara has lived with PH for 21 years and with the treatment of liquid oxygen, she has managed to develop a comparatively active life filled with volunteer work and visits with her children and grandchildren. However, that changed in April 2021 when Barb's Medicare-contracted oxygen supplier stopped delivering liquid oxygen without notice. Instead, they began providing compressed oxygen gas tanks.

Liquid oxygen tanks are light enough to be carried hands-free strapped to the back and hold a sufficient volume of oxygen to provide a continuous stream for 6–8 hours at a time so that Barb is able to breathe easily while still walking around. By contrast, compressed oxygen tanks are heavier and hold a smaller volume of oxygen, so they sustain her for only a fraction of the time that liquid oxygen tanks do. To carry a compressed oxygen tank with her, she must wheel it behind her or struggle with the weight and bulk of the tank if attempting to carry them on her back and change them out every couple of hours.

These new limitations to her lifestyle due to the loss of appropriate treatment for her PH have caused a steep decline in her mood and quality of life and she has quickly become depressed; at a recent visit with her physician, she was told "I've never seen you this bad." The mobility and ease that using a liquid oxygen tank provides Barb is the difference between struggling to complete one errand in a day, versus running multiple errands, feeling capable of going out to have lunch with friends, or being able to comfortably visit her seven grandchildren.

In the past weeks, Barb has spent precious energy calling 30 suppliers within a 100-mile radius of her home searching unsuccessfully for anyone else to provide her with the correct treatment for her PH condition. In her efforts to find out more about the loss of access to liquid oxygen, Barb has heard from many other PH patients from across the country who are experiencing the same situation. This restriction of access to liquid oxygen represents a collective loss in quality of life for the community of PH patients that could have long-lasting and far-reaching consequences for an already serious, degenerative disease.

Thank you again for your consideration of the PH community's priorities as you develop the FY2022 L–HHS Appropriations bill.

[This statement was submitted by Matt J. Granato, LL.M., MBA, President and CEO, Pulmonary Hypertension Association.]

PREPARED STATEMENT OF ANDREW REAMER

I write to request that the report of the Senate Committee on Appropriations accompanying appropriations legislation for Labor, Health and Human Services, Education, and Related Agencies include language that directs the Bureau of Labor Statistics (BLS), U.S. Department of Labor, to provide memoranda to the Subcommittee, and to the Senate Committee on Health, Education, Labor, and Pensions, regarding the following topics:

—Approaches to accurately measuring the extent and nature of telework and remote work in the United States, by geography and industry, with the implications for future appropriations.

—Approaches to creating a new principal federal economic indicator on well-being, with implications for future appropriations.

—Possible impacts of the Census Bureau's new Disclosure Avoidance System on BLS data derived from Census Bureau statistics and used to determine the allocation of federal financial assistance to states, local areas, and households.

I provide information below in support of this request. I write as a research professor at the George Washington Institute of Public Policy, George Washington University, with a focus on the role of the federal government in facilitating national economic development and competitiveness.

Measures of Telework and Remote Work. News reports make clear that the pandemic has catalyzed a substantial increase in the number of employees who telework from home in lieu of commuting to an office and those who work from a geographic location different than the office to which they report. For the purposes of public policy and business decision-making, BLS statistics should provide reliable estimates of telework and remote work by geography and industry.

My research (available here) identifies 14 federal data collections that independently measure the extent and nature of remote work. Eight collected such data before the pandemic; six added telework questions in response to the pandemic. Six are household surveys, six are establishment surveys, and two prepare occupational profiles. Six are conducted by BLS, five by the Census Bureau, and one each by the Employment and Training Administration, the Federal Highway Administration, and the Office of Personnel Management.

While BLS and other federal agencies are to be lauded for their proactive efforts, it would be desirable to rationalize the plethora of data collections so that BLS may point to a single data series as the most appropriate measure. The choice made will have implications for future appropriations. Consequently, I recommend that the Senate Appropriations Committee report accompanying Labor Department appropriations legislation include a directive that BLS provide the Subcommittee with its views on the preferred approach to measuring telework and remote work and resource requirements to implement it.

Measures of Well-being. Numerous scholars, such as Carol Graham of the Brookings Institution and Angus Deaton and Anne Case of Princeton University, demonstrate through their research the significant increase in despair and deaths of despair, particularly among the white working class. As with telework, several federal agencies are independently seeking to measure the extent of and reasons for despair inside American households and, at present, there is no single reliable, consensus

measure of well-being akin to Principal Federal Economic Indicators such as the unemployment rate and the poverty rate.

For FY2021, Congress appropriated funds for BLS to conduct the Well-Being Module of the American Time Use Survey (ATUS). I recommend that Senate Appropriations Committee report language for FY2022 appropriations direct BLS provide the Subcommittee with its views on approaches to creating a reliable, useful well-being indicator and the resources necessary to produce it.

Impacts of Census Differential Privacy Protocols on BLS-guided Federal Financial Assistance. To ensure adherence to Title 13 requirements for confidentiality, the Census Bureau is implementing a new Disclosure Avoidance System (DAS) based on differential privacy protocols that inserts distortions within certain agency datasets while maintaining system-wide statistical accuracy. BLS labor force and price statistics rely on Census Bureau data collections that may be affected by the new DAS; several federal departments use BLS state and local statistics, such as unemployment rate, to determine program eligibility and allocate by formula billions of dollars in federal financial assistance. At the moment, the effect of the new DAS on the geographic allocation of federal funding is not understood. Consequently, I encourage the Subcommittee to direct BLS to identify which of its datasets might be affected by the new Census DAS and, by extension, which federal funding programs might be affected as well, and how.

Note: I gathered the information contained above through my sponsored research and as the research organization representative on the Workforce Information Advisory Council (WIAC) of the U.S. Secretary of Labor. I submit the above request as a private citizen and not as a representative of any organization or body.

[This statement was submitted by Andrew Reamer, Research Professor, George Washington Institute of Public Policy, George Washington University.]

PREPARED STATEMENT OF RESEARCH!AMERICA

On behalf of the Research!America alliance, thank you for this opportunity to submit testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on Fiscal Year 2022 (FY22) appropriations. We are grateful that for FY21, the base budgets of the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) were increased and the base budget of the Agency for Healthcare Research and Quality (AHRQ) was maintained, and that the Subcommittee additionally provided dedicated funding for critical research programs. The need for faster medical and public health progress has never been more apparent. Our nation has an opportunity, and on behalf of every American, the obligation, to fight health threats faster, learn from this pandemic to bolster public health capacity and preparedness, and leverage evidence as never before to optimize health care delivery. In that context, we ask that you provide an increase in the base budget (exclusive of new initiatives) for NIH of at least $4.29 billion, for a total of $47.22 billion; an increase of at least $2.18 billion for CDC, for a total of $10 billion; and an increase of at least $162 million for AHRQ, for a total of $500 million, in FY22.

THE NATIONAL INSTITUTES OF HEALTH

We believe it is in the strategic interests of the U.S. to increase funding for NIH to at least $47.22 billion in FY22, an increase of 10% over FY21 funding. Our nation and the global community have witnessed the broadscale impact of a global pandemic, but the reality is that every American either experiences directly or is the loved one of an individual who dies prematurely of a health threat that we can overcome. NIH-conducted and funded research uncovers new knowledge that is the prerequisite to conquering these threats. No entity, in the U.S. or across the globe, has done more to propel academic and private sector progress that saves lives.

NIH funds almost 50,000 competitive grants that are awarded to researchers at over 500 universities, medical schools, and educational institutions in every state. NIH also plays an integral role in educating and training America's future scientists and medical innovators by sponsoring fellowships and training grants.

We believe our nation should seize the opportunity to change the course of history such that we can out-innovate emerging threats and all live longer, healthier lives. Please allocate at least $47.22 billion in FY22 for the base budget of NIH, an increase of 10% over FY21 funding.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION

We urge you to fund the Centers for Disease Control and Prevention (CDC) at a level of $10 billion in FY22, a 27% increase over FY21 enacted. As demonstrated by the ongoing COVID–19 pandemic, public health threats do not respect international borders, and in our increasingly globalized world, we are more vulnerable than ever to emerging, deadly infectious diseases.

CDC is tasked with protecting and advancing the nation's health, and over the past 70 years it has worked diligently to thwart deadly outbreaks and debilitating disease. Moreover, CDC plays a key role in research that leads to life-saving vaccines, bolsters our nation's defense against and response to bioterrorism, and improves health tracking and data analytics.

CDC has been an integral part of the effort to mitigate and defeat COVID–19. Their 24/7 response and the guidance that has emerged from their efforts has empowered our nation to weather this pandemic, but their role as the key first responder when major threats emerge is just part of their contribution to Americans' health, safety, and wellbeing.

CDC is at the forefront of prevention; is working hard and effectively to forestall antibiotic resistance; is the lead federal agency responsible for tracking and forestalling foodborne illness and other local and regional outbreaks; investigates cancer clusters; and protects, investigates, and advances the health of every one of us in myriad ways. Our nation has underfunded CDC at risk to every American: we need to empower this agency to advance the best interests of every American by protecting and advancing the health of all Americans.

The ongoing COVID–19 pandemic, in addition to past outbreaks of Ebola, Zika, influenza, and measles, have shown just how critical CDC is to the health of our nation and have also revealed the enormity of the challenge the agency faces as it works to safeguard American lives. To protect us, CDC scientists must be on the ground fighting public health threats wherever and whenever they occur. We cannot allow a gap between the funding provided to CDC and the demands and challenges placed before the agency. We request that CDC receive at least $10 billion in FY22, $2.18 billion over FY21 funding, to ensure the agency can carry out its crucially important responsibilities.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

We urge you to fund AHRQ at a level of $500 million, a 47.9% increase over FY21 funding, in FY22. AHRQ has been grossly underfunded for decades relative to its mission and the lives and dollars this agency could save if appropriately equipped. AHRQ is the lead federal agency tasked with making sure our nation is not simply making medical progress, but that this progress translates into more effective, efficient, and affordable health care for Americans across the country. As it stands, our nation overspends by an estimated $1 trillion each year and abides deadly medical errors that cost at least 100,000 lives each year because we don't deploy strategies to address inefficiencies and errors in health care. Now is the time to empower AHRQ to address this massive, counterproductive challenge.

AHRQ-funded research identifies and highlights how to stop waste of limited health care dollars, empowering patients to receive the right care at the right time in the right settings. For example, AHRQ-funded research informed the creation of an Antibiotic Stewardship Program (ASP) in 402 hospitals across the U.S. to address the overprescription of antibiotics, which can ultimately lead to them being ineffective. This research program successfully reduced the length of time patients needed to be on antibiotic therapy by an average of 30 days. The research also identified key improvements for future ASPs.

The value of medical discovery and development hinge on smart health care delivery. If we underinvest in AHRQ, we are inviting unnecessary health care spending and wasting the opportunity to ensure patients receive the quality care they need.

We appreciate your consideration of our funding requests and thank you, and your respective staff members, for your stewardship over these critically important federal spending priorities.

Sincerely.

[This statement was submitted by Ellie Dehoney, Vice President of Policy and Advocacy, Research!America.]

PREPARED STATEMENT OF THE RESTLESS LEGS SYNDROME FOUNDATION

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, as you work to develop the fiscal year (FY) 2022 Labor-Health and

Human Services Appropriations bill, thank you for considering the views of the community of physicians, researchers, patients, and caregivers affected by Restless Legs Syndrome (RLS). Please keep the needs of this community in mind, especially as you continue to work to address the opioid crisis.

ABOUT THE RLS FOUNDATION

The Restless Legs Syndrome Foundation is a nonprofit § 501(c)(3) organization dedicated to improving the lives of men, women, and children living with this often—devastating neurological condition. The Foundation works to increase awareness, improve treatments, and support research to find a cure. From a few volunteers meeting in a member's home in 1992, the Foundation has grown steadily; it now has members in every state, local support groups, and a track record that includes nearly $2 million provided to support translational research.

ABOUT RLS

Restless legs syndrome (RLS) is essentially an irregular biological drive, like hunger or thirst, that forces affected individuals to keep moving, thus reducing their ability to rest. Patients with this disease experience a deep, viscerally-irritating sensation in the legs that continues to increase until they are literally forced to move their legs or get up and walk; and this sensation only abates so long as the individual keeps moving. RLS is best characterized as a neurological, sensory-motor disorder with symptoms that are triggered from within the brain itself. It is estimated that up to 5 to 7 percent of the U.S. population may have RLS, of which half will have moderate to severe stages of the disease. RLS impacts men, women, and children, though it is 3 to 4 times more common in women and twice as common in older Americans.

Due to the inability to sleep and work, RLS can cause disability, depression, and suicidal ideation, as well as increased risk for co-morbid conditions such as heart attack, stroke, and Alzheimer's. There is no cure, and the current standards of care features several medications, which do not provide life-long coverage. One of the established effective treatment options for this disease is low—total daily dose opioid medications. These are commonly used when all other drug classes have failed. Research and clinical experience indicates that the dose of opioids typically used to manage RLS effectively without addiction or drug tolerance issues is significantly lower than dosages used to treat chronic pain.

FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

The RLS Foundation joins the broader medical research community in thanking Congress for continuing to support the National Institutes of Health with sustainable growth. Please continue to advance scientific progress through proportional funding increases by providing at least a $3 billion funding increase for FY 2022 to bring NIH's budget up to $46.1 billion.

In this regard, please provide proportional funding increases for all NIH Institutes and Centers, including, but not limited to the National Institute of Neurological Disorders and Stroke (NINDS), the National Heart, Lung, and Blood Institute (NHLBI), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH). Research on RLS and similar neurological movement disorders is directly related to efforts targeting the opioid epidemic, as many patients with these disorders utilize very low total daily doses of opioid therapies to manage their condition. Additionally, related sleep disorders research activities impact many conditions and are studied across various Institutes and Centers at NIH.

Please provide $5 million for the National Neurological Conditions Surveillance System (NNCSS) for FY 2022. The NNCSS at the Centers for Chronic Disease Control and Prevention (CDC) collects and synthesizes data to help increase our understanding of neurological disorders and to support further neurologic research. RLS remains a severely misunderstood and underdiagnosed neurological disorder, and increased surveillance is vital to improving patient outcomes.

Please provide at least $5,000,000 for the Chronic Diseases Education and Awareness Program at the Centers for Disease Control and Prevention (CDC). With the cessation of the National Healthy Sleep Awareness Project (NHSAP), CDC presently has no active public health activities dedicated to sleep or sleep disorders, despite the fact that sleep affects nearly every body system and many chronic diseases. Please allow the valuable scientific and public health efforts started during the NHSAP to continue.

RLS AND THE OPIOID CRISIS

While you consider the Committee's work to address the opioid epidemic through this fiscal year's appropriations bill, the RLS Foundation asks that you protect the needs of patient communities who depend on appropriate access to low total daily doses of opioid therapies to manage their debilitating condition. RLS is not a chronic pain condition, and many in our community utilize these medications to treat underlying neuropathology issues and not sensations of pain. Studies have shown that appropriate access to these therapies allows patients to live productive lives without an increased risk of developing opioid use disorder. As you consider various legislative proposals and work with federal agencies, please consider the needs of patients who rely on the regular use of low total daily doses of opioids to manage RLS by supporting a diagnosis-appropriate safe harbor for RLS patients, so they do not face arbitrary barriers.

I would like to share with you the experience of Stephen Smith from Colorado, a RLS Foundation Discussion Board Moderator. Like all those with RLS, night can bring a feeling of dread. Is this going to be one of those nights when my RLS acts up and I don't get any sleep or will it just be one of those standard nights when my sleep is just poor?

About a year ago, I had one of those nights when my RLS acted up and I knew that I wasn't going to get any sleep at all. So I called my doctor's night service and was instructed to go to the local hospital's Emergency Room and to tell them to call my doctor.

Contrary to hospital policy, the ER doctor decided not to call and also didn't understand RLS or my insomnia complaints. But he jumped on my depressed feelings from insufficient sleep combined with my RLS pacing, which he assumed was agitation, and the opioid that I take for RLS. He then incorrectly concluded I had a drug problem and was suicidal in spite of being told that I was not. So he placed me under a 72hr psychiatric hold and sent me to a psych hospital 3 hours away. I was shipped 180 miles confined to the back seat of a car with raging RLS. The psych hospital didn't carry one of my RLS meds, tramadol, and forced me to go into withdrawal rather than go to the effort to replace it. The abrupt withdrawal from tramadol led to hours of shakes and sweats followed by even more hours of RLS—like pacing for the second night in a row. Since tramadol also acts as an SNRI antidepressant, the abrupt withdrawal caused me to develop SNRI Withdrawal Syndrome. This caused migraine headaches, severe anxiety and depression, nightmares and dreams centered on the horrible experience of being involuntarily confined to the psych hospital due to a neurological disorder. These symptoms went on for months and required drug treatment for anxiety and psychotherapy for the severe depression.

So, now nightfall brings a feeling of trepidation. Is this going to be another night when my RLS acts up or I cannot fall asleep? If I do manage to sleep, will I once again dream of the nightmare of being confined to the psych hospital all due to failure of a number of doctors to understand RLS or to even listen to their patient who is trying to educate them?

Thank you again for the opportunity to share the views of the RLS community.

[This statement was submitted by Karla M. Dzienkowski, RN, BSN, Executive Director, Restless Legs Syndrome Foundation.]

PREPARED STATEMENT OF ROTARY INTERNATIONAL

Chairwoman Murray, members of the Subcommittee:

Rotary appreciates the opportunity to encourage continuation of funding for FY 2022 to support the polio eradication activities of the U.S. Centers for Disease Control and Prevention (CDC). The CDC is a spearheading partner of the Global Polio Eradication Initiative (GPEI), an unprecedented model of cooperation among national governments, civil society and UN agencies which reach the most vulnerable children through the safe, cost-effective polio immunization. Rotary International requests the Subcommittee provide $176 million for the polio eradication activities of the CDC to ensure recovery of polio eradication progress disrupted by the COVID–19 pandemic, stop polio transmission, protect polio free areas, and leverage the resources developed through this global effort for continued value-added impact. The 300,000 members of Rotary clubs in the US appreciate the United States' generous support and longstanding leadership. Rotary, including matching funds from the Gates Foundation, has contributed more than $2.2 billion and thousands of hours of volunteer service to protect children from polio; and will continue this work until the world is certified polio free. Continued US leadership will help achieve a polio

free world and ensure the continued global health contribution of polio eradication infrastructure and resources.

PROGRESS IN THE GLOBAL PROGRAM TO ERADICATE POLIO

Since the launch of the GPEI in 1988, eradication efforts have led to more than a 99.9% decrease in cases. Thanks to this committee's support, over 19 million people have been spared disability, and over 900,000 polio-related deaths have been averted. In addition, more than 1.5 million childhood deaths have been prevented, thanks to the systematic administration of Vitamin A during polio campaigns.

In 2020, the WHO AFRO region was certified wild polio virus-free after four years without detecting any cases, making it the fifth of six WHO regions to eliminate the virus. This achievement follows the certification of the eradication of Type 3 (WPV3) in October 2019 and wild poliovirus type 2 (WPV2) in September 2015. The eradication of wild polio virus from regions and eradication of strains of the polio virus is further proof that a polio-free world is achievable.

Only two countries, Afghanistan and Pakistan, have confirmed cases of wild polio since August of 2016. As of 3 June 2021, only 2 cases of wild polio virus have been confirmed—one each in Pakistan and Afghanistan. Significant reductions in detection of virus transmission in environmental samples in 2021 are also cause for cautious optimism. Both countries are working to capitalize on low levels of virus transmission by working to reach missed children, prioritizing communities which have had low coverage or which have been resistant to immunization; and ensuring thorough microplanning of immunization and other eradication activities. In Afghanistan, there are increased efforts to target children living in areas which have been inaccessible. This ongoing work is challenging within the context of the NATO withdrawal of troops and related insecurity.

Outbreaks of circulating vaccine-derived poliovirus are ongoing in several countries across Africa and Asia and require continued focus and attention. These were further exacerbated by COVID–19 pandemic-related disruptions in immunization campaigns. These outbreaks are not a failure of the vaccine, but result from a failure to sustain sufficiently high levels of routine immunization which causes the live, but weakened form of the virus used in the vaccine to revert over time to a more virulent, wild-like form. The program has developed a specific Strategy for the Response to Type 2 Circulating Vaccine-Derived Poliovirus, including the use of a new, more genetically stable vaccine, the novel oral polio vaccine type 2 (nOPV2), for outbreak response.

The COVID–19 pandemic has posed new challenges for global polio eradication activities. In order to protect communities and staff, the Global Polio Eradication Initiative paused immunization campaigns and other essential activities for several months in 2020. In countries that have successfully resumed activities, the programme has developed strategies for prevention and control of COVID–19 and is providing resources such as masks and hand sanitizer to keep frontline health workers protected while ensuring that campaign elements meet physical distancing requirements.

As a result of the pause on activities, and also due to the potential exposure to COVID, the number of vulnerable children has increased the real threat for wider spread of the virus. UNICEF, WHO and Gavi estimate that at least 80 million children under the age of one are at risk due to the COVID–19 related disruption to vaccination activities. These challenges are further compounded by the extraordinary economic and financial constraints in both at-risk countries and from donors which may divert essential political and financial commitments.

This combination of progress in the midst of ongoing challenges underscores the urgency of continued focus to protect the vulnerable gains made toward polio eradication as the COVID–19 pandemic continues to disrupt polio immunization and eradication activities; and to stop polio virus transmission in these most complex environments while sustaining high levels of population immunity in polio free areas. Continued support for global surveillance is also essential to monitor and detect cases and virus transmission and provide confidence in the absence of cases.

CDC'S VITAL ROLE IN GLOBAL POLIO ERADICATION PROGRESS

The United States is the leader among donor nations in the drive to eradicate polio globally. Congressional support to CDC has supported the following essential polio eradication activities:

Leadership on surveillance and disease detection. CDC's Atlanta laboratories serve as a global reference center and training facility, providing expertise in virology, diagnostics, and laboratory procedures, including quality assurance, and genomic sequencing of samples obtained worldwide, and training virologists from around the

world in advanced poliovirus research and public health laboratory support. CDC also provides the largest volume of operational (poliovirus isolation) and technologically sophisticated (genetic sequencing of polio viruses) lab support to the 145 laboratories of the Global Polio Laboratory Network (GPLN). CDC also developed methods to directly detect poliovirus from patient stool specimens, allowing faster detection. Specific support was also provided to expand environmental surveillance to detect and respond to vaccine-derived poliovirus outbreaks in Democratic Republic of the Congo, Nigeria, Somalia, and Kenya.

CDC provides critical technical capacity and program management expertise which directly contributes to polio eradication activities and is also used to build in-country capacity.

—CDC supported the international assignment of technical staff on direct 2-year assignments to WHO and UNICEF to assist polio-endemic and polio-reinfected priority countries. Funding was also provided to WHO for surveillance, technical staff and immunization activities' operational costs, primarily in Africa.

—CDC's Stop Transmission of Polio (STOP) members continue to play a key role in providing expertise on polio surveillance, data management, campaign planning, implementation and evaluation, program management, and communications in high-risk countries. In 2020, 210 public health professionals were deployed in 42 countries with two-thirds deployed to the African Region, contributing substantially to the region's achievement of wild polio-free status in 2020. STOP program participants worked to improve broader vaccine-preventable disease (VPD) surveillance. In 2020 STOP participants also supported local governments to promote awareness of COVID–19 and provide contract tracing.

—In Afghanistan, CDC led a comprehensive data review in 2020 that evaluated and streamlined data collection to increase efficiency of the evidence-based decision making in campaigns.

—In Pakistan, CDC worked with the government to transform structural and managerial components of the polio program. CDC and NSTOP assumed a new role to improve evidence-based decision making through data usage and risk assessment in the core reservoir districts/towns. CDC also provided broad support to the COVID–19 response in Pakistan, including trainings, case identification, investigation and tracking, and lab sample collection.

—CDC also provided expertise in technical advisory groups, EPI manager and other key global polio meetings.

—CDC also provided instrumental support internationally and domestically in the areas of disease surveillance, health worker training, contact tracing, risk communications and testing through extensive assignment of Atlanta-based polio staff to the CDC COVID–19 response and through support provided to the COVID–19 pandemic response by polio staff in Afghanistan, Pakistan, and across Africa. CDC's commitment to polio eradication is firm and knowing that CDC's polio eradication program operates in some of the most vulnerable places in the world, the agency is determined to do its part in defeating the COVID–19 pandemic.

CDC also works to build Country-level Capacity.

—In collaboration with the Pakistan Ministry of Health, WHO and USAID's mission in Islamabad, CDC trained 88 national epidemiologists from CDC's Field Epidemiology Training Program (FETP) and deployed them to the highest risk districts for circulation of wild polio virus to help improve the quality of surveillance and immunization activities there and to strengthen routine immunization systems.

—CDC also trained and supported 230 staff at the Local Governing Area level in the highest risk states through CDC's National STOP program for Nigeria, playing a key role in interrupting transmission of wild polio. CDC also contributed to UNICEF's expansion of a Community Based Vaccinator Program in Pakistan that includes over 24,000 workers who reach 4 million children annually with both oral and inactivated polio vaccine (IPV); and $3 million for operational costs for NIDs in all polio-endemic countries and outbreak countries. Most of these NIDs would not take place without the assurance of CDC's support.

CDC provided key leadership in development and rollout of novel oral poliovirus vaccine (nOPV), a new tool for polio eradication through preclinical development, laboratory testing and support for nOPV clinical trials. The new vaccine has low neurovirulence, is genetically stable (low reversion rate), can be scaled to production levels, is highly immunogenic, and was safe and well tolerated in vaccine trials. Initial use of nOPV2 is taking place in countries that have secured national immunization and regulatory group approvals and have met strict criteria.

FISCAL YEAR 2022 BUDGET REQUEST

We respectfully $176 million in FY2022 for the polio eradication activities of CDC, the level appropriated by Congress in FY 2021. CDC's priorities are to stop virus transmission in the remaining polio endemic and outbreak countries. CDC will also work with governments and partners in countries experiencing cVDVP outbreaks to resume high quality vaccination campaigns and to boost routine immunization to close immunity gaps. This includes reaching an estimated 80 million children who are vulnerable due to COVID–19 pandemic related disruptions. CDC will also work to address pandemic-related surveillance gaps to safeguard global disease detection and response capacity. CDC will continue planning for a post-polio transition to advance broader global vaccine-preventable diseases (VPD) control and elimination/eradication targets as outlined in CDC's Global Immunization Strategic Framework 2021–2030.

THE ROLE OF ROTARY INTERNATIONAL

Rotary is a global network of leaders who connect in their communities and take action to solve pressing problems. Since 1985, polio eradication has been Rotary's flagship project, with members donating time and money to help immunize nearly 3 billion children in 122 countries. Rotary's chief roles are fundraising, advocacy (including resource mobilization and political advocacy), raising awareness and mobilizing volunteers. There are nearly 300,000 members throughout the United States who have raised more than US$400 million of the more than US$2.2 billion Rotary has contributed to the Global Polio Eradication Initiative. This represents the largest contribution by an international service organization to a public health initiative ever. These funds have benefited 122 countries to buy vaccine and the equipment needed to keep it at the right temperature, and support the means to ensure it reaches every child. More importantly, tens of thousands of our volunteers have been mobilized to work together with their national ministries of health, UNICEF and WHO, and with health providers at the grassroots level in thousands of communities.

Rotary also plays a key role in encouraging country level accountability. Rotary has National PolioPlus Committees, in the endemic countries and over 20 outbreak/at-risk countries. These national committees work to keep the spotlight on polio eradication amidst competing priority from the community level to the federal level.

BENEFITS OF POLIO ERADICATION

Since 1988, tens of thousands of public health workers have been trained to manage massive immunization programs and investigate cases of acute flaccid paralysis. Cold chain, transport and communications systems for immunization have been strengthened. The global network of 146 laboratories and trained personnel established by the GPEI also tracks measles, rubella, yellow fever, meningitis, and other deadly infectious diseases including COVID–19 and will do so long after polio is eradicated. $27 billion in health cost savings has resulted from eradication efforts since 1988. A sustained polio free world will generate $14 billion in expected cumulative cost savings by 2050, when compared with the cost countries will incur for controlling the virus indefinitely. Polio eradication is a cost-effective public health investment with permanent benefits. As many as 200,000 children could be paralyzed annually in the next decade if the world fails to capitalize on the more than $18 billion already invested in eradication. Success will ensure that the investment made by the US, Rotary International, and many other countries and entities, is protected in perpetuity.

[This statement was submitted by Anne L. Matthews, Chair, Rotary's Polio Eradication Advocacy Task Force.]

PREPARED STATEMENT OF THE RYAN WHITE MEDICAL PROVIDERS COALITION

Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, my name is Dr. Rachel Bender Ignacio and I serve as an HIV primary care physician at the Madison Clinic and Director of the AIDS Clinical Trials Unit at Harborview Medical Center in Seattle, Washington. I am pleased to submit testimony on behalf of the Ryan White Medical Providers Coalition (RWMPC) of the HIV Medicine Association (HIVMA). I currently serve on the Board of Directors of HIVMA. RWMPC is a national coalition of medical providers and administrators who work in healthcare agencies supported by the Ryan White HIV/AIDS Program

funded by the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA).

First, I would like to thank the Subcommittee for increasing FY21 funding for both the Ryan White Program and the Bureau of Primary Health Care at HRSA by funding the bipartisan Ending the HIV Epidemic (ETE) initiative. Supporting the ETE initiative will help target jurisdictions scale up their ability to end the HIV epidemic by increasing access to HIV testing, prevention, care, and treatment services critical to reducing HIV transmission. However, expanding the Ryan White Program even further now would help jurisdictions nationwide address ending the HIV epidemic. To achieve this expansion, I request $225.1 million (a 10% or $24 million increase) in FY22 for Ryan White Part C, which supports approximately 350 HIV medical clinics nationwide.

RWMPC also requests additional resources for the ETE initiative to expand access to HIV prevention, care, and treatment, including $364 million for HRSA's ETE program. This funding would include $212 million for the Ryan White Program to provide additional HIV care and treatment, as well as $152 million for the Bureau of Primary Health Care to support HIV prevention services, including providing Pre-Exposure Prophylaxis (PrEP), medication to prevent HIV. These funding levels also were requested by the President's FY22 budget request.

It is especially important now that increases for Ryan White Part C or for the ETE initiative be new, additional funding and not a repurposing of current resources. The additional pressure that the COVID–19 pandemic has placed on public health infrastructure and medical facilities, including Ryan White clinics, is significant and limited resources cannot be further stretched.

In fact, COVID–19 has demonstrated why our nation needs to strengthen the public heath infrastructure and medical clinics serving people living with HIV. Ryan White clinics have been critical to providing an effective COVID–19 response and many Ryan White medical providers have been pulled in as leaders of the pandemic response in their jurisdictions. This has worked well as these providers are infectious diseases experts who have significant experience caring for vulnerable populations.

The flexibility of the Ryan White Program and the knowledge and innovation of its medical providers also has allowed Part C clinics to respond to the changing needs of patients and the health care system throughout the transitions and challenges of the COVID–19 pandemic. Part C clinics have helped people with HIV by sustaining access to health care and medication through telehealth and key services, such as case management and transportation; by enrolling new patients who lost their health insurance as a result of the economic downturn; and by providing PPE, food, and housing security during this emergency.

Madison Clinic at Harborview Medical Center in Washington Has Expanded Access to HIV Prevention, Care, & Treatment

Since 1986, the Madison Clinic has served as the leading source of HIV primary care in the Pacific Northwest when its HIV care program was expanded with the assistance of Ryan White Program funding. Since then, the clinic has grown dramatically and now serves 2,800 individuals living with HIV, most with complex medical and psychosocial needs. Approximately 30% of our population is Black or African American (Seattle overall has 7% Black representation), 15% is Latinx, and 10% is Asian, Pacific Islander, or Native American. 47% of patients live at or below the federal poverty level. Like other HIV clinics across the US, ours serves an increasingly aging population, with 60% of patients over the age of 45. As a result, the burden of co-morbid illnesses, such as cancer, cardiovascular disease, and metabolic complications such as diabetes is extremely high. Alarmingly, 12% of patients lack permanent housing, and many patients were negatively impacted by the intersection of housing instability; the opioid epidemic and HIV epidemics; and the COVID–19 pandemic. Madison Clinic, like most Ryan White Part C clinics, also receives support from other parts of the Ryan White Program that help us provide medications, additional medical care, and support services, such as case management and transportation, all key to the comprehensive Ryan White care model that produces outstanding outcomes.

Madison Clinic also provides Pre-Exposure Prophylaxis (PrEP) services across the clinic. This critical HIV prevention tool is integrated at Madison Clinic as part of prevention and primary care services. However, more support for the PrEP program, including for PrEP navigators and lab tests, is needed to scale up these services to meet patient needs.

Many Harborview patients struggle with HIV, substance use disorder (SUD), and related infectious diseases, such as hepatitis C. In response, in partnership with the Public Health Department for Seattle-King County, the Max Clinic was established

to care for people living with HIV who have not yet achieved viral suppression and who experience multiple barriers to care. The Max Clinic serves approximately 200 patients, and receives support from Part B of the Ryan White Program as well as funding from the local Health Department.

Ryan White Part C Clinics are Effective Medical Homes and Public Health Programs

Ryan White Part C directly funds approximately 350 community health centers and clinics that provide comprehensive HIV medical care nationwide, serving more than 300,000 patients each year. These clinics are the primary method for delivering HIV care to rural jurisdictions—approximately half of all Part C providers serve rural communities. The program's comprehensive services engage and keep people in HIV care and treatment. This is critical, because HIV disease is infectious, so identifying, engaging, and retaining individuals living with HIV in effective care and treatment saves lives and benefits public health by stopping HIV transmission when individuals are virally suppressed.

In 2019, more than 88% of Ryan White patients were virally suppressed—an almost 27% increase in the program-wide viral suppression rate since 2010. In 2020, 94% of Madison Clinic patients have been virally suppressed in spite of the complex challenges the COVID–19 pandemic has presented. The Ryan White Part C program's comprehensive services engage and keep people in HIV care and treatment. For example, 98% of HIV patients are on antiretroviral therapy at Madison Clinic. Early, reliable access to HIV care and treatment helps patients with HIV live healthy and productive lives and is more cost effective.

Part C Clinics Are on the Frontlines of the Opioid Epidemic and Provide SUD Treatment

Ryan White clinics serve a significant number of individuals living with both substance use disorder (SUD) and HIV. The majority of Madison Clinic providers have the credentials to prescribe buprenorphine therapy (medication assisted treatment for Substance Use Disorder), and our providers treat viral hepatitis, supported by a multidisciplinary team in our clinic. Part C clinics are able to deliver a range of medical and support services, including overdose prevention and harm reduction services, needed to prevent, intervene, and treat substance use disorder as well as related infectious diseases, including HIV, hepatitis C, and sexually-transmitted infections. The experience and expertise of Ryan White Part C medical providers should be leveraged to effectively respond to the opioid epidemic and overdose crisis and to help rapidly expand access to urgently needed SUD services.

Funding for Prevention and Harm Reduction at CDC and Research at NIH is Critical

While my testimony has focused on HRSA programs, the ability to effectively respond to the syndemics of HIV, substance use disorder, and related infectious diseases such as hepatitis C; sexually transmitted infections; and skin, soft tissue, and endovascular infections depends on CDC funding to enhance surveillance and prevention activities, and on NIH to continue to improve the tools to prevent and treat HIV and SUD and to learn how to effectively implement them. The AIDS Clinical Trials Unit, a member of the AIDS Clinical Trials Group funded by the NIH, is co-located within Madison Clinic and provides direct access for our patients to participate in research that pushes the envelope on HIV and viral hepatitis treatment, including a focus on HIV remission/cure strategies.

We request $371 million for CDC to provide surveillance, response, and other HIV prevention services as part of the ETE initiative, as well as $120 million for CDC to address the infectious diseases consequences of the opioid epidemic, including by supporting and expanding access to syringe services programs, harm reduction, and overdose prevention. Finally, we support continued robust funding for NIH, including for HIV research. This funding supports discoveries that will help to end the HIV, hepatitis C, and opioid epidemics and that have informed the treatment and prevention of COVID–19.

Thank you for your time and consideration of these requests, and please don't hesitate to contact me or Jenny Collier, Convener of the Ryan White Medical Providers Coalition, at jcollier@colliercollective.org if you have any questions or need additional information.

[This statement was submitted by Rachel Bender Ignacio, MD, MPH, HIV Physician and Clinical Researcher at the Madison HIV Clinic.]

PREPARED STATEMENT OF SAFER FOUNDATION

Thank you, Chairwoman Murray, Ranking Member Blunt, and members of the Subcommittee, for inviting me to submit testimony on behalf of the Safer Foundation. My name is Kevin Brown and I serve as the Director of Policy, Advocacy, and Legislative Affairs for the Safer Foundation. For almost 50 years, Safer has provided comprehensive workforce development and reentry services for individuals with criminal legal histories seeking employment. There is dignity in work, and Safer Foundation believes that individuals who have made mistakes should have the opportunity to be self-sufficient and contribute to their families and communities through gainful, living wage employment. Clients come to Safer Foundation because they want and need to work, and Safer helps clients discover career path employment that is personally fulfilling and that pays a living wage.

A critical federal program that supports these efforts is the Reentry Employment Opportunities (REO) program (also known as the Reintegration of Ex-Offenders (RExO) program) within the Department of Labor's Employment & Training Administration. I thank the Subcommittee for providing REO with $100 million in FY21. Given the need to train people for the jobs our economy requires in industries such as health care, technology, and logistics; to help employers identify the qualified workers they need now; and to help people with criminal legal histories find living wage employment to support successful, long-term reentry, I urge the Subcommittee to provide $150 million for the REO program in FY22.

EMPLOYMENT REDUCES RECIDIVISM AND IMPROVE REENTRY OUTCOMES

1 in 3 adults in the United States has a criminal record that interferes with their ability to find a job.[1] The COVID–19 pandemic has underscored existing barriers to employment for people with criminal legal histories. Research shows that sustained, living wage employment and life skills are critical components to long-term reentry success. One study found that individuals who were employed and earning higher wages after release were less likely to return to prison within the first year.[2] The REO program improves reentry success by working with individuals to overcome employment barriers with training for jobs in local high-demand industries through career pathways and industry-recognized credentials and by providing needed reentry supports. Increasing REO funding would expand access to these comprehensive workforce development and reentry services that are especially needed now.

Authorized by section 169 of Workforce Innovation and Opportunity Act (WIOA), the REO program provides workforce preparation and reentry services for both adults and young people. REO includes a set-aside to provide services to prepare youth who are justice-system involved and/or who have not completed school or other educational programs for employment. Research has found that incarceration reduces a formerly incarcerated person's earning potential by more than 52 percent,[3] making workforce development services essential for long-term employment and reentry success. In light of the costs of the criminal legal system at the state, local, and federal levels, the REO program is crucial to incubating community-based models of successful reentry through employment.

COVID–19 has impacted employment opportunities for people with criminal legal histories. During the last economic downturn in 2008, the unemployment rate for people with criminal legal histories was 27%—2 points higher than the unemployment rate during the Great Depression. Increasing support for the REO program is an effective way to ensure that individuals with criminal legal histories, who are disproportionately Black people and people of color, are not left out of the nation's economic recovery.

SAFER'S REO-SUPPORTED SERVICES INCREASE EMPLOYMENT BY WORKING WITH BOTH EMPLOYERS AND EMPLOYEES

Safer Foundation offers comprehensive workforce development and reentry services that train individuals, address their reentry obstacles and needs, and help them

[1] "Research Supports Fair-Chance Policies" (March 2016), National Employment Law Project, footnote 1 on p. 7. Available at http://www.nelp.org/publication/researchsupports-fair-chance-policies.

[2] Visher, C., Debus, S., & Yahner, J. Employment After Prison: A Longitudinal Study of Releasees in Three States. Washington, DC: Urban Institute (2008).

[3] Craigie Terry-Ann; Grawert, Ames; Kimble, Cameron, Stiglitz, Joseph (2020); Conviction, Imprisonment, and Lost Earnings: How Involvement with the Criminal Justice System Deepens Inequality: https://www.brennancenter.org/our-work/research-reports/conviction-imprisonment-and-lost-earnings-how-involvement-criminal.

obtain sustained employment. This holistic approach has rendered outstanding results for participants and employers. In 2006, decades of experience and success led Safer to become one of the original REO grantees.

In addition to working with reentering individuals and their communities, Safer also works closely with employers to identify what types of trained employees are needed. In November 2020, the National Federation of Independent Business (NFIB) reported that 53% of businesses overall (and 89% of those hiring or trying to hire) reported few or no qualified applicants for available positions. While the demand for qualified workers exists, many newly unemployed individuals may not meet the qualifications for particular industries. Safer can be responsive to employer needs by tailoring its programs to develop skilled, qualified workers for specific employment sectors and has partnered with hundreds of employers to do so.

Safer's Training to Work (T2W) program, that was funded in part with a REO grant, improved long-term employment prospects for clients at Safer's Adult Transition Centers (ATC). Participants received case management, education, and training that led to industry-recognized credentials for in-demand employment, such as forklift operation, welding, computer numerical control (CNC) operation, and licensed commercial driving (CDL) occupations, and Microsoft technologies training. Given the program's strong employer and credentialing components, REO is uniquely positioned to assist local organizations in developing and providing services that meet the needs of both the local business community and reentering individuals. Increasing REO funding in FY22 to $150 million, including funding for earn and learn apprenticeship opportunities for in demand skills development, would expand these efforts and help provide employers with more qualified employees who are trained, talented, motivated to work.

SAFER'S REO GRANT PRODUCED OUTSTANDING EMPLOYMENT OUTCOMES AND REDUCED RECIDIVISM

Safer's REO grant for the Training to Work (T2W) program significantly outperformed employment targets and dramatically reduced recidivism. For the first cohort of REO T2W participants, 69% of participants obtained employment—15% higher than the grant's employment target. Given the success of this first cohort of participants, T2W was expanded to include a second cohort who did even better with an employment rate of 78%—30% higher than the grant's target. Safer's REO T2W grant also reduced recidivism rates beyond original targets. T2W's first participant cohort had an 11% recidivism rate, and its second participant cohort had a 9% recidivism rate—75% and 80% lower respectively than the national recidivism rate of 44%.[4]

Program evaluation has shown that such success is related to the comprehensive service model that grantees such as Safer provide. Effective, comprehensive services can include interventions such as relationship building between staff and participants, employment verification, trauma-informed training, life skills training, employment preparation, mentoring, intensive case management, strong training provider relationships and support, family involvement, and post-release follow-up and support. These comprehensive services are cost-effective—a 2016 Illinois study found that for every $1 invested in community-based employment and training programs, tax payers saw a net benefit of $20.26, and found that employment and training programs had the highest cost-benefit ratio for reducing recidivism.[5] By increasing and improving employment outcomes, the REO program invests in formerly incarcerated people and their families, provides for a more equitable recovery, and improves public safety.

INVESTMENTS IN REENTRY PROGRAMS ARE CONSISTENT WITH THE FY22 PRESIDENT'S BUDGET REQUEST

Reentry and workforce development are a priority for the current administration, and the FY22 President's Budget requests includes $150 million for the REO program to provide support for "reentry services, and recidivism-reducing programming..." The budget request also calls for increases in skills-building that "advances the goal of developing pathways for diverse workers to access training and career

[4] Durose, Matthew R., Alexia D. Cooper, and Howard N. Snyder, Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010 (pdf, 31 pages), Bureau of Justice Statistics Special Report, April 2014, NCJ 244205.

[5] Illinois Sentencing Policy Advisory Council (2016). A Cost-Benefit Tool for Illinois Criminal Justice Policymakers, pp. 2–3: http://www.icjia.state.il.us/spac/pdf/Illinois__Results__First__Consumer__Reports__072016.pdf, pp. 2–3.

opportunities by also investing in critical programs that serve disadvantaged groups, including justice-involved individuals, [and] at-risk youth."

The REO funding request also is consistent with the administration's goal of pursuing racial equity. Black people and other people of color are disproportionately impacted by the criminal legal system. Black people are incarcerated at more than 5 times the rate of white people. In 2018, the incarceration rate of Black men was 5.8 times higher than that of white men, and Black young men ages 18–19 years old were 12.7 times as likely to be incarcerated as white young men in the same age group. In 2018, Black women were almost twice as likely to be incarcerated as white women, and Black girls were 3 times more likely to be incarcerated than white girls.

Upon release, these disparities persist as a result of systemic and institutional racism and discrimination; collateral consequences of conviction that ban or limit legal access to employment, licensure, and education supports; and a limited investment in resources for the large number of people returning each year who come back to their communities without the basic support and tools needed for long-term success. Providing federal resources for workforce development and reentry helps to ensure greater success and helps to address unfair barriers that exist as a result of systemic racism and inequities that disadvantage individuals directly impacted by the criminal legal system.

Finally, the REO program is critical for economic recovery for people with criminal legal histories, especially Black people and people of color, who also have been disproportionately impacted by COVID–19. There has been very limited COVID–19 relief for incarcerated people and people with criminal legal histories, and REO is the only federally appropriated program that focuses on workforce development and employment for people with records (1 out of 3 adults in the U.S. has an arrest or conviction record). As the economy recovers and workforce needs continue to evolve and change, it is essential to ensure that this significant population has the reentry and workforce supports to facilitate gainful employment and long-term reentry success.

CONCLUSION

By making effective workforce development and reentry services a priority, we fulfill labor market demands, contribute to the economy, and build strong and safe communities. Given the extensive employment and reentry needs nationwide, as well as the significant return on investment related to reduced incarceration costs and reduced crime costs borne by victims, families, and communities, I urge Congress to allocate $150 million to the REO program in FY22.

Thank you so much for your time and consideration of this important program. If you have questions or need additional information, please don't hesitate to contact me or Jenny Collier at jcollier@colliercollective.org.

[This statement was submitted by Kevin Brown, Director of Policy, Advocacy, and Legislative Affairs.]

PREPARED STATEMENT OF THE SCLERODERMA FOUNDATION

THE FOUNDATION'S FISCAL YEAR 2022 L-HHS APPROPRIATIONS RECOMMENDATIONS

—$10 billion in program level funding for the Centers for Disease Control and Prevention (CDC), which includes budget authority, the Prevention and Public Health Fund, Public Health and Social Services Emergency Fund, and PHS Evaluation transfers.

—A proportional funding increase for CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).

—$5 million for the Chronic Disease Education and Awareness Program which seeks to improve public health and lower healthcare costs through targeted awareness, physician education, and public health campaigns conducted in collaboration with stakeholder organizations and communities.

—At least $46.1 billion in program funding for the National Institutes of Health (NIH).

—Proportional funding increases for NIH's National Heart, Lung, and Blood Institute (NHLBI); National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS); National Center for Advancing Translational Sciences (NCATS).

Chairwoman Murray, Ranking Member Blunt and distinguished members of the Subcommittee, thank you for your time and your consideration of the scleroderma community's priorities while working to craft the FY2022 L–HHS Appropriations Bill.

ABOUT SCLERODERMA

Scleroderma is a chronic connective tissue disease affecting approximately 300,000 Americans. The word scleroderma means hardening of the skin, which is one of the most visible manifestations of the condition. The cause of this progressive and potentially fatal disease remains unknown. There is no cure, and treatment options are limited.

Symptoms vary greatly and are dependent on which organ systems are impacted. Prompt diagnosis and treatment by a qualified physician may improve health outcomes and lessen the chance for irreversible damage. Serious complications of the disease can include pain, skin ulcers, anemia and pulmonary hypertension.

ABOUT THE FOUNDATION

The Scleroderma Foundation is dedicated to the concerns of people whose lives have been impacted by the autoimmune disease scleroderma, also known as systemic sclerosis, and related conditions. The foundation's mission is to 1) support individuals affected, 2) promote education and public awareness, and 3) advance critical research and improve scientific understanding to improve treatment options and find the causes and a cure. The foundation has a research program that funds basic, translational and clinical research through a peer review process to find the cause and cure for scleroderma and related conditions.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Early recognition and an accurate diagnosis of scleroderma can improve health outcomes and save lives. CDC in general and the NCCDPHP specifically have programs to improve public awareness of scleroderma and other rare, life-threatening conditions. Please increase funding for CDC and NCCDPHP so that the agency can invest in additional, critical education and awareness activities that have the potential to improve health and save lives. The Foundation supports the continued support of the Chronic Disease Education and Awareness Program, this program seeks to provide collaborative opportunities for chronic disease communities that lack dedicated funding from ongoing CDC activities. Such a mechanism allows public health experts at the CDC to review project proposals on an annual basis and direct resources to high impact efforts in a flexible fashion.

NATIONAL INSTITUTES OF HEALTH

NIH continues to work with the Foundation to lead the effort to enhance our scientific understanding of the mechanisms of scleroderma with the shared-goal of improving diagnosis and treatment, and ultimately finding a cure. Since scleroderma is a systemic fibrotic disease it is inexorably linked to other manifestations of fibrosis such as cirrhosis, pulmonary fibrosis, and the fibrotic damage resulting from heart attack. Scleroderma is a prototypical manifestation of fibrosis as it impacts multiple organ systems. In this way, it is important to promote cross-cutting research across such Institutes as NIAMS and NHLBI.

Please provide NIH with a significant funding increase to the scleroderma research portfolio can continue to expand and facilitate key breakthroughs.

—NIH continues to support the Trans-NIH Working Group on Fibrosis which is working to promote cross-cutting research across Institutes.

—NHLBI, which is leading Scleroderma Lung Study II, is comparing the effectiveness of two drugs in treating pulmonary fibrosis in scleroderma.

—NIAMS, is leading efforts to discover whether three gene expression signatures in skin can serve as accurate biomarkers predicting scleroderma, and investigations into progression and response to treatment to clarify the complex interactions of T cells and interleukin-31 (IL–31) in producing inflammation and fibrosis, or scarring in scleroderma.

PATIENT PERSPECTIVE

"My constantly aching hands begged for mercy of just one day without pain. My joints started to feel like they were being torn away from my body. Anytime I touched something cold, my hands would tingle and burn. Painful sores started appearing on my knuckles. You stole my skin color and with that went my confidence. It was like I was turning into a mummy as my skin tightened with collagen, day

by day. I was beginning to need help performing small tasks. Opening a water bottle or turning a key in the door started to become difficult. Standing for long periods of time made my hips radiate with pain. In 2012 I had to stop working, at 24 years old. The definition of normal as I knew it was being torn down and built into something completely new. And so was my soul.

I now need help with everything! Getting dressed, washing my hair, cleaning, doing laundry; pretty much anything I have to use my hands for. You stole my independence. I had to learn to swallow my pride and ask for help. It's a tough thing to do, especially when you're at an age that's supposed to be your prime. Friends and family around me have blossomed into caregivers and helping me has become second nature to them. It's a beautiful thing when those surrounding you automatically adapt to your disability. Support is the lifeboat that keeps me afloat."

—*Excerpt from "My Letter to Scleroderma"*
Jessica Messingale
Coconut Creek, Florida

[This statement was submitted by Mr. David Murad, Director of Advocacy, Scleroderma Foundation.]

PREPARED STATEMENT OF THE SEATTLE INDIAN HEALTH BOARD

Chair Murray, Ranking Member Blunt, and members of the Senate Committee on Appropriations—Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies, my name is Esther Lucero. I am Diné, and of Latina descent and as the third generation in my family to live outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Health Programs (UIHP) nationwide. I have had the privilege of serving SIHB for five years. I am honored to have the opportunity to submit my testimony today, including a request for the following 1) Address Department of Health and Human Services (HHS) grant eligibility and grant restrictions 2) Develop an HHS urban confer policy; 3) Ensure HHS public health data access to Tribal Epidemiology Centers (TEC) 4) Create National Institutes of Health (NIH) research funding opportunities specific to urban Indian populations; 5) Invest in Indian healthcare and public health infrastructure, including culturally attuned integrated workforce development.

INDIGENOUS RESILIENCE IN ACTION

I would like to thank the Subcommittee for COVID–19 supplemental funding which has included at least $18 million for UIHPs from the Centers of Disease Control and Prevention (CDC); $9.5 billion for Federally Qualified Health Centers (FQHC) from the Health Resources and Services Administration (HRSA), and; at least $140 million to Indian Health Care Providers through the Substance Abuse and Mental Health Services Administration (SAMHSA). Supplemental funding has demonstrated how successful and resilient our Indian healthcare system can be when properly resourced. I would also like to acknowledge the President's Budget for FY 22 which includes $131.7 billion for HHS, including $12.6 billion for HRSA, and $9.7 billion for SAMHSA. We hope President Biden's proposed increases will support significant investments to FQHCs, tribal and urban Indian populations, and reducing chronic health disparities in Black, Indigenous, and Communities of Color (BIPOC).

As one of 41 Indian Health Service (IHS) designated UIHPs and a HRSA 330 FQHC, SIHB serves over 5,000 patients annually of which 70% identify as American Indian and Alaska Native. UIHPs are a critical component of the Indian healthcare system and offer culturally attuned health services to the 2.2 million American Indians and Alaska Natives who live in 115 counties across 24 states. We also house the Urban Indian Health Institute (UIHI), an IHS designated TEC and public health authority, which conducts research and evaluation, collects and analyzes data, and provides disease surveillance for 62 urban Indian communities nationwide.

As an Indian Health Care Provider, we are actively limiting the spread of COVID–19 in tribal and urban Indian communities. In December 2020, SIHB was the first organization in Seattle to receive a shipment of the Moderna vaccine and since has vaccinated over 12,500 individuals. Locally, we serve as a COVID–19 testing site at our main clinical facility and operate a community-based walk-up testing site at our satellite clinic serving American Indian and Alaska Native people experiencing homelessness in Seattle, Washington. With the support of federal supplemental funding, we continue to secure pharmacy supplies and equipment to respond

to the immediate and forthcoming COVID–19 needs in the greater Puget Sound region, including testing kits, panels, and a diagnostic testing machine to improve testing capacity and response times. We have implemented a telehealth program, expanded outpatient behavioral health services, provided rental assistance, and developed a pediatrics clinic to increase child immunization rates. Throughout the pandemic, UIHI has disseminated culturally attuned COVID–19 information through fact sheets, reports, and a COVID–19 Vaccine Poster series to address vaccine hesitancy in the Native community. Recently, UIHI launched For the Love of Our People, a webpage dedicated to bringing Native health experts and creatives to provide engaging, up-to-date information about COVID–19 vaccines and COVID–19 related topics. UIHI has also led local to national public health surveillance for UIHPs through weekly reporting and analysis of local to state COVID–19 case surveillance data.

CONTINUED GAPS FOR URBAN INDIAN ORGANIZATIONS

Address Department of Health and Human Services (HHS) grant eligibility and grant restrictions: UIOs offer culturally responsive services for the 71% of American Indians and Alaska Natives in urban areas. Given that the average IHS grant to an UIHP is $280,000, most UIHPs must seek additional resources from HHS agencies to ensure robust access to health and social services that allow our communities to thrive. Yet, many HHS agencies exclude UIHPs from grant eligibility or apply restrictive grant terms that hinder our ability to provide culturally specific and low-barrier services. To ensure HHS resources for American Indian and Alaska Native people fulfill trust and treaty obligations, we ask Congress to:

Ensure Urban Indian Organizations are included in grant eligibility: If the intent of Congressional funds is to reach all American Indian and Alaska Native people, then legislative and administrative language must include 'tribes, tribal organizations, and Urban Indian Health Programs as defined in Section 4 of the Indian Health Care Improvement Act (authorized under 25 U.S.C. Ch. 18. Subchapter IV § 1653). This ensures federal resources reach American Indian and Alaska Native people, regardless of where they reside.

Address barriers created by GPRA tools: Current requirements of the Government Performance and Results Act (GRPA) performance data is burdensome to patients and providers. To operate a truly culturally attuned and low-barrier Medication Assisted Treatment (MAT) programs, we must address the long-standing issues with cumbersome and onerous GPRA reporting requirements. For example, SIHB provides an unduplicated service of low-barrier MAT services for urban American Indians and Alaska Natives who are disproportionately affected by substance use in Washington State. Our American Indian and Alaska Native patients come to SIHB for our integrated patient-centered care model that promotes the wellness of our patients and is centered on Traditional Indian Medicine. Lengthy and invasive GPRA survey tools directly affect our service delivery system to provide accessible low-barrier and culturally attuned MAT services. We ask that Congress address barriers created by GRPA tools to better support culturally attuned and low barrier services provided by Indian Health Care Providers.

Develop an HHS urban confer policy: To ensure trust and treaty obligations are upheld to all American Indian and Alaska Native citizens, we request the development of an Urban Confer policy across all agencies and departments within HHS jurisdiction. The federal government has an obligation to consult with Tribal Nations on issues that impact tribal communities. In the Indian healthcare system, UIHPs have an Urban Confer mechanism with the IHS that provides an opportunity for an exchange of information and opinions that lead to mutual understanding and emphasize trust, respect, and shared responsibility between UIHPs and government agencies. Urban Confer policies do not substitute for nor invoke the rights of a Tribe as a sovereign nation. An Urban Confer supports the advocacy for the urban Indian community by Indian Health Care Providers who are part of the Indian healthcare system.

The importance of an Urban Confer was made evident in the COVID–19 supplemental resources from Congress. Without an Urban Confer policy, HHS agencies outside of IHS had no formal mechanism for gathering feedback from UIOs and vice versa. As a result, submitting feedback to HRSA, SAMHSA, and the CDC was a significant barrier to accessing COVID–19 supplemental resources for UIOs. For example, the CDC created a funding opportunity for 11 of the 12 TECs by selecting a grant mechanism that failed to include UIOs as eligible entities. This barrier leaves UIOs without access to federal resources, despite Congressional intent.

Ensure HHS public health data access to Tribal Epidemiology Centers (TEC): Despite Congressional authorization to access HHS data as a public health authority, CDC continues to deny UIHI and other TECs access to data collected through the National Notifiable Disease Surveillance System (NNDSS). Timely analysis of NNDSS data and other CDC collected COVID–19 data is critical to supporting both tribes and UIOs to prevent, prepare, and respond to system health inequities experienced by American Indian and Alaska Native communities. A failure to uphold data access perpetuates systemic health inequities in American Indian and Alaska Native communities. With the limited COVID–19 case surveillance data provided, TECs have been able to monitor, evaluate, and respond to COVID–19 through contact tracing, primary collection and secondary analysis of epidemiological data, and development of culturally attuned public health resources. The COVID–19 resources developed by TECs range from public health guidance to treatment and vaccine information that have been disseminated to tribes, tribal organizations, UIOs, and government agencies. We ask Congress to ensure compliance with data sharing requirements by all HHS agencies with TECs.

Create NIH research funding opportunities specific to urban Indian populations: Current NIH initiatives often are not inclusive of urban Indian populations, despite 71% of all American Indian and Alaska Native people living in urban settings and a growing body of documentation of health disparities among urban Native populations. In addition, the COVID–19 pandemic has highlighted the lack of diversity in clinical trials which perpetuates bias in research studies. In Indian Country, the lack of an American Indian and Alaska Native population samples in clinical trials contributed to vaccine hesitancy and has been used by anti-vaccination advocates to push misinformation into Native communities. We do not advocate for taking away funding for tribally based research. Instead, we urge Congress to ensure NIH create dedicated funding for research and clinical trials that are inclusive of urban Indian populations.

Invest in Indian healthcare infrastructure:

Public health infrastructure: The COVID–19 pandemic has exacerbated the crumbling infrastructure of our public health systems, specifically data systems. Many of the data quality issues identified by UIHI in the Data Genocide report are linked to outdated public health data infrastructure systems that limit the ability to appropriately collect and report data for national public health surveillance and epidemiology. There is an urgent need to invest significant resources in data modernization, specifically across our Indian healthcare system—including tribal health programs, UIHPs, and TECs. Data modernization increases inter-operability of data systems and advances data standards so information can be stored and shared across systems, and facilitate complete reporting of data critical for achieving equity in public health responses. We recommend an increased investment dedicated to infrastructure improvement and construction specifically for UIHPs that does not divert any resources from tribal communities that are also in desperate needs of public health infrastructure investments.

UIHP healthcare facilities: There is no national level data on the infrastructure needs of UIHPs, yet we know from experience our facilities are inefficient and overcrowded, which compromises the provision of critical health services and contribute to health disparities among urban Indian communities. UIHPs are ineligible for the Health Care Facilities Construction line item in the IHS budget. Recent COVID–19 supplements have allowed for some flexible spending to address the overwhelming infrastructure needs of UIHPs, yet lack we still lack the resources needed to develop integrated care settings that are patient-centric and culturally attuned. We ask that Congress identify resources for UIHPs for the construction, expansion, alteration, and renovation of healthcare facilities.

Culturally attuned integrated workforce development: Our healthcare systems are in need of additional investments to fulfill integration of behavioral health and medical care. A 2018 GAO report on IHS found a 25% vacancy rate for nurses, physicians, and other care providers. It is a critical time to make targeted investments in building up a culturally attuned workforce across the Indian healthcare system that is prepared to provide integrate care that address pervasive health disparities among American Indian and Alaska Native populations. We ask Congress to invest in recruitment and retention of health professionals to address chronic health care provider shortages in Indian Country.

Thank you for your support and consideration of the requests. We look forward to our continued work to improve the health and well-being of American Indian and Alaska Native people.

Sincerely.

[This statement was submitted by Esther Lucero (Diné), MPP, President & CEO, Seattle Indian Health Board.]

PREPARED STATEMENT OF THE SLEEP RESEARCH SOCIETY AND PROJECT SLEEP

FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—The sleep community joins the broader research community in requesting $46.1 billion in discretionary funding for the National Institutes of Health (NIH), an increase of $3.2 billion over FY 2021. Sleep impacts nearly every system of the body and various disease processes, please provide proportional funding increases for all NIH Institutes and Centers to further support sleep, circadian, and sleep disorders research activities.

—Please support adequate funding to establish the new Advanced Research Projects Agency for Health (ARPA–H) at NIH as proposed in the Administration's Budget Request to Congress to facilitate robust and tangible scientific progress on a variety of conditions.

—The sleep community joins the broader public health community in requesting $10 billion in overall funding for the Centers for Disease Control and Prevention (CDC) to reinvigorate meaningful professional education, public awareness, and surveillance activities.

—Please provide the new CDC Chronic Disease Education and Awareness Program with $5 million, an increase of $3.5 million over FY 2021, to facilitate additional cooperative agreements to advance timely public health efforts with community stakeholders.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, thank you for considering the views of the sleep, circadian, and sleep disorders advocacy community as you work on FY 2022 appropriations for medical research and public health programs. We would like to take this opportunity to thank you for providing ongoing investment in the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) through FY 2021 appropriations, particularly for establishing and funding the new CDC Chronic Disease Education & Awareness Program. Please bolster the commitments to NIH and, in particular, CDC as you and your colleagues work on appropriations for FY 2022.

ABOUT THE SLEEP RESEARCH SOCIETY

The Sleep Research Society (SRS) was established in 1961 by a group of scientists who shared a common goal to foster scientific investigations on all aspects of sleep, circadian rhythmicity, and sleep disorders. Since that time, SRS has grown into a professional society comprising over 1,300 researchers nationwide. From promising trainees to accomplished senior level investigators, sleep and circadian research has expanded into areas such as pulmonology, psychology, neurology, pharmacology, cardiology, immunology, metabolism, genomics, learning and memory, and healthy living. SRS recognizes the importance of educating the public about the connection between sleep, circadian rhythmicity, and health outcomes. SRS promotes training and education in sleep and circadian research, public awareness, and evidence-based policy, in addition to hosting forums for the exchange of scientific knowledge pertaining to sleep and circadian rhythms.

ABOUT PROJECT SLEEP

Project Sleep is a 501(c)(3) non-profit organization raising awareness about sleep health and sleep disorders by working with affected individuals and families across the country. Believing in the value of sleep, Project Sleep aims to improve public health by educating individuals and policymakers about the importance of sleep health and sleep disorders. Project Sleep will educate and empower individuals using events, campaigns, and programs to bring people together and talk about sleep as a pillar of health.

NIH SLEEP RESEARCH ACTIVITIES

Over recent years, NIH has seen a meaningful infusion of critical funding. This investment has improved grant funding pay lines, led to significant scientific advancements, and helped to prepare the next generation of young investigators. For FY 2014, the sleep research portfolio at NIH was $233 million annually. For FY 2020, the sleep research portfolio at NIH had grown to $436 million annually, which

has been transformative for the field. However, there are still meaningful opportunities for further scientific progress and improved patient care.

Underserved Sleep Disorders State of the Science Conference

While research in sleep and circadian has moved forward in significant ways (including the 2017 Nobel Prize in Medicine), research into specific sleep disorders at NIH remains relatively modest. Narcolepsy, hypersomnia, Kleine Levin syndrome and many other sleep disorders have only a few active grants at any given time. To ensure scientific progress in sleep is translated to innovative therapies, improved diagnostic tools, and meaningful health information, the time is now for a State-of-the-Science conference on sleep disorders. This collaborative opportunity will help create a long-range research plan across NIH that features specific activities for various sleep disorders. Committee recommendations and related interest in this regard would be timely.

Sleep Health & Health Disparities

Racial-ethnic minorities are more likely to get insufficient sleep, and are more likely to have sleep disorders. Since sleep plays important roles in cardiovascular function, metabolism, immunity, mental health, and brain function, this sleep disparity creates a situation where racial/ethnic minorities are systematically set up for worse health outcomes. Not only does poor sleep lead to worse outcomes on its own, it interacts with other conditions, worsening the already-important problems associated with heart disease, diabetes, obesity, cancer, depression, and other medical conditions. The causes of these sleep disparities are complex and involve a combination of socioeconomic, environmental, and other factors. Unfortunately, there is almost no research on targeting sleep disorders diagnosis and treatments for racial/ethnic minorities, and securing funding for sleep disparities research is extremely difficult. As NIH works to address health disparities, promote health equity, and enhance workforce diversity, sleep and sleep research should be incorporated into emerging activities.

National Heart, Lung, and Blood Institute/National Center on Sleep Disorders Research

NCSDR has a new Director, Dr. Marishka Brown, who is taking the field of sleep research in new and exciting directions while reinvigorating the enthusiasm for sleep research across the federal government. Under Dr. Brown's leadership, NCSDR is preparing to release a strategic plan for research. We ask Congress to provide Dr. Brown with the support she needs, including adequate resources for NHLBI and NCSDR to coordinate ongoing and emerging initiatives.

CDC Chronic Disease Education & Awareness Program

Thank you for establishing the CDC Chronic Disease Education & Awareness program and providing an initial investment of $1.5 million for FY 2021. CDC currently lacks meaningful public health activities focused on sleep and the community plans to engage this new funding mechanism. For FY 2022, please provide $5 million in annual support.

Stacy's Story

Stacy Edwards, of Langley, Washington, first started seeing doctors for fatigue at the age of 15. As she got older, her health declined significantly and she couldn't figure out why. Stacy could sleep 15–18 hours and still felt tired. Doctors were sympathetic, but usually tested for anemia and mono and sent her on her way with no solutions. At age 31, Stacy was finally referred for a sleep study. The results showed that she woke up 29 times per hour due to breathing obstructions, making her diagnosis of sleep apnea on the high side of moderate (almost severe).

Once diagnosed, Stacy started using a CPAP machine and now raises awareness and reduces stigma via her website and social media campaign called CPAP Babes. More recently, at age 34, Stacy was diagnosed with a second sleep disorder, idiopathic hypersomnia. She continues to look for better treatment options to reduce her daytime sleepiness, brain fog, and other associated symptoms. Stacy is passionate about sleep research and awareness because she believes that she lost many years of her life in bed and doesn't want others to suffer for years without answers the way she did. Educating the public and the medical community is a high priority for Stacy.

[This statement was submitted by H. Craig Heller, PhD, President, Sleep Research Society and Project Sleep.]

PREPARED STATEMENT OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

On behalf of SMFM, I am pleased to submit testimony in support of the important work related to optimizing the health of birthing people and infants being conducted at HHS for FY 2022. SMFM urges Congress to ensure that the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and Agency for Healthcare Research and Quality (AHRQ) are adequately funded in FY 2022. Specifically, SMFM urges the Committee to provide at least the following in base program level funding:

—$46.1 billion for the NIH, with $1.7 billion of that funding to support the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD);

—$10 billion for the CDC, including $89 million for the Safe Motherhood Initiative, $100 million for the Surveillance for Emerging Threats to Moms and Babies initiative, and $200 million for the National Center for Health Statistics (NCHS);

—$9.2 billion for the HRSA, including $822.7 million for the Title V Maternal and Child Health Services Block Grant; and

—$500 million for AHRQ.

Established in 1977, SMFM is the national voice for clinicians and researchers with expertise in high-risk pregnancies. A non-profit association representing more than 5,000 individuals, the core of SMFM's membership is comprised of maternal-fetal medicine (MFM) subspecialists. MFM subspecialists are obstetricians with an additional three years of formal education and who are board certified in MFM making them highly qualified experts and leaders in the care of complicated pregnancies. Additionally, SMFM welcomes physicians in related disciplines, nurses, genetic counselors, ultrasound technicians, MFM administrators, and other individuals working toward optimizing the care of people with high-risk pregnancies. SMFM members see the most at-risk and complex patients, with the goal of optimizing outcomes for pregnant people and their children.

NIH/NICHD

The NICHD's investment in maternal and child health outcomes is essential to understanding and combatting the rising maternal mortality and severe morbidity rates and to optimizing maternal and child health.

Task Force Specific to Pregnant Women and Lactating Women (PRGLAC): SMFM urges Congress to continue its strong support for NIH's efforts to advance the inclusion of pregnant and lactating people in clinical trials and research, specifically by taking necessary steps to implement the recommendations of the PRGLAC Task Force, which was convened by NICHD. PRGLAC submitted its report to the Secretary in the fall of 2018 with 15 recommendations on including pregnant and breastfeeding people in clinical trials and broad research initiatives, and the Task Force further outlined how to implement those recommendations in a follow-up report submitted to the Secretary of Health and Human Services in 2020. In that implementation report, the PRGLAC Task Force described the need to convene an expert panel to develop a framework for addressing medicolegal and liability issues when planning or conducting research specific to pregnant people and lactating people. SMFM requests $1.5 million for NICHD to contract with the National Academies of Sciences, Engineering, and Medicine to convene a panel tasked with developing that framework (language below).

The COVID–19 pandemic again emphasized the importance of including pregnant and lactating people in clinical research. This population was largely excluded from clinical trials for treatments and vaccines, leaving them and their health care providers without clear evidence on safety and efficacy to guide clinical decision-making. It is essential that Congress support broader inclusion of pregnant and lactating people in research, so that lifesaving interventions and treatments can be addressed for mother and their infants.

NICHD Report Language

Liability Study.—Pregnant and Lactating Individuals. The Committee includes $1,500,000 for NICHD to contract with NASEM to convene a panel with specific legal, ethical, regulatory, and policy expertise to develop a framework for addressing medicolegal and liability issues when planning or conducting research specific to pregnant people and lactating people. Specifically, this panel should include individuals with ethical and legal expertise in clinical trials and research; regulatory expertise; plaintiffs' attorneys; pharmaceutical representatives with tort liability and research expertise; insurance industry representatives; federally funded researchers who work with pregnant and lactating

women; representatives of institutional review boards (IRBs) and health policy experts.

Maternal-Fetal Medicine Units Network (MFMU): SMFM urges continued strong support of the MFMU and asks that Congress allocate $30 million to support the Network's ongoing work. Established in 1986, MFMU pursues the development of treatments for medical complications during and after pregnancy, including maternal mortality and morbidity, preterm birth, low birth weight, fetal growth abnormalities, and fetal mortality. MFMU is a critical resource to stemming the nation's growing maternal health crisis and addressing emerging threats to maternal and infant health. For instance, during the COVID–19 pandemic, the MFMU was able to quickly pivot resources to monitor the health impact of COVID–19 on pregnant people and their infants, as well as researching effective treatments for pregnant populations. We hope that the NICHD will ensure the MFMU's continued success by maintaining its highly efficient structure of multicenter collaborative research. The MFMU has a strong history of changing and improving clinical practice and obstetric management, improving outcomes of pregnant people and babies in the United States, and is extremely successful. 25.6 percent of all publications from the network are cited in clinical practice guidelines. These guidelines are relied upon by Medicaid and Medicare programs to define evidence-based services covered under the plans. The work of the network is even more urgent given the recent increase in maternal mortality and severe morbidity in the United States. We urge Congress to ensure stable and sustained funding and infrastructure for the MFMU, and to ensure that any proposed change in the funding mechanism or structure for the MFMU not compromise the ability of the network to remain nimble and directly address the changing landscape of women's health, including to reduce health disparities.

Preterm Birth: Delivery before 37 weeks gestation is associated with increased risk of death in the immediate newborn period as well as in infancy and can cause long-term complications. Although the survival rate is improving, many preterm infants have life-long disabilities including cerebral palsy, intellectual disabilities, respiratory problems, and hearing and vision impairment. Preterm birth costs the United States $25.2 billion annually.[1] Great strides are being made through NICHD-supported research to address the complex situations faced by mothers and their babies. One of the most successful approaches for testing research questions is the NICHD research networks, which allow researchers from across the country to collaborate and coordinate their work to change the way we think about pregnancy complications and to change medical practice across the country.

CDC

The CDC's Division of Reproductive Health (DRH) and National Center for Birth Defects and Developmental Disabilities (NCBDDD) are doing important work related to pregnancy. Data collection efforts related to pregnancy outcomes, maternal mortality, and medications in pregnancy must continue.

For instance, CDC's ongoing support for state-based perinatal quality collaboratives and new funding for state maternal mortality review committees (MMRCs) is essential to address the nation's unacceptable maternal death rate. According to the NCHS, the maternal mortality rate in 2019 was 20.1 deaths per 100,000 live births, and racial disparities persisted with a maternal mortality rate of 44.0 per 100,000 live births among non-Hispanic black women compared to 17.9 among non-Hispanic white women.[2] SMFM fully supports Congress' attention to reducing maternal mortality through CDC's Safe Motherhood Initiative, and we ask that you provide at least $89 million for this work. Of that, we ask Congress to allocate the full $43 million included in the President's FY 2022 budget request to fund additional state MMRCs.

SMFM also urges Congress to allocate $100 million for the CDC's Surveillance for Emerging Threats to Moms and Babies initiative housed at the NCBDDD. The state-level surveillance infrastructure supported by the initiative allows state public health departments to monitor health threats stemming from maternal exposures, including infectious diseases such as COVID–19.

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[1] Waitzman NJ and Jalali A. Updating National Preterm Birth Costs to 2016 with Separate Estimates for Individual States. Salt Lake City, UT: University of Utah; 2019. Available at: https://www.marchofdimes.org/peristats/documents/Cost_of_Prematurity_2019.pdf.

[2] Hoyert DL. Maternal mortality rates in the United States, 2019. NCHS Health E-Stats. 2021.Available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality-2021/maternal-mortality-2021.htm.

HRSA

The work of HRSA is critical to maternal and child health. HRSA's initiatives reduce infant mortality, improve maternal health and wellbeing, and serve more than 50 million people through the Maternal and Child Health (MCH) Block Grant. The funds provided through the MCH Block Grant increase access to comprehensive prenatal and postnatal care—especially for patients who are most at risk for adverse health outcomes. The Title V MCH Block Grant programs save federal and state governments money by expanding the delivery of preventive services to avoid more costly chronic conditions later in life. Additionally, HRSA's family planning initiatives ensure access to comprehensive family planning and preventive health services for more than 4 million people, thereby reducing unintended pregnancy rates. Finally, HRSA's support for the Alliance for Innovation in Maternal Health Care (AIM) reduces maternal mortality through implementation of care bundles at the state and institutional level. These bundles help reduce maternal mortality through quality improvement in various areas including postpartum hemorrhage and hypertension. We encourage Congress to provide at least $822.7 million for this important program that will help improve maternal and infant health across the United States.

AHRQ

Projects conducted at AHRQ are critical to translate research from bench to bedside through comprehensive implementation in the everyday practice of medicine. AHRQ is the only federal agency that funds research on "real-life" patients—those with comorbidities and co-existing conditions, including high-risk pregnant people. The agency's work is instrumental in collecting data; funding health services research; and, most importantly, disseminating findings to clinicians to improve maternal health care. Together, AHRQ's intramural programs, such as the Healthcare Cost and Utilization Project (HCUP), Evidence-Based Practice Center Program and Safety Program in Perinatal Care, and extramural research are essential to reducing maternal deaths and adverse pregnancy outcomes. By providing at least $500 million to AHRQ in FY 2022, Congress will allow AHRQ to expand its maternal health portfolio, improving care for nearly 4 million pregnant patients each year.

CONCLUSION

The COVID–19 pandemic has further exposed existing inequities and gaps within our healthcare system for people across the country, including pregnant people. It is more important than ever to prioritize the needs of pregnant people and their infants in federal programs from research, to public health surveillance, to care. We urge HHS to prioritize and adequately fund maternal health efforts for that aim to reduce maternal mortality and severe morbidity during and after the pandemic.

With your support of vital HHS programs, obstetric researchers, clinicians, and patients can address the complex problems of pregnancy and truly improve the health and wellbeing of mothers and infants. Please direct any inquiries about this testimony to Rebecca Abbott, SMFM's Director of Government Relations (rabbott@smfm.org).

PREPARED STATEMENT OF THE SOCIETY FOR NEUROSCIENCE

Chair DeLauro, Ranking Member Cole, and members of the Subcommittee, on behalf of the Society for Neuroscience (SfN), we are honoured to present this testimony in support of robust appropriations for biomedical research at the National Institutes of Health (NIH). SfN urges you to provide at least $46.1 billion, a $3.2 billion increase over FY21, in funding for existing institutes and centers at NIH for FY22, including $496 million from the NIH Innovation Account for 21st Century Cures programs and $560 million for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. Dr. Moses Chao and I, as Chair of the Government and Public Affairs Committee and President of SfN respectively, understand the critical importance of federal funding for neuroscience research in the United States. I currently serve as a researcher and as a Professor in the Department of Psychology at Cambridge University and Dr. Chao is a professor of Cell Biology, Physiology and Neuroscience, and Psychiatry at the New York University School of Medicine. Our research serves as two examples of the wide variety of neuroscience research advancing our collective understanding of the brain.

My own research focuses on the neural and psychological basis of drug addiction and is dedicated to understanding the maladaptive engagement of the learning, memory, and motivational mechanisms underlying compulsive drug use. Drug abuse and addiction have devastating consequences at the individual, family, and society

levels. My research group made significant advances in showing structural and neurochemical changes in the brain associated with behavioral impulsivity confer a major risk on vulnerability to develop cocaine addiction. We have also demonstrated the neural circuit basis of transition from recreational to compulsive use of opioids, stimulants, and alcohol, revealing commonalities as well as differences in the neural basis of addiction to these drugs. This understanding has opened the door to development of novel pharmacological and psychological treatments for addiction that may promote and maintain abstinence from drug use.

Dr. Chao's research efforts focus on growth factors (also called neurotrophins) in the brain. These proteins are crucial for everything from neuron differentiation, growth, and survival during development to learning and memory in children and adults. Deficits in neurotrophins are involved in neurodegenerative disorders such as Alzheimer's, Parkinson's and Huntington's diseases, and Amyotrophic Lateral Sclerosis (ALS), as well as limiting recovery after stroke or brain injury.

Dr. Chao and I cover different areas of neuroscience research, though we have come together to convey the need for further and ongoing investment in neuroscience research. SfN believes strongly in the research continuum: basic science leads to clinical innovations, which leads to translational uses impacting the public's health. Basic science is the foundation upon which all health advances are built. To cure diseases, we need to understand them through fundamental discovery-based research. However, basic research depends on reliable, sustained funding from the federal government. SfN is grateful to Congress for its investments in biomedical research and increases for NIH over the last six years. Growing the NIH budget over $12 billion in that period is exactly the kind of sustained effort that is needed, and your continued support will pay dividends for years to come.

THE IMPORTANCE OF THE RESEARCH CONTINUUM

NIH funding for basic research is critical for facilitating groundbreaking discoveries and for training researchers at the bench. For the United States to remain a leader in biomedical research, Congress must continue to support basic research that fuels discoveries as well as the economy. The deeper our grasp of basic science, the more successful those focused on clinical and translational research will be. We use a wide range of experimental and animal models not used elsewhere in the research pipeline. These opportunities create discoveries—sometimes unexpected discoveries—expanding knowledge of biological processes, often at the molecular level. This level of discovery reveals new targets for research to treat all kinds of brain disorders affecting millions of people in the United States and beyond.

NIH basic research funding is also a key economic driver of science in the United States through funding universities and research organizations across the country. Federal investments in scientific research fuel the nation's pharmaceutical, biotechnology and medical device industries. The private sector utilizes basic scientific discoveries funded through NIH to improve health and foster a sustainable trajectory for American's Research and Development (R&D) enterprise. Basic science generates the knowledge needed to uncover the mysteries behind human diseases, which leads to private sector development of new treatments and therapeutics. This important first step is not ordinarily funded by industry given the long-term path of basic science and the pressures for shorter-term return on investments by industry. Congressional investment in basic science is irreplaceable on the pathway for development of drugs, devices, and other treatments for brain-related diseases and disorders.

For example, in 2019, NIH launched—at Congress's direction—the cross-institute Helping to End Addiction Long-term (HEAL) Initiative to respond to the ongoing opioid public health crisis. Through this program, NIH supports the development of new medications to treat all aspects of the opioid addiction cycle and invests in preclinical and translational research in pain management. This work is vital to the translation of exciting new discoveries in the treatment of addiction. In our lab, we have shown a novel opioid receptor antagonist greatly decreases opioid, cocaine, and alcohol use in animal models, as well as showing its efficacy and safety in experimental studies in humans. We have further revealed reducing the impact of maladaptive drug memories can promote abstinence from drug use, as well as be effective in treatment of anxiety disorders and post-traumatic stress disorder (PTSD). The NIH, especially NIDA and NIAAA, supports the great majority of the global research on addiction and its treatment; this is a shining example of how governmental funding for research in the US leads the world and inspires related and collaborative research internationally on this major brain disorder.

Another example of NIH's success in funding neuroscience is the BRAIN Initiative. While only one part of the research landscape in neuroscience, the BRAIN Ini-

tiative has been critical in promoting future discoveries across neuroscience and related scientific disciplines. By including funding in 21st Century Cures, Congress helped maintain the momentum of this endeavor. Note, however, using those funds to supplant regular appropriations would be counterproductive. There is no substitute for robust, sustained, and predictable funding for NIH. SfN appreciates Congress' ongoing investment in the BRAIN Initiative and urges its full funding in FY22. Some recent exciting advancements in NIH funded neuroscience research include the following:

Personalized Medicine for Treating Depression

Major depressive disorder (often referred to as "depression") is one of the most common mental disorders in the United States, affecting more than 17 million adults each year in the United States alone. While there have been great strides in pharmacological treatments for depression, a patient's response to any given antidepressant will vary widely based on their particular brain chemistry. A group of researchers funded by NIH recently used a machine learning algorithm to analyze patients' brain waves and predict their response to sertraline, a popular antidepressant. These data were taken from an NIMH funded study that used electroencephalography (EEG) to measure the brain's response to taking either a placebo or sertraline. Using an algorithm specially designed to analyze EEG data, the researchers were able to predict whether patients would respond to sertraline treatment based on brain waves measured before treatment. This work is a critical step towards quickly determining the most effective treatment for patients based on their personal brain chemistry and illness.

Understanding How COVID Affects the Brain

In addition to its well-documented effects on the respiratory system, it has become clear that SARS-CoV–2, the virus responsible for COVID–19, has a profound effect on the brain, with neurological symptoms from dizziness and mental fogginess to encephalitis and stroke appearing in COVID–19 patients. SARS-CoV–2 has been found in the cerebrospinal fluid (CSF) of some of these patients, indicating the virus was able to cross into the brain. To understand how the virus could enter the brain, researchers with NIH COVID–19 research funding used stem cells created from human skin cells to make clusters of brain cells called organoids. These organoids were made of cells found in different areas of the brain, and the researchers found that SARS-CoV–2 had a high infection rate for cells from a specialized region called the choroid plexus. The choroid plexus is the region of the brain that creates the CSF cushioning the brain and spinal cord; it is known as a site of infection for other viruses. This finding provides a lead on the location through which SARS-CoV–2 may be entering the brain and a potential target for developing treatments of the neurological effects of COVID–19.

COVID–19 IS A CHALLENGE AND OPPORTUNITY FOR NEUROSCIENCE RESEARCH

Unfortunately, the COVID–19 pandemic slowed progress in neuroscience research, with social distancing requirements hampering ongoing research related to the brain. Investment in neuroscience research, including on the neurological aspects of the SARS–CoV–2 virus and the COVID–19 pandemic itself is needed but cannot be allowed to eclipse or replace regular funding for neuroscience research. We urge you to identify ways to ensure current necessary funding increases to address the COVID–19 emergency do not slow progress on other important and innovative research, including the groundbreaking research in neuroscience and mental health. SfN is grateful Congress requested NIH seek to understand the psychosocial and behavioral health consequences of COVID–19. SfN encourages the Subcommittee to fund basic research on the biology of COVID–19 impacts on brain function as well as impacts on the nervous system in preclinical models and, by extension, on humans. In doing so, SfN encourages Congress and the NIH to prioritize intentional collaboration and coordination to effectively allocate scarce resources so researchers may investigate all facets of infectious and non-infectious disease.

Ongoing research already demonstrates the need for scientists to examine the neurological impacts of COVID–19. While mortality due to SARS–CoV–2 may be primarily due to its effects on the lungs, it is now apparent the virus damages many other organs, including the central nervous system. We need to understand how these direct and indirect effects on other organ systems are producing chronic diseases and long-term disability, making people more susceptible to other chronic disorders covered by the different NIH Institutes. A recent study (Lancet article, Taquet et al 2020) shows an increased risk of psychiatric conditions after COVID–19 diagnosis. Symptoms, such as anxiety, depression, post-traumatic stress disorder, and insomnia were reported. These data, though incomplete, suggest brain impair-

ment occurs as a result of COVID–19 infection. Furthermore, it was found people with two copies of the risk gene for Alzheimer's disease were more likely to have severe COVID–19 (Kuo et al J. Gerontology 2020). These findings, coupled with incidents of memory loss, brain fog and hallucinations reported in the New York Times (3/23/21) demand increased resources to study the impact of this virus on the peripheral and central nervous systems, as well as the immune and inflammatory systems. The COVID–19 public health emergency provides an important example of the critical need for collaborative research and coordinating data and resources across institutes. A balanced and collaborative research effort across institutes will likely be the path toward solving these multiple issues.

CONGRESS & NIH MUST SUPPORT ACCESS TO MODELS NECESSARY FOR NEUROSCIENCE DISCOVERY

Adequate NIH funding is necessary to advancing our understanding of the brain; however, full realization of this funding's promise requires appropriate access to research models, including non-human primate and other animal models. Animal research is highly regulated to ensure the ethical and responsible care and treatment of the animals. SfN and its members take their legal and ethical obligations related to this research very seriously. While SfN recognizes the goal of the reduction, refinement, and eventual replacement of nonhuman primate models in biomedical research, much more research and time is needed before such a goal is attainable. Premature replacement of non-human primate and other animal models may delay or prevent the discovery of treatments and cures-not only for neurological diseases like Alzheimer's disease, addiction, and traumatic brain injury, but also for communicable diseases and countless other conditions. There are currently no viable alternatives available for studying biomedical systems that advance our understanding of the brain and nervous system; or when seeking treatments for diseases and disorders like depression, addiction, Parkinson's Disease, and emotional responses. This research is critically important and has the opportunity to benefit countless people around the world. SfN urges Congress to work with the NIH to ensure this important research can continue.

FUNDING IN REGULAR ORDER

SfN joins the biomedical research community supporting an increase in NIH funding to at least $46.1 billion for existing NIH institutes and centers, a $3.2 billion increase over FY21. This increase is consistent with those provided by this committee for the past few years and provides certainty to the field of science, allowing for the exploitation of more scientific opportunity, more training of the next generation of scientists, more economic growth and more improvements in the public's health. Equally as important as providing a reliable increase in funding for biomedical research is ensuring funding is approved before the end of the fiscal year. Your success in 2018 in completing appropriations prior to the start of the fiscal year was a tremendous benefit to research. Continuing Resolutions have significant consequences on research, including restricting NIH's ability to fund grants. For some of our members, this means waiting for a final decision to be made on funding before knowing if their perfectly scored grant will be realized, or operating a lab with 90 percent of the awarded funding until appropriations are final. All of the positive benefits research provides in this country may be negatively impacted by these real time considerations. SfN strongly supports the appropriation of NIH funding in a timely manner which avoids delays in approving new research grants or causes reductions in funding for already approved research funding. Meeting the example Congress set in 2018 would be another substantial benefit to science.

SfN thanks the subcommittee for your strong and continued support of biomedical research and looks forward to working with you to ensure the United States remains the global leader in neuroscience research and discovery. Collaboration among Congress, the NIH, and the scientific research community has created great benefits for not only the United States but also for people around the globe suffering from brain-related diseases and disorders. On behalf of the Society for Neuroscience, we urge you to continue this strong support of biomedical research.

[This statement was submitted by Barry Everitt, Sc.D., F.R.S., President, and Moses Chao, PhD, Chair, Government and Public Affairs Committee, Society for Neuroscience.]

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH

On behalf of the Society for Women's Health Research (SWHR)—whose mission is dedicated to promoting research on biological sex differences in disease and improving women's health through science, policy, and education—I am pleased to submit testimony describing SWHR's funding requests for fiscal year 2022. While SWHR supports strong funding across all federal public health programming, we specifically urge appropriators to support at least $46.1 billion for the National Institutes of Health (NIH), including at least $1.7 billion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and $55.4 million for the Office of Research on Women's Health (ORWH).

Biological differences between women and men influence disease development, progression, and response to treatment, while social determinants of health, including gender, affect disease risk, health care access, and outcomes.

Over the past 15 months, as the world has collectively faced the myriad consequences of the COVID–19 pandemic, we have also seen an array of health disparities exposed, including significant sex and gender differences. For example, men are more likely to develop severe complications from COVID–19 and have a heightened risk of death, while women are more likely to be diagnosed with post-acute sequelae of COVID–19 and report more adverse events following vaccination. Additionally, women have been disproportionately affected by layoffs and socioeconomic challenges, food insecurity, domestic violence, and mental health concerns related to COVID–19.

Nevertheless, much of the ongoing COVID–19 research fails to thoroughly investigate the impact of sex and gender. We have long known that robust funding for federal institutes and offices that prioritize women's health research is critical to achieve health equity for women. Therefore, SWHR urges Congress to prioritize women's health and women's health research in FY 2022 funding legislation, which includes supporting the NIH, ORWH, and NICHD.

THE NATIONAL INSTITUTES OF HEALTH

The NIH is America's premier medical research agency and the largest source of funding for biomedical and behavioral research in the world. As such, its public health mission is vital to promote the overall health and well-being of Americans by fostering creative discoveries and innovative research, training and supporting researchers to ensure continued scientific progress, and expanding the scientific and medical knowledge base.

Within the NIH, there are several initiatives aimed at improving the health of women. Among these initiatives was the agency's Trans-NIH Strategic Plan for Women's Health Research, released in April 2019. The Strategic Plan laid out broad NIH goals that complement its more targeted women's health programs. These initiatives—along with the NIH's continued emphasis on improving standard research methodologies to address sex and gender and providing funding for women's health research—make continued support of NIH necessary in our mission to support women's health.

SWHR urges Congress to provide at least $46.1 billion for the NIH, a $3.2 billion increase over current funding, in FY 2022. This funding level would sustain and bolster NIH's ability to award competitive research grants, support the work of researchers within NIH, and build upon efforts to mitigate the COVID–19 pandemic's impact on ongoing and future research. We also encourage the Committee to work with NIH to ensure that the agency studies the impact of COVID–19, including the race and gender breakdown of participation in the workforce in the wake of the pandemic and how sex as a biological variable impacts short- and long-term health outcomes due to infection with SARS–CoV–2.

THE OFFICE OF RESEARCH ON WOMEN'S HEALTH

For decades, and as late as the 1990s, women were treated as small men in research. Research on diseases and treatments were conducted almost exclusively on male subjects, as researchers sought to avoid the presumed "complications" introduced by including female subjects in their work. Unfortunately, this approach ignored the impact of sex and gender on human development, disease progression, and ultimately, on approaches to research as a whole.

As the NIH focal point for coordinating women's health research, ORWH ensures women are represented across all NIH research and works to improve representation of women and women's health issues within federally funded research. ORWH provides critical leadership to programs, such as the Specialized Centers of Research Excellence, which advances translational research on the role of sex differences in

the health of women, and the Implementing a Maternal health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative, which coordinates interdisciplinary research on factors impacting maternal mortality.

In order to allow the Office to continue to coordinate and drive the conversation on women's health across NIH, SWHR recommends $55.4 million in funding for ORWH, an increase on par with the overall NIH budgetary recommendations, for FY 2022. SWHR also recommends an additional $3 million be allocated to the Building Interdisciplinary Research Careers in Women's Health program, an initiative that trains investigators to research sex and gender influences on health. This program has the potential not only to improve women's health by advancing our understanding of sex and gender differences, but also to support a diverse research workforce.

EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

The NICHD provides a home for women's health research in areas including reproductive sciences and maternal health. While the Institute is conducting several areas of critical research, there are two key areas of need within NICHD that could be further supported through additional funding in FY 2022:

Pregnant and Lactating Individuals: Nearly 94% of women take at least one medicine during pregnancy, and 50% take at least one medication during the postpartum period. Yet, pregnant and lactating individuals are excluded from the majority of biomedical research. Consequently, these women and their health care providers do not have access to the information they need to make confident decisions about their health care.

SWHR supports the appropriate inclusion of these populations in clinical research. The federal Task Force on Research Specific to Pregnant Women and Lactating Women, housed within the NICHD, has been crucial to outlining next steps for improving research in pregnant and lactating populations. Based on the Task Force recommendations from August 2020, SWHR requests that Congress include report language recommending that NICHD contract with the National Academy of Medicine to convene a panel with specific legal, ethical, regulatory, and policy experts to develop a framework for addressing legal and liability issues in research specific to pregnant and lactating people.

Uterine Fibroids: There is also need for improved attention to uterine fibroids, one of the most common gynecological conditions nationwide. Approximately 26 million individuals in the United States from ages 15 to 50 have fibroids, and 15 million experience symptoms like severe menstrual bleeding, anemia, impaired fertility, and pregnancy complications. Fibroids cost the health care system $5.9 to $34.4 billion annually.

Additionally, prominent and troubling health disparities exist in fibroids prevalence, onset, and severity. Black women are two to three times more likely to develop fibroids than white women. Black patients also tend to develop fibroids at earlier ages, develop more and larger tumors, and show increased symptom severity.

Yet, despite the prevalence of fibroids, fibroid research remains drastically underfunded compared to disease burden. In 2019, fibroid research received about $17 million in NIH funding, putting it in the bottom 50 of 292 funded conditions.

SWHR calls on Congress to provide at least $1.7 billion for NICHD in FY 2022 and to urge the NICHD to prioritize funding to expand basic, clinical, and translational research pathophysiology to identify early diagnostic methods and fertility-preserving treatments and to understand and mitigate the impact of health disparities.

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The Society for Women's Health Research appreciates the opportunity to submit this testimony and thanks the Subcommittee for considering our requests of at least $46.1 billion for NIH, $55.4 million for ORWH, and at least $1.7 billion for NICHD. We look forward to working with you to support medical and health services research and, therein, the health of the nation. If you have questions or would like more information, please do not hesitate to contact me at kathryn@swhr.org.

[This statement was submitted by Kathryn G. Schubert, President & CEO, Society for Women's Health Research.]

PREPARED STATEMENT OF THE SOCIETY OF GYNECOLOGIC ONCOLOGY

The Society of Gynecologic Oncology thanks the Subcommittee for the opportunity to submit comments for the record regarding our report language recommendations for prioritizing research activities on gynecologic cancers at the NIH National Cancer Institute in Fiscal Year 2022. The Society of Gynecologic Oncology (SGO) is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. The SGO's 2,000 members in the United States and abroad represent the entire gynecologic oncology team dedicated to the treatment and care of patients with gynecologic cancers. The SGO's strategic goals include advancing the prevention, early diagnosis, and treatment of gynecologic cancers by establishing and promoting standards of excellence. Key priorities for the SGO are to advocate for more equitable care for all patients and support research aimed to improve outcomes for diverse patient populations.

Gynecologic cancers are cancers that start in a patient's reproductive organs. There are five types of gynecologic cancers: cervical cancer, ovarian cancer, uterine also referred to as endometrial cancer, vaginal cancer, and vulvar cancer. Cervical, ovarian, and uterine cancers have both the highest incidence and mortality rates of all the gynecologic cancers.

The American Cancer Society estimates that this year in the United States over 100,000 people will be diagnosed with gynecologic cancers, including 66,570 new cases of uterine cancer, 21,410 cases of ovarian cancer, and 14,480 new cases of cervical cancer. More than 30,000 people will die from these malignancies, including 12,940 deaths from uterine cancer, 13,770 deaths from ovarian cancer, and 4,290 deaths from cervical cancer.

What is most alarming is the American Cancer Society's Annual Report to the Nation on the Status of Cancer, 1975–2014, which compared overall cancer survival rates from 1975–1977 and from 2006–2012 and reported that survival rates increased significantly for all but two cancer types in women, cancer of the cervix and of the uterus.

Furthermore, there are significant health disparities among patients who are diagnosed with these cancers. Despite overall declines in cervical cancer mortality in the U.S. over the past 6 decades, racial and socioeconomic disparities continue to exist in cervical cancer screening, incidence, and mortality, resulting in a disproportionate impact on low-income patients and patients of color. Hispanic patients are most likely to get cervical cancer, followed by African Americans, American Indians and Alaskan natives, and Whites. Hispanic patients are sixty percent (60%) more likely to be diagnosed with and thirty percent (30%) more likely to die from cervical cancer than white patients. Black patients are approximately twice as likely to die of cervical cancer. Socioeconomic status plays a role in these disparities. Patients living below the poverty level and without a high school education are 4.9 and 6.3 times more likely to die of cervical cancer than patients with the highest income and education levels, respectively. As concerning as these figures remain, they may in fact represent an underestimation of the problem especially in black patients. A patient that is diagnosed with invasive cervical cancer often reflects a patient who did not have access to or failed to receive a Pap smear test.

Uterine or endometrial cancer is the most common gynecological cancer, and the fourth most common malignancy among women in the United States. There are significant racial disparities in endometrial cancer as well. Endometrial cancer has been reported to be thirty-one percent (31%) lower among black patients compared to white patients. However, both black and Hispanic patients are less likely to receive evidenced based care. These racial disparities in treatment likely contribute to racial disparities in outcome. The age-adjusted mortality among black patients is approximately 84% higher.

Disparities in access to genetic testing, preventive services, and other aspects of providing care for patients with gynecologic cancers are creating enormous inequities in outcomes and survivorship in our health care system, particularly for endometrial cancer and cervical cancer. Research is needed to help understand barriers to screening programs, discover new approaches to screening, and promote wider implementation of known strategies to facilitate optimal treatments and improved mortality for minority populations with these diseases.

The SGO urges the Subcommittee to adopt the following report language focused on gynecologic cancers in the report accompanying the Fiscal Year 2022 Labor-HHS-Education appropriations bill.

National Institutes of Health

National Cancer Institute

Gynecologic Cancers.—The Committee continues to be concerned about the growing racial, socioeconomic, and geographic disparities in gynecologic cancers. In contrast to most other common cancers in the United States, relative survival for women with newly diagnosed advanced cervical or endometrial cancer has not significantly improved since the 1970s.[1] Furthermore, historical data demonstrates that Black and Latinx women with gynecologic cancers are not as likely to receive standard therapy and/or die more frequently.[2] The current COVID–19 pandemic has only exacerbated the health care disparities that were already present in minority and underrepresented communities. For example, in early 2021 the Centers for Disease Control (CDC) published findings that cervix cancer screenings in California decreased by as much as 78% during the pandemic—and have not recovered. They specifically noted concern because "cervical cancer incidence and mortality rates are disproportionately higher in Hispanic women and non-Hispanic Black women."[3] Therefore, the Committee urges the NCI to expand the number of program projects, clinical trials, research grants, and contract opportunities for investigators that focus on discoveries that will positively impact access to prevention, early detection, diagnosis, and treatment for gynecologic cancers and address these now well documented disparities. Accelerated progress in reducing gynecologic cancer mortality has been a need for some time. The Committee requests an update on NCI's research program for gynecologic cancers in the fiscal year 2023 Congressional Budget Justification, including specific grants and strategies where the intent is to overcome these racial disparities in gynecologic cancers outcomes, including the underrepresentation of minority women in gynecologic cancer clinical trials.

Thank you in advance for your favorable consideration of this report language request. The SGO believes that pursuit of these important research objectives will help alleviate disparities in prevention, diagnosis, treatment, and survivorship of gynecologic cancers, benefitting minority patients and all patients who are impacted by these diseases.

PREPARED STATEMENT OF THE SOCIETY OF NUCLEAR MEDICINE AND MOLECULAR IMAGING

Madam Chair and members of the Subcommittee, I am Richard L. Wahl, MD, President of the Society of Nuclear Medicine and Molecular Imaging and the Elizabeth E. Mallinckrodt Professor and head of radiology at Washington University School of Medicine in St. Louis, MO.

The Society of Nuclear Medicine and Molecular Imaging (SNMMI) is a nonprofit scientific and professional organization that promotes the science, technology, and practical application of nuclear medicine and molecular imaging. Research in this field has led to breakthroughs for diagnosing and treating patients with deadly conditions such as cancer, heart disease, and Alzheimer's disease. SNMMI strives to be a leader in unifying, advancing, and optimizing molecular imaging, with the ultimate goal of improving human health through noninvasive procedures and therapeutic approaches utilizing internally-administered radiopharmaceuticals. With over 15,000 members worldwide, SNMMI represents nuclear medicine and molecular imaging professionals, including physicians, physicists, radiochemists, pharmacists, and technologists, all of whom are committed to the advancement of the field. It is my pleasure to submit this testimony on behalf of SNMMI. We strongly support the President's request of $52 billion for the National Institutes of Health and ask that no less than $46.111 billion of that be for the NIH's base program budget for FY2022.

Moreover, SNMMI supports a proportional increase to the National Institute of Biomedical Imaging and Bioengineering (NIBIB), resulting in at least $441.1 million for FY2022—a $30.4 million increase over FY2021. These base increases reflect approximately 5% above the biomedical research and development price index (BRDPI). Through consistent, strong funding for NIH and our national research infrastructure we can continue to make advancements that will improve the lives of

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[1] Jemal A, et al. Annual report to the nation on the status of cancer, 1975–2014, featuring survival. J Natl Cancer Inst 2017; 109(9): djx030.

[2] Rauh-Hain JA, et al. Racial and ethnic disparities over time in the treatment and mortality of women with gynecological malignancies. Gynecol Oncol 2018; 149(1): 4–11.

[3] Miller MJ, et al. Impact of COVID–19 on cervical cancer screening rates among women aged 21–65 years in a large integrated health care system. CDC Morbidity and Mortality Weekly Report. January 29, 2021; 70(4): 109–113.

patients with a wide spectrum of diseases and disorders. SNMMI is grateful for the Subcommittee's past support of NIH and encourages the Subcommittee to continue advancing discovery and innovation in nuclear medicine and molecular imaging.

Nuclear medicine, in particular, is undergoing a renaissance as a precision medicine specialty, with new radiopharmaceuticals, radiopharmaceutical therapies, and instrumentation to elucidate biology and benefit patients. Federal research funding allows our members, partners, and stakeholders to improve imaging tools and therapies, which, in turn, broadens the resources available to address many challenging conditions. As a physician/clinician-scientist, my work has been greatly impacted by NIH funding, resulting in 18 patents, over 450 peer-reviewed scientific manuscripts, and several FDA-approved theranostic (therapy + diagnostics) drugs and devices. I use state-of-the-art technologies like positron emission tomography (PET) combined with computer tomography (CT) and other advanced imaging modalities to improve the diagnosis and treatment of cancer types, including prostate, breast, neuroendocrine, and pancreatic, while also researching rare and orphan diseases.

NUCLEAR MEDICINE AND MOLECULAR IMAGING: PRECISE AND PERSONALIZED MEDICINE

Nuclear medicine and molecular imaging procedures are used in a wide array of diseases and disorders, including cancer, Alzheimer's and Parkinson's Diseases, and cardiac disease, among others.[1] Congress's support of NIH has helped to advance the science and the researchers who make these discoveries. NIH support is often the foundation of the newest technologies that go on to help patients. This subcommittee's continued support of the NIH, especially the National Cancer Institute (NCI), NIBIB, National Institute on Aging (NIA), National Institute of Neurological Disorders and Stroke (NINDS), National Institute of Mental Health (NIMH), and National Heart, Lung, and Blood Institute (NHLBI), will help scientists address many unmet medical needs. Some of the advances from the nuclear medicine and molecular imaging community in detecting and treating cancer and selecting the right patient for the right therapy are detailed below.

Radiopharmaceutical Imaging and Therapy for Cancer

In the last month alone, two major advancements in the fight against prostate cancer were in the news. Pylarify®, a radioactive imaging agent, was approved by FDA on May 27. This radiotracer seeks out prostate cancer cells throughout the body so the active foci of cancer can be seen on a PET/CT scan. This class of agents targeting prostate specific membrane antigen or PSMA, can identify cancer months or years ahead of standard imaging such as CT or MRI, allowing patients to receive appropriate treatment sooner when it can be more effective. One week later, the results from the VISION trial were announced. This phase III trial enrolled men with late-stage castrate-resistant prostate cancer that had spread and were treated with either a PSMA targeting molecule with the radioisotope lutetium-177 (^{177}Lu) attached, or with the best standard of care. The PSMA part of the drug acts like GPS to seek out prostate cancer cells. The attached lutetium-177 radioisotope destroys the cancer cells while leaving healthy tissue intact. Combined, the radiopharmaceutical therapy is in effect a "smart bomb" to selectively destroy foci of prostate cancer. The men treated with ^{177}Lu-PSMA had a four-month longer median survival than men receiving best standard of care alone. These results prompted FDA to label the treatment as a breakthrough therapy which will accelerate its approval time and allow it to reach patients in need faster. None of this would have been possible without the early support of 13 NIH grants.[2]

Imaging and therapy molecule pairs, such as those using PSMA molecules as targeting agents, are often referred to as theranostics, a rapidly developing area of personalized medicine. If the diagnostic version of the molecule can find the cancer with a PET scan, then the same molecule with a therapeutic isotope can be used to attack the cancer. Further advancements in the theranostics space are anticipated. This treatment principle is being applied to cancer types for which we have no or few treatment options, such as pancreatic cancer. An exciting new class of

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[1] Wahl RL, Chareonthaitawee P, Clarke B, Drzezga A, Lindenberg L, Rahmim A, Thackeray J, Ulaner GA, Weber W, Zukotynski K, Sunderland J. Mars Shot for Nuclear Medicine, Molecular Imaging, and Molecularly Targeted Radiopharmaceutical Therapy. J Nucl Med. 2021 Jan;62(1):6–14. doi: 10.2967/jnumed.120.253450. PMID: 33334911.

[2] Szabo Z, Mena E, Rowe SP, et al. Initial Evaluation of [(18)F]DCFPyL for Prostate-Specific Membrane Antigen (PSMA)-Targeted PET Imaging of Prostate Cancer. Mol Imaging Biol. 2015;17:565–574.

theranostic molecules are those targeting fibroblast-activation-protein (FAP).[3] This protein (FAP) is overexpressed in many cancer types including breast, pancreas, lung, kidney, and ovarian. The FAP molecule can be labeled as a diagnostic agent and then as a therapy. This treatment paradigm gives doctors a new tool in the fight against cancer. The NCI is currently supporting a phase 1 clinical trial (NCT04457258) on this promising new agent.

None of these advances would be possible without the support of radiochemistry and isotope production research. The next generation of radioisotopes, alpha emitting therapeutic isotopes, which have much greater cancer killing power per radioactive decay, are in clinicals trials and are expected to provide better patient outcomes. Support of that research is critical.

Quantitative Molecular Imaging

A PET scanner is often thought of as an imaging tool; however, it is inherently a highly specific measuring tool. Recent advances in PET technology such as PET/MRI and total-body PET, where the whole body can be imaged at once, have opened new research possibilities.[4] To realize the full potential of these advances, quantitative analysis will be required to appreciate the sensitivity of the scanner and the tracers it measures. The NCI has supported the harmonization of PET/CT scanners through numerous grants including NIH R01CA169072, and for the last decade, the NCI, through their Cancer Imaging Program has developed and supported a consortium of academic sites called the Quantitative Imaging Network performing and advancing quantitative imaging mostly in support of clinical trials.

Imaging of the brain in Alzheimer Disease

In the past weeks, the FDA approved an innovative antibody therapy for Alzheimer's disease which removes amyloid plaque from the brain. At present, PET scanning using radiotracers that target the amyloid protein or the abnormal tau protein seen in dementias of the Alzheimer type have been key to identifying patients who may be suitable candidates for such clinical trials and these emerging therapies. The support of the NIH was key to developing these brain imaging agents and continued NIH support is essential to allow PET to probe the earliest changes of dementia and to monitor the effects of emerging innovative therapies. There are now several FDA approved PET imaging agents to identify patients with amyloid or tau deposition, helping identify how to best target limited resources to patient groups most likely to benefit from such therapies. The ability to select patients most likely to respond to therapy is expected to save tens of billions in healthcare dollars per year.

Immuno-oncology Imaging

In 1980, the NCI added $13.5M to their budget for new Biological Response Modifiers, this triggered a search for agents able to modify a body's response to tumor cells.[5] That investment spawned the multi-billion-dollar drug class of immune checkpoint inhibitors (ICI), starting with the approval of Yervoy® (ipilumimab) in 2011. In the US in 2020, a year severely impacted by the COVID–19 pandemic, sales of the top three ICI topped $17B. ICIs are generally considered to be safe and effective treatment options for numerous cancer types including lung cancers and melanoma, and some people like former US President Jimmy Carter had a remarkable response to ICI therapy. However, they do not work in all patients; indeed over half of patients treated with these agents die of their disease. New radiotracers are in development to image the immune system in conjunction with a PET or SPECT camera. Clinical trials with these tools have demonstrated the ability to predict response to ICI therapy after just one cycle of therapy. Future studies will aim to preselect, with imaging, patients who are likely to respond to immune checkpoint inhibitors thus enabling effective therapy earlier and eliminating side effects of futile

[3] Kratochwil C, Flechsig P, Lindner T, Abderrahim L, Altmann A, Mier W, Adeberg S, Rathke H, Röhrich M, Winter H, Plinkert PK, Marme F, Lang M, Kauczor HU, Jäger D, Debus J, Haberkorn U, Giesel FL. 68Ga-FAPI PET/CT: Tracer Uptake in 28 Different Kinds of Cancer. J Nucl Med. 2019 Jun;60(6):801–805. doi: 10.2967/jnumed.119.227967. Epub 2019 Apr 6. PMID: 30954939; PMCID: PMC6581228.

[4] Meikle SR, Sossi V, Roncali E, Cherry SR, Banati R, Mankoff D, Jones T, James M, Sutcliffe J, Ouyang J, Petibon Y, Ma C, El Fakhri G, Surti S, Karp JS, Badawi RD, Yamaya T, Akamatsu G, Schramm G, Rezaei A, Nuyts J, Fulton R, Kyme A, Lois C, Sari H, Price J, Boellaard R, Jeraj R, Bailey DL, Eslick E, Willowson KP, Dutta J. Quantitative PET in the 2020s: a roadmap. Phys Med Biol. 2021 Mar 12;66(6):06RM01. doi: 10.1088/1361–6560/abd4f7. PMID: 33339012.

[5] https://www.whatisbiotechnology.org/index.php/timeline/science/immunotherapy/80.

treatments. The ability to select patients likely to respond to therapy will also save billions in healthcare dollars.

Data Science and Workforce

The field of nuclear medicine and molecular imaging is rapidly expanding with new diagnostic imaging tracers, radiopharmaceutical therapies (RPT), and technologies. With new diagnostic tracers comes a need to properly interpret the innovative scans. Artificial intelligence (AI) algorithms can assist with the tedious components of image interpretation and even help with quality report generation. Development of well-credentialed registries of studies to train and validate such AI algorithms, reflecting diverse sets of patients will help advance this field. Radiopharmaceuticals therapies (RPTs), like other oncology therapies, are often studied in and approved for patients with late-stage disease, for example, after all other treatments have failed. To harness the full potential of RPTs, use earlier in the disease course may be advisable. Image and clinical data registries are needed to capture post-approval information on the use of RPTs and the patient outcomes to further guide their use. Recent imaging and therapy FDA approvals in prostate cancer and Alzheimer's disease, two highly prevalent conditions, require that the highly specialized field of nuclear medicine and molecular imaging train a cadre of qualified individuals to diagnose and treat these patients. It is critical for the NIH to fund and expand training grants so that our brightest scientists have the skills to develop a sustainable career pathway. Funding for AI technologies and registries will improve patient care and outcomes.

SUMMARY AND CONCLUSION

Robust NIH funding is crucial to advancing our efforts to detect and treat serious medical conditions. NIH investments help to sustain both our local and national research institutions across every state in the nation. China is advancing rapidly in the high technology medical space notably in AI. Funding NIH's base program with at least $46.111 billion will help researchers, scientist and physicians retain its competitive edge.

Thank you for your strong, continued support of NIH, NCI, NIMH, NIBIB and all the Institutes and Centers working to advance molecular imaging and radiopharmaceutical therapies to improve the lives of patients worldwide. On behalf of the Society of Nuclear Medicine and Molecular Imaging, I urge you to continue your strong support of our nation's research and innovation enterprise.

[This statement was submitted by Richard L. Wahl, MD, President, Society of Nuclear Medicine and Molecular Imaging.]

PREPARED STATEMENT OF THE STUDENT SUPPORT AND ACADEMIC ENRICHMENT PROGRAM

Dear Chairwoman Murray, Ranking Member Blunt, Chairwoman DeLauro, and Ranking Member Cole:

As you consider Fiscal Year 2022 appropriations for the U.S. Departments of Labor, Health and Human Services, and Education, we encourage you to help close opportunity and resource gaps in our nation's public schools by funding the Student Support and Academic Enrichment (SSAE) grant program authorized by Title IV–A of the Every Student Succeeds Act (ESSA) at $2 billion, which represents a $780 million increase over FY2021.

Title IV–A is a flexible grant that supports state and district efforts to: (1) support safe and healthy students by providing comprehensive mental and behavioral health services, implementing violence prevention programs, trauma informed care, school safety trainings; and other evidenced based initiatives; (2) increase student access to a well-rounded education, such as: STEM; computer science and accelerated learning courses; career and technical education; physical education; music; the arts; foreign languages; college and career counseling; effective school library programs; and social and emotional learning; and (3) provide students with access to technology and digital learning materials and educators with professional development and coaching opportunities necessary to effectively use those resources.

Over the last four fiscal years, on a bipartisan basis, Congress has provided a $4 billion investment for Title IV–A, which has allowed districts to meaningfully invest in programs that provide direct educational services and equitable supports to students. Its flexibility has allowed districts to provide funding for critical programs that support educators, school leaders, and students. As district leaders continue to leverage the flexibility of the SSAE grants, they are eager to plan for the continu-

ance and/or expansion of existing programs and services, and to create new programs.

To address unprecedented interruptions to learning caused by COVID–19, we call on Congress now to go beyond what was authorized in ESSA by providing $2 billion for the SSAE block grant. This will allow additional school districts, especially in rural areas, to make investments in not just one, but all three areas that this grant supports. Right now—more than ever—districts need the continued investments in the Title IV–A program.

The continued funding in these critical areas, especially during these uncertain times, will give districts the opportunity to build on the successes from the past 5 fiscal years as well as the ability to use Title IV–A funds to address issues that the COVID–19 crisis has made apparent and exacerbated. This pandemic has made clear that districts face a wide range of unique challenges, whether it's ensuring all children have access to technology for remote or blended learning or the ability to provide mental health supports from afar. As school systems prepare for the return to the classroom, they will need the flexibility of Title IV–A funds to provide social and emotional learning programs, engaging well-rounded classes like music and physical education, and active learning opportunities enabled through technology.

In order to support a safe and healthy school environment and make sure our students receive a well-rounded education that puts them on a path to success, we must continue to invest in our nation's schools, educators, and most importantly, our students. For these reasons, we urge Congress to fund the SSAE flexible grant program at $2 billion in FY 2022.

Thank you for the consideration of this request, we are grateful for the continued investments in the Student Support and Academic Enrichment grant program under Title IV–A of the Every Student Success Act (ESSA).

Sincerely.

National Organizations
AASA, The School Superintendents Association
Afterschool Alliance
American Counseling Association
American Federation of School Administrators
American Heart Association (AHA)
American Library Association
American Occupational Therapy Association
American Psychological Association
American School Counselor Association
ASCD
Association of Educational Service Agencies
Association of School Business Officials International (ASBO)
Chiefs for Change
City Year Inc.
Collaborative for Academic, Social, and Emotional Learning (CASEL)
Committee for Children
Common Sense
Communities In Schools
Council of Administrators of Special Education
EDGE Consulting Partners
Educational Theatre Association
EduColor
Futures Without Violence
Girl Scouts of the USA
Girls Inc.
Girlstart
International Society for Technology in Education
Joint National Committee for Languages
League of American Orchestras

MENTOR National
National Afterschool Association
National Association for College Admission Counseling
National Association of School Nurses
National Association of School Psychologists
National Association of Secondary School Principals
National Association of State Directors of Special Education (NASDSE)
National Center for Learning Disabilities
National Council for Languages and International Studies
National Council for the Social Studies
National PTA
National Rural Education Advocacy Consortium
National Science Teaching Association
National Summer Learning Association
National Superintendents Roundtable
School Social Work Association of America
School-Based Health Alliance
SHAPE America - Society of Health and Physical Educators
State Education Agency Directors of Arts Education
State Educational Technology Directors Association (SETDA)
Teach Plus
State Organizations
Alabama Association of School Psychologists
Alaska Science Teachers Association

Arizona Science Teachers Association
Arkansas School Psychology Association
Association of School Psychologists of Pennsylvania
Connecticut School Counselor Association
Connecticut Science Teachers Association
Delaware Association of School Psychologists (DASP)
Florida Association of Science Teachers
Guam Association of School Counselors (GASC)
HASTI (Hoosier Association of Science Teachers, Inc.)
Idaho Science Teachers Association (ISTA)
Illinois School Psychologists Association
Indiana Association of School Psychologists
Kentucky Association for Psychology in the Schools (KAPS)
Maine School Counselor Association
Maine Science Teachers Association
Maine Science Teachers Association
Maryland Association of Science Teachers (MAST)
Maryland School Psychologists' Association
Massachusetts Association of Science Teachers
Michigan Science Teachers Association (MSTA)
Michigan Association of School Psychologists
Minnesota Science Teachers Association
Missouri Association of School Psychologists
Montana Science Teachers Association
Nebraska Association of Teachers of Science
Nebraska School Psychologists Association
Nevada School Counselor Association

Nevada State Science Teachers Association
New Hampshire Association of School Psychologists
New Jersey Association of School Psychologists
New York Association of School Psychologists (NYASP)
New York State School Counselor Association
North Dakota Association of School Psychologists
North Carolina School Counselor Association
Ohio School Counselor Association
Oklahoma School Psychological Association
Pennsylvania Science Teachers Association
Rhode Island School Psychologists Association
Science Teachers Association of New York State
Science Teachers Association of Texas
Science Teachers of Missouri
South Carolina Science Council
South Dakota Association of School Psychologists
South Dakota Science Teaching Association
Tennessee Association of School Psychologists (TASP)
Tennessee Science Teachers Association
Texas Association of School Psychologists
Utah Association of School Psychologists
Utah School Counselor Association
Utah Science Teachers Association
Vermont Association of School Psychologists
Washington Science Teachers Association
Washington State Association of School Psychologists
West Virginia School Psychologists Association
West Virginia Science Teachers Association
Wisconsin School Counselor Association
Wisconsin School Psychologists Association

PREPARED STATEMENT OF SUSAN G. KOMEN BREAST CANCER FOUNDATION

Susan G. Komen (Komen) is the world's leading nonprofit breast cancer organization representing the millions of Americans who have been diagnosed with breast cancer and are currently living in the United States. Komen has an unmatched, comprehensive 360-degree approach to fighting this disease across all fronts—we advocate for patients, drive research breakthroughs, improve access to high-quality care, offer direct patient support and empower people with trustworthy information. Komen is committed to supporting those affected by breast cancer today, while tirelessly searching for tomorrow's cures. We advocate on behalf of the estimated 284,200 women and men in the United States that will be diagnosed with breast cancer and the more than 44,000 that will die from the disease in 2021 alone.

Screening tests are used to find breast cancer before it causes any warning signs or symptoms. Regular screening enables us to detect potential cancers at earlier stages and refer patients to further care, often yielding better outcomes for patients and resulting in decreased financial pressure on our healthcare system. Without access to early detection programs, many individuals are forced to delay or forgo screenings, which can lead to disease progression and later-stage breast cancer diagnoses. To ensure access to early detection programs, Komen is requesting that Congress fully fund the Centers for Disease Control's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) at the authorized amount of $275 million in Fiscal Year (FY) 2022.

NBCCEDP was established with the passage of the Breast and Cervical Cancer Mortality Prevention Act in 1990. The program plays a critical role in helping low-income, uninsured, and underinsured women who do not qualify for Medicaid receive timely breast and cervical cancer screening, diagnostic and treatment services that are free or low-cost. The covered services include clinical breast examinations, mammograms, pelvic examinations, Pap tests, human papillomavirus (HPV) tests, diagnostic tests if screening results are abnormal, and referrals to treatment. Additionally, the NBCCEDP provides patient navigation services to help women overcome barriers and get timely access to quality care.

For 30 years, NBCCEDP has provided lifesaving breast cancer screening and diagnostic services to eligible women in all 50 states, the District of Columbia, six territories and 13 American Indian/Alaska Native tribes or tribal organizations. NBCCEDP has served more than 5.8 million women since it launched in 1991, detecting over 72,000 breast cancers, nearly 23,000 premalignant breast lesions, 4,900 cervical cancers and 226,000 premalignant cervical lesions. More statistics on the number of women served by the program in each state is available here.

The program, which is a partnership between the CDC and state health departments, also provides public education, outreach, care coordination and quality assurance to increase breast cancer screening rates and reach underserved, vulnerable populations. Each state program operates within the national framework of legislation, policy, and oversight; however, programs vary in funding, infrastructure, populations served and geographical barriers. Programs can prioritize the population they serve based on their cancer burden, environment, available resources and goals. Unfortunately, these are often influenced and limited by state funding and state legislative constraints.

The COVID–19 pandemic highlighted the broad systemic trend that exists with almost every public health crisis: consequences are more commonly and more severely experienced in low-income, minority and rural communities. Black women in the United States have a breast cancer mortality rate about 40 percent higher than white women. Similarly, Hispanic/Latina and American Indian/Alaska Native women are 30 percent more likely to be diagnosed with advanced stage breast cancer compared with white women. NBCCEDP funding supports interventions which help address inequities in breast cancer screening and diagnosis since the program places special emphasis on women who are geographically or culturally isolated and who identify as racial or ethnic minorities. The program focuses on factors at the interpersonal, organizational, community and policy levels that influence screening. NBCCEDP invests in evidence-based interventions, for health care systems and communities, which reflect cultural competencies needed to reach communities that often distrust the medical system. Use of multicomponent interventions of this type are found to be more effective at connecting historically marginalized communities to services. However, the CDC and state health departments need more support.

More than 2.6 million women are eligible for NBCCEDP breast cancer screening services. Authorized at $275 million, the program is currently funded at approximately $197 million. Unfortunately, at current funding levels NBCCEDP serves fewer than 15 percent of the estimated number of eligible women for breast cancer screening services and less than seven percent of eligible women for cervical cancer screening.

An increase in funding in FY22 will be especially crucial as the nation recovers from the COVID–19 pandemic. Data show that the pandemic has caused people to delay life-saving breast cancer screenings. Models, based on data from the 3-month period from early March 2020 through early June 2020, suggest there could be as many as 36,000 missed or delayed diagnoses of breast cancer because of COVID–19.[1] This delay can mean women will not seek care until the cancer is more advanced, leading to worse outcomes for the patient and much more costly treatment. Furthermore, with many Americans experiencing job loss and financial difficulties

[1] IQVIA Institute for Human Data Science, Shifts in Healthcare Demand, Delivery and Care During the COVID–19 Era (April 2020).

related to the COVID–19 pandemic, with resulting loss of healthcare benefits, continued access to NBCCEDP is needed now more than ever.

The availability of the NBCCEDP impacts every taxpayer and people in every congressional district, as the uninsured will eventually seek care at our states' hospitals with late-stage disease, putting an even greater strain on the patients, the health system and state budgets. Ensuring adequate NBCCEDP funding is key to ensuring that low-income, uninsured, and underinsured women across the country continue to have access to vital screening services, health education and patient navigation services, as well as enabling proper monitoring of state and local breast cancer patterns and trends.

An increased investment in the NBCCEDP will allow the CDC and its state and local partners to broaden its reach and pursue important goals such as implementing innovative strategies and new methods to find eligible women currently not using the program, including those with no source of care, and lower incomes, education, and health literacy levels, ultimately helping to create a more equitable health care system.

The NBCCEDP has bipartisan support in both the Senate and House of Representatives, with letters being submitted in both chambers in support for full authorized funding for the program this year. Increasing funding for NBCCEDP to the authorized level of $275 million in the FY 22 Labor, HHS, Education Appropriations Bill will result in more women being screened, more cancers being diagnosed at earlier stages and ultimately better outcomes for women and lower costs for our health care system.

[This statement was submitted by Molly Guthrie, Sr., Director, Public Policy and Advocacy.]

PREPARED STATEMENT OF THE TASK FORCE FOR GLOBAL HEALTH

Thank you for this opportunity to provide testimony on polio activities at The Task Force for Global Health. I write to express our support for full funding for CDC's polio initiatives.

The Task Force for Global Health, founded nearly 40 years ago to advance health equity, works with partners in more than 150 countries to eliminate diseases, ensure access to vaccines and essential medicines, and strengthen health systems to protect populations. Our expertise includes polio, influenza, COVID–19, hepatitis, neglected tropical diseases; vaccine safety, distribution and access; and health systems strengthening. Our COVID–19 activities include working with 50 countries to deliver vaccines, address vaccine hesitancy, provide vaccine safety guidelines; advise on digital contact tracing; train epidemiologists in disease surveillance and response; distribute essential protection and treatment to hard-hit communities; work through existing health programs to ensure protection for vulnerable groups, such as those afflicted with other diseases; and leverage our existing supply chains to support ongoing response and assist countries in delivering vaccines.

CDC has been engaged in the fight against polio for over 31 years. Its leadership, in providing technical guidance and expertise in countries, regionally and globally as part of the Global Polio Eradication Initiative, has resulted in a reduction in the number of worldwide polio cases from an estimated 350,000 in 1988 to 176 in 2019—a decline of more than 99% in reported cases. It has also resulted in polio-free certification in five of the six regions of the world—the African Region, the Americas, Europe, South East Asia and the Western Pacific. Only two polio-endemic countries (nations that have never interrupted the transmission of wild poliovirus) remain—fghanistan and Pakistan. Without CDC's polio eradication efforts, more than 18 million people who are currently healthy would have been paralyzed by the virus.

At the Task Force for Global Health, we are providing surge capacity expertise and technical assistance to outbreak countries and those at high risk of future outbreak in the African region. Since April 2018, the Global Polio Surge Capacity Team, consisting of a project manager and four senior epidemiologists, have deployed a total of 17 times to Ghana, Ethiopia, Indonesia, Congo-Brazzaville, and Zambia, with a total of nearly 1,250 person days. In a time of growing scale and scope of circulating type 2 vaccine-derived poliovirus (cVDPV2) outbreaks, the team provides highly respected and valued expertise across the Global Polio Eradication Initiative (GPEI) partnership.

In Ministry of Health forums, the team is considered a crucial component of polio outbreak response efforts, often working closely with Emergency Operations Centers and national public health institute staff. They have provided technical assistance for improving active case search, enhancing surveillance efforts, and preparation

and implementation of vaccination campaigns. Supplementary immunization activities have targeted hundreds of millions of children since the team was created, and the long-term nature of their deployments has provided essential continuity in settings that often see high staff turnover.

Since CDC began the Frontline Polio Surge activities in October 2019, the team has provided supervision and direction to the deployed staff, connecting them with district surveillance staff, WHO colleagues, and Ministry of Health staff. They serve as in-country experts and resources to teams deployed at district levels for campaigns and surveillance strengthening activities. A training program to prepare 100 NSTOP (National Stop Transmission of Polio) staff for field deployments was developed and conducted.

In Ethiopia and Zambia, members of the team have taken the lead on supporting the Ministries of Health in developing comprehensive surveillance proposals for continued active case search of Acute Flaccid Paralysis (AFP) cases, with SOPs and protocols for district surveillance staff. These include the utilization of Field Epidemiology Training Program (FETP) residents as sources of valuable local human resource capacity. The institutionalization of this expertise is crucial for these countries working towards controlling outbreaks and ultimately eradicating polio.

Moving forward, we will continue to provide in-person technical assistance to countries facing circulating vaccine-derived type 2 poliovirus outbreaks, to meet surveillance and response needs. This work will include pre-, intra-, and post-vaccination campaign activities. Additionally, the team will apply its extensive breadth of experience in using data for action to strengthen surveillance networks, country outbreak preparedness and response plans, and training materials.

Lastly, we will provide remote technical assistance as needed on campaign data quality, monitoring and evaluation of campaigns, strengthening of EOCs, and supervision of local consultants. Members of the team will continue to provide guidance on various long-term requests from Ministries of Health and international agencies.

Due to Congress's support in FY 2019 and FY 2020, select CDC polio accomplishments include:

—Provide instrumental support internationally and domestically through extensive details to the CDC COVID–19 response and through polio-supported staff to the COVID–19 pandemic response in Afghanistan, Pakistan, and across Africa in the areas of disease surveillance, health worker training, contact tracing, risk communications and testing.

—Provide $56.13 million in FY 2020 to UNICEF for the expansion of Community Based Vaccinator Program in Pakistan that now includes over 24,000 workers (nearly 90% are women) who reach 4 million children annually, approximately 60 million doses of oral polio vaccine, 2.9 million doses of inactivated polio vaccine, and $3 million for operational costs for NIDs in all polio-endemic countries and outbreak countries. Most of these NIDs would not take place without the assurance of CDC's support.

—Provide expertise in virology, diagnostics, and laboratory procedures, including quality assurance, and genomic sequencing of samples obtained worldwide; provide the largest volume of operational (poliovirus isolation) and technologically sophisticated (genetic sequencing of polio viruses) lab support to the 145 laboratories of the global polio laboratory network. CDC has the leading specialized polio reference lab in the world.

—Deploy 210 Stop Transmission of Polio (STOP) members in 42 countries with two-thirds deployed to the African Region which has significantly benefited from STOP support, contributing substantially to the region's achievement of wild polio-free status in 2020. CDC's Stop Transmission of Polio (STOP) program trained and deployed 2100 public health professionals to improve vaccine-preventable disease surveillance and to help plan, implement, and evaluate vaccination campaigns.

—Use STOP participants to support local governments, health facilities, and communities during the COVID–19 pandemic to promote awareness of COVID–19 and provide contract tracing while still supporting VPD surveillance, essential immunization services, and polio eradication efforts.

Global polio initiatives are leading us to a day when polio will be eradicated from our planet. The Task Force for Global Health is honored to support CDC's leadership in its mission and to serve as part of this strong global partnership to end polio in our lifetime.

With Congress' continued support, we will be able to support CDC's outbreak priorities, which include strengthening surveillance for polioviruses in all areas currently below certification standard and rapidly responding to the detection in a population of the types of polioviruses included in discontinued oral polio vaccines. We will also ensure that populations are not exposed to the types of polioviruses in-

cluded in discontinued oral polio vaccines while laying the logistic and epidemiologic groundwork for the complete cessation of use of all oral polio vaccines.

Thank you for the opportunity to provide this testimony.

[This statement was submitted by Dr. Fabien Diomande, Director, Polio Surge Program: Task Force for Global Health.]

PREPARED STATEMENT OF THE TASK FORCE FOR GLOBAL HEALTH

Thank you for allowing me to provide written remarks on behalf of the Coalition for Global Hepatitis Elimination of the Task Force for Global Health. I want to express the Coalition's strong support for funding of at least $250 million for the Department of Health and Human Services' national strategy for the elimination of viral hepatitis and the global and domestic activities needed to achieve the plan's goals for hepatitis elimination.

As the COVID–19 pandemic has taught us, we must eliminate deadly viral threats when we have the opportunity. Now is the time to eliminate hepatitis B virus (HBV) and hepatitis C virus (HCV).

The Task Force for Global Health, founded in 1984 to advance health equity, works with partners in more than 150 countries to eliminate diseases, ensure access to vaccines and essential medicines, and strengthen health systems to protect populations. Our expertise includes neglected tropical diseases and other infectious diseases; vaccine safety, distribution and access; and health systems strengthening.

The Coalition for Global Hepatitis Elimination, a program of the Task Force for Global Health, with support of CDC and NIH, assists the work of public health authorities, clinicians and community organizations working on the front lines to prevent, detect and treat HBV and HCV.

HBV AND HCV INFECTIONS ARE LARGE GLOBAL HEALTH PROBLEMS

In 2015, a total of 296 million and 58 million persons worldwide were living with HBV and HCV infections, respectively, which cause over 1 million deaths per year. In the United States, as many as 2.3 million persons are living with HBV infection and 3.5 million persons are living with HCV infection. The United States has the third largest burden of HCV in the world, after only China and India. Of HBV and HCV infected persons, if undiagnosed and untreated, 20%–25% will die of liver disease or liver cancer. Three of four liver cancer deaths are caused by HBV or HCV.

Hepatitis is a health disparity for racial/ethnic minority populations and for rural America. The health threat of hepatitis B is greatest for Asian Americans who were not vaccinated as children before arriving in the United States. Hepatitis-infected persons in communities of color have limited access to testing and lifesaving treatment, leading to higher death rates for American-Indians/Alaskan Natives and Black Americans. New infections of HCV are rising at an alarmingly fast pace, fueled by the opioid crisis and increases in injection drug use with unsafe equipment. HCV infections rates are increasing the most among young adults in Appalachian states.

All of the public health and biomedical tools needed to address these gaps in hepatitis prevention, testing, and treatment are available. HBV vaccines have been in use for decades. Indeed, the 2020 Nobel Prize in Medicine was awarded to two American scientists for work leading to the discovery of HCV and making possible the reliable tests and first curative therapies for a chronic viral infection. Rarely in public health do we have this opportunity. Now is the time to act within our borders and globally to eliminate viral hepatitis.

Support for the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021–2025

In January 2021, the Department of Health and Human Services released the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021–2025. The Plan is the first to join with the global goals adopted by other nations and to aim for elimination of viral hepatitis as a public health threat in the US. With the support of this Committee and of Congress, the nation can act on this first national elimination plan and strengthen efforts to stop hepatitis in its tracks and ensure all people benefit from disease elimination.

The Coalition activities supported by federal agencies, including CDC and NIH, assist the implementation of the HHS strategic plan and achievement of goals for hepatitis elimination. With federal partners, the Coalition is focused on 4 key objectives for advancing hepatitis elimination. The US must advance these priorities at home to ensure the success of the national strategic plan and also provide global leadership in addressing this public health threat.

Priority 1. Assure all newborns receive Hepatitis B vaccination and are protected from HBV infection and liver cancer. A birth dose of hepatitis B vaccine followed by two doses of infant immunizations decreases risk of mother-to-child HBV transmission by 90%. However, less than 50% of children globally receive hepatitis B vaccine within 24 hours, a critical intervention interrupting mother-to-child transmission. Coverage is lowest (10%) in Africa where the prevalence of HBV is the highest in the world. In collaboration with CDC, the Coalition is training public health officials and assisting countries to develop improved vaccination policies. Over 200 Ministry of Health officials, research partners, and civil society members are participating in training sessions to support more governments in adopting hepatitis B newborn vaccine policies and improving coverage. Through these efforts, the Coalition limits continued introduction of HBV into the US and reduces HBV as a health disparity for Asian and African-born Americans.

Priority 2. Implement simple models of care to detect and treat persons living with HBV and HCV. The therapies for HBV and HCV are low cost and safe. Therapies for HCV cure 95% of persons who receive treatment. Most persons globally remain undiagnosed and untreated. Proven models of care by non-specialists increase access to lifesaving testing and treatment. in the US and globally. The Coalition assists health systems simplify care and eliminate HBV and HCV as major causes of death.

Priority 3. Develop tools for tracking progress in elimination. Over the course of the next year, the Coalition will develop national hepatitis elimination profiles for the United States and other high-burden countries bringing together the latest data regarding hepatitis burden and status of policy development with trends in access to vaccination, testing and treatment. These profiles will help countries identify gaps in hepatitis services and assist US Government agencies to prioritize support.

Priority 4. Create additional opportunities to disseminate lessons on effective hepatitis prevention care and treatment. Despite effective tools and model programs, many countries like the United States are facing a rise in new cases or low screening rates. Programs in the United States and across the world benefit from sharing lessons learned, saving time and avoiding redundant research. Over the past year, the Coalition has reached over 1,000 individuals in 64 countries through over 20 stakeholder meetings and web-based educational and training sessions. These events are opportunities for programs to share experiences and resources. The Coalition is collaborating with NIH to publically share NIH-funded research advancing hepatitis elimination and identify further research priorities.

Thank you again for this opportunity to support full funding of the HHS roadmap for hepatitis elimination. The Coalition looks forward to continued collaborations with HHS on the domestic and global activities needed to eliminate viral hepatitis in the United States and globally.

[This statement was submitted by William P. Nichols, Executive Vice President and Chief Operating Officer, Task Force for Global Health.]

PREPARED STATEMENT OF THE TASK FORCE FOR GLOBAL HEALTH, INC.

Thank you for this opportunity to provide testimony on influenza activities at The Task Force for Global Health. I write to express our support for full funding for CDC's influenza initiatives.

The Task Force for Global Health, founded nearly 40 years ago to advance health equity, works with partners in more than 150 countries to eliminate diseases, ensure access to vaccines and essential medicines, and strengthen health systems to protect populations. Our expertise includes polio, influenza, COVID–19, hepatitis, neglected tropical diseases; vaccine safety, distribution and access; and health systems strengthening. Our COVID–19 activities include work with 53 countries to deliver vaccines, address vaccine hesitancy, provide vaccine safety guidelines; advise on digital contact tracing; train epidemiologists in disease surveillance and response; distribute essential protection and treatment to hard-hit communities; work through existing health programs to ensure protection for vulnerable groups, such as those afflicted with other diseases; and leverage our existing supply chains to support ongoing response and assist countries in delivering vaccines. The Task Force's influenza program has provided the framework for our work in COVID–19.

In 2013 with funding from CDC, the Task Force for Global Health established the Partnership for Influenza Vaccine Introduction (PIVI) to create sustainable, seasonal influenza vaccination programs in low- and middle-income countries. The initiative protects communities from the annual impact of flu, and also builds the adult immunization infrastructure, capacity, and vaccine delivery systems critical for future influenza pandemics and other infectious disease epidemics.

During the 2009 influenza pandemic, countries with seasonal influenza vaccination programs were able to import, and use vaccines much faster than countries without such programs.[1] With financial and technical support from CDC, PIVI supports countries in building legal, programmatic, policy-making, and regulatory capacity to quickly import and deploy influenza vaccines. The public-private collaboration provides influenza vaccines allowing countries to annually exercise and evaluate program effectiveness while moving towards country ownership and sustainability. In support of this objective, PIVI funds and fosters creation of regional collaborations that establish multi-country region-level working groups to share data, programmatic experience and explore opportunities for joint vaccine procurement efforts.

The influenza program infrastructure has supported, and continues to support, the efforts to fight COVID–19. From disease risk education and prevention, surveillance, the collection and analysis of laboratory specimens, and the sharing of information and genetic sequence data—the global and national influenza infrastructure is an indispensable component of the public health response to COVID–19. The same influenza vaccine delivery systems that enabled timely and efficient use of seasonal influenza vaccine are, and will be, utilized to deploy COVID–19 vaccine(s) as they become available. PIVI is at the forefront of this work.

In 2020, building on the expertise, the experience, and the lessons learned from the program, the Task Force quickly developed a new program called CoVIP, a public-private partnership between CDC and the Task Force engaging a global collaboration of public health technical experts, to ensure that low and middle-income countries are ready and able to deploy and evaluate COVID–19 vaccines as they become available.

With funding from the CARES Act, the Task Force's influenza program is currently supporting 53 countries with technical assistance and some funding to develop national deployment plans, evaluate programmatic approaches, and refine their vaccine program approaches.

Applying the influenza program tools to the COVID–19 vaccine rollout provides a unique opportunity to rapidly gather information to improve and sustain the vaccines for global use, and establish long-lasting national capacities for future use.

Thank you for the opportunity to provide this testimony.

[This statement was submitted by Dr. Mark McKinlay, Director, Center for Vaccine Equity: Task Force for Global Health, Inc.]

PREPARED STATEMENT OF THE TOURETTE ASSOCIATION OF AMERICA

Dear Chairwoman Murray, Ranking Member Blunt and Members of the Subcommittee:

The Tourette Association of America (TAA) would like to take this opportunity to thank the members of the Subcommittee for the opportunity to submit written testimony and for considering our request for funding for Fiscal Year 2022 (FY22). The Centers for Disease Control and Prevention (CDC) play a pivotal role in educating the public. To that end, the Tourette Syndrome Public Health Education and Research Program at the CDC is critically important to the TS and Tic Disorder community. We respectfully request that you continue funding the enacted level $2 million appropriation for the program in FY22 Labor, Health and Human Services (LHHS), Education and Related Agencies Appropriations. The program on Tourette Syndrome is administered within the National Center on Birth Defects and Developmental Disabilities (NCBDDD) at the CDC, in partnership with the TAA. This program was established by Congress in the Children's Health Act of 2000 (PL. 106–310 Title 23) and is the only such program that receives federal funding for Tourette Syndrome (TS) public health education. With your support at the previously enacted level of $2 million, CDC can ensure critically necessary progress continues in the areas of public education, research and diagnosis for TS and Tic Disorders.

The TAA is the premier national non-profit organization working to make life better for all people affected by TS and Tic Disorders. We have served in this capacity for 49 years. Tics are involuntary, repetitive movements and vocalizations. They are the defining feature of a group of childhood-onset, neurodevelopmental conditions known collectively as Tic Disorders and individually as Tourette Syndrome, Chronic Tic Disorder (Motor or Vocal Type), and Provisional Tic Disorder. People with TS and Tic Disorders often have substantial healthcare costs across their lifespan for

[1] Porter, R. M. et al. (2020) 'Does having a seasonal influenza program facilitate pandemic preparedness? An analysis of vaccine deployment during the 2009 pandemic', Vaccine. Elsevier, 38(5), pp. 1152–1159.

healthcare visits, special educational services, medication, and psychological and behavioral counseling. In a recent survey conducted by the TAA (2018 TAA Impact Survey: https://tourette.org/research-medical/impact-survey/), 63% of parents struggle to cover the high costs of services for their child such as counseling, appointments and tutoring; 34% of parents report they lost their job or they are not able to work as often due to the increased caregiver duties of having a child living with TS; and, 18% of parents are not able to afford medications and/or desired medical care for their child. A recent Coronavirus impact survey, conducted by TAA (https://tourette.org/coronavirus-and-tourette-syndrome/), found that 82% of respondents said their tics or other symptoms worsened during the pandemic.

The CDC Tourette Syndrome Website (https://www.cdc.gov/ncbddd/tourette/data.html) on data and statistics states that data suggest roughly 50% of children and teens with TS are not diagnosed. Studies including children with both with diagnosed and undiagnosed TS have estimated that 1 out of every 162 children (0.6%) have TS. However, these numbers do not include children with Chronic or Provisional Tic Disorders. The estimated combined total of all school-aged children with TS or another related Tic Disorder is approximately 1-in-100. Factoring in lifelong prevalence, we estimate 1 million adults and children are living with Tourette Syndrome or another Tic Disorder in the United States today. These statistics outline the need for additional research on prevalence. Diagnosis is often complicated. Among children diagnosed with TS, 83% have been diagnosed with at least one additional mental, behavioral, or developmental condition according to the CDC website. These co-occurring conditions include Attention Deficit-Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD), Autism, Oppositional Defiance Disorder, anxiety, depression, learning difficulties among others and can significantly impact the lives of those affected by TS. In fact, in TAA's 2018 Impact Survey, 42% of children felt that dealing co-occurring conditions was one of the biggest challenges in managing TS. In addition, 32% of children and 51% of adults have considered suicide or participated in self-harming behaviors. This underscores the need to increase the diagnosis rate so physicians, teachers and parents can ensure that adequate support services are in place. The CDC TS Program works to ensure primary care, family doctors or pediatricians are equipped with the additional knowledge necessary either to diagnose or to refer a patient for optimal treatment.

Education professionals often do not receive detailed instruction on how to assess and accommodate students who may have TS and Tic Disorders. A study published in the Journal of Developmental & Behavioral Pediatrics and written in partnership between the CDC and the Tourette Association of America, "Impact of Tourette Syndrome on School Measures in a Nationally Representative Sample", found children with Tourette were more likely to have an individualized IEP, have a parent contacted about school problems and have incomplete homework as compared to children without Tourette or a Tic Disorder. Additionally, most children with Tourette Syndrome had other mental, behavioral, or emotional disorders or learning and language disorders. In TAA's 2018 Impact Survey, 83% of children felt that TS negatively impacted their school experience and education and 69% of parents noted their child having an individualized education plan (IEP) or 504 plan in place at their school. Educators spend a significant amount of time with their students providing more opportunities to assess symptoms and behavior over a longer period of time. By increasing their knowledge base and understanding of Tourette Syndrome, Tic Disorders and associated co-morbidities, educators can refer students for medical assessment and can also better serve the needs of this population whose challenges are unique to the disorder. Educators can then begin to work more closely with medical providers to develop effective, individualized education plans.

TS and Tic Disorders are greatly misunderstood and often suffer from misinformation and stigma. For example, coprolalia, the involuntary utterance of obscene and socially unacceptable words and phrases, is an extreme and rare symptom often sensationalized by the media. Less than 10% of those diagnosed have this symptom, it is not required for diagnosis, and does not persist in many cases. The CDC TS Public Health, Education and Research Program provides important information on symptoms/diagnostic criteria on their website and through the outreach program educating the public and parents on Tourette Syndrome and Tic Disorders to ensure a better understanding which can lead to better diagnosis, earlier treatment and a better understanding.

Delayed diagnosis or the lack of diagnosis can increase health care costs, increase education costs and delay important treatment and therapy for the patient. Comprehensive Behavior Intervention for Tics (CBIT) is a non-medicated treatment consisting of three important components: training the patient to be more aware of his or her tics and the urge to tic; training patients to do competing behavior when they

feel the urge to tic; and, making changes to day-to-day activities in ways that can be helpful in reducing tics. CBIT is now recognized as a first line treatment by the American Academy of Neurology: https://www.aan.com/Guidelines/Home/GuidelineDetail/958. The CDC Tourette Syndrome Public Health, Education and Research Program strives to increase the understanding and awareness among these critically important medical and education professionals to increase the percentage of school aged children with TS who are diagnosed, improve the timeframe from symptoms to diagnosis and educate them about treatment options like CBIT.

We appreciate the opportunity to submit testimony and appreciate your thoughtful consideration of our request. TAA urges you to provide continued funding for Fiscal Year 2022 for the Tourette Syndrome Public Health Education and Research Program at CDC's National Center for Birth Defects and Developmental Disabilities at the previously enacted level of $2 million.

PREPARED STATEMENT OF THE TRAINING PROGRAMS IN EPIDEMIOLOGY AND PUBLIC HEALTH INTERVENTIONS NETWORK

Thank you for this opportunity to provide written testimony on behalf of the Training Programs in Epidemiology and Public Health Interventions Network, known as TEPHINET, based at The Task Force for Global Health.

The Task Force for Global Health, founded in 1984 to advance health equity, works with partners in more than 150 countries to eliminate diseases, ensure access to vaccines and essential medicines, and strengthen health systems to protect populations. Our expertise includes neglected tropical diseases and other infectious diseases; vaccine safety, distribution and access; and health systems strengthening. Our COVID–19 activities include: working with 50 countries to help vaccinate their populations, providing vaccine safety guidelines; advising on digital contact tracing; training epidemiologists on disease surveillance and response; distributing essential protection and treatment to hard-hit communities; using existing health programs to ensure protection for vulnerable groups, such as those afflicted with other diseases; overcoming vaccine hesitancy in the United States and leveraging our existing supply chains for ongoing response and to help countries deliver vaccines.

As the Director of TEPHINET, one of the Task Force's 16 global health programs, I am sharing my support for efforts to build the global field epidemiology workforce needed to advance global health security by detecting and responding to disease outbreaks before they become pandemics with devastating human and economic consequences. I would also like to share with you the incredible impact that U.S. funding is already having on building a public health workforce of field epidemiologists worldwide.

TEPHINET, is the global network of Field Epidemiology Training Programs (FETPs) that is funded primarily through the Centers for Disease Control and Prevention (CDC). You might be wondering what a field epidemiologist does and why it is important to train more field epidemiologists around the world. Think of it this way: when there is a fire, we call upon trained and skilled firefighters to rush to the scene of the fire and put it out as soon as possible. Not only are field epidemiologists the firefighters of public health, but they set up the fire alarm systems by developing disease surveillance systems to catch cases early. When there is a disease outbreak, a natural disaster, or a humanitarian crisis unfolding that threatens people's health, field epidemiologists are deployed to the scene. Their task is to understand how and why the health threat is occurring, who is affected, and how to stop its spread at the source. For this reason, field epidemiologists are known as "Disease Detectives." They conduct outbreak investigations, perform contact tracing, monitor travelers at points of entry and attendees at mass gatherings, engage with communities on disease prevention measures, and much more. They are based at ministries of health, national public health institutes (like our CDC) and are in many ways the lynchpin of the overall public health system in a country.

TEPHINET consists of 75 Field Epidemiology Training Programs training field epidemiologists in more than 100 countries. To date, trainees and graduates of our member programs have investigated more than 12,000 outbreaks or acute health events and developed more than 5,000 disease surveillance systems to improve case detection. Worldwide, more than 19,000 FETP alumni have trained as the "boots on the ground" to detect and respond to public health threats.

The need for greater public health capacity to prevent, detect, and respond to public health threats and emerging infectious diseases is a matter of life or death for people around the world. Such capacity makes countries better able to sustain their own national systems, leading to economic growth and reducing the likelihood of political or economic instability.

Never has the need for increased field epidemiology capacity around the globe been more apparent than now, as the world has grappled socially and economically with COVID–19. The field epidemiologists in our network have been working around the clock to trace contacts, investigate and manage cases, analyze COVID–19 data, educate their communities, and much more. Without them, the governments of most countries, like my former home of South Africa, would not have access to reliable data on the spread of COVID–19 in their populations. In many countries, especially the poorest, there is simply no other workforce in place to conduct contact tracing or case investigations. Field Epidemiology Training Programs supported by TEPHINET fill that gap and have been steadily expanding since their founding by the CDC and other partners nearly 40 years ago.

FETPs have trained an estimated 19,000 "Disease Detectives" so far, but the world needs more. COVID–19 and other emerging diseases are not the only threats—FETPs fight every health threat known to us, from well-known issues like Ebola, measles, and polio to lesser known but deadly and debilitating diseases like Lassa fever and monkeypox. While COVID–19 is clearly an emergent threat, there will always be a "disease X" that poses a grave threat to the health of Americans.

In Guinea, a resource-challenged country in West Africa, the FETP housed within the Ministry of Health is providing critical support to help control a recent Ebola outbreak. As of April 13, 2021, Guinea had 23 reported cases of Ebola. FETP trainees and graduates made vital contributions to slowing the outbreak, particularly in the areas of coordination and epidemiology surveillance. They led the development of a surveillance system to detect Ebola cases, as well as the country's Ebola response plan, contact tracing guides, and case definitions for Ebola patients. FETP trainees and graduates consisted the leading Ministry of Health workforce deployed in the field to conduct Ebola-related surveillance. Thanks to the involvement of the FETP, the vast majority (83%) of reports of suspected cases are being investigated. Because of the Guinea FETP, established after the 2014–2016 Ebola outbreak in West Africa had claimed thousands of lives, today Guinea is seeing a dramatically different response compared to the 2014–2016 outbreak—including a significant increase in the known number of contacts traced: 95% of contacts have been traced in the current response.

Before coming to The Task Force, I was the director of the South African Field Epidemiology Training Program (SAFETP), which was started with CDC funding in partnership with the Ministry of Health and the University of Pretoria, which conferred the Master of Public Health degree to graduates. Over time, the program became owned by the National Institute of Communicable Disease, but CDC Pretoria continued to provide support in the form of a Resident Advisor, Scientific Writer, and Statistician. There was an outbreak of diarrheal disease in a small town in Free State province, and the FETP trainees or residents identified the root cause to be poor maintenance at the water treatment plant. Diarrheal disease from drinking unsafe water causes dehydration, which is a killer of children under five. As a result of the investigation done by the FETP residents, the town installed a new water reticulation plant that ultimately benefited residents of the town and improved their quality of life with fewer days of productivity lost due to gastrointestinal illness.

Without enough "Disease Detectives" or boots on the ground to detect and respond to public health emergencies, it will not be long before another outbreak becomes a pandemic with severe human and economic costs. There will be other outbreaks, and no single institution has all the capacity required to be adequately prepared to face future threats. We need to harness the resources and capacities of a wide range of partners and stakeholders and we need political leadership, whole-of-government and whole-of-society commitment. We need to continue the United States' tradition of helping to build sustainable public health systems across the world that ultimately protect all people, including the American people.

In addition to supporting the development of Field Epidemiology Training Programs, TEPHINET and The Task Force for Global Health have been instrumental in developing the Global Field Epidemiology Roadmap, a plan to advance field epidemiology training and capacity building worldwide. As we speak, we at TEPHINET are coordinating a Strategic Leadership Group of more than a dozen public health experts from around the world to lead the implementation of this Roadmap, so that all countries can develop the field epidemiology capacity needed to protect and promote the health of their own populations and collaborate with others to promote global health.

Thank you for your ongoing support of FETPs through the vital funding you provide. Because of this support, more than 100 countries now have a field epidemiology workforce that did not exist prior to the establishment of their FETPs. However, we are still working to achieve the International Health Regulations' target of having one trained field epidemiologist per 200,000 population in every country.

The good news is that this goal is achievable with continued investment. A global commitment to improving global health security by investing in field epidemiology capacity building strengthens health systems by training our world's "Disease Detectives" to respond to public health emergencies, humanitarian crises and natural disasters, and in so doing, saving money, saving resources, and saving lives.

[This statement was submitted by Dr. Carl Reddy, Director, Training Programs in Epidemiology and Public Health Interventions Network.]

PREPARED STATEMENT OF THE TRAUMA CENTER ASSOCIATION OF AMERICA

As you consider Labor Health and Human Services appropriations for Fiscal Year FY (2022), the Trauma Center Association of America (TCAA) asks the Committee to provide $11.5 million in funding for the Military and Civilian Partnership for the Trauma Readiness Grant Program.

In 2016, the National Academies of Science, Engineering, and Medicine (NASEM) released a report titled, *"A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury."* This report finds that one of four military trauma deaths and one of five civilian trauma deaths could be prevented if advances in trauma care reach all injured patients. In the report, the National Academies recommended that the United States adopt an overall aim for trauma care of "zero preventable deaths after injury," and sets forth elements of system redesign that would provide military personnel with real-world training and experience at civilian trauma centers. This training has the dual benefit of maintaining military surgical battle readiness between wars while at the same time improving civilian access to trauma care. The report concludes that military and civilian integration is critical to saving these lives both on the battlefield and at home, preserving the hard-won lessons of war, and maintaining the nation's readiness and homeland security.

Section 204, of S. 1379, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 (PAHPAI), known as the MISSION ZERO Act was signed into law June 24, 2019 (Public Law No: 116–22). MISSION ZERO takes the recommendations of the NASEM report to create a U.S. Department of Health and Human Services (HHS) grant program to cover the administrative costs of embedding military trauma professionals in civilian trauma centers. These partnerships will allow military trauma care teams and providers to gain experience treating critically injured patients and increase readiness for when these units are deployed. Similarly, best practices from the battlefield are brought home to further advance trauma care and provide greater civilian access.

According to the Centers for Disease Control and Prevention trauma is the leading cause of death for children and adults under age 44, killing more Americans than AIDS and stroke combined.

Fully funding of MISSION ZERO will allow us to continue to save lives, enhance trauma training for our military healthcare personnel and help trauma centers manage and recover from mandatory furloughs of surgeons, nurses and other staff that were a direct result of the COVID 19 pandemic.

We are grateful for your consideration of this important request. Please do not hesitate to contact us directly if you have any questions or need additional information regarding the MISSION ZERO Act.

PREPARED STATEMENT OF THE TREATMENT ACTION GROUP

Treatment Action Group (TAG) thanks the esteemed members of the subcommittee for the opportunity to submit testimony regarding funding for the U.S. Centers for Disease Control and Prevention (CDC) Division of Tuberculosis Elimination (DTBE) for fiscal year 2022 (FY22) appropriations. TAG is an independent, activist and community-based research and policy think tank fighting for better treatment, prevention, a vaccine, and a cure for HIV, tuberculosis (TB), and hepatitis C virus (HCV). TAG works to ensure that all people with HIV, TB, or HCV receive lifesaving treatment, care, and information. We are science-based treatment activists working to expand and accelerate vital research and effective community engagement with research and policy institutions. Together with a broad coalition of stakeholders in the TB advocacy community, TAG requests that the Subcommittee appropriate $225 million to CDC DTBE for FY22, in particular to expand critical TB research activities at the TB Trials Consortium (TBTC) and mitigate the impact of the COVID–19 pandemic on struggling TB programs across our country.

TAG works in close partnership with TB program practitioners and researchers across the country to advance the collective goal of eliminating TB through comprehensive, safe, and effective TB prevention and treatment. TB cases continue to be reported in every state in the United States (US) every year, with 8,916 cases reported in 2019.[1] It is estimated that approximately 13 million people in the US are currently living with latent TB infection, which can progress to active and contagious disease if left untreated.[2] TB trends in the US are also influenced by many of the same social determinants of health that determine other health disparities—including poverty, lack of access to healthcare, overcrowded housing and homelessness, and other structural factors.[3] This leaves many of the most vulnerable and marginalized members of our society at greater risk of being exposed to TB and developing active disease.

The state and local TB programs that are on the frontlines of preventing and treating TB are engaged in critical work, and they rely on the support of the CDC DTBE for guidance and funding. One important way DTBE supports state and local TB programs is through its research initiatives, including the TBTC. Housed within DTBE, the TBTC is a unique partnership between CDC, health departments, academic research institutions, and trial sites throughout the US and across the globe.[4] TBTC's research is mandated to be programmatically relevant to health departments, meaning that investments in this research network are some of the most cost-effective of any federal research program. Tax payers' investments in the work of the TBTC have supported dozens of studies of critical import to advancing the field and improving TB treatment and prevention for people and communities affected by TB at home and abroad.

This research is sorely needed to advance more tolerable and effective options for TB prevention and treatment. Current treatment guidelines for drug-sensitive TB have been the same for almost four decades, leaving programs and patients reliant on a regimen made up of four drugs taken for 6–9 months requiring long periods of isolation and management of difficult side effects necessitating intensive treatment monitoring. However, promising results from a pivotal phase III trial, TBTC's Study 31 demonstrated that a different combination of medicines enables treatment for drug-sensitive TB to be shortened to just four months without compromising any efficacy.[5] This groundbreaking finding has the potential to dramatically improve rates of treatment completion, drive down TB transmission, and allow TB patients to return to their loved ones and support themselves more quickly than ever before.[6] Study 31 and prior TBTC research at DTBE has had profound global health security implications, where TB was the world's leading cause of death to an infectious disease prior to COVID–19. Research at CDC's TBTC has been the basis for public health treatment and prevention guidelines developed by the World Health Organization (WHO) that are critical for country TB programs where TB is particularly endemic and claims 1.6 million lives a year.

While these results are certainly cause for celebration, much work remains to be done to translate these findings into real public health impact and ensure the availability of shorter treatment regimens to all TB patients and programs. Many other areas of research are also still on the horizon, including better TB prevention options and tools for children and pregnant people. Some of this research is already underway through other TBTC studies.[7] The recent process by TBTC to solicit research proposals (i.e. TBTC re-competition) sets up this heralded research network for the next 10 years of programmatically-relevant research that could include many

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[1] U.S. Centers for Disease Control and Prevention. U.S. TB Statistics. Division of TB Elimination. https://www.cdc.gov/tb/statistics/default.htm.

[2] Ibid.

[3] Ibid.

[4] U.S. Centers for Disease Control and Prevention. Tuberculosis Trials Consortium. Division of TB Elimination. https://www.cdc.gov/tb/topic/research/tbtc/default.htm.

[5] Dorman SE, Nahid P, Kurbatova EV, Goldberg SV, Bozeman L, Burman WJ, Chang KC, Chen M, Cotton M, Dooley KE, Engle M, Feng PJ, Fletcher CV, Ha P, Heilig CM, Johnson JL, Lessem E, Metchock B, Miro JM, Nhung NV, Pettit AC, Phillips PPJ, Podany AT, Purfield AE, Robergeau K, Samaneka W, Scott NA, Sizemore E, Vernon A, Weiner M, Swindells S, Chaisson RE; AIDS Clinical Trials Group and the Tuberculosis Trials Consortium. High-dose rifapentine with or without moxifloxacin for shortening treatment of pulmonary tuberculosis: Study protocol for TBTC study 31/ACTG A5349 phase 3 clinical trial. Contemp Clin Trials. 2020 Mar;90:105938. doi: 10.1016/j.cct.2020.105938. Epub 2020 Jan 22. PMID: 31981713; PMCID: PMC7307310. https://pubmed.ncbi.nlm.nih.gov/31981713/.

[6] Treatment Action Group. TAG Statement: Finally a New Four Month Treatment for Drug Susceptible TB. 2020 October. https://www.treatmentactiongroup.org/statement/finally-a-new-four-month-treatment-for-drug-susceptible-tb/.

[7] U.S. Centers for Disease Control and Prevention. Tuberculosis Trials Consortium—Research Projects. Division of TB Elimination. https://www.cdc.gov/tb/topic/research/tbtc/projects.htm.

of these pressing priorities for TB R&D. But this progress is marred by decades of insufficient federal funding for DTBE, which limits the ambition and scientific integrity of how TBTC can approach its research agenda. In turn, the historical lack of funding to DTBE limits the possibilities of implementation of such research through state and local TB programs.

Decades of stagnant appropriations for DTBE have led to the Division currently being funded at nearly the same level as it was in fiscal year 1994 (see right figure on impact of inflation). Factoring in the rate of inflation over that period, that stagnant funding level has drastically reduced the purchasing power of DTBE.[8] In addition, the costs of TB diagnosis and treatment have steadily risen, especially for drug-resistant forms of TB which can now cost up to several hundred thousand dollars to treat per person.[9] As a direct result, DTBE has been forced to do more with less, necessitating difficult decisions about resource allocation to its lifesaving programmatic and research initiatives. Without sufficient funding to bolster our nation's TB programs, implementation of U.S.-led TB treatment strategies and interventions made possible through publicly funded research at TBTC, remains severely limited.

The COVID–19 pandemic has worsened these capacity constraints. According to a survey of TB program staff in the US, 87% of respondents reported that they or their colleagues had been either partially or completely reassigned to work on COVID–19.[10] In many cases, these reassignments were indefinite, and state and local TB programs continue to operate under reduced capacity and temporary leadership. Many TB clinics, hospitals, and other resources were also designated exclusively for use in the COVID–19 pandemic response, as they were uniquely outfitted for airborne isolation. The expertise of TB public health clinicians, researchers and practitioners in particular, are drawn upon in the COVID–19 response for their critical experience in addressing an airborne infection.

Some of the impacts of the pandemic are not yet visible. TB case reporting dropped by 20% in 2020 compared to 2019. Unprecedented barriers to accessing testing and care stemming from COVID–19 health service disruptions and the reallocation of TB staff and resources from conducting contact tracing, community outreach, and TB treatment monitoring, to COVID–19 response efforts are likely the major causes of this steep drop in TB notifications.[11] The impacts of this reduced capacity to prevent and respond to TB cannot be overstated, and the costs of recovering from such impacts will be much higher than current funding levels allow.

Stagnant funding, and the additional damage wrought by the COVID–19 pandemic, also threaten TB research and development efforts at DTBE. In the aforementioned recent TBTC "re-competition" process for the next 10-year funding cycle, four of the prominent academic institutions that housed some of the crucial leadership for TBTC's most promising studies were excluded in the subsequent cycle due to shrinking research dollars to expand this highly successful clinical trials network.[12] The collective TB expertise held within these institutions is irreplaceable. Higher funding levels for DTBE and its research initiatives, such as TBTC, are vital to retain the invaluable experience necessary to complete study enrollment, data collection, analysis, publication, and translation into policy. Furthermore, expanded resources would position TBTC to embark on a new era of clinical research led by these partners, building on its success shortening treatment and prevention of TB and looking to future opportunities, such as the possibility of TBTC trialing novel TB vaccines. However, without an increase in funding, this experience will be lost, taking with it the promise of TB research breakthroughs like those shown in TBTC Study 31, which demonstrated the first effective short course TB treatment in over 40 years.[13]

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[8] Treatment Action Group. The TB Research Engine That Could: Sustaining the Success of the Tuberculosis Trials Consortium in Turbulent Times. 2021 April. https://www.treatmentactiongroup.org/publication/the-tb-research-engine-that-could/.

[9] U.S. Centers for Disease Control and Prevention. CDC Fact Sheet: The Costly Burden of Drug Resistant TB Disease in the U.S.. National Center for HIV, Hepatitis, STD, and Tuberculosis Prevention—Newsroom. https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/costly-burden-dr-tb-508.pdf.

[10] Stop TB Partnership. The Impact of COVID–19 on the TB Epidemic: A Community Perspective. Geneva: March 2021 https://spark.adobe.com/page/xJ7pygvhrIAqW/.

[11] Deutsch-Feldman M, Pratt RH, Price SF, Tsang CA, Self JL. Tuberculosis—United States, 2020. MMWR Morb Mortal Wkly Rep 2021;70:409–414. DOI: https://www.cdc.gov/mmwr/volumes/70/wr/mm7012a1.htm?s__cid=mm7012a1__w.

[12] Treatment Action Group. The TB Research Engine That Could: Sustaining the Success of the Tuberculosis Trials Consortium in Turbulent Times.

[13] U.S. Centers for Disease Control and Prevention. Landmark TB Trial Identifies Shorter-Course Treatment Regimen. National Center for HIV, Hepatitis, STDs, and Tuberculosis Pre-

In order to avert further devastating impacts on TB programs, prevention, care, and research, increased funding for CDC DTBE is critically important. TAG requests that the subcommittee appropriate $225 million—an increase of $90 million—to safeguard the lifesaving progress that DTBE has made against TB in the US, sustain and grow the government's vital TB research agenda at TBTC by retaining critical R&D expertise, and to bring us closer to the elimination of TB once and for all, here and abroad. We thank you for your support of public health programs and research, and we look forward to working with you to ensure the health of all those impacted by TB in the US and around the world.

PREPARED STATEMENT OF THE TREATMENT ACTION GROUP

Treatment Action Group (TAG) thanks the esteemed members of the subcommittee for the opportunity to submit testimony regarding funding for the government's End the HIV Epidemic (EHE) at the U.S. Centers for Disease Control (CDC) Division for HIV Prevention (DHAP) for fiscal year 2022 (FY22) appropriations. TAG is an independent, activist, and community-based research and policy think tank committed to racial, gender, and LGBTQ+ equity; social justice; and liberation, fighting to end HIV, tuberculosis (TB), and hepatitis C virus (HCV). We work closely with community partners and stakeholders in the jurisdictions funded by the federal government's EHE initiative towards an inclusive, community-centered approach to end the HIV epidemic across our country.

TAG requests that the Subcommittee exceed the President's budget proposal for the CDC EHE initiative of an $100 million increase in FY22 with an additional increase of $96 million to a total of $196 million for DHAP ETE. In particular these resources would be critical to expand EHE efforts, advance and expand vital community partnership activities, and mitigate the impact of the COVID–19 pandemic among the hardest-hit jurisdictions.

While there has been immense progress in the HIV epidemic with rates declining from 37,500 new infections in 2015 to 34,800 infections in 2019—much work remains on truly ending the epidemic in the hardest-hit jurisdictions and populations in the U.S.[1] HIV rates are not evenly distributed across the nation and continue to be primarily skewed towards the Southern states as the bulk of new diagnoses.[2] Even more concerning, HIV disparities continue to severely persist among the Black and Latinx communities. We see these troublesome trends particularly among Black and Latinx gay and bisexual men, as well as Black women. Black communities represent 13% of the U.S. population, but make up 44% of new diagnoses.[3] Similarly, Latinx communities represent 18% of the U.S. population and account for 30% of new HIV diagnoses.[4] HIV comparably disparages Native American community, people of trans experience, and people who use drugs with stark disparities.

It is of no surprise that social determinants of health deeply impact these communities. These include housing, food security, employment and economic justice, as well as undoing numerous policies that violate the human rights of these communities and limit their ability to seek treatment and care. Criminalization for example is intertwined with the HIV epidemic, with many states continuing to have arcane laws that do not align with science and only further stigmatize communities of people living with, and vulnerable to HIV. Without addressing the myriad of social, economic and legal needs of communities impacted by HIV through a combination of targeted resources and a human-rights policies, reaching the vision for ending the epidemic across all communities will remain unclear and unattainable.

The previous administration ambitiously approached this challenge of ending the HIV epidemic once and for all, by redoubling U.S. efforts and formulating the landmark EHE initiative that would direct federal resources towards 57 jurisdictions hardest-hit by HIV through CDC and HRSA. While Congress, has responded in lockstep with bipartisan increases to EHE since its inception, we believe that the COVID–19 pandemic has significantly impacted efforts at the community-level, requiring a significant scale up in assistance to these jurisdictions.

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vention—Newsroom. 21 October 2020 https://www.cdc.gov/nchhstp/newsroom/2020/landmark-tb-trial-media-statement.html.

[1] Health Resource and Services Administration. HIV Data and Trends. HIV.gov. https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics.

[2] Ibid.

[3] U.S. Centers for Disease Control and Prevention. Racial and Ethnic HIV Rates—African Americans and Hispanic/Latinos. Division of HIV/AIDS Prevention. https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html.

[4] Ibid.

Organizations and partners involved in the ACT NOW:END AIDS coalition—of which TAG is a cofounder—report significant impact upon services and outreach efforts to communities impacted by HIV. The lack of swift and robust federal guidance on COVID–19 to HIV organizations in the early stages of the pandemic led to many organizations having to decide between either risking the safety of their staff by continuing essential services, or temporarily closing programs. Additionally, many already financially strained organizations struggled to obtain the technologies necessary for telemedicine and many reported that clients—especially low-income, and unstably housing individuals—could not access these tools. Such delays led to clients missing care and contributed to an overall sense of burnout among HIV professionals.

In addition to the direct impact upon services for PLHIV and communities vulnerable to HIV, we have noted a significant shift in human resources and public health personnel detailed to the COVID–19 pandemic. CDC HIV program staff are also contributing significantly to the nation's COVID–19 response. The pandemic has caused severe disruptions to care and treatment activities of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). According to research from the Kaiser Family Foundation, nearly 700 CDC staff (with 1,125 cumulative deployments) from NCHHSTP have been detailed and deployed to the COVID response since the early days of the pandemic.[5] This is primarily due to the Center staff's expertise in infectious diseases. HIV public health practitioners from the CDC are drawn upon for the COVID–19 pandemic, primarily for their expertise in centering communities in prevention efforts and their ability to form key relationships, conduct outreach, while grounding public health prevention work in respect for human rights. However, scarce public health resources and personnel corresponds to a shift away from EHE efforts.

Furthermore, HIV community contributions to the COVID–19 response have been significantly extended through HIV/AIDS research investments at the National Institutes of Health (NIH) as well. For example, HIV research first piloted the of use mRNA as a vaccine platform for HIV prevention. These previous investments in HIV vaccine research boosted the development of widely disseminated COVID–19 vaccines that increasingly leveraged the well-developed research infrastructure of HIV research.[6]

In sum, the programmatic and research contributions of HIV have been invaluable to the nation's COVID–19 response. But the shift in HIV sector resources leaves EHE efforts in peril and limited in reaching its ambitious goals for treatment and prevention of HIV. Due to the our weakened public health infrastructure that COVID–19 leaves in its wake, without significantly targeted and expanded resources, HIV disparities will continue to be deeply entrenched in our nation's historically disenfranchised and marginalized communities. We urge the subcommittee to maximize resources to backfill the contributions of the HIV sector and launch our HIV response with the same level of vigor that we saw with the COVID–19.

To that end, we request an allocation of at least $196 million in FY22 for CDC DHAP EHE Plan to begin to align the necessary resources to mitigate the effects of COVID–19 upon struggling HIV programs and shore-up the necessary HIV infrastructure. We applaud the administration's and Congressional attention towards rooting out systemic racism, and believe that these investments will go a long way to begin addressing HIV as health disparity that primarily effects communities of color.

Thank you for the members of the subcommittee for this opportunity to submit testimony in support of CDC DHAP ETE initiative. We hope you will take action and recommit to realizing the end of the HIV epidemic with urgent, new resources.

PREPARED STATEMENT OF TRUST FOR AMERICA'S HEALTH

Trust for America's Health (TFAH) is pleased to submit this testimony on the fiscal year (FY) 2022 Labor, Health and Human Services, Education, and Related Agencies (LHHS) appropriations bill. TFAH is a non-profit, non-partisan organization that promotes optimal health for every person and community. Communities across the country are overwhelmed with responding to the Coronavirus Disease 2019 (COVID–19) pandemic with a depleted public health infrastructure and work-

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[5] Dawson L, Kates J. Issue Brief: Key Questions on HIV and COVID–19. Kaiser Family Foundation. 20 May 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-hiv-and-covid-19/.

[6] Chibbaro L. HIV Research Sped the Develop of the COVID–19 Vaccine. Washington Blade. 23 June 2021 https://www.washingtonblade.com/2021/06/23/hiv-research-sped-development-of-covid-vaccine/.

force, while also responding to longstanding issues due to increases in chronic diseases, substance misuse and suicide, health disparities, and environmental health risks. TFAH's recent report, The Impact of Chronic Underfunding on America's Public Health System, finds that although health threats continue to increase, core public health budgets at the federal and state levels remain stagnant.[1] While Congress has allocated billions of dollars to address COVID–19, this funding is short-term and largely for use in response to the pandemic. It follows a similar pattern since 9/11 of annually underfunding core public health and then providing significant infusions of emergency funding for a short time when a disaster hits. This is like building a house on a shaky foundation. Without an investment in public health year in and year out, problems cannot be prevented, or emergencies reduced. While many thanks are due for your support during COVID, now is the time to fix an underfunded system so we can ensure every resident of the nation has the chance for optimal health and wellbeing. Bold action is needed to strengthen and modernize public health. TFAH urges Congress to fund the Centers for Disease Control and Prevention (CDC) at $10 billion for the FY2022 budget, including investing in these effective public health programs (unless otherwise noted, all programs are in CDC):

EMERGENCY PREPAREDNESS

The COVID–19 response was weakened because the CDC's emergency preparedness funding had been repeatedly cut, reducing essential training and eliminating expert personnel. The CDC's Public Health Emergency Preparedness (or PHEP) cooperative agreement has been reduced by a quarter since FY2003 (48 percent when inflation is considered). PHEP grants support 62 state, territorial, and local grantees to develop core public health capabilities, including in areas of public health laboratory testing, health surveillance and epidemiology, community resilience, countermeasures and mitigation, incident management, and information management. TFAH recommends at least $824 million for the PHEP (CDC), the level authorized in 2006.

The pandemic has also demonstrated the impact of failing to invest in comprehensive readiness and surge capacity of the healthcare delivery system. Funding for the Hospital Preparedness Program (HPP), administered by the Assistant Secretary for Preparedness and Response, has been cut in half since FY2003 (62 percent when inflation is considered). HPP provides critical funding and technical assistance to health care coalitions (HCCs) across the country to meet the disaster healthcare needs of communities. There are 360 HCCs, comprised of public health agencies, hospitals, emergency management and others, that develop and implement healthcare and medical readiness plans; response coordination; continuity of healthcare services delivery; and medical surge. TFAH recommends at least $474 million for HPP (PHSSEF), the level authorized in 2006.

ENVIRONMENTAL HEALTH

Not all federal emergencies are caused by infectious disease. Many occur due to environmental factors. Here, too, core funding has been insufficient. Since CDC's National Environmental Public Health Tracking Network began in 2002, grantees have taken over 400 data-driven actions to eliminate risks to the public. Data includes asthma, drinking water quality, lead poisoning, flood vulnerability, and community design. State and local health departments use this data to conduct targeted interventions in communities with environmental health concerns. Currently, 25 states and one city are funded to participate in the Tracking Network. With a $1.44 return in health care savings for every dollar invested, the Tracking Network is a cost-effective program that examines and combats harmful environmental factors.[2] Yet only half the states receive funding. TFAH recommends at least $40 million for National Environmental Public Health Tracking Network (CDC), which would enable at least three additional states to join the network.

[1] The Impact of Chronic Underfunding of America's Public Health System. Trust for America's Health 2021. https://www.tfah.org/report-details/pandemic-proved-underinvesting-in-public-health-lives-livelihoods-risk/.

[2] Return on Investment of Nationwide Health Tracking, Washington, DC: Public Health Foundation, 2001.

OBESITY AND CHRONIC DISEASE PREVENTION

The COVID–19 pandemic has been exacerbated by preventable, chronic health conditions, including obesity. In 2017–2018, 42.4 percent of adults had obesity.[3] Even though obesity accounts for nearly 21 percent of U.S. healthcare spending, funding for CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) is only equal to about 31 cents per person.[4] This Division funds state health departments to protects the health of all Americans by promoting healthy eating, active living, and obesity prevention in early care and education facilities, hospitals, schools, and worksites and neighborhoods; building capacity of state health departments and national organizations to prevent obesity; and conducting research, surveillance, and evaluation studies. However, DNPAO only has enough money to implement its State Physical Activity and Nutrition Programs (SPAN) in 16 states. TFAH recommends at least $125 million for DNPAO to allow CDC to continue building its capacity and scaling its interventions.

Additionally, this year we once again saw the impact of inequities in social and economic conditions facing people of color and tribal nations. Among the programs at CDC that are effective in reducing racial and ethnic health disparities are Racial and Ethnic Approaches to Community Health (REACH) program and Good Health and Wellness in Indian Country (GHWIC). CDC's REACH) program, within DNPAO, works in 31 communities across the country. It supports innovative, community-based approaches to develop and implement evidence-based practices, empower communities, and reduce racial and ethnic health disparities. As we are seeing the effect that underlying health disparities are having on COVID–19 patients, we urge renewed investment in programs such as REACH that promote health equity. TFAH recommends at least $102.5 million for REACH (CDC) to restore funds historically diverted from core REACH programs. Within that total, TFAH recommends at least $27 million for the Good Health and Wellness in Indian Country (GHWIC) program. Also within DNPAO, GHWIC works with 21 tribes directly and funds 15 Urban Indian Health Centers and 12 Tribal Epidemiology Centers (TECs). GHWIC supports healthy behaviors in Native communities by supporting coordinated and holistic approaches to chronic disease prevention, continuing to support culturally appropriate, effective public health approaches, and expanding the program's reach and impact by working with more tribes and tribal organizations, including Urban Indian Organizations. In addition, these GHWIC funds support the Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI).

Healthy Outcomes in Schools: Specialized efforts are needed within certain age groups as well. CDC's Division of Adolescent and School Health (DASH) provides evidence-based health promotion and disease prevention education for less than $10 per student. Through school-based surveillance, data collection, and skills development, DASH collaborates with state and local education agencies to increase health surveillance and services, promote protective factors, and reduce risky behaviors. DASH programs reach approximately 2 million of the 26 million middle and high school students. TFAH recommends at least $100 million for DASH (CDC) to expand its work to 20 percent of all middle and high school students.

Age-Friendly Public Health: The COVID–19 outbreak has shown that collaboration between the public health and aging sectors is vital. Every day 10,000 Americans turn 65 years of age, yet there have been limited collaborations between the public health and aging sectors. Public health interventions play a valuable role in optimizing the health and well-being of older adults by prolonging their independence, reducing their use of expensive health care services, coordinating existing multi-sector efforts, and identifying gap areas, as well as disseminating and implementing evidence-based policies. Yet as of now, there is no comprehensive health promotion program for older adults. We recommend the Committee provide CDC at least $50 million to administer and evaluate an Age Friendly Public Health program to promote and address the public health needs of older adults and collaborate with partners in the aging sector.

Social Determinants of Health: Social determinants of health (SDOH) such as housing, employment, food security, and education have a major influence on individual and community health,[5] as illustrated by disparate outcomes and risk from

[3] State of Obesity 2020. Trust for America's Health. Sept 2020. https://www.tfah.org/report-details/state-of-obesity-2020/.

[4] J. Cawley and C. Meyerhoefer, "The Medical Care Costs of Obesity: An Instrumental Variables Approach," Journal of Health Economics 31, no. 1 (2012): 219–30, doi: 10.1016/j.jhealeco.2011.10.003.

[5] Taylor, L et.al, "Leveraging the Social Determinants of Health: What Works?" Yale Global Health Leadership Institute and the Blue Cross and Blue Shield Foundation of Massachusetts, June 2015

COVID–19. Public health agencies are uniquely situated to build these collaborations across sectors, identify SDOH priorities in communities, and help identify strategies that promote health. Currently most public health departments lack funding and tools to support such cross-sector efforts and are limited by disease-specific federal funding. TFAH thanks for the Committee for $3 million in FY2021 to establish a new CDC SDOH program. We recommend the Committee fund CDC to support local and state public health agencies to convene across sectors, gather data, identify priorities, establish plans, and take steps to address and improve community social and economic conditions that promote health. Aligned with the President's budget request, TFAH recommends at least $153 million to further develop CDC's Social Determinants of Health Program and enable grants to states and localities.[6] More than 200 organizations have endorsed this funding level.[7]

SUICIDE PREVENTION

In 2019, suicide took 47,500 lives, and rates increased by 33 percent between 1999 and 2019.[8] The complex nature of this issue requires a comprehensive program that focuses on vulnerable populations, data collection to inform efforts, and research on risk factors. CDC's work helps identify and disseminate effective strategies for preventing suicide, from strengthening access and delivery of suicide care to promoting policies and programs that reduce the risk. The programs consist of multisector partnerships, use of data to identify vulnerable populations and risk and protective factors, leveraging existing suicide programs and filling gaps through complementary strategies and effective communications. TFAH recommends at least $36 million to expand innovative prevention activities to an estimated 25 sites from its current number of nine, and to support state health departments as they develop and implement comprehensive suicide prevention plans.

ADVERSE CHILDHOOD EXPERIENCES

CDC estimates that if Adverse Childhood Experiences (ACEs) such as abuse and neglect were prevented, there would be 21 million fewer cases of depression, 1.9 million fewer cases of heart disease, and 2.5 million fewer cases of obesity.[9] Preliminary evidence suggests the pandemic is likely to increase children's exposure to ACEs due to economic hardship, increased stresses on families, and reduced access to school-based services and supports.[10] CDC's approach to ACEs prevention involves translating research into action and helping states identify and implement effective prevention strategies. In 2020, four state health departments were awarded funding to enhance or build infrastructure for ACEs surveillance, implement strategies to prevent ACEs, and leverage multisector partnerships to coordinate prevention activities. TFAH recommends at least $7 million to expand innovative ACEs prevention activities to four additional state health departments and to build upon CDC's work on preventing early adversity in life and mitigating the impact of ACEs on healthy child development.

CONCLUSION

The COVID–19 pandemic has underscored the dangers of the chronic underfunding of public health. It has also exposed and exacerbated longstanding disparities that have plagued our nation for far too long. It is imperative that we not wait for the next emergency to fix this problem. Instead, now is the time to invest in public health and fund CDC at $10 billion in FY 2022, to become a more resilient and healthy nation. Thank you for the opportunity to present this testimony to the Committee.

[This statement was submitted by J. Nadine Gracia, MD, MSCE, President & CEO, Trust for America's Health.]

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[6] The President's request for fiscal year (FY) 2022 discretionary funding. (2021). Executive Office of the President. https://www.whitehouse.gov/wp-content/uploads/2021/04/FY2022–Discretionary-Request.pdf.

[7] Letter to House Appropriations LHHS Subcommittee. April 26, 2021. https://www.tfah.org/wp-content/uploads/2021/04/CDC__SDOHFunding__SignOn.pdf.

[8] Suicide Prevention, CDC. https://www.cdc.gov/suicide/.

[9] BRFFS 2015–2017, 25 states, CDC Vital Signs, November 2019. https://www.cdc.gov/vitalsigns/aces/index.html.

[10] MMWR 2021, https://www.cdc.gov/mmwr/volumes/69/wr/mm6949a1.htm.

PREPARED STATEMENT OF UNITED FOR CHARITABLE ASSISTANCE

SUMMARY OF FISCAL YEAR 2022 APPROPRIATIONS RECOMMENDATIONS

—Please continue to support and advance committee recommendations, as well as related funding and policy initiatives, which further encourage HHS and the Centers for Medicare and Medicaid Services (CMS) to address arbitrary barriers that disrupt patient access to essential charitable assistance in a meaningful and timely way.
—Please work with your colleagues to encourage HHS to establish a transparent and patient-centered regulatory system formally governing charitable assistance programs that is consistent with the current framework of OIG opinions and ensures all policymakers and stakeholders have appropriate mechanism to address challenges and opportunities in this space.
—Please provide meaningful funding increases for medical research and public health progress to initiate further progress and improve outcomes for the patient community.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the Subcommittee, thank you for your leadership on patient care, and coverage and access issues. On behalf of United for Charitable Assistance (UCA), we deeply appreciate the opportunity to provide a critical, patient-centered perspective as you consider FY 2022 appropriations issues that impact healthcare coverage and patient access. Most notably, we urge you to continue to advance committee recommendations that feature and emphasize the need to quickly restore access to critical charitable assistance programs that serve patients with no other options. Moreover, please continue the investment in medical research and public health activities. The COVID–19 pandemic has hit the patient community hard and identified a litany of reasons to enhance resources for medical research and public health while addressing critical coverage and access challenges for those with the greatest need (such as due to pandemic related job loss). Thank you again for this important opportunity. Please consider UCA a resource on moving forward.

ABOUT UNITED FOR CHARITABLE ASSISTANCE

We are a growing ad hoc group of patient community leaders that seek to protect access to the charitable financial support programs, which serve as a crucial part of the healthcare safety net for individuals with rare, chronic, and life-threatening medical conditions. We work together to educate policymakers so they understand the value, impact, and vital nature of these programs and ultimately support efforts to actively defend the lives and livelihoods of those facing serious conditions that can now be better-managed through proper care and innovative therapies.

ABOUT CHARITABLE ASSISTANCE

Over recent years, CMS promulgated rules that effectively allow private insurance companies to simply deny (or reserve the right to deny at will) any premium or related healthcare payments made on behalf of a patient. While these restrictions initially started in marketplace plans, they have spread to Medigap plans, and various other forms of coverage. The tangible result of these policies is that patients are often denied access to mission-driven charitable support from non-profits, civic groups, and houses of worship. Ultimately, these restrictions form a back-door to pre-existing condition discrimination where they are targeted at the most vulnerable populations and patients lose their coverage due to an inability to utilize available support or are simply steered towards one of the few remaining plans that has not implemented restrictions (if they are available in their state). Recently, the practice of copay accumulators has taken hold where some assistance is accepted, but it is never applied to the patient's out-of-pocket limits, thus rendering the support inconsequential for the seriously ill. Finally, there is now an emerging practice for employer-provided insurance known as the "alternative funding model". This prescription drug procurement model improperly utilizes drug manufacturers' free assistance programs to the detriment of patients who are forced to continually switch drugs. Further, any costs associated with filling the prescriptions or obtaining the medications are not counted toward a patient's out-of-pocket insurance costs.

The situation is particularly dire for patients with rare, chronic, and life-threatening illness that rely on innovative life-sustaining medications and who occasionally turn to charities following a job loss or similar hardship to ensure there is no catastrophic disruption in access to care. Often times, when properly medicated,

these patients work and contribute to society, and they do not qualify for Medicaid or similar need-based programs. Further, despite the severity of their illness, the therapy or medical intervention likely blunts or slows the progression of their disease meaning they also do not readily qualify for disability programs. When assistance and access to proper care is lost, a dangerous situation is created where the dramatic decline in health rapidly outpaces the patient's ability to transition on to tax-payer funded safety net programs.

We cannot overlook the fact that many patients in the aforementioned situation also continue to turn to charitable assistance during the process of transitioning on to federal programs as their illness progresses. The disability waiting periods alone would be insurmountable for many without charitable assistance. In this regard, the need for charitable assistance is certainly not mitigated in Medicare and related programs with some patients utilizing charitable assistance to make ends meet and cover cost-sharing requirements.

CONTEMPORARY EXAMPLES OF CHARITABLE ASSISTANCE CHALLENGES

Ms. Lisa Wright is a patient advocate for the Fabry Disease Community. Fabry disease is a rare genetic disorder that prevents the body from making a certain enzyme called alpha-galactosidase A. The symptoms of Fabry Disease are varied and progressive including kidney, heart and neurological damage. There are several FDA approved treatments for Fabry Disease. However, those treatments are very expensive and as more and more costs are shifted to patients they need access to financial assistance programs. Lisa is a wonderful example of the importance of patient assistance. Lisa receives health insurance premium and copayment assistance from a charitable assistance program. This enables Lisa to remain working and volunteering for her community. Patient assistance groups help Lisa and many other Fabry disease patients obtain access to these expensive treatments and therapies which mitigate the symptoms of the disorder and keep patients living productive lives. Congress should work to ensure access to these programs.

The situation of Dr. Jeffrey Swigert is an example of the new Alternative Funding. Dr. Swigert is the father of two children with Cystic Fibrosis. Cystic Fibrosis is a progressive, genetic disease that causes persistent lung infections and limits the ability to breathe over time. Dr. Swigert's employer is a self-insured plan that has implemented a carve out for specialty treatments such as those for cystic fibrosis. The employer will not cover treatments but instead attempts to obtain them free of charge from manufacturer compassionate treatment programs. However, the manufacturer programs are individual with their own specific criteria. These programs are often time limited and reserved for patients who are uninsured. Congress needs to review this practice and potentially introduce legislation to modify.

RECOMMENDATION

Please include committee recommendations, similar to the language below, in the committee report accompanying the FY22 Senate L–HHS Appropriations Bill. Please also work through the annual appropriations process to facilitate a meaningful dialogue between the community and HHS on challenges, opportunities, and potential solutions. Thank you for your time and for your consideration of this request.

CENTERS FOR MEDICARE AND MEDICAID SERVICES PROGRAM MANAGEMENT

Charitable Assistance and the Healthcare Safety Net.—The Committee notes the important role that third-party charitable assistance plays in regards to maintaining access to care and therapies, particularly for patients impacted by life-threatening illness that have no other options. The Committee notes the current significance of premium assistance, co-pay assistance, travel assistance, and related programs due to COVID–19 related economic challenges and loss of employment, and their disproportionate role in ensuring access to care for those with health disparities and from underserved communities. CMS is encouraged to re-evaluate policies that facilitate pre-existing condition discrimination for patients with serious illness by allowing covering entities to reject or simply not apply assistance from independent charities.

[This statement was submitted by James Romano, Executive Director, United for Charitable Assistance.]

PREPARED STATEMENT OF THE UNITED STATES WORKFORCE ASSOCIATIONS

Dear Chairman Murray and Ranking Member Blunt:

The undersigned organizations make up the United States Workforce Association (USWA), a collaborative effort of local workforce boards, businesses, educational institutions, and organizations involved in workforce and economic development activities across the country. These organizations are directly involved in the implementation of the bipartisan Workforce Innovation and Opportunity Act (WIOA) of 2014, specifically promoting the successful execution by local workforce boards of the law to serve businesses, employers, and job—and career-seekers. As our country grapples with unprecedented demand for unemployment insurance and economic recession within the COVID–19 pandemic, the employer-led, local workforce development system continues to respond with critical supports and services. Adequate federal funding would ensure the system is poised to address these community needs as we continue to recover from the devastating health and economic effects of COVID–19.

As the Senate Appropriations Committee considers the Fiscal Year 2022 Labor-HHS Appropriations Bill, we urge you to support further federal investment into WIOA and fully fund the law beyond its FY2020 authorized levels. Appropriated levels have fallen short of authorized levels specifically in Title I accounts at the Department of Labor (Adult Employment and Training Services, Youth Workforce Investment Activities, and Dislocated Worker Employment and Training Services). An expanded federal investment across WIOA programs leads to more job training, education, skills development and innovative, proven practices like industry-based sector partnerships, career pathways, and apprenticeships. These strategies need to be implemented seamlessly to respond to the effects of COVID–19. The established local workforce system is well-positioned to enhance efforts for an equitable recovery; low wage, low skill workers and minority populations were hit hardest by COVID–19. The federal funding structure, which allows these funds to be invested locally, provides for intentional investments to help those most in need.

Local workforce development leaders are engaged directly with businesses to help keep individuals employed and design training/education programs to prepare the workforce for the future. We continue to work with unemployed individuals to help them stay connected to the workforce and evaluate other opportunities; recent BLS data suggests nearly 41% of those unemployed have been unemployed for at least 27 weeks (long-term unemployed).[1] Business services, especially for small and medium-sized enterprises, have been critical during the COVID–19 pandemic as employers sought to maintain payrolls and find workers as businesses began to reopen. Increased federal appropriations are greatly needed to address this unprecedented health, economic, and social destabilization.

The Fiscal Year 2022 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill must fully fund all Titles I, II, III, and IV at a minimum to the level authorized by the Workforce Innovation and Opportunity Act (WIOA).

The funding levels we are requesting in the FY2022 Labor, HHS, Education Appropriations Bill are listed below:

Title I—Department of Labor

—At least $899.987 million for Adult Employment and Training Services,

—At least $963.837 million for Youth Workforce Investment Activities, and

—At least $1.436 billion for Dislocated Worker Employment and Training Services

Title II—Department of Education

—$678.640 million for Adult Education

Title III—Department of Labor

—$692,370,000 for Wagner-Peyser (FY2021 Enacted)

Title IV—Department of Education

—$3,675,021,000 for Vocational Rehabilitation Services (FY2021 Enacted)

This training, support and business partnership is vital to our country's economic prosperity. For further information, please contact Chris Andresen.

Sincerely,

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[1] https://www.bls.gov/charts/employment-situation/unemployed-27-weeks-or-longer-as-a-percent-of-total-unemployed.htm.

Bob Lanter
Executive Director
California Workforce Association

Luann Dunsford, CEO
Michigan Works! Association

Jennifer Meek Eels
President
Ohio Workforce Association

Kelly Folks, President
Rocky Mountain Workforce
Development Association

Melinda Mulawka Mack
Executive Director
New York Association of Training and
Employment Professionals

Greg Vaughn
Executive Director
Texas Association of Workforce Boards

Michelle Cerutti, President
Illinois Workforce Partnership

Jeff Frederick
President
North Carolina Association of
Workforce Development Boards

Mari Kay-Nabozny
Chief Executive Officer
Northwest Wisconsin Workforce
Investment Board, Inc.

Tonja Mettlach, Executive Director
Massachusetts Workforce Association

Michelle Day, President
Maryland Workforce Association

Heather Ficht, Chair
Oregon Workforce Partnership

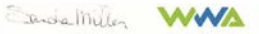
Robin King, President
Florida Workforce Development Association

Teri Drew, Chairman
Arizona Workforce Association

Jeanna Fortney, Director
Minnesota Association of Workforce Boards

Angela Carr Klitzsch, Chair
Indiana Workforce Board Alliance

Carrie Amann, Executive Director
Pennsylvania Workforce Development Association



Sandra Miller, Executive Director
Washington Workforce Association

Morgan Romeo
Chair, Virginia Association of Workforce Directors

Kevin J. Kurdziel
President-Elect
Garden State Employment Training Association

PREPARED STATEMENT OF THE UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE

Committee Members,

I am writing in support of a FY 2022 budget request for Department of Health and Human Services to develop a strategic plan and national strategy to improve the diagnosis, treatment and prevention of herpes simplex virus, types 1 and 2 (HSV). According to the Centers for Disease Control and Prevention, over half of Americans have been infected with HSV type 1 which can cause cold sores and genital ulcers, and one in eight Americans are currently infected with HSV type 2, which causes recurrent genital ulcers and is associated with significant stigma. There are significant disparities by race and sexual orientation, with HSV–2 impacting nearly half of all Black women, and approximately one in three men who have sex with men, with HSV being linked to HIV acquisition and transmission. Similar to HIV, HSV can be transmitted from mother to child during birth, which causes approximately 1,000 infant deaths annually. However, due to the poor quality of currently available antibody tests, routine testing in pregnancy or of the general population is not recommend by the United States Preventive Services Task Force. Finally, there is a growing body of evidence associating HSV to neurodegenerative diseases such as Alzheimer's, highlighting the urgency to develop better prevention and treatment strategies.

As a practicing clinician in the field of sexual health, I cannot overstate the negative impact of herpes simplex virus on patients' mental health. Countless studies have documented the mental health toll of an HSV diagnosis on a patient's well-being, and though not usually a fatal or serious infection itself, can lead to significant anxiety and depression given the burden of living with a chronic infection which must be disclosed to all future sex partners.

There is currently no national strategy to address HSV in the current Federal STI Strategic Plan (2021–2025). There is no surveillance for the condition, including its fatal outcomes among neonates. The majority of disease spread is via asymptomatic carriers unaware of their status. While antibody testing is readily available, it is prone to false positive results and there is poor access to confirmatory testing such as the Western Blot (previously used widely for confirmation of positive HIV results, but not widely available for herpes simplex virus). Given the implications for neonatal health, HIV transmission, and potential impact on general population of sexually active Americans, there is an urgent need for investment into the development of more accurate diagnostic testing, prophylactic and therapeutic vaccines, and antiviral medication that is more effective at viral suppression.

In short, if we care about maternal-child health, the health of communities of color, LGBTQ and other at-risk communities, and the mental health of Americans, we must prioritize funding to address herpes simplex virus infections.

Sincerely.

[This statement was submitted by Ina Park, MD, MS, Associate Professor, Departments of Family and Community Medicine & Obstetrics, Gynecology, and Reproductive Sciences, UCSF School of Medicine.]

PREPARED STATEMENT OF THE WASHINGTON STATE ASSOCIATION OF HEAD START AND ECEAP

Dear Chairman Murray, Ranking Member Blunt, and Members of the Subcommittee,

On behalf of the Head Start community, thank you for this opportunity to share the FY22 recommendation for Head Start funding.

I have the distinct pleasure of serving as the Executive Director of the Washington State Association of Head Start and ECEAP (WSA)—a statewide non-profit organization composed of representatives from Head Start, Early Head Start, Migrant/Seasonal Head Start, Native American Head Start and the Early Childhood Education and Assistance Program (ECEAP, the statewide early childhood program). WSA represents 52 Head Start programs from Bellingham to Walla Walla, including migrant and seasonal and tribal programs. We are immensely proud of our efforts to build early learners and support families facing financial hardships.

These past 16 months have been like none other. The COVID–19 pandemic has tested and challenged the nation's 1,600 Head Start programs and required program managers and directors to adapt overnight, think creatively, and juggle the complexities of supporting children and families while also protecting them as well as staff and meeting local, state, and federal guidelines. Last program year, little did we

know, social distancing, virtual learning, higher health and sanitation standards, and workforce safety would emerge as daily issues and priorities.

Thankfully, Congress and this Committee stood with us through this turbulent season. Because of you, Head Start programs by and large were able to return to services quickly, stay open, and support children with in-person learning. When the first major outbreak overtook Washington state, in-person services had to be rethought and virtual learning options made swiftly available. Quickly and competently, programs responded to emerging family needs including delivering food, learning materials, and cleaning supplies to doorsteps, holding Zoom dance parties with preschoolers, and supporting the mental health needs of parents and guardians. Several Head Start programs remained open onsite during the entirety of the pandemic including the Denise Louie Education Center in Seattle which provided childcare to many front line and essential workers and parents that needed to be at work in person.

These heroic efforts undertaken by the Head Start community this past year would not have been possible without COVID–19 relief funding from Congress. Thank you.

As Head Start increasingly returns to regular programming and doubles down on recruitment and enrollment, and the nation comes out from underneath the cloud of COVID–19, the National Head Start Association (NHSA) is seeking $12.1 billion in FY22. This level of funding will help Head Start programs get back on track in three distinct ways:

(1) by reassuring and bolstering the workforce ($247 million);

(2) by addressing growing and compounded childhood trauma through staff training and additional counseling support ($363 million); and

(3) by extending program duration for programs and families desperate for more hours of care and support ($730 million).

These are all long-standing priorities for NHSA and for programs across the country—workforce investment, Quality Improvement Funding for trauma-informed care, and extended duration—and we look forward to working with Congress to meet these goals. Addressing these critical needs is foundational to delivering the best results for children from at-risk backgrounds.

Equally important to the quality of our programs and the health, safety, and future success of Head Start is a long-overdue, often overlooked issue: infrastructure.

Five years ago, the US Department of Health and Human Services identified over $4.2 billion in Head Start capitalization needs, yet Head Start's facilities needs have largely gone unaddressed. Local programs are unable to afford critical health and safety updates, to support access and compliance with the Americans with Disabilities Act, to acquire licensable space in new neighborhoods, or to make modest updates to align with what we know is best for early childhood facilities. Head Start programs are serving children and families from the most at-risk backgrounds-those below the poverty line and a disproportionate share of children of color. In many cases, these children are in buildings that are a half-century old, crumbling, and out-of-date. Our Head Start programs, the children who spend most of their days in these centers, and the communities that house these facilities are in desperate need of long overdue investment.

In the state of Washington, our programs have persistently underfunded facility construction and classroom upgrades. Washington State Head Start programs are in desperate need of:

—HVAC systems and air filtration.

—Building repairs, including stairs and railings.

—Updated and/or new buses to ensure children can consistently get back and forth to school.

—New classrooms to handle an influx of children who need in person services; and

—Funds to build and construct new early learning facilities.

Please allow me to share specific examples from Head Start providers in my state:

Tulalip Tribe Head Start currently serves 74 Early Head Start children, 80 state funded preschool children, 112 child care spots, and 112 tribally funded kids. They need $1.6 million to add three classrooms to their Head Start/Child Care wing. This expansion project would address social distancing needs to meet licensing requirements and the influx of children moving from remote to in-person learning this fall as well as enable programing for another 30 children and families.

This year has highlighted the need for outdoor play and learning spaces. Family Services of Grant County in Moses Lake has active plans to acquire neighboring property to create outdoor classroom space for each preschool room. This expansion

would add gardens and make critical safety improvements. The cost of this project totals $1 million.

Moses Lake is also in immediate need for a larger transportation and maintenance building, additional parking, and improved drop-off vehicle access. The existing garage space is restrictive and lacks on-site storage. Moses Lake would like to turn the current garage into storage space, and build a new bus barn with more bays, so that the current space could be used as a small mechanical repair shop and perform preventative maintenance, reducing costs and extending the life of existing buses. They estimate that the cost for this project is about $1.7 million.

Finally, Okanogan County Child Development Association (OCCDA) in Northeast Washington has struggled to find long-term, sustainable educational space for five years and COVID–19 guidelines exacerbate this concern. OCCDA previously partnered with the Tonasket School District but after failed levy attempts, and the school district's own struggles for space, the lease was terminated in 2017. This forced OCCDA to relocate Tonasket Head Start and ECEAP programs to the building that was used for Early Head Start and subsequently relocate Early Head Start to a local church for a short period before landing at a workable, but not ideal downtown location. These moves have squeezed more children and staff into fewer and fewer square feet.

In 2018, OCCDA applied and was awarded and the Early Learning Facilities Technical Assistance Grant to plan for a potential future consolidated learning center; however, funds to purchase the property and build the facility are still lacking. The estimated cost for purchase and build at the time of our Feasibility Study was $1.5 million. For OCCDA, the pandemic has made a bad infrastructure concern far worse. As a result, current facility size and availability limits OCCDA's ability to conduct five-day per-week in-person classes to two days a week in Tonasket.

These examples are replayed over and over again in the 52 Head Start programs in the State of Washington. While there is a strong desire to return to pre-COVID–19 conditions, for Head Start programs, the road back is harder and longer. Candidly, we are not interested in simply "going back." We want to go forward. The pandemic has shone a bright light on deferred maintenance and strained or inadequate childcare facilities. Every Head Start program would welcome more children, however, the present-day constraints in many ways prevent expansion. Meaningful investments in our infrastructure—alongside funding for our workforce, sustained support for mental health and trauma response, and strengthening our existing program service hours—are critical in FY22 to helping children and families make a strong return.

In the days and weeks ahead, the Head Start community would appreciate Congress's full embrace of the NHSA FY22 Recommendation of $12.1 billion. The community also urges Congress to commit to an examination of Head Start's infrastructure constraints and how the federal government might partner with local programs to address these urgent needs.

Thank you for your consideration.

[This statement was submitted by Joel Ryan, Executive Director, Washington State Association of Head Start and ECEAP.]

PREPARED STATEMENT OF THE WOMEN FIRST RESEARCH COALITION

The Women First Research Coalition (WFRC) appreciates the opportunity to provide this outside witness testimony to the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS) for the Fiscal Year (FY) 2022 LHHS appropriations bill. As you begin work on FY 2022 appropriations, we respectfully request that you provide $46.11 billion for the National Institutes of Health (NIH) as well as additional emergency funds to support the biomedical research enterprise recover from the COVID–19 pandemic. We also request that you consider including our report language on "Diversity of the Biomedical Research Workforce" and the "BIRCWH Fellows Program" in the report that accompanies the final FY 2022 Labor-HHS appropriations bill.

WFRC is a coalition comprised of the nation's leading professional medical and research organizations specializing in women's health. Our coalition was formed to address pressing challenges in women's health research and to raise awareness among federal policymakers, Executive Branch officials and the public about the need for sustained and strengthened investment in women's health research, the prioritization of research in conditions that are specific to women or those conditions that may present differently in women than men, advance an equitable and appropriate investment in women's health research that improves the health outcomes of women, and ensure an adequate women's research workforce.

FUNDING FOR NIH

Robust, sustained and predictable funding is important for all biomedical research, particularly research on conditions that are unique to or predominately occur in women. As Congress appropriates funding for FY 2022, the WFRC is requesting that Congress provide $46.11 billion, an increase of $3.1 billion, to the NIH, which would allow for meaningful growth above inflation that would expand NIH's capacity to support promising science in all disciplines. Any funding increases should be allocated proportionately to all NIH institutes and centers to ensure that meritorious research in women's health is supported across the NIH. This would build on Congress' recent investments in NIH that have allowed for advances in discoveries toward promising therapies and diagnostics, supported current and new scientists nationwide and advanced the potential of medical research. It will also allow NIH to support meritorious research in women's health.

As the country continues to address the COVID–19 pandemic, WFRC also requests additional emergency supplemental funding for NIH to address the costs associated with restarting biomedical research including the increased costs of research related to personal protective equipment, reagents, and existing drugs in the COVID-era as well as ensure early stage and early established investigators remain part of the biomedical research workforce. We are deeply appreciative of the emergency funds Congress has already appropriated, but additional emergency funding is needed to enable a full recovery from the pandemic.

We urge Congress to designate a portion of these emergency funds for the Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the National Institute on Aging (NIA), three institutes that support significant amounts of women's health research and have not yet received specific emergency funding. It is clear that there are significant impacts on patients with chronic conditions, as well as differences between how COVID–19 impacts women and men and the impact on older adults. We also must study the effects that COVID–19 has on conditions that are unique to or predominantly occur in women, such as pregnancy. Without additional funding, NICHD, NIDDK, and NIA will not have the capacity to continue adequately supporting existing research projects within their mission while also undertaking new research on COVID-related complications and comorbidities.

SUPPORT DIVERSITY OF THE BIOMEDICAL RESEARCH WORKFORCE

Recent reports demonstrate that women in the workforce have been disproportionately impacted during the COVID–19 pandemic. While women comprise 47 percent of the US labor force, they accounted for 54 percent of initial COVID-related job losses and continue to make up 49 percent of losses.[1] The recent May jobs report further emphasized this point, with unemployment among women showing little improvement.[2] During the COVID–19 pandemic, women in academia are balancing work with child care and virtual learning, financial issues, and other issues at a disproportionate rate to men. OBGYNs have been uniquely impacted during the pandemic since not only has their work not slowed down during the pandemic, but has become more complicated. For physician-researchers, there is little to no support currently in the system that addresses their situation. This is exacerbated for women of color, who are already underrepresented in obstetrics and gynecology. We are concerned that the losses we have seen thus far represent just the tip of the iceberg, and these inequities may result in loss of women from the research workforce for many more years to come even as the country continues to recover from the pandemic.

Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2022 LHHS appropriations bill under the NIH Office of the Director:

> *Diversity of the Biomedical Research Workforce*.—The Committee is concerned with the impact of COVID–19 on the diversity of the biomedical research workforce, particularly women and women of color early stage and midcareer investigators. The Committee directs NIH to study the race and gender breakdown of the impact of COVID on participation in the workforce by monitoring the types of awards applied for and granted by gender and race for two years. If

[1] https://www.wsj.com/articles/how-the-coronavirus-crisis-threatens-to-set-back-womens-careers-11601438460#:~:text=Women%20have%20already%20lost%20a%20disproportionate%20number%20of%20jobs.&text=While%20women%20are%2047%25%20of,%2C%20according%20to%20McKinsey%20%26%20Co.

[2] https://www.bls.gov/news.release/empsit.nr0.htm.

the data demonstrate that less women are applying for grants, then it is imperative that NIH take steps to address this disparity. The Committee requests a status update from NIH on this research in the FY 2023 Congressional Justification as well as the steps being taken to maintain the diversity of the research workforce.

SUPPORT FOR THE BIRCWH FELLOWS PROGRAM

Administered by the NIH Office of Research of Women's Health (ORWH), the Building Interdisciplinary Research Careers in Women's Health (BIRCWH) program is a mentored career-development program designed to connect junior faculty, known as BIRCWH Scholars, to senior faculty with shared interest in women's health and sex differences research. There are currently 20 active BIRCWH programs across the country—each one is a 2-year program, and costs approximately $170,000 per fellow per year. BIRCWH research areas include cardiovascular disease, aging, cancer, neurosciences, musculoskeletal conditions, autoimmunity, mental health, reproductive health, health disparities, and infectious diseases/emerging infections & HIV/AIDS. Since its creation in 2000, the BIRCWH program has trained over 700 fellows and has an extremely strong track record of training successful women and URiM Scholars and preparing them for independence.

Approximately 70 percent of BIRCWH fellows supported during 2000–2018 received at least one successful R-level grant from the NIH and many received private grants as well. To continue this important work, more funding is necessary to support additional BIRCWH fellows at all existing sites with a goal of increasing the diversity of the scholars, sites, research areas supported by the program, and ultimately the diversity of the biomedical research workforce.

Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2022 LHHS appropriations bill under the NIH Office of the Director:

> *BIRCWH Fellows Program*.—The Committee allocates $3 million to the ORWH's Building Interdisciplinary Research Careers in Women's Health (BIRCWH) program to fund additional BIRCWH fellows at all existing sites with a goal of increasing the diversity of the scholars, sites, and research areas supported by the program. These funds would support additional researchers focused on women's health and sex differences, which are priority research areas, as well as expand the program's work in the reproductive sciences. The Committee recognizes the effectiveness of the BIRCWH program, which is a mentored career-development program designed to connect junior faculty and senior faculty with shared interests.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2022 appropriations bills. We look forward to working with you to ensure that there is appropriate funding for women's health research at the NIH, and to improve the diversity of the biomedical workforce.

PREPARED STATEMENT OF THE YALE SCHOOL OF PUBLIC HEALTH

To the Committee Members:

In my personal capacity, I am writing in support of a FY 2022 budget request for DHHS to develop a strategic plan and national strategy for treatment and prevention of Herpes Simplex Virus (HSV) Types 1 and 2. As you know, HSV is a chronic viral infection that disproportionately affects women of color, LGBTQ populations, and adolescents. HSV is well-known risk factor for HIV acquisition since it disrupts and is a widely recognized driver of the HIV epidemic. As a pediatrician, I wish to highlight the devastation that HSV causes through neonatal herpes, often fatal to newborns or the cause of overwhelming developmental abnormalities. Other neurodegenerative diseases have been linked to HSV.

There is currently no centralized national strategy to address HSV, it is not tracked or tested for, and the majority of spread is via asymptomatic carriers unaware of their status. We can and should be doing more to stop the spread and provide better treatment to the 1 in 3 Americans with this chronic condition.

I chaired a recent Committee for the National Academies of Sciences, Engineering, and Medicine that produced a 2021 report for the CDC entitled: Sexually Transmitted Infections: Advancing a Sexual Health Paradigm. This report highlights the crisis of rising rates of sexually transmitted infections in the United States. I hope that you support the HSV Strategic Plan mandate for DHHS. Thank you.

Sincerely yours.

[This statement was submitted by Sten H. Vermund, Anna M.R. Lauder Professor of Public Health, and Dean of the Yale School of Public Health, and Professor in Pediatrics at the Yale School of Medicine.]

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REVIEW OF THE FISCAL YEAR 2022 BUDGET BLUEPRINT FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION

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