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Senate Hearings

Before the Committee on Appropriations

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

Fiscal Year 2023

117th CONGRESS, SECOND SESSION

H.R. 8295

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, 2023 (H.R. 8295)

**DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES,
AND EDUCATION, AND RELATED AGENCIES APPROPRIA-
TIONS FOR FISCAL YEAR 2023**

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

ON

H.R. 8295

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, 2023, AND
FOR OTHER PURPOSES

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

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

WEDNESDAY, MAY 4, 2022

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

The subcommittee met at 9:35 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Patty Murray (chairman) presiding.

Present: Senators Murray, Reed, Shaheen, Baldwin, Manchin, Blunt, Moran, Hyde-Smith, and Braun.

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 please come to order. Today we are having a hearing on the Biden Administration's fiscal year 2023 budget request for the Department of Health and Human Services. Senator Blunt and I will each have an opening statement, and then I will introduce our witness, Secretary Becerra.

After his testimony, Senators will each have 5 minutes for a round of questions. And while we were unable to have the hearing fully open to the public or media for in-person attendance, live video is available on our committee website. 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 glad to have you before our committee today to provide answers to the questions the American people have, especially this morning, given the alarming reporting that the Supreme Court is planning to end the Constitutional right to abortion in this country and overturn *Roe v. Wade*.

If this is true, it will be devastating to many people across the country. I have been warning about this for years and I want you to know I am going to keep fighting back with all I have to protect every woman's rights in this country. But people across the country are worried.

They need to see leadership from the Biden Administration on this. So I hope to hear more from you today about what the Administration's plan is to respond to this and protect women's health. Because make no mistake, women's lives are on the line. Later this week, you will be hearing from my constituents firsthand, coming out to Washington State. We will welcome you there.

And Mr. Secretary, I want you to know, people are not just worried about this attack on abortion, they are worried about other challenges they are facing as well, because the past 2 years, to say nothing of the past 2 days, have put such a strain on families and communities and our entire health care system. People are depending on the Biden Administration for support, for resources, and for real solutions, and I am pushing to make sure that they get them.

After all of the hard won progress we have made in the fight against COVID-19, families in my State and across the country are depending on us to pass urgently needed emergency COVID funding for tests, for treatments, and vaccines to protect our communities across the country. But keeping up the fight against COVID is just the start.

We have to learn from this pandemic and strengthen our public health system to make sure we are better prepared with more resources for CDC (Centers for Disease Control and Prevention), like this budget proposes, with sustained annual investments for local health departments, like my Public Health Infrastructure Saves Lives Act would provide, and with steps like my bipartisan Prevent Pandemics Act, because we know all too well things like modern data systems, a robust public health workforce, access to tests and vaccines, clearer information, and more can make all the difference when it comes to saving lives during a public health crisis.

But Secretary Becerra, the past few years have also shone a harsh spotlight on the other healthcare challenges our communities are facing, like the mental health crisis, which the pandemic has made even more devastating, especially for our kids. Over the last 2 years, we have seen a sharp rise in youth mental health emergencies. I have heard from so many parents back home whose kids are just not okay.

And over 200,000 kids have had their world shattered by the heartbreaking loss of a parent or a caregiver. And we are already stretched thin when it comes to providing communities the support they need to address these crises. In Washington State, our mental health workforce is only able to meet 17 percent of our State's needs. We have just got to do better.

This budget has crucial support for school based mental healthcare and training, which can help reach students in need, mental health support during early childhood, which is such an important time for kids, community health centers which help families across the country get connected to mental health services, and increased resources for the 9-8-8 Suicide Prevention and Crisis Lifeline.

I will be digging in here during questioning and during your visit to Washington State later this week, because I want to know how the Administration is doing and what it is doing to address the mental health crisis. Secretary Becerra, I also want to hear more from you about how the Administration is working to address our

Nation's substance use disorder crisis, which has gotten so much worse during this pandemic and has grown even more deadly due to fentanyl.

I hear about the tragic consequences of this crisis every single day. Overdose deaths in Washington State have increased by two-thirds since 2019. And nationally, we recently passed the tragic milestone of over 100,000 overdose deaths in 1 year. Our communities are doing what they can. But, Mr. Secretary, we desperately need reinforcements.

The significant increase in this budget for prevention, treatment, and recovery efforts is absolutely necessary. But it is going to take more to get this done. And that is why I am working with my Senate colleagues on bipartisan legislation. But I want to hear more from you about your plan to address this crisis.

When it comes to women's health, I was relieved to see this budget does include significant resources for the Title X Family Planning Program, which helps get women birth control they need to plan a family on their own terms, lifesaving breast and pelvic exams that detect cancer early, and more.

Mr. Secretary, I have fought hard to protect the Title X Program, and I heard from Washington State patients and providers recently about what this program means in their lives. They told me first-hand how it makes all the difference to people with the tightest budgets who might not have access to this basic lifesaving healthcare without Title X.

It is unthinkable to me anyone would not support this program. But as we are being reminded every day, Mr. Secretary, reproductive healthcare is under attack at every angle, and we need to be doing everything we can to protect it. So I want to hear more from you today about what we can do to continue strengthening this program and do everything we can to support other programs that protect women's health.

That is why I was so pleased to see this budget also increases resources to help lower our Nation's unacceptably high maternal mortality rate. And like so many other issues, we know our maternal death rate has been particularly devastating for black and Native American women, which is why the investments in this budget to advance equity and reduce health disparities are vital, especially the significant proposed increase to CDC's work in this space.

This budget also calls for additional support in the fight against HIV, AIDS to increase access to lifesaving treatment, reduce new cases, and continue our progress towards ending this epidemic in our country. Finally, I want to make crystal clear how important it is that we invest in childcare and early education programs and bring down those costs for parents.

This pandemic has made clear to everyone what I have been saying for years, quality, affordable childcare is not optional. It is essential for parents, for kids, for our businesses, for our economy, for everyone. When it comes down to it, parents not being able to work because they cannot find childcare is never just a problem for them, it is one more position a small business can't fill, and it is one less link in our supply chain moving things along.

That is why I believe this has to be a top priority to help parents get back to work and to lower costs. That is such a massive strain

on parents' budgets right now. Mr. Secretary, I know this budget includes a boost in childcare resources. I was glad to see that.

But I need to be clear, right now millions of families across the country are struggling to find or afford childcare, providers are struggling to keep their doors open, and childcare workers cannot make ends meet and are leaving their jobs to find better pay.

So we have got to go bigger to solve this problem here, and which is why I have been fighting so hard to make a truly historic investment in childcare that would bring down costs for families, bring up wages for workers, and all fully paid for simply by asking those at the top to pay their fair share.

I am going to keep pushing to make sure we get that done through reconciliation, because at the end of the day, as happy as I am to see these boosts for childcare in this budget, which I have fought for a long time as well, it is clear to me we can't just tinker at the edges here, we need bold solutions.

And that is why I will keep pushing to deliver on that, just as I am pushing for more progress in all the issues that we will be talking about today. I always like to say that a budget is a statement of values, and I am pleased to see this budget does make it crystal clear that the Administration's values are in the right place. But families back home need us to do more than just state our values, they need us to live up to them.

They need us to act on them with steps that take stress off their shoulders, put money back in their pockets and actually solve the problems they are facing. So I look forward to working with you and President Biden to make sure that happens. Thank you again for being here. With that, I will turn it over to Senator Blunt.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Thank you, Chair Murray. Secretary Becerra, certainly appreciate you being here today. We served together in the House, but I think in the last year we have had a chance for our relationship to grow and I am grateful that that has happened. I am grateful that we have—I think you have made a better effort than we have seen sometimes in the past to get information to us as quickly as you could.

And as you and I have talked about, sometimes we just need to know the direction you are headed in a quick way and find out all of the granular detail when you can get to it. But I am appreciative that I think that is headed on a better path. I think both Chair Murray and I are eager to try to get a bill completed this year.

You are much better off if you have money to spend in next year's spending cycle, October 1, or even December 1 than if it is April 1 or March 1 or May 1, and I hope we can work together to continue to move this process forward. I do think that the completion of the process last year was late enough that some of the gains we made in the final appropriations bill aren't reflected in the budget that was submitted by the President, and I look forward to a chance to talk to you more about that.

You know, at last year's hearing, my opening statement focused almost totally on the pandemic. At that point, we were a year in. The Trump Administration had provided the country with several FDA (Food and Drug Administration) authorized vaccines, tests,

and treatments for COVID-19, while starting a campaign to vaccinate the most high risk Americans. And of course, the Biden Administration continued that vaccine campaign.

Where we were last year was pretty significant in terms of the vaccines that were available and what we had done, considering the fact that a year earlier we had never heard of COVID-19, and we were making real progress. The Biden Administration came into the White House with lots of COVID promises on how it would get it under control and do so by following the science.

Unfortunately, I have some concerns that the Administration has really abandoned the approach of following the science when it became clear over the last year and a half that Federal vaccine mandates, school closure guidance, mask requirements on public transportation have, I think, overreached the moment and overreached the science. Most recently, politics appear to have colored some of the COVID decisions the Department has made.

The CDC announced the termination of the Title 42 order last month. They announced it would occur at a specific date in the future, but they announced it at a time when we were still trying to deal in the Congress and with your Department of the ongoing challenges of COVID. You know, COVID can't be a challenge one place and not a problem, in my view, at another place.

Congress has been provided few details on the impact of the decision of what would happen if Title 42 goes away at the border. Yet no plans to see what we do with an influx of illegal individuals into the country, or in your Department, what happens with the unaccompanied children that come under your responsibility. I don't see the money in this budget reflecting every news story I see about how those numbers intend to grow.

Further, CDC's decision to vastly increase the number of people coming into the country who are unvaccinated that was made after CDC said what they considered the current—this is their quote, “current public health conditions and increased availability of tools to fight COVID-19 allowed the border to be looked at in a different way.” Just days later, the Department made contradictory decisions to extend our own country's public health emergency.

Emergency here, not a problem there really doesn't make much sense to many people and even people in the Congress who can be persuaded that things that don't make sense somehow do make sense. Just yesterday, the CDC updated guidance that two and a half years into the pandemic, it is now everyone—recommending everyone get tested before domestic travel.

It seems to me that it is so out of focus with every other discussion that is going on, and hopefully we will have a chance to talk about that today also. I think these decisions just aren't consistent and intellectually create lots of problems. How do you expect Americans to follow your recommendations when you say it is safe to open the borders to unvaccinated immigrants, but not safe enough to remove mask on planes, and not safe enough to have even domestic travel without a test?

Meanwhile, even as the borders reopen as if the pandemic is over, Americans remain under Federal vaccine and mask mandates. And the Department is asking Congress to provide additional funding for therapeutics, for tests, for vaccines. And I want

to make it very clear, I am actually for that funding. You and I have talked about it. I have worked hard to try to come up with a package that would provide the money we need.

Those accounts, on my view, need to be restored. We are not out of the woods yet with COVID-19, and we need to be prepared for a future wave that very easily could happen. We need to think about what needs to happen with vaccinating the under-five population, and to ensure that any American who needs a therapeutic can get one. Unfortunately, the Administration made two poor decisions that make this additional funding nearly impossible.

First, it pushed through a \$1.9 trillion COVID-19 funding bill that provided less than 6 percent of COVID and less than 1 percent of funding toward vaccines and therapeutics, and only 5 percent toward COVID public health.

Simply put, the Administration had the opportunity to purchase more vaccines, more tests, more treatments, and to continue more research into additional therapeutics, and to prepare for a disease that we will likely be facing for the next several years, and in that huge package that went into the economy, not very much of it was dedicated to the purpose of the COVID-19 fight.

Secondly, we were actively negotiating a bill last month to provide the Department with \$10 billion to purchase those additional therapeutics, vaccines, and tests. And right at the end of that negotiation, before the Congress could vote on the bill, again CDC announced that COVID is not a problem at the border.

Finally, Mr. Secretary, as it did in last year's bill, COVID-19, has overshadowed the budget request, and I think assuming that we will just continue to do all of the COVID spending as emergency spending. There are a lot of new plans in this budget that the Congress just rejected in the omnibus bill.

And frankly, if we have a bill this year, and I hope we do, I think we have to look at what this Congress was willing to agree to after months of negotiation and use that as the blueprint. It doesn't mean the blueprint can't be adjusted, but assuming we are going to see dramatic changes like the removal of the long standing Hyde Amendment.

You know, every person on this committee who has ever voted for a final Labor, HHS (Health and Human Services) bill has voted for Hyde since it first appeared in 1976. And the bills you and I voted for in the House, if we voted for the Labor, HHS bill, all had that amendment in them.

Mr. Secretary, the committee been successful over the last several years of passing bipartisan bills because we have not made fundamental, drastic funding changes.

I was concerned when I saw the money for ARPA-H (Advanced Research Projects Agency for Health), which I also support, but there was \$4 billion of new money in the budget for ARPA-H and no money for the traditional research at NIH (National Institutes of Health), which of course is exactly what people who have been concerned about ARPA-H—have been concerned about, whether it was at NIH or somewhere else, does ARPA-H begin to slow down the momentum of the overall research that we need to continue to see in NIH?

I hope we can set aside our partisan difficulties, as we did last year in this committee, and support programs like maternal mortality programs that benefit all Americans.

The mental health programs. I will say that I was very heartened with the mental health program increases and had some concerns about some structural changes in the mental health agency of SAMHSA (Substance Abuse and Mental Health Services Administration) that you are responsible for.

But we will get back to that and talk about that later. And again, while this will be a challenging hearing, as these always are, welcome and I have appreciated our chance to begin to work together with this new responsibility that you have taken in the last year and look forward to the time to ask questions today.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Thank you, Chair Murray. I appreciate Secretary Becerra being here today to discuss the Administration's fiscal year 2023 budget request.

At last year's hearing, my opening statement focused on the pandemic. At that point, we were a year in, and the Trump Administration had provided the country with several FDA-authorized vaccines, tests, and treatments for COVID-19, while starting a campaign to vaccinate the most high-risk Americans. That was a significant accomplishment considering the year before we had never heard of COVID-19.

The Biden Administration came into the White House with lots of COVID promises of how it would "get it under control" and do so by "following the science."

Unfortunately, it appears that the Administration has all but abandoned that approach, instead making pandemic decisions and policies based purely on politics.

This has been clear over the past year and half with Federal vaccine mandates, school closure guidance, and mask requirements on public transportation that have been overreaching and ripe with partisan politics.

Most recently, politics appear to have colored every COVID decision the Department has made.

When CDC announced the termination of the Title 42 Order last month, which is a public health protocol that limits the number of illegal immigrants entering the country due to the pandemic, it appears to have made this decision in a bid to satisfy vocal opponents, without fully considering the impacts on any other agency, including the Department of Homeland Security.

Congress has been provided few details as to the impact of this decision, and as far as I can tell, there is no plan in place for the influx of illegal immigrants, no real strategy to deal with the problem, and no money in place to do so.

Further, CDC's decision to vastly increase the number of illegal, unvaccinated immigrants coming into the country was made after CDC considered "current public health conditions and an increased availability of tools to fight COVID-19."

Yet just days later, the Department made contradictory decisions to extend our own country's Public Health Emergency and to appeal the Federal mask mandate on public transportation that was struck down in the courts. Even just yesterday, the CDC updated guidance that, two-and-a-half years into the pandemic, it is now recommending everyone get tested before domestic travel.

Mr. Secretary, these decisions make no sense. They are intellectually inconsistent and they send mixed messages to the American people.

I am afraid that CDC and the Department have now clearly crossed a line with credibility. And I don't think the American public will follow public health guidance if they don't trust the agency providing the guidance. How do you expect Americans to follow your recommendations when you say it's safe to open the borders to unvaccinated illegal immigrants, but not safe enough to remove masks on planes?

Meanwhile, even as the borders reopen as if the pandemic is over, Americans remain under Federal vaccine and mask mandates and the Department is asking Congress to provide additional funding for therapeutics, tests, and vaccines. I want to be very clear: I am supportive of this funding.

We are not out of the woods yet with COVID-19 and we need to be prepared for a future wave, to vaccinate the under 5 population, and to ensure that any American who needs a therapeutic can receive one.

Unfortunately, the Administration made two poor decisions that make this additional funding nearly impossible.

First, it pushed through a \$1.9 trillion, partisan COVID-19 funding bill that provided less than 1 percent of funding toward vaccines and therapeutics, and only 5 percent toward COVID-19 public health priorities.

Simply put, when the Department had the opportunity to purchase more vaccines, tests, and treatments, to continue researching additional therapeutics, and to prepare for a disease that we will likely be facing for the next several years, it failed to do so.

Second, as we were actively negotiating a bill last month to provide the Department \$10 billion to purchase additional therapeutics, vaccines, and tests, CDC announced the termination of the Title 42 Order.

While this imprudent decision on Title 42 does not lessen the need for additional funding, it sure makes it significantly harder for Congress to provide it.

Finally, Mr. Secretary, as it did last year, COVID-19 has once again overshadowed the budget request. That may actually be a good thing because this budget is wrought with recycled partisan programs that I had hoped had been resolved when Congress rejected them in the last Omnibus.

I once again wholeheartedly disagree with the Administration's removal of the longstanding Hyde Amendment.

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. Last year was not any different, and I do not expect this year to be either.

Mr. Secretary, this Committee has been successful over the last 7 years with passing bipartisan bills because we haven't made fundamental, drastic funding or policy changes. We've been able to find agreement on funding for important national priorities, such as ARPA-H and addressing the substance use disorder crisis and mental health needs.

As we did in the Omnibus last year, I hope we will set aside partisan policies to support programs that benefit all Americans.

Thank you, again, for being here today.

Senator MURRAY. Thank you, Senator Blunt. Again, welcome, Secretary Becerra. Our witness today is Javier Becerra, the Secretary of the Department of Health and Human Services. Again, thank you for joining us. It is important that you are here. We look forward to your testimony. And with that, you may begin.

SUMMARY STATEMENT OF HON. XAVIER BECERRA

Secretary BECERRA. Chairwoman Murray, Ranking Member Blunt, and members of the committee, I look forward to discussing with you the President's fiscal year 2023 budget. But it is most important that I begin today by responding to the chilling news that certain justices on the Supreme Court appear to be plotting to dismantle settled legal authority that recognizes and protects every woman's right to make her own decisions about her health and her body, including abortion.

22 years into the 21st century and nearly 50 years after *Roe v. Wade*, some, mostly men, seek to impose their judgment over every woman in America who may seek to exercise their Constitutional right to privacy in personal decisionmaking. That is dangerous, that is wrong, and that, we must repel with every just bone in our body.

America is not a Nation prone to regression, and the Department of Health and Human Services is not in the business of stripping Americans of access and protections to care. So at HHS, we will double down on our authorities to protect every American's right and access to reproductive healthcare, including abortion.

Turning to the budget first, to recap, today more than 250 million Americans have received at least one dose of a COVID-19 vaccine, and two-thirds of adults over age 65 have gotten a booster shot. We have also closed the glaring gap in vaccine rates across

communities often left behind. It has paid dividends to surge resources, including tests and treatment to our hardest hit and highest risk communities.

340 million free COVID-19 at home test shipped across America. 270 million free N95 masks. 100 million booster shots. Almost \$186 billion in provider relief funds distributed through more than 800,000 payments to over 441,000 providers for COVID losses and expenses. That is 441,000 hospitals, community health centers, doctors, pharmacies, nursing homes, rural health clinics, behavioral health providers, and many more. Real money, real relief, real results.

That is why it is critical that we have the funds to finish the fight on COVID-19. It is not just a good investment for our health and all of our people's health, it is a smart investment for the health of our economy. Beyond COVID-19, today more Americans have insurance for their healthcare than ever before in our country.

That includes a record breaking 14.5 million Americans who secured health insurance through the Affordable Care Act. Many of those insured Americans are paying less than \$10 per month in premiums for that solid insurance coverage and the peace of mind that comes with it. I am also pleased that last week the FDA issued two proposed tobacco product standards, one prohibiting menthol as a flavor in cigarettes, and another prohibiting all flavors in cigars.

These standards are based on scientific evidence and would improve the health of all Americans. In addition, we launched Operation Allies Welcome, an HHS led effort that has helped over 68,000 of our Afghan brothers and sisters resettle as refugees in America. And we have begun to extend support to Ukrainian refugees fleeing the Russian invasion of their homeland.

As you know, we are working to tackle America's mental health challenges. We are coordinating nearly \$300 million with our 50 States, Tribal governments, and territories to prepare for the launch of the new three digit 9-8-8 National Suicide Prevention Lifeline this July. What 9-1-1 is for local emergency, we are working hard to make 9-8-8 for Americans experiencing a mental or behavioral health crisis.

On sexual and reproductive healthcare, including access to abortion care, which is still legal and available, the Department has worked to restore the Title X Family Planning Program, awarding \$256.6 million in grant funding to restore access to care nationwide and strengthen program rules. This importantly, fills service gaps caused by more than a quarter of Title X providers withdrawing from the program under the previous Administration's rule.

We have also made funds available to help with clinics in dire need. Issued guidance under EMTALA (Emergency Medical Treatment and Active Labor Act) to help patients' access emergency services safely, and guidance to support providers against discrimination. We are continuing to do our work to ensure access to quality care for all patients.

We made these investments to close holes in our public health system in areas like maternal health, where we have extended Medicaid coverage for postpartum care for a new mother and her baby, from 2 months to 12 months. We recently awarded \$16 mil-

lion to community health organizations to expand HHS Maternal and Child Home Visiting Program. And we are working across agencies to make more children eligible for high quality early education programs like Headstart.

The President's 2023 budget lets us build on that record of unprecedented investment in America's health. It proposes \$127 billion in discretionary budget authority and \$1.7 trillion in mandatory funding, including a standout and historic investment to transform the mental health infrastructure in our country, a priority I know you share.

We also ask for \$82 billion for the President's pandemic preparedness and response to get ready for whatever might come next after COVID-19. Considering that COVID has cost our country more than \$4.5 trillion in direct support from the Federal Government so far, this is a no brainer to continue fighting COVID-19 and prepare for any future pandemic.

Madam Chair, members, we are here to turn hardship into hope, inclusion into opportunity. We look forward to working with you. And I look forward to answering any questions you may have.

[The statement follows:]

PREPARED STATEMENT OF 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) 2023 Budget for the Department of Health and Human Services (HHS). I am pleased to appear before you today, and I look forward to continuing to work with you to serve the American people.

HHS addresses many of the challenges facing our country today—ending the COVID-19 pandemic, reducing healthcare costs, expanding access to care, improving health equity, ending HIV/AIDS, enhancing child and family well-being, addressing the overdose epidemic, and strengthening behavioral health—and we are making meaningful progress on these priorities. Our work has never been more important, and I am honored to lead HHS at this critical moment.

The Budget advances the HHS mission to enhance and protect the health and well-being of all Americans. We are proud to be Congress' partner in supporting the American people, and we are grateful for the funding you have provided in support of the HHS mission. We take very seriously our commitment to ensure we are good stewards of every dollar in our budget.

Before I dive deeper, I first want to reflect on the Department's incredible achievements over the past year to save lives and improve health. Thanks to our work to develop and distribute vaccines and boosters, nearly 220 million Americans are fully vaccinated against COVID-19, and two-thirds of adults over age 65 have gotten their booster shots—an unprecedented accomplishment that saves lives every day. HHS procured and provided life-saving antivirals, monoclonal antibodies, and ongoing testing support, with more to come. To date, HHS has provided critical support that resulted in the emergency use authorization (EUA) of 3 vaccines (2 of which are now fully licensed), 7 therapeutics, and 29 diagnostics against COVID-19. HHS has procured millions of COVID-19 treatment courses for Americans, and is supporting the President's pledge to directly provide 1 billion tests to American households for free.

Testing capacity has dramatically increased, and we've supplied free, high-quality masks to the American people. HHS has invested \$250 million in U.S.-based manufacturing of personal protective equipment (PPE) and \$950 million in manufacturing the supplies and equipment needed for vaccines, therapeutics, and diagnostic tests to strengthen the public health supply chain. We distributed Provider Relief Funds to support healthcare providers hit hard by the pandemic, and to reimburse providers for testing, treatment, and vaccine administration for uninsured patients. We provided guidance to support the safe return to the classroom, enabling schools nationwide to reopen.

As the President has said, it is critical to get Americans back to our more normal routines, while still protecting people from COVID-19, preparing for new variants, and preventing economic and educational shutdowns. HHS contributions over the

past 2 years position our country to move forward safely, and we look forward to working with you to continue these efforts.

The country has seen historic increases in health insurance enrollment through the Marketplaces, with a record 14.5 million people signed up for 2022 healthcare coverage during the latest Marketplace Open Enrollment Period. Uninsured rates fell last year after the American Rescue Plan Act took effect, and continue to fall due to the success of innovative and targeted consumer outreach campaigns. We are implementing initiatives like the No Surprises Act, which establishes new Federal protections against certain kinds of surprise medical bills. We are preparing for the expansion of the Suicide Lifeline with the 9-8-8 implementation that will launch this summer. Working with our interagency partners, we also launched interagency initiatives like Operation Allies Welcome, a whole-of-government effort that helped over 68,000 Afghans to permanently resettle in 2021.

HHS has made key investments to address disparities and improve equity and launched new efforts to protect vulnerable communities who bear the brunt of climate change. We are prioritizing rural health and the needs of our Tribal partners. We released a new HHS Overdose Prevention Strategy and made significant investments in behavioral health. It is also an Administration priority to advance legislation that helps lower costs for families, including for child care, preschool, and long-term care, and I look forward to working with Congress to achieve this together.

The President's Budget will enable us to continue these critical efforts and achieve our mission in fiscal year 2023. The fiscal year 2023 Budget proposes \$127.3 billion in discretionary and \$1.7 trillion in mandatory budget authority, including newly proposed mandatory funding for the Indian Health Service and an historic mandatory funding request to transform our ability to protect the nation from future pandemics and other biological threats. The Labor-HHS-Education total is \$123.4 billion, an increase of \$12.9 billion. These investments support families through early education, behavioral health, and access to care. The Budget demonstrates the Administration's commitment to reinvesting in public health, research, and development to drive growth and shared prosperity for all Americans by making major investments in priority areas, including overdose prevention, mental health, maternal health, cancer, and HIV/AIDS. COVID-19 has shown that health inequities and insufficient Federal funding leave communities vulnerable to these crises. The Budget advances equity and helps ensure our programs serve people of color and other underserved communities with the opportunities promised to all Americans.

TACKLING COVID-19 AND PREPARING FOR THE NEXT BIOLOGICAL THREAT

First, I want to highlight that although HHS has made tremendous progress in the fight against COVID, we now face a dire moment. As you know, the Administration requested \$22.5 billion for immediate needs to avoid severe disruptions to our COVID response. We requested these funds as emergency resources, in the same way Congress provided multiple times on a bipartisan basis under the prior Administration. We face unavoidable impacts of not receiving these resources. Testing and treatment capacity will decline. The uninsured fund—which offers coverage of testing, treatments, and vaccinations for tens of millions of Americans who lack health insurance—will run out of money and stop paying provider claims. Already, it has stopped accepting provider claims for testing, treatment, and vaccine reimbursement. Many Americans will no longer be able to access life saving monoclonal antibodies and antiviral drugs. We will be unprepared for a new variant and unable to provide life-saving vaccines to the American people. It is critical that we work together to avoid these and other severe consequences.

Beyond the need for investment in immediate COVID-19 response requirements, the fiscal year 2023 budget builds on Congress' response investments to transform our preparedness for biological threats and strengthen national and global health and health security. The Budget includes a historic \$81.7 billion in mandatory funding over 5 years across the Office of the Assistant Secretary for Preparedness & Response (ASPR), CDC, the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) to support the Administration's vision for pandemic preparedness.

This request provides \$40 billion to the Office of the Assistant Secretary for Preparedness and Response to invest in advanced development and manufacturing of countermeasures for high priority threats and viral families, including vaccines, therapeutics, diagnostics, and personal protective equipment. It provides \$28 billion for the Centers for Disease Control and Prevention (CDC) to enhance public health system infrastructure, domestic and global threat surveillance, public health workforce development, public health laboratory capacity, and global health security. It provides \$12.1 billion to NIH for research and development of vaccines, diagnostics,

and therapeutics against high priority biological threats; biosafety and biosecurity research and innovation to prevent biological incidents; and safe and secure laboratory capacity and clinical trial infrastructure. The Budget also includes \$1.6 billion for the Food and Drug Administration to expand and modernize regulatory capacity information technology, and laboratory infrastructure to support the evaluation of medical countermeasures.

Collectively, these activities will build capabilities the nation urgently needs to respond to future pandemics and biological threats from any source, strengthen international systems so that we can detect threats early and respond to threats quickly, and enable us to boldly and decisively act on the lessons from COVID-19.

In addition to this mandatory investment, the Budget also funds critical ongoing response and preparedness efforts through discretionary budgets. The HHS Coordination Operations and Response Element (H-CORE) within ASPR is responsible for coordinating the development, production, and distribution of COVID-19 vaccines and therapeutics. The Budget requests \$133 million for H-CORE, which is critical to beat COVID-19 and for future emergency response efforts beyond the pandemic, as ASPR builds an enduring response infrastructure. These resources will support the necessary staffing, acquisition support, and data analytics for COVID-19 countermeasures when emergency funding is no longer available to cover these costs.

The Budget requests \$828 million for the Biological Advanced Research and Development Authority (BARDA), to develop novel medical countermeasure platforms to enable quicker, more effective public health and medical responses to detect and treat infectious diseases. The Budget also requests \$975 million for the Strategic National Stockpile to sustain and expand the current inventory of supplies to ensure readiness for potential future pandemics.

COVID-19 has shown the importance of timely, reliable data to respond effectively to public health threats. The Budget makes robust investments in science and public health to improve and protect health at home and abroad, including at CDC for public health infrastructure and capacity, data modernization, global public health protection, and the Center for Forecasting and Outbreak Analytics. The Budget also includes \$197 million to expand state, local, tribal, territorial, and international capacity to combat antibiotic resistance at CDC, as well as an HHS-wide mandatory proposal to encourage the development of innovative antimicrobial drugs.

ADVANCING SCIENCE AND RESEARCH

The Budget prioritizes research and scientific advancement. We are grateful for the support from Congress to establish the Advanced Research Projects Agency for Health (ARPA-H), and the Budget proposes \$5.0 billion to revolutionize how to prevent, treat, and even cure a range of diseases including cancer, infectious diseases, Alzheimer's disease, and many others. This funding is part of a proposed \$49.0 billion in discretionary funds for NIH to continue its incredible track record of turning discovery into health. NIH invests in basic research and translation into clinical practice to address the most urgent challenges including preparing for future pandemics, reducing health disparities and inequity, driving innovative mental health research, and ending the overdose crisis.

The Budget proposes investments in NIH, CDC, and FDA to reignite the President's Cancer Moonshot with an ambitious goal to reduce the death rate from cancer by at least 50 percent over the next 25 years, improve the experience of people and their families living with and surviving cancer, and end cancer as we know it today. The Budget includes increases for CDC to enhance a range of cancer related programs and for FDA's Oncology Center of Excellence.

The Budget proposes \$6.8 billion for FDA to continue to work with developers, researchers, manufacturers, and other partners to help expedite the development and availability of therapeutic drugs and biological products, and to apply the best science in its food and tobacco work. The Budget also proposes \$527 million program level resources for the Agency for Healthcare Research and Quality (AHRQ) to support evidence-based research, data, and tools to make healthcare safer, higher quality, more accessible, equitable, and affordable for all Americans.

Importantly, the Budget also includes \$25 million for CDC and \$20 million for AHRQ to launch Centers for Excellence to study long COVID conditions and equip healthcare providers and systems to deliver patient-centered, coordinated care for this patient population.

REDUCING HEALTH CARE COSTS AND EXPANDING ACCESS TO CARE

To enhance the health and well-being of all Americans, the Budget makes access to more affordable healthcare a top priority. The Affordable Care Act (ACA), bol-

stered by the American Rescue Plan, has expanded health insurance coverage to historic numbers of Americans and the Budget builds on that legacy.

The American Rescue Plan made groundbreaking investments in the ACA by expanding premium subsidies to make coverage affordable for millions more Americans. As I mentioned earlier, a record-breaking 14.5 million people have signed up for 2022 healthcare coverage through the Marketplaces during the latest Marketplace Open Enrollment Period, including nearly 6 million people who have newly gained coverage. The American Rescue Plan lowered healthcare costs for most consumers and increased enrollment to record levels. In fact, consumers saw their average monthly premium fall by 23 percent compared to the prior open enrollment period. As you know, the American Rescue Plan subsidies will expire at the end of 2022 and without new legislation this will result in millions of Americans losing this more affordable coverage. I look forward to working with the Congress on this key priority. We are also concerned about millions of vulnerable Americans who could lose their Medicaid coverage when the COVID-19 Public Health Emergency ends. To address this concern, CMS has provided multiple rounds of guidance to state Medicaid and CHIP agencies that include a robust selection of best practices and recommended strategies allowed under current law when returning to routine operations after the Public Health Emergency ends. For example, recently, CMS released a State Health Official Letter that extends the time states have to process Medicaid redeterminations after the end of the Public Health Emergency from 12 months to 14. HHS is also working to increase awareness of coverage options through targeted outreach campaigns and making renewal of coverage for those eligible easier to navigate. We also look forward to working with the Congress to find solutions to providing coverage options for the nearly 4 million Americans in non-covered states. Additionally, the Administration supports strengthening home and community-based services as an alternative to institutionalized care, to ensure people have access to safe options that work for them.

Rising healthcare costs affect all Americans. HHS has taken steps to increase competition, improve transparency, and strengthen consumer protections. Under the No Surprises Act, a critical bipartisan law passed by Congress, HHS continues to implement the law that shields consumers from certain kinds of surprise medical bills and requires greater transparency from providers. HHS also issued a proposed rule to make hearing aids available to individuals over-the-counter that can help provide consumers with more affordable options and lead to a more competitive market.

I look forward to working with the Congress to lower healthcare costs and expand and improve coverage for all Americans. Reaffirming the President's charge in his State of the Union address, we will work to lower the costs of prescription drugs, such as by capping the cost of insulin at \$35 per month, and to allow Medicare to negotiate payment for certain high-cost drugs.

During the COVID-19 public health emergency, telehealth has been a reliable resource for providers to reach patients directly in their homes to ensure access to care and continuity of services. The Administration is committed to supporting a temporary extension of broader telehealth coverage under Medicare beyond the declared COVID-19 Public Health Emergency to study its impact on utilization of services and access to care. I want to thank Congress for provisions included in the fiscal year 2022 Omnibus spending bill that extend Medicare telehealth flexibilities for 5 months after the end of the public health emergency.

Additionally, the COVID-19 pandemic highlights the importance of vaccines and prevention. Long-standing, deep disparities exist in adult vaccination coverage based on race and ethnicity, particularly among Black and Hispanic populations as compared to other groups. The Budget proposes Vaccines for Adults, a new mandatory program modeled after the existing Vaccines for Children (VFC) program, to provide uninsured adults with access to vaccines, free of charge, that are recommended by the Advisory Committee on Immunization Practices. The Budget further expands the VFC program to include all children under age 19 enrolled in the Children's Health Insurance Program. The Budget also includes a proposal to consolidate Medicare coverage of vaccines under Part B, which will make vaccines more accessible, remove financial barriers, and streamline the process for Medicare beneficiaries and providers.

The Budget continues to support the fourth year of the Ending the HIV Epidemic initiative with \$850 million in funding across CDC, HRSA, IHS, and NIH for fiscal year 2023. The initiative is critical to achieve President Biden's plan to end the HIV/AIDS epidemic by 2030 and ensure access to HIV prevention, care, and treatment. HHS works closely with communities to support the four key strategies—Diagnose, Treat, Prevent, and Respond—to end the HIV epidemic. The Budget also creates a national program that invests \$9.8 billion over 10 years to provide a financing and

delivery system to ensure everyone has access to pre-exposure prophylaxis, also known as PrEP, and essential wraparound services.

TACKLING HEALTH AND HUMAN SERVICES DISPARITIES

Advancing equity is at the core of the Budget. HHS works to close the gaps in access to healthcare and human services to advance equitable outcomes for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. HHS is committed to carrying out the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. Even before the pandemic, we were not doing enough to provide equitable preventive measures, services, and treatment options in every community—and COVID has only made this disparity worse.

Maternal mortality in the United States is significantly higher than most other developed nations and is especially high among Black and Native American/Alaska Native women, regardless of their income or education levels. The Biden-Harris Administration is committed to promoting maternal health and ensuring equitable access to affordable, quality healthcare for our nation's mothers. The Budget invests over \$470 million across AHRQ, CDC, HRSA, IHS, and NIH to reduce maternal mortality and morbidity. This includes increased funding to CDC's Maternal Mortality Review Committees and other Safe Motherhood programs, HRSA's State Maternal Health Innovation Grants program and a new Healthy Start program initiative, and other maternal health programs across HHS.

The Budget also invests in maternal and broader women's health and health equity, including \$86 million for the Office of Minority Health to focus on areas with high rates of adverse maternal health outcomes and areas with significant racial or ethnic disparities. In addition, the Budget also includes \$42 million for the Office on Women's Health to fund prevention initiatives that address health disparities for women.

Black and Latino/Hispanic people, along with American Indian/Alaska Native people, are much less likely than white people to have health insurance. Evidence shows that expanding coverage is not only essential for facilitating equitable access to healthcare, but also is associated with reduced morbidity and mortality, poverty reductions, and protection from debilitating financial bills. The Budget supports policies to promote a stronger and more equitable health insurance system beginning with new requirements for data on race and ethnicity in Medicare.

The Budget also invests \$35 million for a new initiative to systematically identify and resolve barriers to equity in each Centers for Medicare & Medicaid Services (CMS) program through research, data collection and analysis, stakeholder engagement, building upon rural health equity efforts, and technical assistance. CMS is committed to obtaining more accurate and comprehensive race and ethnicity data on Medicare beneficiaries, and to require reporting on social determinants in post-acute healthcare settings. CMS also proposes to add Medicare coverage for services furnished by community health workers who often play a key role in addressing public health challenges for underserved communities. These proposals will help identify, mitigate, and lessen health disparities.

Health Centers are the first line of defense in addressing behavioral health issues nationwide when resources are available. This is particularly true for underserved populations, including low-income patients, racial and ethnic minorities, rural communities, and people experiencing homelessness. The Budget provides \$5.7 billion for health centers, including \$3.9 billion in mandatory resources.

The COVID-19 pandemic has further disrupted access to reproductive health services and exacerbated inequalities in access to care. HHS commits to protecting and strengthening access to reproductive healthcare, and the Budget proposes \$400 million to the Title X family planning program to address increased need for family planning services. Title X is the only Federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services in communities across the United States.

The Budget increases services to prevent child maltreatment and the need for foster care, and supports states in moving towards child welfare systems that provide more tailored and comprehensive prevention services to a broader, more diverse group of families. Prevention services and support are particularly important for at-risk Black, Latino, Indigenous, Native American, and members of other underserved communities, which have disproportionate involvement with the child welfare system.

The Budget provides \$3.1 billion for the Administration for Community Living (ACL), reflecting significant demand increases for critical services caused by popu-

lation growth and pandemic impacts. ACL supports caregivers and advances equitable access to healthcare, education, employment, transportation, recreation, and other systems, resources, and opportunities. ACL advances equity by targeting those in greatest social and economic need, with particular attention on people with disabilities and older adults who are marginalized due to race, ethnicity, sexual orientation, gender identity, poverty, language spoken, and who are at risk of institutionalization.

Lastly, the Budget takes a historic first step toward redressing health disparities faced by American Indians and Alaska Natives by proposing all funding for the Indian Health Service (IHS) as mandatory. In fiscal year 2023, the Budget provides \$9.3 billion, which includes \$147 million in current law funding for the Special Diabetes Program for Indians. This substantial funding increases of \$2.5 billion above fiscal year 2022 enacted will support direct healthcare services, facilities and IT infrastructure, and management and operations. It also provides targeted increases to address key health issues that disproportionately impact American Indians and Alaska Natives such as HIV, Hepatitis C, opioid use, and maternal mortality. With current law funding for the Special Diabetes Program for Indians, the total program level for IHS is \$9.3 billion in fiscal year 2023.

To address chronic underinvestment in IHS, the Budget increases funding for each year over 10 years, building to \$36.7 billion in fiscal year 2032. This increase of 296 percent over the ten-year budget window accomplishes funding growth beyond what can be accomplished through discretionary spending. Over a five-year period, the budget will reduce existing facilities backlogs, fully fund the level of need identified by the Federal-Tribal Indian Health Care Improvement Fund workgroup and support the modernization of the IHS electronic health record system. Additionally, the Budget grows IHS funding to keep pace with inflation and population growth. This request responds to the long-standing recommendations of tribal leaders shared in consultation with HHS to make IHS funding mandatory, and HHS will continue consulting with tribes to inform future policy and budget requests. HHS appreciates the strong partnership with Congress to grow funding for the IHS budget over the last decade, and looks forward to continuing our shared efforts to improve healthcare in Indian Country.

STRENGTHENING BEHAVIORAL HEALTH

HHS is committed to combating America's mental health and substance use crises. The pandemic has had a devastating impact on mental health, particularly for young people, by dramatically changing Americans' experience of home, of school, of work, and in their communities. The President has outlined a bold strategy for tackling the nation's mental health crisis, calling for an increased focus on building system capacity, connecting more people to care, and creating a continuum of support to keep people healthy and help Americans thrive. I also recently launched a National Tour to Strengthen Mental Health, to hear directly from Americans across the country about the mental health and substance use challenges they're facing and to engage with local leaders to strengthen the mental health and crisis care system in our communities. We are also working with the Department of Education to develop and align resources to ensure children have the physical and behavioral health services and supports that they need to build resilience and thrive. Individuals who develop substance use disorders are often also diagnosed with mental disorders—the budget addresses the significant connection between mental health and substance use by investing in a broad spectrum of behavioral health services.

The Budget includes new, historic mandatory investments in totaling \$51.7 billion over 10 years to address the nation's behavioral health crisis. In support of the President's call for reforming our mental healthcare system to fully meet the needs of our communities, the Budget includes a new \$7.5 billion Mental Health Transformation Fund, allocated over a 10 year period, to increase access to mental health services through workforce development and service expansion, including through healthcare and community settings that have not traditionally provided mental health services but that are well-positioned to reach more people. The Mental Health Transformation Fund will also support the expanded use of evidence-based practices for mental healthcare, to ensure that families and communities affected by mental illness receive the highest quality care and supports.

The Budget improves Medicare coverage of mental healthcare and makes access to such care more affordable by eliminating the 190-day lifetime limit on psychiatric hospital services and requiring Medicare to cover three behavioral health visits per year without cost-sharing. In addition, the Budget would recognize licensed professional counselors and marriage and family therapists as independent practitioners who are authorized to furnish and receive direct Medicare payment for their mental

health services, aligns the criteria for psychiatric hospital terminations from Medicare with that of other healthcare providers, and applies the Mental Health Parity and Addiction Equity Act to Medicare.

Additionally, the Budget establishes a Medicaid provider capacity demonstration program for mental health treatment and establishes a performance bonus fund to improve behavioral health services in Medicaid. The Budget also expands and converts the Demonstration Program to Improve Community Mental Health Services into a permanent program. Further, the Budget prevents states from prohibiting same day billing and allows providers to be reimbursed for Medicaid mental health and physical health visits provided to a Medicaid beneficiary that occur on the same day and requires that Medicaid behavioral health services, whether provided under fee-for-service or managed care, be consistent with current and clinically appropriate treatment guidelines.

For people with private health insurance, the Budget requires all health plans to cover mental health and substance use disorder benefits and ensures that plans have an adequate network of behavioral health providers. The Budget also establishes grants to states to enforce parity between mental and substance use disorder and other medical benefits.

The Budget also proposes \$20.8 billion in discretionary funding for behavioral health programs in fiscal year 2023, including significant investments in mental health programs such as the National Suicide Prevention Lifeline, a free, confidential 24/7 phone line that connects individuals in crisis with trained counselors across the United States. The Lifeline receives calls from people with substance use; depression; mental and physical illness; economic worries; loneliness; and concerns about relationships and sexual identity. Ensuring the success of the Lifeline particularly as it transitions to the universal 3-digit number 988 is a top priority for HHS.

To support the health workforce, the Budget includes \$397 million for Behavioral Health Workforce Development Programs and \$25 million in the National Health Service Corps funding specifically for mental health providers. The Budget also includes \$50 million for the Health Resources and Services Administration (HRSA) for Preventing Burnout in the Health Workforce. This investment will provide crucial support for health workforce retention and recruitment, which is essential for addressing current and future behavioral health workforce shortages.

Suicide remains the second leading cause of death among young people between the ages of 10 and 34. Many youth, especially young people of color, Indigenous youth, and LGBTQ+ youth, still lack access to affordable healthcare coverage that is necessary for them to receive treatment for mental health conditions.

The Budget also includes \$308 million for Project AWARE and the Mental Health Awareness Training program to expand support for comprehensive, coordinated, and integrated state and tribal efforts to adopt trauma-informed approaches and increase access to mental health services. School and community-based programs like Project AWARE have been shown to improve mental health and emotional well-being of children at low cost and high benefit. Prevention is an investment in our future, and it lowers adverse outcomes with high societal impact.

According to CDC data, drug overdose deaths increased nearly 30 percent in 2020. Last fall, I announced the release of a new, comprehensive HHS Overdose Prevention Strategy for the nation, designed to increase access to the full range of care and services for individuals with substance use disorders and their families. This new strategy focuses on the multiple substances responsible for overdose and the diverse treatment approaches needed to address them.

The Budget invests \$11.0 billion to combat the overdose crisis across HHS in support of four key target areas—primary prevention, harm reduction, evidence-based treatment, and recovery support—and reflects the Biden-Harris Administration principles of equity for underserved populations, reducing stigma, and evidence-based policy.

The Budget also proposes \$553 million for Certified Community Behavioral Health Centers Expansion Grants to provide coordinated, high-quality, comprehensive behavioral health services. The Budget also proposes to remove the word “abuse” from the agency names within HHS—including the Substance Use and Mental Health Services Administration, the National Institute on Alcohol Effects and Alcohol-Associated Disorders, and the National Institute on Drugs and Addiction. Individuals do not choose to “abuse” drugs and alcohol; they suffer from addiction, which is a chronic medical condition. It is a high priority for this Administration to move past outdated and stigmatizing language that is harmful to these individuals and their families.

SUPPORTING CHILDREN, FAMILIES, AND SENIORS

HHS has a responsibility to ensure our programs serve children equitably, and the high-quality care of children positively impacts their success later in life. The Budget proposes \$20.2 billion in discretionary funding for the Administration for Children and Families' early care and education programs. This includes \$12.2 billion for Head Start to provide services to more than a million children, pregnant women, and families, \$7.6 billion for the Child Care and Development Block Grant, and \$450 million for Preschool Development Grants to increase capacity of states to expand preschool programs.

The Budget expands home visiting programs over 5 years to provide economic assistance, child care, and health support for up to 165,000 additional families at risk for poor maternal and child health outcomes. This funding will help strengthen and expand access to home visiting programs that provide critical services directly to parents and their children in underserved communities.

The mandatory budget includes a \$4.9 billion expansion of services to prevent child maltreatment and the need for foster care. For children who must be removed from their parents, the Budget includes \$1.3 billion in support for states to prioritize placing children with kin, as well as a \$3 billion increase for programs to stabilize and support families and adoptive families, and a \$1 billion increase in support for the transition to adulthood for youth who experienced foster care. While not part of HHS's budget, the Budget proposes to make the adoption tax credit fully refundable so that more families can benefit and to expand the credit to include qualifying legal guardianships.

We face a public health crisis of violence in our communities, which disproportionately affects communities of color. The Budget includes \$250 million for CDC for the Community Violence Intervention initiative, in collaboration with Department of Justice to implement evidence-based community violence interventions at the local level, as well as funding for firearm violence prevention research. The Budget also promotes prevention of and early intervention after adverse events, like community violence, to mitigate longer term impacts, including \$15 million for CDC to advance surveillance and research aimed at preventing Adverse Childhood Experiences. The Budget also includes \$519 million for ACF's Family Violence Prevention and Services programs, including \$250 million to provide direct cash assistance to survivors of domestic violence.

The Budget supports FDA's public education campaigns to educate youth about the dangers of e-cigarette use; provide resources to educators, parents, and community leaders to prevent youth use; and provide resources to help kids who are already addicted to e-cigarettes quit using these harmful products. The Budget includes \$812 million for FDA's tobacco program, an increase to enhance product review and evaluation, research, compliance and enforcement, public education campaigns, and policy development.

The Administration for Community Living (ACL) protects seniors and persons with disabilities from abuse through investments in Adult Protective Services and the Long-Term Care Ombudsman Program. As the populations served by ACL continue to grow, the Budget provides \$139 million to protect vulnerable older adults. The Budget also bolsters ACL's role as an advocate for older adults and people with disabilities.

REFUGEES AND UNACCOMPANIED CHILDREN

Amid the COVID-19 pandemic, large numbers of unaccompanied children continue to arrive at our Southern border. HHS is committed to fulfilling our legal and humanitarian responsibility to care for all unaccompanied children (UC) referred to us by Federal partners. The fiscal year 2023 Budget includes \$6.3 billion in discretionary funding for the Office of Refugee Resettlement, including \$4.9 billion for the unaccompanied children program so that HHS may continue to care for UC safely and humanely, in alignment with child welfare best practices. The Budget also proposes a mandatory contingency fund to provide additional funds if there is a surge in UC referrals, as well as mandatory funding to build towards universal UC legal representation. HHS is committed to unifying these children with vetted sponsors, usually a parent or close relative, as safely and quickly as possible, and the Budget includes funding to implement critical programmatic reforms and service expansions. The Budget also builds on the nation's refugee infrastructure to support resettling of up to 125,000 refugees in 2023, and requests authority to use these funds to support the successful reunification of families who were cruelly separated under the Trump Administration.

IMPROVING SAFETY AND OVERSIGHT NURSING HOMES

Building on the President's State of the Union Address, the Budget is committed to ensuring nursing homes are safe and providing high quality care to vulnerable Americans by increasing funding for nursing home health and safety inspections by nearly 25 percent. Additionally, by increasing nursing home owners' accountability for minimum quality standards, noncompliant facilities can be held financially responsible for poor safety and care. The Budget also requests authority to publish accreditation surveys for other healthcare facilities, like hospitals, rural health clinics, and ambulatory surgical centers, which will better inform the public when selecting care locations for loved ones. The Administration also supports strengthening home and community-based services to ensure people have access to safe options that work for them.

FUNDING CORE PROGRAM OPERATIONS

While the service provided by HHS continues to grow, investment in the Department's operational needs ensures HHS can carry out its mission to enhance and protect the health and well-being of all Americans while maximizing our resources. This investment 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 importance and magnitude of HHS' work, ensuring the integrity of our spending is a core value and responsibility of HHS. The Budget increases discretionary Health Care Fraud and Abuse Control program spending to a total of \$899 million to provide oversight of CMS health programs, strengthen OIG investigations, and protect beneficiaries against healthcare fraud, yielding a return-on-investment of \$13.6 billion over 10 years. The pandemic has unleashed new healthcare fraud risks related to the implementation of billions in new Federal spending, as well as multiple provider regulatory and other flexibilities. These funds are critical to help HHS root out bad actors and ensure program integrity.

CONCLUSION

I want to thank the Committee for inviting me to discuss the President's fiscal year 2023 Budget for HHS. The Budget offers a vision for the nation that reinvests in America's health, supports growth and prosperity, and meets our commitments to the American people and especially to the most vulnerable. I look forward to working with you to fulfill that vision. If we step up in this moment, we can lay the foundation now.

These are critical programs and issues that deserve attention and adequate funding. Thank you for your partnership in advancing our shared goal to improve the health, safety, and well-being of our nation.

Senator MURRAY. Thank you very much, Mr. Secretary. We will now begin a round of 5 minute questions of our witness. I ask my colleagues, please keep track of the clock and stay within your 5 minutes.

TITLE X

Secretary Becerra, when Texas passed its highly restrictive abortion ban, President Biden promised a whole of Government response. And in a statement yesterday, he said the Administration will be ready when any ruling is issued. What can you tell us about the Administration's plan for a whole of Government response to defend the right to abortion?

Secretary BECERRA. Madam Chair, as I mentioned before, we are working at HHS through a reproductive healthcare task force that we established to make sure that we continue to protect the rights of women that exist today. Those rights that exist today to have access to care. We have expanded program services like Title X, and we will work with all of our partners throughout the Federal

Government to make sure that every woman has the legal right to access the care that she is entitled to.

Senator MURRAY. Well, I have been really alarmed that some Republicans have made it clear they don't intend to stop at abortion. Some saying the case that ruled against birth control bans was wrongly decided.

And they have refused to increase funding for the Title X program, which I have been talking about, that provides funding for birth control, cancer screening, and lifesaving care. And in fact, they voted to undermine that program just last week.

Now, HHS approved, but had to turn away dozens of highly qualified applicants for this program in March as a result of that funding. Can you tell us what that means for patients?

Secretary BECERRA. First, I want to make note that because Congress was successful in passing its omnibus budget, we are going to be able to do far more than what the President's budget first proposed, because it was based on a baseline using the continuing resolution funding levels.

So we will do much more working with you to make sure adequate funds are available for programs that provide women access to the care that they need. We are also going to make sure that we speak to all those providers who are out there who have an obligation to make sure women are receiving the services they are entitled to.

I yesterday spoke to a number of health plans and representatives of various health plans throughout the country to make it clear that we intend to enforce the law when it comes to women accessing the care that they are entitled to.

Senator MURRAY. Can you tell us how the proposed increase in HHS will expand access for women of color and low income women?

Secretary BECERRA. We are working hard to make sure that we are addressing some of the maternal mortality and morbidity circumstances that we see in this country, where typically a woman in the black community and in our native populations will suffer the consequences of lost birth, possibly a loss of life, in far greater numbers, probably 3 to 1 compared to in the white community.

And so we are investing in the President's budget close to half a billion dollars to increase our services in maternal health and mortality. We are also calling on States through the American Rescue Plan to increase the number of days that a woman is entitled to postpartum care from 60 days under Medicare, Medicaid—excuse me, to 365 days under Medicaid. COVID-19 Funding

Senator MURRAY. Okay. Thank you. On another topic, I am really concerned that further delay in passing emergency COVID funding could undermine our hard won progress. What are the immediate effects if Congress does not provide more funding for the COVID-19 response as soon as possible?

Secretary BECERRA. Madam Chair, thank you for that question. I have said this publicly many times, we have been first in line to receive vaccines, some of the therapeutics, the antiviral medications, because we have been at the beginning of the negotiations to have access to those therapies and drugs.

Without the money to make the long term commitment going forward, we can't assume that we will get first in line. Many other

countries are already negotiating for access to those treatments. And what we need to do is plan ahead. We have a stock right now of vaccines and treatments that cover us for the next several months.

But we can't say that if there is a new variant that hits or if we need to buy the next generation vaccine that we'll be the first in line if we don't have the money.

Senator MURRAY. Meaning there is a limited supply, and we won't have access to that supply unless we have the funds available now?

Secretary BECERRA. Correct.

Senator MURRAY. Okay. Parents across the country are waiting anxiously for vaccines for young kids. I know FDA is working on this, but having safe, effective vaccines is the first step, and we need the Administration to be ready to distribute enough doses and make it easy for parents to get them for their kids. Are you ready for that?

Secretary BECERRA. We are ready and anxious, as anxious as you are. As you said, safe and effective are the key words. FDA will move when they have the data that reflects if they are safe and effective to use for those under 5 years of age. And we are already coordinating with a number of providers, including pediatricians, to make sure we are making those available as quickly as possible.

Senator MURRAY. Do we have enough doses available, once it is approved?

Secretary BECERRA. We will be able to purchase, because we made a reservation of funds to make sure we could purchase. But once again, how much, how far, and what the vaccine might look like will determine whether or not we have access to the supply we need.

Senator MURRAY. Thank you very much. Senator Blunt.

ARPA-H

Senator BLUNT. Thank you, Chair. Let's talk about ARPA-H for a little bit. This for people who have not been thinking about—an idea the President has to take the long experience with DARPA, Defense Advanced Research, which is different than the way we have done basic health research, and in those instances where we can work toward a rapid conclusion and a more hands together partnered way to do that, I am for that.

Chair Murray has supported the approach of trying to get there quickly as she and Senator Burr have introduced legislation to codify this concept. I really want to ask two questions here, and one is, talk a little bit about your decision to structurally put ARPA-H under the NIH umbrella but directly reporting to you, and then we will come to the spending decision later.

Secretary BECERRA. Senator, thank you for the question and the support you provided to ARPA-H. ARPA-H at the end of the day is like NIH, an agency that takes that research. But how it differs from NIH is it wants to be able to launch from the pad very quickly. And working in partnership with the private sector, those innovators that are out there, the biomedical scientists, be able to actually give the American people a product quickly.

And that is why we want ARPA-H to be more nimble, more facile, and have the opportunity to break away from the tethers of governance that you see at NIH to be able to launch as quickly as possible. We believe we are going to be able to do that while using the efficiencies at NIH has.

So, for example, starting up, your human relations office, your payroll office, your accounting office, rather than have ARPA-H have to start from very scratch, make use of what NIH provides, but give them the autonomy to launch the way they think fit.

Senator BLUNT. And at ARPA-H, I think is, I have heard that discussed while all of those assets would be there, the umbrella agency of NIH, the ARPA-H system would not necessarily work like the NIH system.

You would have the ability to bring people in for shorter periods of time, understanding that this is a project, we are bringing you in to work on it, and at the end of, say, 3 years, we expect this project to be done and you will have the ability to go on to some other work somewhere else. Is that your understanding of this as well, Secretary?

Secretary BECERRA. That is correct. It will not work the way NIH works. It will work much closer to what you understand the way DARPA works in the Department of Defense.

Senator BLUNT. I do think that NIH showed during COVID with RADx and with some of the Warp Speed involvement that even NIH had, but particularly gives RADx the ability to do things in a different way. But I think looking at how that worked and how DARPA works and figuring out how they all work together would be a good thing.

So Senator Murray and I have worked together on this committee for 7 years, and have increased the NIH funding by more than 50 percent after a decade with no real increase. It has been an important goal that we have worked on together. The concern at NIH about ARPA-H—or the NIH advocates, not necessarily the people working there, but the support groups and advocates of NIH, has always been that it would take money that otherwise would go to NIH. It appears that is exactly what is happening here.

We did \$1 billion for startup money for ARPA-H last year. This budget proposes another \$4 billion for ARPA-H and zero for NIH. I am confident that based on our past, working on this topic, zero will not be the number we come up with. But why did you submit zero as opposed to an increase in NIH and money for ARPA-H as well?

Secretary BECERRA. Appreciate the question and to explain. We, when the President asked us to submit our budgets to Congress, we had to work with the baseline that we knew that was in front of us.

At that point, Congress had not completed the work on a fiscal year 2022 budget, and so we had to operate expecting that our baseline would be the continuing resolution, which is far lower than what you ultimately passed in the omnibus bill for 2022.

Certainly now, knowing what the omnibus bottom line is for NIH, we will work using that bottom line to talk about increases for NIH. And we look forward to working with you to make sure

that NIH continues to receive the robust funding that it has always received from Congress.

Senator BLUNT. Thank you, Senator Murray. I will have some other questions, but I assume we will have a chance to ask a second round of questions.

Senator MURRAY. Yes, we will do that. Thank you. Senator Manchin.

SUPPLY CHAIN

Senator MANCHIN. Secretary, thank you for being here. Appreciate it. Thank you for your service. On supply chains, we have spoken quite a bit about supply chains, and we learned that during the COVID-19 pandemic, how fragile it is and trying to make sure that we are able to meet the needs of the people.

This Administration, Biden Administration, they instituted a whole of Government effort to assess what can be done to strengthen competitiveness and supply chain resilience, including the 100 day reviews. And later this year, I think you all will issue your first annual report to provide an update on the challenges, developments, and opportunities.

So the only thing, I know that we are running into these timeframes and everything, so I guess what progress has the Department made in confronting this supply chain crisis that jeopardizes the supply of medications that patients are going to rely on and need?

Secretary BECERRA. Senator, I look forward to working with you on that. As you know, this Administration has used the Defense Production Act on several occasions to try to increase and expand our supply chain. Quick example.

Last year, all the manufacturers of COVID test kits were not domestic, and we worked really hard not only to expand the number of testing kits that would be available for Americans to test themselves against COVID, but we worked really hard to make sure those were domestically manufactured.

And today we have several in America that are domestically manufactured, which, by the way, they will begin to shut down those lines of production if we don't have the monies to guarantee that we will be able to fund test kits moving into the future.

Senator MANCHIN. You have been able to track manufacturing, but people are willing to come back into our manufacturing base?

Secretary BECERRA. Absolutely.

LIHEAP

Senator MANCHIN. You show them the support, they will be there. Okay. The other thing is on LIHEAP, the LIHEAP, Low Income and Energy Assistance Program. We are having a hard time, and advocates both from back home in West Virginia and nationally, challenge in the States facing administering this program. They are having trouble getting the people to administer the program and getting the money to be administered.

So I guess, quickly, have you all looked into this, and can you look into it on LIHEAP, how you can maybe help or make sure that money is getting there, or they have the administration that they are going to need, the support that they are going to need to get

this money out, because it just has been very, very difficult for a lot of poor people.

Secretary BECERRA. Americans need heat in the winter, and they need to be cool in the summer. And we will do everything. We have expanded LIHEAP. We will do everything we can, Senator, working with you and others to make sure that the resources that you all provided get to people who need it.

Senator MANCHIN. I think basically just accept—helping them with their application approval process. That will help tremendously, if you can look into that. The other thing is that I had one thing that I wanted to mention to you, and I think we have talked about before, I have been trying to support and trying to pass the Lifeboat Act.

And only thing it does, Lifeboat truly is saying that we are going to charge manufacturing of opiates one penny per milligram. That one penny per milligram goes to treatment centers all over America. Every one of us in our States have an addiction problem. But we have so few facilities, and the Government can only do so much. But I think the manufacturing that is a manufacturing fee, it won't be passed on as far as cost to the consumer.

But for—if you are going to put this product on the market, you ought to know the damage it does. And right now, we see lawsuits all over the country. I would hope you are looking into that and see if it is something you all could support. It is not onerous at all. It basically directs every penny to treatment centers.

And the final thing I want to ask you about, the \$10 billion that we are stuck on, I cannot believe it. What is it going to do? What risk are we really going to be faced if we don't get this funding?

Secretary BECERRA. Well, the \$10 billion is certainly not enough to carry us to the end of the fiscal year. But what it does do is it lets us stay at the front of the line to make sure we are purchasing the medicines, the treatments, and the vaccines that we need moving forward. Without that, again, we could lose our place in line.

COVID-19

Senator MANCHIN. This is like the different variants, that first of all, we thought COVID-19 was over. Then we have been told, Dr. Fauci told us, that there are going to be different variations. And it is exactly true what he said. And now we even have more. But what is the time element? Where are you going to be crunched on if politics is being played? Democrats and Republicans got to come together for the health of all Americans.

Secretary BECERRA. Our scientists are telling us that in the fall, winter, we probably will see another surge. How big, who knows. But in order to be ready for that fall or winter, we have got to start purchasing today, not in the fall or winter.

Senator MANCHIN. I just, I know you all have a yeoman's task in front of you, and I appreciate the job you are doing. And I just want make sure that we can help you and assist in any way possible. So communications between the offices have been great and I appreciate that. We need a lot more and we are going to try to do all we can to make sure we can protect Americans.

Secretary BECERRA. Thanks, Senator.

Senator MANCHIN. Thank you. Thank you.

Senator MURRAY. Thank you. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Chairwoman Murray and Ranking Member Blunt, for holding this hearing today. And I also want to thank the Secretary for being here and your willingness to serve and your willingness to answer these questions. On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 into law. Out of the nearly \$2 trillion in this bill, only 6 percent went to vaccines and public health.

Despite the fact that a lot of ARPA funding has yet to be disbursed, the Biden Administration continues to press Congress for more money. Over the past few months, your Department in particular has asked Congress for more funding to ensure continuation of critical aspects of the U.S. healthcare response to COVID-19.

Knowing that there would be a continued need for pandemic related healthcare, why did HHS divert healthcare related funds toward the care of illegal immigrants who were coming here due to the Biden Administration's open borders policy?

Secretary BECERRA. Senator, thank you for the question. And as you recall, in the midst of the American Rescue Plan, America was sinking and the rescue plan was to do more than just the healthcare side, it was to make sure that those families who had lost their jobs, those business owners who were losing their businesses, could survive the pandemic. And so that is why so many of the resources went to keep America afloat. And today we see that very few Americans are unemployed.

The economy is moving. But I get—to your point on the resources, we used resources to deal with COVID in its many different facets, including at the border. And so when it came to those migrant children, we wanted to make sure that everyone was safe, including those children.

So we used some of the COVID money to make sure for COVID related reasons, we kept America safe and including those children safe from any particular spread. And so we documented the spending on those programs to Congress, and we continue to show that the success of keeping COVID from spreading, including on the border, was not only important, but kept our economy moving.

Senator HYDE-SMITH. I am well aware of the need for that funding and all the American children that needed the vaccines as well. Knowing these healthcare needs exist, why isn't your Department working with the Office of Management and Budget to shift undisbursed funds toward the healthcare priorities before asking for more money?

COVID-19

Secretary BECERRA. Senator, we are more than willing to go through with you and your team the way we have used the money. We have allocated all the dollars we have, the discretion to move towards the task of dealing with unaccompanied children or dealing specifically with COVID, but we are more than willing to get into some of the specific if you would like to see how we have been able to use the resources you provided.

Senator HYDE-SMITH. And staying on the topic of COVID-19, this is incredibly important to me. I have been in touch with your Department for months on behalf of a gentleman by the name of

Cody Flint in Mississippi. He is an agricultural pilot in Mississippi. Cody received his first dose of the Pfizer vaccine on February the 1st, 2021, and immediately began experiencing very adverse side effects, such as headaches, vision, and hearing issues, dizziness, loss of balance, and a lot of pain.

COUNTERMEASURES INJURY COMPENSATION PROGRAM

Due to these serious health issues, he has not been able to fly as an Ag (Agricultural) pilot since receiving the COVID vaccine shot, rendering Cody unable to provide for his family as an Ag pilot in Mississippi. For more than a year, Mr. Flint has been painstakingly going through the Countermeasures Injury Compensation Program, seeking compensation he may be entitled to based on his experience.

I have worked with him to try to navigate this process. And I have been stunned not only by your agency's lack of urgency in refusing such claims, many claims, but also the lack of the transparency in that process. I certainly still advocate for the vaccine, and I myself received the vaccine, and I encourage others to speak to their doctors about receiving it, however, as with any new medical product, some people will have side effects.

The CICP (Countermeasures Injury Compensation Program) exists for that very reason, and I am very concerned about the amount of time it takes your agency to process claims and the lack of clarity given to those folks who were adversely affected. Can you tell me what you are going to do to address the thousands of claims currently in backlog at HHS?

And what are you doing to improve the transparency of the CICP process so that Americans like Mr. Flint are properly compensated in a reasonable time period?

Secretary BECERRA. Senator, well, you have asked a very important question not just to Mr. Flint, but to so many Americans who did what they should, which is to get vaccinated. We are finding that there are a number of Americans who are suffering from what we are calling today long COVID, and we are doing everything we can to make sure we provide them with the support that they need to get through this, who knows how long it may be. We are doing research on this as well.

I will say this, transparency is important. Accountability is important. And we want to make sure that those who really do have a medical issue to report are the ones who are receiving the assistance. We, as you are aware, in some cases, some of the COVID money has been used fraudulently by many.

We want to make sure that no one is trying to game the system to get relief for something that doesn't exist, that way we can reserve the funds that we have for people like Mr. Flint and provide him with some help.

And so why don't we do this? I am more than willing to have my team reach out to you, and we can see about Mr. Flint and where he is in his process, because we have heard this story on many occasions. We know that millions have been saved because of the vaccine, but we also know that many people are still suffering, so we look forward to working with you.

Senator HYDE-SMITH. He has totally lost his income and the financial burden is just unbelievable, but the frustration of trying to just get some answers of when something could be done for him for this compensation has been very great. Thank you for your help and for answering my questions.

Senator MURRAY. Thank you. Senator Reed.

LIHEAP

Senator REED. Thank you very much, Madam Chairman. Let me go back, Mr. Secretary, to an issue that Senator Manchin raised, that is LIHEAP. I am pleased to say that the President slightly increased LIHEAP in his budget this year, but the reality is that energy prices are just exploding. In the past 12 months alone, the price of natural gas has increased by 22 percent and the price of heating oil has increased by 70 percent.

So would you support any type of supplemental funding to enhance the LIHEAP so that we can deal with this extraordinary increase in prices?

Secretary BECERRA. Senator, we will support any effort to try to further fund LIHEAP given the circumstances that we are in.

Senator REED. Thank you very much. Also, let me go back to the point you raised, which I am pleased that you are moving aggressively. That is the 9-8-8 number. We all understand that we were in a mental health crisis in the country. I hear that not only from my constituents, but as I visit troops around the globe, I hear it from our military personnel also. And we just had a terrible incident, you know, multiple suicides at one of our Navy carriers. 9-8-8 is a great idea, I think.

NATIONAL SUICIDE PREVENTION LIFELINE

I had something to do with it and that is why I think that way. But anyway, it is going to allow someone to call who has a suicidal ideation and try to get help. But it has to be implemented thoroughly throughout the Nation. In Rhode Island, my State has done, I think, a very good job of setting up the counseling centers, the technology, and etcetera. But as I understand the system, if someone calls in and a State doesn't have the infrastructure, they are referred someplace else.

So you have a not a very good relationship, long distance, and also adding more work to States that have enough work already. So can you give us sort of a sense of how the Nation is doing and are we all going to come online together?

Secretary BECERRA. Thank you, Senator. And I do believe your State is doing very well in moving forward. We have a patchwork right now of call centers that accept these calls from folks who are suffering from mental stress. We are trying to turn that into one cohesive network. It is difficult because it won't be run by the Federal Government, it will be run by the 50 States, the territories, and the Tribal governments.

But what we are doing is working with them with your support. We have so far invested \$300 million throughout the country with all the States, local governments to try to make it work. We will also provide back up call centers to make sure that if any particular location is receiving a large volume of calls, there will still

be someone who answers the phone, because the worst thing you can have when someone reaches out, instead it goes in the wrong direction, is to get a busy signal or be put on hold.

Senator REED. No, I completely agree, Mr. Secretary. And, you know, there are long term costs to not implementing something properly. We understand that. And this is an opportunity. We have to get it right. I also understand the President has requested nearly \$700 million in his budget for the National Suicide Prevention Lifeline.

And I think you will need that money, but I think right now we have a few months to get it right. And if you need additional help or assistance, please let us know.

Secretary BECERRA. Thank you. We are keeping tabs. We are contacting every Governor of every State every month to let them know where they stand.

Senator REED. Well, thank you, Mr. Secretary. It was a pleasure working with you in the House, and it is a pleasure working with you in your capacity. Thank you.

Secretary BECERRA. Thank you, Senator.

Senator MURRAY. Senator Moran.

ORGAN SHARING

Senator MORAN. Chairwoman, thank you very much. Mr. Secretary, good morning. Let me start with a topic that I asked you about in your confirmation hearing or in our conversation prior to your confirmation hearing, organ transplants. For over 30 years, HHS has contracted with United Network for Organ Sharing, UNOS, yet it is currently under a Congressional investigation by the Senate Finance Committee.

I would tell you my experience is their attitude approach to their policy has been very discouraging and detrimental to the lives and well-being of those individuals who are hoping to be a recipient of an organ transplant. Damaging geographically in their outlook and damaging geographically in their policy. The contract that UNOS holds with HHS for organ procurement and transplantation is up for competition in 2023.

A recently published request for information on the contract, which I joined Senator Grassley and Senator Wyden and Young in supporting—this RFI (request for information) is an essential step to improving the Nation's organ transplant network. Numerous reports have highlighted the best way to increase competition for the contract is to divide it up.

I don't know whether that is the right answer or not, but I would love to hear from you what specific steps—I want to know that you are aware of these problems and what specific steps you intend to take to increase competition for potential organ procurement and transplant network contractors.

Secretary BECERRA. Senator, this is an issue where you have real people who come to you and tell you about their real life circumstances. So we absolutely know about this. We are trying to prepare to make sure that in the process of coming up with these new contracts, we increase supply, not diminish supply, that we make it a more fair distribution of these organs and that we make it more transparent.

And that is in the works. And what I offer to you, because I think it is so important across the country, we will work with you if you and your team have any particular ideas, if we haven't already incorporated them. I am more than willing to make sure we take that into consideration.

Senator MORAN. If you would give me a name of a contact, you give my staff a name of a contact today, we would be glad to follow up. I would love for your team to hear from not only me, but from those who are actively engaged in trying to make the system work better.

Secretary BECERRA. I will follow up with you at the end of the hearing. Whether we meet directly or through our staffs, I will make sure that happens.

THE NATIONAL STRATEGIC STOCKPILE

Senator MORAN. Xavier, thank you very much. Let me highlight a couple of other things. The National Strategic Stockpile, Strategic National Stockpile, you request, the budget requests \$975 million for the national stockpile for fiscal year 2023. Ensuring that—and I raised this topic in the authorizing committee, and I want to make sure that it is not lost between the two committees. I serve on both of them.

But ensuring that the SNS (Strategic National Stockpile) is restocked and maintained to its maximum capacity is important. I think it became more important with Russia's invasion of Ukraine, and I would ask your commitment to prioritizing fully stockpiling the biodefense and pandemic response supplies maintained by the SNS.

Secretary BECERRA. You have got my commitment, and I hope you will take a look at the President's pandemic preparedness plan moving forward. I think you will like what you see.

PROVIDER RELIEF FUND

Senator MORAN. Thank you very much. And I will do that. Rock Regional Medical Center is a new hospital in the suburbs of Wichita. We have been, me and my office have been working with the Health Resources and Services Administration for the past year flagging Rock Regional, which did not receive a fair allocation of provider relief funding.

It is a new hospital and was treated in a way that—it seemed to me that HRSA (Health Resources and Services Administration) seemed uncaring about solving this problem, and it is not the only hospital in which that is the circumstance. And I don't think I am the only member of the Senate who believes that. So why is HRSA so unwilling to reconsider their methodology for PRF (Provider Relief Fund) funding for new hospitals?

Secretary BECERRA. Senator, you are absolutely correct. You are not the first and Rock Creek is not the only facility. Here is the difficulty. All those funds that were dispersed before 2021 were done under a formula that we could not change. That formula, to your point, relied on looking at past performance. If you are a new hospital, it is hard to talk about your past performance.

That did damage a lot of these facilities that were newer. The difficulty, as you will understand, is we could not change the statu-

tory framework of the provider relief fund and the distribution. To undo that would have meant to have to pull back all the funds. What we did do was we changed the formula with the tranches of dollars that was still existed that we could move forward with.

But we are more than willing to work with you and those providers in your State so we can try to address some of that. But it is tough because we can't undo what was previously used.

Senator MORAN. You described it—I am always pleased when an administration official of any administration says they want to follow the Congressional law. That is pleasing to me. It is not always the case that I find it to be the case that it happens. But I would indicate that we thought this could be better addressed in the later phases, and our conclusion was that it was not. So I would be glad if you will, again, help me get again to somebody who can address this issue.

Secretary BECERRA. And if you will permit me a quick response, it is not that we don't want to, it is just that what was left with the final phases was so little, and there were still so many new incoming requests and some facilities that had gotten no money whatsoever. For example, nursing homes had been left out in the first tranches. So it is not that we didn't want to go back. It is that with what was left, we couldn't try to undo the formula requirements of the previous Administration.

Senator MORAN. Thank you for your explanation.

Senator BALDWIN [presiding]. I will now recognize myself for 5 minutes of questions. Secretary Becerra, thank you so much for appearing here today. I am, as are you, prepared to talk about the fiscal year 2023 budget, but I did want to acknowledge what we saw from the Supreme Court on Monday night. If the court is really going to legislate from the bench and turn back the clock 50 years on *Roe v. Wade*, then I think the Senate needs to pass the Women's Health Protection Act, an act that I have co-led with Senator Blumenthal.

And frankly, I would say that if we need to eliminate the filibuster to get it done, that is what we should do. And I encourage strongly my colleagues to support that effort. Now, the Biden Administration has worked to expand access to comprehensive, affordable coverage through the Affordable Care Act.

INSURANCE PLANS

And I support these efforts. But unfortunately, we continue to wait for the Administration to address the issue of junk insurance plans. I wanted to share the story of Phillip from Janesville, Wisconsin. He received a \$34,000 bill for an emergency room visit and an overnight stay at an area hospital. Rather than paying the bill, his junk insurance plan rescinded coverage due to an alleged pre-existing condition. When Phillip wrote to my office, he said he wanted to warn people about the dangers of these plans.

And he shouldn't have to do that. So, Secretary Becerra, during the hearing to consider last year's budget request, I asked why the Administration hadn't yet taken action to address these junk insurance plans. It has been a year. Can you tell me when the Administration will take action to address these plans?

Secretary BECERRA. Senator, absolutely an appropriate question. And we are in the midst of rulemaking. As you know, rulemaking could take a little while, but we started that process because of what you have explained. It does happen. Junk plans are leaving Americans with these tremendously expensive bills.

Fortunately, with your help, the No Surprises Act is now law. And so individuals who get these surprise bills will no longer have to worry about paying such exorbitant bills. We hope that what we find is between the No Surprises Act statute and are changed to try to undo these junk insurance plans—that we will provide Americans the protections they thought they had.

NATIONAL SUICIDE PREVENTION LIFELINE

Senator BALDWIN. Yes. Well, please keep me apprised of the timeline. We are very anxious to see this addressed in rulemaking. I know that you were just asked some questions about the 9–8–8 Suicide Prevention and Lifeline Hotline.

I want to just add that I was very proud to be the co-lead on the 9–8–8 bill and very supportive of the additional funding in the budget to prepare the States to make this line live. I still, though, hear from leaders in Wisconsin who are concerned that our State may not be fully prepared for the 9–8–8 transition.

So can you tell me a little bit more about the guidance that the Department is giving to States when it comes to securing the additional funding? And do we need to take more action to make sure that there is adequate preparation in the States for this transition?

Secretary BECERRA. Senator, the most important thing you can do is to continue to advocate that your State build the capacity to handle its 9–8–8 response. There are several States that have. We are working with every State with the resources you have made available to us to work with States, the territories, and the Tribal governments.

But without the States taking control of this, it will be very difficult to believe that they will be able to manage the calls that they will get. And the last thing any of us want is for someone who is reaching out at a time of pain to not have a real person respond.

Senator BALDWIN. Can you, as a follow up, make me aware of the interactions that you have had with Wisconsin? It is troubling to hear these concerns raised by mental health leaders. And I want to make sure that our State is accessing the Federal funding that is available.

Secretary BECERRA. Senator, I can make sure we give you a copy of the letter we sent to every Governor, in this case, your Governor, to let them know where they stand in implementation.

Senator BALDWIN. I see I have run over my time. We might start a second round of questioning now, and I will call on Senator Blunt for a second round.

Senator BLUNT. Thank you, Senator. Let's talk about mental health for just a little bit. I was pleased in the budget that you have shown—asked for a substantial increase in the certified community behavioral health clinics, allowing them to continue to treat mental health like all other health, and also making the current demonstration program permanent and allowing all the States and territories to participate.

So I am pleased to see that. I look forward to seeing how far we can go to create a reality of that request. One thing I did want to talk to you about with the mental health agency, SAMHSA. The budget was released on March 29. Three weeks later, we got the first of two notices of a fairly substantial reorganization, three reorganizations. One established a new Office of Recovery within the Office of the Assistant Secretary.

Another created an Office of 9-8-8, which is the suicide helpline number, Behavioral Health Crisis Coordination. A third established a new program of prevention initiative. I have several concerns here. One is, there is nothing in the budget that reflects these agencies being there or so far no direction as to where money should come from to fund them.

Two, I think some of the prevention efforts have become more harm reduction efforts than I think that Congress would have intended for, or certainly that I would intend for. And three, there are even press reports that the Administration is thinking about safe injection sites under the guise of prevention, even though I believe those sites are against the law.

Now, we did have an update just yesterday, the first update of our staff of what that Office of Prevention might do. And we asked about some of these controversial things. I think we are not at all sure yet that there is enough information out there to not be concerned about this or not stay fully engaged.

One, why would we get that kind of reorganization 3 weeks and only 3 weeks after the budget was submitted? And two, how do you expect us to incorporate this into the budget that you have already asked for?

Secretary BECERRA. Senator, thanks for the chance to respond. And as I mentioned to you previously in a conversation, we would reach out to your team. We have reached out to your team. Let me tell you what my team is explaining to me. First, the reorganization does not impact the budget. We are going to work with the monies that we have.

We don't need new authorities because what we are simply doing is reflecting the President's priority on behavioral health, to really tackle this, and also to focus on trying to have a new strategy on drug use. And so what these offices are doing is essentially consolidating what exists in our agencies to really focus in more directly on these very important subjects.

And so what we could do is we will follow up again with your team to give you details. As I said, it doesn't impact the budget. And what we can do is explain how the reorganization helps us achieve the President's desire to really tackle mental health and drug use as directly as we can. We established, for example, a coordinating council among all of HHS's agency so that we wouldn't wait to learn what each other is doing.

SAMHSA and the Office of Public Health are coordinating that. So we are working immediately to deal with mental health, and so we are going to do more of that so we can make the best use of our money. But we will follow up.

Senator BLUNT. Well, we need you to do that. And it will impact the budget to the extent that we need to know where that funding comes from and what new authority—new line items, lines need to

be created for that reorganization if there need to be new items. And we look forward to continuing to work with you on that.

Secretary BECERRA. Thank you.

Senator BLUNT. Thank you, Chair.

Senator MURRAY [presiding]. Thank you. Senator Baldwin.

PERSONAL PROTECTIVE EQUIPMENT

Senator BALDWIN. Thank you. So I am thinking back to the first months of our struggles with the COVID-19 pandemic and all of the work we were doing with first responders and hospitals and others to secure PPE (Personal Protective Equipment).

And in particular, respirator, N95 masks were in desperately short supply. And at that time, American companies began stepping up and they retooled manufacturing lines to help compensate for these weaknesses in the supply chain when there was a global demand.

And working around the clock, they met the need for essential products, including N95 respirator masks and other PPE. These companies helped save lives, and now they are in trouble. I wrote to President Biden earlier this year urging him to prioritize long term contracts for the purchase of masks made by American workers in American factories with American materials.

So I wonder, Secretary Becerra, as Health and Human Services works to replenish the Strategic National Stockpile, can you commit to prioritizing American made PPE?

Secretary BECERRA. Senator, absolutely. That is what we have done. As I mentioned earlier, we made it possible to actually have tests that were manufactured here. But to keep those lines of production going domestically, we have to be able to commit now, otherwise they are going to start to phase those lines down and it would take months for them to try to ratchet back up, which could cause us to have to go to foreign sources for that supply of tests or masks.

Senator BALDWIN. Are you procuring American made N95 masks right now for the national stockpile? Have you been?

Secretary BECERRA. We—and I will get back to you on exactly how much of that might be domestic production. But you will recall that we put out about 270 million N95 masks to Americans free of charge to help people deal with COVID the pandemic. We are resupplying the stockpile, and we are doing everything we can to make sure that when we do resupply, it is with domestic manufactured product.

Senator BALDWIN. Okay. Thank you.

Senator MURRAY. Senator Braun.

GENDER AFFIRMING CARE

Senator BRAUN. Thank you, Madam Chair. So when we have had an opportunity to talk, you know, early on I have been a proponent of reforming healthcare by making it more transparent, more competitive. I think that has largely been lost in all the other issues that have come up. Still interested in that. But the subject that is really creating controversy across the country would be gender affirming care for young people, and it is on the HHS website.

I would like to work through what gender affirming care actually means and do it with a couple of subjects in mind, drugs and surgeries. Let's start with prescription drugs. I don't think these drugs have been proven safe and effective for the use you are recommending. That is probably why the FDA has not approved puberty blocking and hormone therapy drugs for gender transition.

Any time a physician, you know, prescribes it, they are doing it off label. Would you agree that off label prescriptions for usages not approved by the FDA are potentially dangerous for patients, especially kids?

Secretary BECERRA. Senator, thank you for the question. And that is a question that HHS, including FDA, CDC, have been tackling quite a bit as a result of the pandemic. What I would simply say to you is that the FDA would raise alarms if they saw that a particular medicine or a treatment were being misused.

And at this stage, what we know is that for a drug to be out there available, it has to be safe and effective as FDA has found it. So, what I would simply say with regard to this particular subject is, when individuals go in for care, it is their physician who is making that decision with them about what type of medicine or treatment they should receive.

Senator BRAUN. You know, if you use that same logic on what we have just navigated through COVID, it seems like there would have been a different point of view. And to me, for many parents across the country, this has more potentially tragic consequences and it seems like it is a double standard.

Let's look at surgeries that would be even more impactful. And I am not going to mention the particulars there. It is almost grotesque to mention what could occur. Could you explain what irreversible top and bottom sex change surgeries are and why that is on the portal as well?

Secretary BECERRA. Senator as you have just indicated, there are many different types of procedures that can be deployed. What I will say to you is, again, in any case, no individual, no patient will proceed forward unless his or her doctor has advised of the procedure. And it is considered by the FDA and others who have to go ahead and certify a medicine or a procedure to be safe and effective.

Senator BRAUN. So I will try to distill it into a more simple form. In what case would it be appropriate to perform irreversible sex change surgery on kids?

Secretary BECERRA. Those decisions are made by that individual in consultation with physician and caregivers, and no decision would be made without having consulted appropriately.

Senator BRAUN. You know, I think the Government shouldn't be pushing or have it out there on a portal that moves you towards irreversible sex change therapy. And I think we just need to think about it carefully because we are navigating into territory that we have never done before as a government.

Kids going through this are having a hard time. We should be maybe focusing more on mental health and not things that are irreversible. And I think leading the HHS, it might be a little more important to be a little more definitive rather than making it look like, well, a laissez faire approach and whatever happens, happens.

I think that is out of sync with most of America. And it seems to me it would be wise to maybe back up a little bit.

Secretary BECERRA. Senator, I hear what you are saying. I believe that we should help those have the life affirming care that they need. There are many transgender youth who have actually gone in the opposite direction, taking their life. If we can make a life better for someone in America, we should, especially if, in consultation with their physician, they approve of those procedures.

Senator BRAUN. You think it would be reasonable, my last question, in the meantime to maybe take this off the site until there is a little more kind of science built into the approach, a little more discussion about what may or may not make sense, rather than having an out there where it looks like it condones the process?

Secretary BECERRA. I would say to you that many of our medical experts would tell you that we have explored this subject for a long time, and what we find is that we are helping improve the lives of many Americans by providing them with the care that they have chosen, with the informed consent of family, and also with the consent and advice of their own physician.

Senator BRAUN. Thank you.

Senator MURRAY. Thank you. Senator Shaheen.

WOMEN'S HEALTHCARE

Senator SHAHEEN. Thank you, Madam Chairman. And thank you, Mr. Secretary, for being here this morning and for the work that you and everyone at the Department of Health and Human Services does to promote the healthcare of the people of this country.

I was stunned, as I am sure all of us were, by the news on Monday when we saw the draft opinion leaked from the Supreme Court that proposed eliminating access to safe and legal abortions for women and for healthcare that goes along with that. I think it is stunning. And this is a statistic that I found incomprehensible, that the United States could become one of only 25 countries in the world that would totally ban abortion.

And if this decision is correct and this is what the court decides, it would leave up to the States decisions about women's reproductive freedom that presents challenges in States like mine, New Hampshire, where we have seen funding denied to family planning centers on the front lines of these efforts, even though it is funding that does not support performing abortions.

TITLE X

But these family planning centers provide healthcare to thousands of women in New Hampshire. We appreciated your visit to see how Title X is working to keep doors open for family planning services for thousands of women in the Granite State. So I am very concerned about what is going to happen.

And I wonder if you could update us on the work of Health and Human Services Reproductive Health Care Access Task Force?

Secretary BECERRA. Senator, thank you very much. We are going to double down on the effort to make sure that the legal rights of all Americans, women, to access the care that they are entitled to continue forward.

Yesterday I had an opportunity to address a number of the representatives of many of the insurance plans, health insurance plans in America, and made it very clear that we intend to continue to enforce the law. We have heard complaints that some women are not being provided with access to the care that they are entitled to through their insurance plans.

We will continue to do that. We will continue to support the efforts of family planning efforts that are available through Title X. We will also make it clear what the law requires of anyone who accepts Federal funding through Medicare, Medicaid to provide services to all Americans without discrimination.

As I said, we are going to double down to make sure that no one goes without the care that they are entitled to.

STATE OPIOID RESPONSE GRANTS

Senator SHAHEEN. Thank you very much. I appreciate that. Another crisis that New Hampshire and so many other States in the country are dealing with is substance use disorder epidemic. And we have seen how the COVID pandemic has exacerbated that. In New Hampshire, we are still in the middle of this crisis, and the State opioid response grants have really been a vital source of funding for our State to provide treatment that people need.

So as you work to administer those grants this year, will you commit to working with me and with other members of New Hampshire's delegation to ensure that changes in a State's ranking in opioid overdose deaths don't result in large scale reductions in funding.

One of the things that I am—I should preface that with saying, one of the things that we have seen in New Hampshire is that our overdose deaths have leveled out to some extent because we have gotten so good at using Narcan and providing Narcan to local police departments and firefighters so that they can respond when someone has overdosed, but that doesn't mean the underlying problem isn't there.

Secretary BECERRA. Senator, first, thank you for keeping this issue of the SOR (State Opioid Response) grants top of mind to make sure that no State, no community suffers a cliff in the funding that they need to continue to provide service to those who are suffering from drug use. We will continue to work with you.

We have provided additional resources. The budget proposes \$475 million above the previous fiscal Year because we understand how important it is. But I have no doubt that you will continue to insist that we do this the right way and that no one loses the funding they need.

AFFORDABLE CARE ACT PREMIUM RELIEF

Senator SHAHEEN. Well, thank you. I know that is of interest to others on this subcommittee. So thank you very much. A final question has to do with the Affordable Care Act premium relief, which one of the very positive aspects of the American Rescue Plan was the Act's premium tax credits that extend for 2 years to help provide coverage for people who can't afford the cost of healthcare.

Those provisions are set to expire at the end of this year. Can you talk about what the plans are to ensure that we don't see a

number of people kicked off of the Affordable Care Act insurance because those premium tax credits are expiring?

Secretary BECERRA. Senator, thank you for what you and your colleagues did to make that possible. As a result, today, more Americans have access to healthcare, they have insurance, health insurance, than at any point in our country's history, a greater number. And part of that is the 14.5 million Americans who receive their coverage through the Affordable Care Act marketplace.

That came because you made it possible for us to avoid the, again, the cliff that some families faced when it came to the cost of coverage by providing those subsidies and made it very affordable. And in some cases for some families so affordable that they were finding that they were paying \$10 or less per month for their monthly premiums.

And as I always try to say, go try to see a movie in America for less than \$10 a month, for one movie, not for a whole month. And so we will continue to work with you, because it has clearly proven itself successful to make sure Americans can afford to have their health insurance coverage.

Senator SHAHEEN. Can I just ask one follow up—?

Senator MURRAY. Yes—

Senator SHAHEEN [continuing]. Madam Chair. So when you say you will continue to work with us, should we expect a proposal coming from the Administration to extend those premium tax credits or to look at other ways to provide help to people who need help with the cost of health insurance?

Secretary BECERRA. The President has made it very clear, we want to see those premium tax credits extended. In the President's proposals, Build Back Better proposals, and others, we have talked about how we continue to expand access to healthcare and reduce costs, and we will continue to work with you.

Senator SHAHEEN. Thank you. Thank you, Madam Chair.

Senator MURRAY. Senator Moran.

NATIONAL SUICIDE PREVENTION LIFELINE

Senator MORAN. Thank you, Chairman. Mr. Secretary, in the time that I have been here, you have been asked a number of times about 9-8-8. Let me just ask a specific question about your plans.

Would you fill in the details on the \$700 million request for the National Suicide Prevention Hotline with the opportunity to explain the reasoning behind that amount and what it would be used for?

Secretary BECERRA. Senator, thank you. We are finding that because we have had this patchwork, as I have mentioned before, of response and we are trying to make it into one unified response—so if you today are in D.C. and you are feeling stressed, but then you travel into Maryland or West Virginia, you don't find that you lose the same access to services that you might have had if you were in one of those different locations.

To make that happen so it is seamless, requires a great deal of support because the States are accustomed to dealing only with the folks in their communities. We are trying to make it so that there are—it makes no difference. If you have an area code phone from the State of Kansas, but you happen to find yourself in my State

of California, you are still going to get response regardless of where you are. That requires resources. Some States have moved to actually provide a permanent line of funding for their 9-8-8 services.

Others have not. We don't want to see anyone fall through the cracks. And so we are working hard to provide them with services. We put in over \$300 million in this current fiscal year. The President is requesting more because we know it is not just a matter of making sure that the system works, but moving forward, we want to make sure that the follow up services are available so that you don't just get a voice that says we are here to help, but that the services will be there to follow within the States.

Senator MORAN. So is the \$700 million utilized for the technology of the phone call? Or in providing actual services once you get somebody on the line?

Secretary BECERRA. More for the services. So for example, many States are not able to handle the call volume they get. We want to make sure that regardless of where you are, even if a State is receiving a high volume or exceeds its capacity, that that call will still get answered. So we have backup call centers that are set up.

That is something that we are really supporting because States, if they don't have enough in their own State, are probably not prepared to fund a callback—or call capacity. So we are trying to make sure we have those fallback centers in place.

Senator MORAN. Excuse my obtuseness, but that sounds to me as if that is the technology of the phone call, the access to reaching somebody, not—that is not money to provide the psychologist to talk to or the mental health counselor on the other end of the line?

Secretary BECERRA. The technology isn't that difficult. We are actually working with the FCC (Federal Communications Commission) right now to try to make sure that those calls can be connected regardless of where the individual is and who the responder will be.

So we are going through those technical aspects, but the resources are to make sure there is actually a professional, a health professional who will be available to answer those calls. Some States, as I said, are more prepared than others. That shouldn't be a reason why an individual who is crying out for help doesn't get support.

Senator MORAN. Secretary, so if a State is lax in their implementation of this legislation, there will be a Federal response to the phone call from that State?

Secretary BECERRA. Well, that is the thing. We don't—you all did not give us the resources or the authority to essentially run the whole lifeline. But what you did give us was the capacity to help States lift up their capacity. And so we are working very hard right now and for the immediate future to make sure that July 16, if someone calls 9-8-8, they get a response.

Some States will be better prepared July 16 than others. The funding that we are requesting lets us get everybody up to speed.

Senator MORAN. I think the way I would say what you are saying is they get a response, and the response is more than someone saying, hello.

Secretary BECERRA. Yes.

Senator MORAN. It is the follow on to that.

Secretary BECERRA. So crucial. So crucial.

Senator MORAN. Okay. Thank you. I was one of the original sponsors of this bill. I am trying to see and figure out how—I guess what you are describing is that the legislation, it provides what you are supposed to do, and you are trying to do it.

Secretary BECERRA. Yes. And we can provide you with an update on where Kansas is because we are providing every Governor with an update every month of where they stand so they are aware of what they need to do or how well they have done.

Senator MORAN. Okay. Thank you, Madam Chairman.

OPIOID CRISIS

Senator MURRAY. Thank you. Secretary Becerra, I want to go back to a topic that Senator Shaheen mentioned, and that is that our communities are really being hammered by the opioid crisis. Just last year, more than 105,000 Americans died from a drug overdose. In Washington State, synthetic opioid use is up drastically.

Overdose deaths are now up 66 percent since 2019, and over half of those are attributable to fentanyl. This is just unacceptable. We really need some urgent action from the Administration. Can you talk to us about what your plan is to stop the harm being caused by opioids, especially fentanyl?

Secretary BECERRA. Madam Chair, in response to some of Senator Blunt's questions, I mentioned that we have reorganized within HHS to make it a priority to address drug use and address the disorder that is there, especially with opioid.

So we have come up with a different strategy where we forget about the stigma, we forget about the old way of doing it. And our strategy now not only relies on prevention and treatment, but on harm reduction and follow up services so that we don't let people regress.

And so what we are doing right now is working with local communities, because we don't do it at the Federal level, we work with local communities, with the resources you all are giving us to help beef up their capacity to provide not just testing and treatment, but also to help them with harm reduction.

Senator MURRAY. Well, I am especially alarmed by the rise in overdose deaths among adolescents. Fatal overdoses among youth nearly doubled in 2020 and have continued to rise since then, which appears to be driven by these counterfeit pills that are laced with fentanyl.

Parents in my State want to know, what is the Biden Administration doing to protect our kids and prevent young people from seeking out illicit drugs and make life saving overdose reversal drugs more available?

Secretary BECERRA. Well, Senator, we broke through that ceiling that existed that prevented us from supporting local successful operations that, for example, let someone know if the drug they were about to take was laced with fentanyl.

The bugaboo back then, the stigma was, oh, you are helping someone take drugs. We would rather save a life than judge that person who is about to take a drug because they will take the drug, whether we try to help them or not.

And so today, the Federal Government will support those local programs that are, for example, providing fentanyl strips to people so they can test that drug that they may be about to use to find out if it is going to have a harmful—

Senator MURRAY. Does that help adolescents?

Secretary BECERRA. That would help anyone who comes in and who has access to that service from that local provider.

Senator MURRAY. And kids would seek that out?

Secretary BECERRA. Madam Chair, there is—everyone, every walk of life, every age as well, who is coming to some of these centers. And some of these kids may require some adult authorization in order to take certain treatments, but fentanyl strips are available for those who are about to inject themselves or use a drug that is—could likely kill them.

Senator MURRAY. And kids know about this?

Secretary BECERRA. I suspect many adolescents are aware of some of the local anti-drug programs that are available. I can't tell you I know if they make use of them directly or not. And I can't tell you what every State has in terms of laws and making some of these services available to those who are adolescents. But I do know that those programs are made available to those who have drug issues.

Senator MURRAY. Okay. Well, let me just change the topic a little bit. The pandemic, as you know, has been really hard on our kids and it has turned their lives upside down. They have lost time at school, time with their friends.

Some have lost loved ones and they are dealing with a lot of stress and anxiety and trauma, and they really need our help. But even before the pandemic, I was hearing from parents who are frustrated by how hard it is to find mental health services for their kids.

The President's budget would invest heavily in crisis care systems, which I agree are important to handle emergency situations and prevent tragic outcomes. But let me be clear, children should not have to wait until their mental health hits this crisis point to be able to get care. Parents are really desperate to get help for their children here.

How would this budget, particularly your proposal, allowing States to use 10 percent of their mental health block grant funding for prevention and early intervention programs help with that?

Secretary BECERRA. Madam Chair, let me point out one particular program that I know you and Senator Blunt have worked hard on over the course of some time, and that is a certified community behavioral health clinics and how we are planning to expand access to those.

We provide about a quarter of a billion dollars for the expansion of those services because we know that locally in the community, if a family, if a young person has access to those services, we get to them a lot sooner and perhaps save a life. And so we are going to try to expand that.

The \$51.7 billion, 10 year investment that the President is making in mental health services is transformative. If you all pass that in the President's budget, we will be able to do far more in reach-

ing these families because too many, as you said, don't have the access they need.

Senator MURRAY. Okay. Thank you very much. That will end our hearing today. And I want to thank my fellow committee members and Secretary Becerra for a very thoughtful discussion about how we can do more to support our communities, and keep people safe and healthy, and address the challenges we hear about from back home.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due May 13 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 SECRETARY XAVIER BECERRA¹

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. The fiscal year 2023 President's Budget includes \$400 million for the Title X—Family Planning program, which provides birth control, cancer screening, and other lifesaving care. Unfortunately, HHS approved but had to turn away dozens of highly qualified applicants in March as a result of the flat funding in fiscal year 2022.

What does that mean for patients? How many women will not have access to life-saving healthcare services this year as a result of flat funding?

Answer. Title X has not received an increase in service delivery funding in the annual appropriations in 8 years. In total, we received more than \$420 million in requests for the \$256 million that was published available, meaning that approximately \$165 million in requests went unfunded. Due to internal budget adjustments, an additional \$3 million was used to award grants. It means that there remains a high need for Title X reproductive health services needed across the nation.

Question. How would HHS use the proposed increase for next year to expand access for women of color and low-income women?

Answer. In fiscal year 2022, all new Title X grantees were awarded at a 20–40 percent reduction of their requested amount, which reduced the overall projected number of individuals that will be served in year one. In many instances, that translated to significantly less than they received in fiscal year 2021 because that funding has been redirected to cover service areas that were entirely unfunded. Also, existing Title X grantees that were approved in the grant review but not funded were awarded funds for 1 year to help them serve and transition their clients to other locations as they closed out their grants.

If \$400 million were allocated to the Title X program in fiscal year 2023, all of the Title X service grantees would be funded at their original requested amounts. Additionally, those Title X approved but not funded grantees would be fully funded for another year. As a result, approximately 3.5 million clients would be served.

Question. The fiscal year 2023 President's Budget request includes \$975 million, an increase of \$130 million, for the Strategic National Stockpile. The request states that the SNS investments would "make meaningful investments across several portfolios necessary to ensure readiness for future public health emergencies." Among such threats, I remain concerned about the perennial danger of another influenza pandemic, which infectious disease experts believe is not a matter of "if" but "when."

Do you share my concern about a flu pandemic, and would you support the procurement of available medical countermeasures for the SNS to prepare for this possibility?

Answer. The United States Government has and continues to support preparedness for a flu pandemic. Influenza antivirals were originally purchased by SNS using funds provided in 2005 under a pandemic influenza supplemental. SNS has

¹ Responses are current as of the date of the hearing.

worked closely with the Food and Drug Administration (FDA) to extend the expiration dates of many of the influenza antivirals held by the SNS. The most recent extension of expiration dates for influenza antivirals held by SNS was granted in April 2022.

Question. The fiscal year 2023 President's Budget for Sexually Transmitted Disease (STD) prevention is funded at the same level as fiscal year 2022. These funds provide the bulk of the Federal dollars going to State departments of public health to help prevent the spread of STDs. Recently, the CDC has released data showing that STD rates continue to climb and are at a 20-year high. The COVID-19 pandemic likely contributed to the spread of STDs, since most of the health departments across the country discontinued STD fieldwork because their contact tracers were diverted to work on COVID-19.

What is your plan to ensure that when the next pandemic or other public health crisis hits, we will have enough resources to address both STDs and any new maladies that may be coming down the pike?

Answer. CDC's STD Program is utilizing the disease intervention specialists (DIS) Workforce American Rescue Plan Act (ARPA) funding (fiscal year 2021–fiscal year 2026) for COVID-19 and other infectious diseases to directly fund DIS hiring, retention, and support by state and local health departments; training and formal certification for DIS; and providing DIS with critical tools such as diagnostic tests for use in the field. CDC's STD Program will award a total of \$1 billion to state and local health departments from fiscal year 2021–fiscal year 2026. Fiscal year 2021 and fiscal year 2022 funds (\$200 million each fiscal year) have been awarded through a supplement to CDC's Strengthening STD Prevention and Control for Health Departments cooperative agreement, which funds all 50 states and 9 local/territorial health departments. These funds can be used to address the existing emergencies of COVID-19, STDs, and HIV, as well as emerging issues such as monkeypox or other public health crises.

Question. Given the dramatic rise in STDs, why did the Department not ask for a more robust budget to combat STD rates?

Answer. The Administration, the Department and CDC must assess a wide range of funding priorities when developing the President's Budget request, within constrained resources. CDC is the only Federal agency that directly supports and funds sexually transmitted infection prevention and control activities of state, territorial, and local health departments. STIs compromise Americans' health and cost billions. To address the substantial increases in the rates of STIs, CDC will continue to conduct STI surveillance and support states to conduct STI prevention and control activities (e.g. contact tracing), support training and educational materials for healthcare professionals, and studies to translate STI research to practice and to improve program delivery. CDC will also continue to support efforts in alignment with the HHS STI Federal Action Plan and continue to bridge implementation science, public health program management, and STI prevention services that are high impact, scalable, cost-effective, and sustainable.

Question. 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—and the horrifying reality is that the vast majority of these deaths are preventable. And Black women, Tribal women, and women who live in rural areas are at much greater risk. I've been constantly pushing for more investments here, and it's good to see this budget does the same. But we still haven't managed to provide what's needed here.

What are the gaps in care that HHS won't be able to address this year due to Congress' failure to fully fund your department's request.

Answer. The fiscal year 2023 President's Budget includes \$164 million, an increase of \$81 million over the fiscal year 2022 enacted level, for the Safe Motherhood and Infant Health Activities at CDC. The requested funding level included to expand the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program to all 50 states, Washington D.C., and territories for organizations coordinating and managing Maternal Mortality Review Committees to identify, review, and characterize maternal deaths and identify prevention opportunities. With the lower funding level in the fiscal year 22 omnibus, CDC will be able to fund 38 awards in 39 states which falls short of a national ERASE MM program.

Wide disparities exist in maternal morbidity and mortality, with racial and ethnic minority women and women in rural communities at higher risk of pregnancy-associated death and complications. The trans-NIH Implementing a Maternal Health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative, launched in 2020, supports research focused on reducing preventable causes of maternal deaths and improving health for women before, during, and after delivery. IMPROVE also focuses on health disparities and populations disproportionately affected (African

American/Black women, American Indians/Alaska Natives, Asian Pacific Islanders, Hispanics/Latinas, and people with disabilities). One of the goals in fiscal year (FY) 2023 is to establish a national network of Maternal Health Research Centers of Excellence (COE). These COEs will conduct research to mitigate preventable maternal mortality, decrease severe maternal morbidity, and promote health equity by engaging communities, addressing health disparities, and including communities that are maternity health deserts.

The fiscal year 2023 budget request dedicates \$276 million across HRSA to improve maternal health; \$202 million above fiscal year 2022 enacted funding levels. This includes funding for new and existing HRSA programs that prioritize reducing maternal mortality and addressing the disparity in maternal outcomes for women of color. The initiatives aim to:

- Increase access to equitable, high quality maternity care services for all pregnant and postpartum individuals;
- Expand and diversify the perinatal workforce; and
- Support strategies that impact maternal health where women live, learn, work, and play.

This investment will help address gaps in care, including patient-centered services, care to tribal communities, and direct support to rural communities to respond to hospital closures and workforce shortages.

Without the funding requested in the fiscal year 2023 President's Budget for these new or expanded programs, HRSA will be unable to adequately support these important efforts. These critical investments will help transform maternal healthcare to better meet women where they are with the services they need, especially women of color and those in underserved and rural communities, and to reduce health disparities and improve maternal health outcomes.

The fiscal year 2023 budget addresses gaps in care by expanding and diversifying the perinatal workforce with new investments in the doula (\$20 million) and certified nurse midwife (\$25 million) workforces, along with funding to create a research network for minority-serving institutions to advance maternal health research and practice that focuses on addressing health disparities and equity (\$10 million).

The budget also proposes new investments to address social and structural determinants of health including:

- A new program, Addressing Emerging Issues and Social Determinants of Maternal Health (\$55 million), that will:
 - Support communities in addressing social determinants of maternal health for pregnant and postpartum individuals to address racial and ethnic disparities;
 - Expand access to behavioral health services;
 - Promote equitable access to care through digital tools; and
 - Support technology-enabled collaborative learning to build provider capacity to improve maternal health outcomes.
- Increased funding for Healthy Start (\$145 million, \$13 million above fiscal year 2022 enacted) to support new programs in communities with the highest rates of disparities to address factors that contribute to disparities in poor outcomes for mothers and their babies, including mothers of color.

The budget also includes a Pregnancy Medical Home Demonstration Project (\$25 million) to support integrated healthcare services to pregnant women and new mothers; Implicit Bias Training Grants for Health Care Providers (\$5 million); and a National Academy of Medicine Study on incorporating bias recognition in clinical skills testing (\$1 million).

The budget proposes increases for existing programs that help expand access and improve quality of maternal health for women of color. These include the State Maternal Health Innovation Grants (\$55 million, \$26 million increase from fiscal year 2022 enacted) that implement state specific innovative action plans to improve access to maternal care services and address workforce needs and the Alliance for Innovation on Maternal Health (\$15 million, \$3 million above fiscal year 2022 enacted) to expand the implementation of maternal safety bundles.

To increase access in areas with healthcare shortages, the budget increases funding for Rural Maternity and Obstetrics Management Strategies (\$10 million, \$4 million above fiscal year 2022 enacted) to expand access to maternal and obstetrics care in rural communities. The budget also invests in

Maternity Care Target Areas (\$5 million, \$4 million above fiscal year 2022 enacted) to help better identify areas in need of provider capacity.

The budget expands access to behavioral healthcare for pregnant and postpartum women through increased investments in the Screening and Treatment for Maternal Depression program (\$10 million proposed for reauthorization, \$3.5 million above

fiscal year 2022 enacted) and the Maternal Mental Health Hotline (\$7 million, \$3 million above fiscal year 2022 enacted).

Finally, the budget also increases funding for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) (\$467 million, an increase of \$67 million from the fiscal year 2022 enacted level of \$400 million) to expand the capacity of MIECHV awardees to reach more women, families, and communities. Current authorization of the MIECHV Program is set to expire at the end of fiscal year 2022.

The HHS Office on Women's Health initiated an \$8 million nationwide contract with a healthcare improvement company to improve maternal health data and recruited 220 nationally representative hospitals to deploy clinical, evidence-based best practices in maternity care. The Maternal Morbidity and Mortality Data and Analysis Initiative builds upon HHS's maternal health work as outlined in the President's fiscal year 2021 Budget. This vital data will inform policy and validate evidence-based practice to improve maternal and infant health outcomes. OWH would have used additional funds to recruit more hospitals that serve Black women, Tribal women, and women who live in rural areas to participate in the Maternal Morbidity and Mortality Data and Analysis Initiative.

Question. How will the \$470 million requested in the President's new budget address the disparities for women of color and women who live in rural areas?

Answer. The fiscal year 2023 President's Budget invests in several HRSA programs to address disparities for women of color and women who live in rural areas, including:

- An increase to the Healthy Start program (\$145 million, \$13.16 million above fiscal year 2022 enacted) to support new programs in communities with the highest rates of disparities, focusing on addressing the unique structural, environmental, and systemic factors that contribute to disparities in poor outcomes for mothers and their babies.
- New funding to support an Addressing Emerging Issues and Social Determinants of Maternal Health program (\$55 million) that will support community-based investments to improve outcomes particularly in areas with high rates of adverse maternal health outcomes and/or significant racial and ethnic disparities in maternal health outcomes. Efforts may focus on addressing social determinants of maternal health for pregnant and postpartum individuals; expanding access to behavioral health services for women; promoting equitable access to care through digital tools; and supporting technology-enabled collaborative learning to build provider capacity to improve maternal health outcomes.
- A proposed \$10 million in funding for minority-serving institutions to support research on health equity and racial disparities in maternal health. Institutions may use funds to promote diversity within the workforce and advance research into the field of maternal minority health to best serve their patient populations.
- An increase in funding for MIECHV (\$467 million, an increase of \$67 million from the fiscal year 2022 enacted level of \$400 million) would expand the capacity of MIECHV awardees to reach more women, families and communities. Current authorization of the MIECHV Program is set to expire at the end of fiscal year 2022.
- The MIECHV Program supports voluntary, evidence-based home visiting services for pregnant people and parents with young children up to kindergarten entry living in communities that face greater risks and barriers to achieving positive maternal and child health outcomes. MIECHV-funded programs currently serve 71,000 families, reaching only approximately 15 percent of the more than 465,000 families who are likely eligible and in need of MIECHV services. With the proposed five-year funding increase, HRSA anticipates the MIECHV Program could provide home visiting services to up to 165,000 additional families in over 600 additional communities through targeted evidence-based home visiting over the course of 5 years.
- The MIECHV Program also includes a 3 percent set-aside for grants to Tribal organizations to implement home visiting programs in American Indian and Alaska Native communities, which include geographically rural areas.
- The budget also expands the Screening and Treatment for Maternal Depression and Related Behavioral Disorders (MDRBD) program (\$10 million, \$3.5 million above fiscal year 2022 enacted) to expand healthcare providers' capacity to screen, assess, treat, and refer pregnant and postpartum individuals for maternal depression and related behavioral disorders, including in rural areas and medically underserved areas. Current authorization of the MDRBD program is set to expire at the end of fiscal year 2022.

The fiscal year 2023 President's Budget includes \$164 million, an increase of \$81 million over the fiscal year 2022 enacted level, for the Safe Motherhood and Infant

Health Activities at CDC. This increase would help optimize critical public health infrastructure, improve maternal health outcomes, and eliminate persistent racial/ethnic and geographic disparities in healthcare outcomes. Investments in state, local, and territorial public health infrastructure would dramatically improve timely and relevant clinical, non-clinical, and systems level data to guide implementation and evaluation of maternal and infant health policies and programs. In addition to expanding the ERASE MM Program to all 50 states, Washington D.C. and territories, the fiscal year 2023 President's Budget includes support for key public health infrastructure, including expanding Maternal Mortality Review Committees (MMRCs) capacity to acquire detailed and complete data on maternal mortality and develop recommendations for prevention. CDC is partnering with HHS' Office of Minority Health and others to build a health equity framework for maternal mortality review and prevention. With this proposed increase, CDC would also modernize the Pregnancy Risk Assessment Monitoring System (PRAMS) to test and implement strategies for rapid-data collection and dissemination, including facility-based data collections; establishing individual, facility, and community level data linkages; improve response rates and representative samples; and develop a queryable data system. PRAMS collects jurisdiction-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy and are used to better understand emerging issues in the field of reproductive health. CDC would also support significant expansion of the Hear Her Campaign, which is an effort to prevent pregnancy-related deaths by sharing potentially life-saving messages about urgent warning signs. Finally, CDC would promote diverse and representative community engagement in MMRCs and Perinatal Quality Collaboratives (PQCs).

OWH initiatives aim to address disparities and advance health equity for women across the life course for women of color and women who live in rural areas. The President's new budget will allow OWH to continue ongoing initiatives, such as our Breastfeeding Education and Promotion Campaign for African American Mothers and Families. An increase in the budget would also allow OWH to increase the funding amount for the Reducing Maternal Deaths due to Substance Use Disorder grant opportunity.

Question. The President's budget includes increased funding to end HIV in the U.S. as well as an increased focus on PrEP for medications that prevent HIV. These drugs, which can be a daily oral regimen or now, long acting injectables, are underutilized in the communities that need them most, such as Black and Latino gay men, and Black women, particularly in the South. The budget proposes a new \$9.8 billion mandatory spending PrEP delivery program that largely focuses on bulk purchasing of generic drugs.

Please provide detail to support how HHS calculated the \$9.8 billion figure over 10 years.

How will the \$9.8 billion be allocated for different services and distributed to communities throughout the country? Please provide detail on what is needed to cover the costs of the drug, as well as community outreach, and provider education and training programs.

Answer. The new mandatory Pre-Exposure Prophylaxis Delivery Program to End the HIV Epidemic in the United States ("PrEP Delivery Program") is designed to expand access to PrEP and essential wraparound services for uninsured and underinsured individuals at high risk of HIV infections across the United States.

This national program would create a financing and delivery system for PrEP. Currently, there is a patchwork of PrEP access programs for uninsured individuals; this comprehensive new program is a key pillar of the Administration's efforts to meet the commitments laid out in the National HIV/AIDS Strategy for the United States 2022–2025 to reduce HIV infections by 75 percent by 2025.

The PrEP Delivery Program will guarantee access to PrEP at no cost; eliminate costs for essential associated services; and establish a network of providers in underserved communities that provide culturally and linguistically appropriate services. It will create an efficient, systematic approach to drug acquisition and distribution and also provide the critical wrap-around services that make it possible for individuals to successfully participate in the ongoing intervention.

The Department will purchase PrEP medications in bulk directly from manufacturers, leveraging its large purchasing power to obtain the lowest possible price, creating a long-term, sustainable model for purchasing medication. The PrEP Delivery Program will expand PrEP access at clinical settings through on-site dispensing and lab services for those without healthcare coverage.

Additionally, the PrEP Delivery Program will establish and support PrEP programs for state, tribal, and local public health departments, community-based organizations (CBOs), and healthcare facilities that serve the highest risk populations, such as the CDC's health department and CBO grantees, tribal-servicing organiza-

tions, STI clinics, community health centers, Title X clinics, substance use disorder treatment programs, mobile prevention units, homeless shelters, and domestic violence shelters. These organizations will administer the program for clients and work to implement PrEP education campaigns, medication support services, and provide outreach and education to increase utilization of PEP and PrEP among individuals at risk of HIV infection.

Question. Nationwide, we're facing a child care crisis. Parents are struggling to find or afford child care, and too many can't get the early education or pre-k that would help their children thrive. At the same time, early educators are making poverty wages and can't make ends meet, and are leaving the field to get higher pay elsewhere, which is creating real problems in Head Start classrooms, where programs cannot find enough staff to fully operate.

A cost-of-living adjustment is critical in the Head Start Program to allow programs to keep up with inflation, but may not adequately address the issues programs are having recruiting and retaining highly-qualified educators. How does the proposed budget address the child care and early educator shortages we are seeing nationwide?

Answer. Head Start programs across the nation are facing workforce challenges and this instability prevents classrooms from being fully staffed. Low wages have been a key driver for turnover among the early childhood education workforce. With that in mind, the fiscal year 2023 President's Budget includes a request for funding to provide a cost-of-living adjustment and allow programs to keep pace with inflation. While this does not help make wages to be more competitive, it does help preserve their real value.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

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 these emotional scars can harm the developing brain, change the way a child sees the world, and 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 substance use disorder—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. We have now secured \$17 million over the past 3 years for this work. We also created the Interagency Task Force on Trauma-Informed Care that brings our Federal agencies around the table to promote trauma "best practices" in every grant program, we were pleased to secure \$1 million in fiscal year 2022 for this effort. And in fiscal year 2022, we provided \$7 million for the first time to stand up a trauma and mental health support program in schools, under Project AWARE (Sec. 7134 of the SUPPORT Act).

Now, the 2023 budget proposes a \$250 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 needed to grapple with our gun violence epidemic—including street outreach efforts, and trauma programming in schools.

Under a program called the HEAL Initiative that I launched with the ten largest hospitals serving Chicago, as hospitals stitch up their physical wounds, they also pair victims of violence with counselors to address their trauma to prevent retaliations—otherwise nearly half of those gunshot victims would wind up back in the hospital within 5 years. They are also improving data-sharing across hospitals and getting into the community to delivery violence prevention and intervention services.

Secretary Becerra, can you explain how this new community-violence proposal can support programs like those in Chicago, and how you envision these various Federal trauma and violence prevention programs working together?

Answer. SAMHSA leads the Interagency Task Force for Trauma-Informed Care. The Task Force is comprised of 21 agencies and has been identifying, evaluating, and making recommendations regarding best practices for children and families who have experienced trauma or are at risk of experiencing trauma and ways Federal agencies can better coordinate responses to families affected by substance use disorders and trauma. The Task Force developed a National Strategy for Trauma-informed Care grounded in four pillars: best practices, research, data, and Federal co-

ordination. The fiscal year (FY) 2023 budget request will help support SAMHSA in leading the Task Force; collecting data and identifying and evaluating trauma-informed resources for practice; making recommendations to the general public and to Federal agencies through an Internet website; ongoing solicitation of input from stakeholders to inform the work; and coordinating Federal agencies in their integration of trauma-informed principles and interventions into their ongoing work.

The ACEs work is a critical priority at CDC. People who experience ACEs are more likely to have physical, mental and behavioral health challenges, including future experiences with violence. We understand even more now that protective factors, including but not limited to growing up in communities with access to nurturing and safe childcare and strong partnerships with businesses, healthcare, government, and other sectors, help establish safe and stable environments across generations. Through our program Preventing ACEs: Data to Action (PACE: D2A), we currently fund six states to build a state-level surveillance infrastructure that ensures enhances the capacity to collect, analyze, and use ACEs data to inform ACEs prevention activities and to support implementation of ACEs primary prevention strategies selected from the best available evidence.

CDC will continue to work to better understand both protective and risk factors as well as primary prevention strategies and contribute to the evidence base for community violence prevention work. In addition, there is a great need at the state and local level for resources to support this critical work. The fiscal year 2023 President's Budget includes a request for an additional \$8 million in funding to further support states in ACEs prevention.

The \$250 million investment proposed for community violence intervention in the fiscal year 2023 President's Budget has been designed to stem the rise of violence in cities across the country through prioritizing evidence based-prevention strategies, research, and data to inform action. With these funds, CDC would support up to 75 cities and communities disproportionately impacted by homicides to establish a collaborative, community driven approach to reduce community violence. CDC would also expand our research and evaluation investments to further build the evidence base for preventing violence in communities experiencing the greatest burden, and to reduce the racial, ethnic, and economic inequities that characterize such violence across our country.

Hospital-community partnerships, such as the Chicago Hospital Engagement, Action and Leadership (HEAL) Initiative that you mentioned, represent one type of strategy to prevent and reduce community violence and could be supported under the proposed community violence initiative. Rigorous evaluation will be an important component of CDC's community-violence prevention work to help us identify the most effective programs for reducing community violence and re-injury.

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 hospital-community partnerships, can create safer, healthier, and more resilient communities. For more information about these upstream approaches, we would recommend CDC's A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors.

Question. Too often in our country, new moms and infants—especially women and babies of color—are dying from preventable health problems. Nationwide, more than 800 women die every year as a result of pregnancy—more than 70,000 others have near-fatal complications. And it's getting worse—we saw a 15 percent increase in maternal deaths in 2020 compared with 2019.

In Illinois, more than 70 women die every year due to pregnancy-related complications—70 percent of these deaths are preventable.

Not only are we losing new moms, we also are losing their babies. Annually, more than 23,000 babies die in the U.S., many due to preventable factors, such as pre-term birth and low birth weight.

I introduced a bill—the MOMMA's Act—to expand Medicaid coverage to new moms for a year post-partum, versus 60 days. A version of my bill was included in the American Rescue Plan, and Illinois was the first state to offer this expanded Medicaid coverage.

How many states have now expanded their Medicaid programs for new moms, and how do you think this change will improve health outcomes for new moms and babies?

Answer. CMS has taken a series of actions to further advance the safety and quality of maternal care. CMS is encouraging hospitals to implement evidence-based pa-

tient safety practices for managing obstetric emergencies along with interventions to address other key contributors to maternal health disparities.

CMS encourages states to take advantage of the American Rescue Plan's option to provide 12 months of postpartum coverage to pregnant individuals who are enrolled in Medicaid or CHIP beginning April 1, 2022. Even before this option became available, in 2021, CMS approved section 1115 demonstrations in Georgia, Illinois, New Jersey, and Virginia to extend Medicaid and CHIP postpartum coverage beyond the required 60-day postpartum period.

On April 1, 2022, Louisiana became the first state to use the ARP option to extend Medicaid postpartum coverage to 12 months, covering an estimated 14,000 pregnant and postpartum individuals. Two weeks later, Michigan received CMS approval to extend postpartum coverage to 12 months for an estimated 16,000 pregnant and postpartum individuals. CMS continues working with other state partners to extend coverage for 12 months after pregnancy, which has also been proposed in several other states, including Indiana, Maine, Minnesota, New Mexico, Pennsylvania, West Virginia, North Carolina, South Carolina, Tennessee, Washington, and Connecticut, as well as the District of Columbia. As a result of these efforts, as many as 720,000 pregnant and postpartum individuals across the United States, annually, could be guaranteed Medicaid and CHIP coverage for 12 months after pregnancy.

Question. A large majority of Americans take dietary supplements daily—from calcium chews, to multi-vitamins, to fish oil. Yet, there is very little oversight or transparency into these products—we do not even know how many supplements are on the market today, with guesses ranging anywhere from 50,000 to 80,000.

We don't know because FDA doesn't currently have the authority to require dietary supplement companies to register their products, nor are they required to submit ingredient lists, allergen statements, health claims, or even the copies of the labels for these products.

Senator Braun and I introduced the bipartisan Dietary Supplement Listing Act to change all of that. Our bill—which is supported by dietary supplement companies, as well as consumer and physician groups—would require companies to provide basic, vital information about their products.

Mandatory listing of dietary supplements was a new authority that President Biden—and President Trump—requested in their budgets. Can you tell the Committee why you think this issue is so important?

Answer. The dietary supplement industry has grown ten times the size it was when the Dietary Supplement Health and Education Act (DSHEA) was enacted in 1994. Under DSHEA, FDA does not approve dietary supplement products, and generally does not review and approve label claims before dietary supplements are introduced to consumers. As a result, FDA has no systematic way to know when new dietary supplements are introduced or what they contain; therefore dangerous and otherwise unlawful products that contain undeclared or otherwise improper ingredients continue to be marketed.

The fiscal year 2023 President's Budget includes a legislative proposal—similar to proposals offered in other recent budgets—for a mandatory listing requirement for dietary supplements. Under this proposal, FDA is seeking to modernize DSHEA to strengthen and clarify FDA's authorities relating to products marketed as "dietary supplements." These new authorities would allow FDA to know when new products are introduced and enhance FDA's ability to quickly identify and act more effectively against dangerous or otherwise illegal products.

Question. Last year, the President signed into law the Accelerating Access to Critical Therapies for ALS Act (ACT for ALS)—legislation spear-headed by Senators Coons and Murkowski. I was pleased to cosponsor this important legislation, which will fund essential research into fast-progressing terminal diseases like ALS, and expand access to promising investigational new therapies.

This issue is personal to me. My friend, and constituent, Brian Wallach is a 41-year-old man living with ALS. He, and his wife Sandra, took Brian's terminal diagnosis and turned it into hope—starting I Am ALS, an organization that advocates for real, tangible results in the fight against ALS.

Secretary Becerra, last year, you joined a Zoom with Brian and Sandra to celebrate ACT for ALS becoming law. Can you talk about the importance of engagement, input, and collaboration from the ALS patient leadership community as HHS, NIH, and FDA work to urgently implement this law?

Answer. The National Institutes of Health (NIH) agrees that engagement, input, and collaboration with the ALS community will be crucial for implementing the law. To that end, the U.S. Food and Drug Administration (FDA) and NIH held a listening session with leaders in the patient community on March 25 to discuss Access to Critical Therapies (ACT) for ALS implementation. Additionally, NIH plans to in-

clude people affected by ALS on the review panel for expanded access grant applications, and the request for applications for this program strongly encourages applicants to establish relationships with patient groups and solicit their input on recruitment, the clinical meaningfulness of the question under study, the relevance of the proposed clinical outcomes, and approaches to minimizing the burden on study participants.

Question. Please also clarify what resources you need from Congress to get this law implemented quickly and efficiently.

Answer. Fiscal Year (FY) 2022 appropriations for NIH included \$25 million for ACT for ALS implementation. These funds should be sufficient for NIH to support the expanded access grant program in section 2 of ACT for ALS for fiscal year 2022 and to initiate the Public Private Partnership in section 3 of the statute this fiscal year.

Question. Secretary Becerra, the budget proposes \$848 billion for Medicare. One of the greatest drivers of outlays by the Medicare program is the cost of chronic conditions. By some estimates, 10 percent of Medicare spending is attributable to smoking and its health harms. So it would seem that the Department would want to be doing everything it can to prevent tobacco use, especially among youth.

While I was pleased to see FDA finally act to ban menthol cigarettes and all flavors in cigars, I remain concerned that JUUL e-cigarette products—which fueled the youth vaping epidemic in our country—remain on the market EIGHT months past a court-ordered deadline for FDA to act.

For years, FDA refused to act in the face of mounting evidence that millions of children were becoming addicted to nicotine because of JUUL—or JUUL knock-off—products. Mango, cool mint, fruit medley—these were the flavors JUUL used to hook our children. And, today, despite millions of other products being ordered off the market, JUUL remains on store shelves—despite not having authorization from FDA.

One could argue that the FDA's actions to regulate virtually every vaping product except for JUUL is tantamount to clearing the market so that JUUL can sell its products without competition. In fact, these products are only on the market today because FDA is exercising enforcement discretion. They can and should take JUUL off the market TODAY.

Secretary Becerra, why is the FDA now 8 months past the court order?

Answer. FDA's review of premarket tobacco product applications (PMTAs) for electronic nicotine delivery systems (ENDS) continues to be a high priority for the Department of Health and Human Services and for FDA, and FDA is committed to completing its review of premarket applications as soon as possible. FDA has made significant progress on the entire body of submissions, taking action on 99 percent of the applications for about 6.7 million products received by the September 9, 2020 deadline. As the Agency has described publicly, FDA has dedicated resources to the review of applications from companies whose products account for the largest share of the ENDS market, including JUUL. These PMTAs tend to be voluminous and complex and have required additional review time. The Agency has issued decisions for products from four of the five brands that held more than 95 percent of the ENDS market in the summer of 2020, when applications were due. But we have more work to do, including completing review of all of the applications from the larger market share companies. FDA continues to work expeditiously on the remaining applications and is issuing decisions on a rolling basis. The Department and FDA continue to work steadfastly to transform the ENDS market to one where all products have undergone thorough scientific review.

Question. Because we are 8 months past the September 9th court-permitted window, all e-cigarettes that have not been authorized yet remain on the market currently are only allowed to do so because of FDA's enforcement discretion. Why not restore the statutory burden of proof as envisioned in the Tobacco Control Act for manufacturers to prove to FDA that their products are appropriate for the protection of public health, by removing all yet-unauthorized products from the market UNTIL their PMTAs are adjudicated?

Answer. All new tobacco products on the market without the statutorily required marketing authorization are marketed unlawfully and are subject to enforcement by FDA. FDA continues to make enforcement decisions on a case-by-case basis according to its enforcement priorities and individual circumstances.

FDA is committed to working as quickly as possible to transition the current marketplace for deemed new tobacco products to one in which all products available for sale have undergone a careful, science-based review by FDA and met the statutory standard. It is imperative that we get it right.

It is also important to note that FDA does not possess independent litigation authority. FDA works closely with the Department of Justice (DOJ), without whose

support neither injunctive actions nor seizures can occur. FDA regularly consults DOJ with respect to potential enforcement actions, including in relation to unauthorized tobacco products that are the subject of pending applications. Although the Agency does not discuss the substance of its internal deliberations with the dedicated attorneys at DOJ, their legal analysis and expert legal judgment greatly inform FDA's enforcement decisionmaking.

Question. Do you believe that JUUL products—which have been proven to hook kids on nicotine—benefit the public health?

Answer. At this time, FDA has not authorized any JUUL tobacco products for marketing.

As you know, premarket tobacco product applications (PMTAs) must provide scientific data to FDA that demonstrate that permitting the product to be marketed would be appropriate for the protection of the public health (APPH). As set forth in Section 910(c)(4) of the Federal Food, Drug, and Cosmetic Act, the finding as to whether the marketing of each tobacco product for which an application has been submitted is APPH shall be determined with respect to the risks and benefits to the population as a whole, including users and nonusers of the tobacco product.

FDA continues to work expeditiously on the remaining PMTA applications and is issuing decisions on a rolling basis. We will keep your office apprised of any updates and would be happy to offer briefing or discussion as those decisions are made.

Question. I recently met with the Illinois Health and Hospital Association, who shared that their top concern is workforce shortages. But this is not a new problem caused by the pandemic. Even before COVID, our nation faced a shortfall of 120,000 doctors and a quarter- million nurses.

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 averaging 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. And less than 10 percent of doctors are Black or Latino, which can lead 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 Corps.

It will help surge tens of thousands of new clinicians into under-served areas, and already has built the healthcare pipeline by quadrupling the number of scholarship recipients.

Secretary Becerra, your budget proposes a significant increase to the National Health Service Corps. Can you talk about the importance of this program in addressing our workforce needs, our preparedness, and health disparities?

Answer. For the past 50 years, the National Health Service Corps (NHSC) has been a dedicated resource for building healthy communities by mobilizing a primary care workforce to serve in the nation's high-need areas. The NHSC does this by providing scholarships and loan repayment for clinicians who commit to practice in underserved communities. NHSC-approved sites provide care to individuals regardless of their ability to pay. Currently, there are approximately 20,000 medical, dental, and behavioral healthcare clinicians, the largest cohort ever, providing quality care to more than 21 million Americans in rural, urban, and tribal communities. The increase to the number of clinicians providing care is the result of the \$800 million appropriated for the NHSC in American Rescue Plan (ARP) Act in fiscal year 2021, \$700 million of which is for the NHSC Scholarship Program (SP), Loan Repayment Programs (LRPs), and Students to Service (S2S). These funds enabled the NHSC to award all qualified applicants; the remainder of these funds will be fully obligated in fiscal year 2022.

In recent years, the NHSC has demonstrated the ability to be agile and address the emerging health needs across the U.S. States and Territories. This includes, but is not limited to, supporting a workforce dedicated to addressing the Zika epidemic (2016), combatting the nation's substance use disorder crisis (2018-present), and expanding access to care during the height of the COVID-19 pandemic (2021-present). Further, NHSC appropriations have been dedicated to deliver healthcare services in Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs (ITUs). With this directed funding, the NHSC has awarded all eligible clinicians serving in ITUs who applied to the NHSC Loan Repayment Programs (LRPs).

Through the NHSC Substance Use Disorder (SUD) Workforce loan repayment program and Rural Community loan repayment program, HRSA is working to support the SUD workforce needs of underserved communities by helping to recruit and retain health professionals to improve access to quality opioid and evidence-based SUD treatment in rural and underserved areas nationwide, and to prevent overdose deaths. As of September 30, 2021, there are more than 44,000 clinicians in the NHSC providing substance use disorder treatment.

Additionally, ensuring greater racial and ethnic diversity of the healthcare workforce is essential for increasing access to culturally competent care for all patients, improving opportunities and representation of all groups within the health professions, and meeting the overall needs of our diverse population, particularly in the most underserved areas.² Many racial and ethnic minority groups are underrepresented nationally within the major health professions,³ and the share of racial and ethnic minority NHSC providers exceeded their share in the national workforce:

Primary Care

- Black or African American physicians represented 14.9 percent of the NHSC LRP and Scholarship Program (SP) participants, exceeding their 5.0 percent share in the national physician workforce.⁴
- Hispanic or Latino physicians represented 12.9 percent of the NHSC LRP and SP participants, exceeding their 5.8 percent share in the national physician workforce.⁵
- American Indian and Alaska Native physicians represented 1.6 percent of the NHSC LRP and SP participants, exceeding their 0.3 percent share in the national physician workforce.⁶
- Black or African American nurse practitioners represented 15.7 percent of the NHSC LRP and SP participants, exceeding their 9.1 percent share in the national healthcare workforce averages of nurse practitioners.⁷
- Hispanic or Latino nurse practitioners represented 9.1 percent of the NHSC LRP and SP participants, exceeding their 6.3 percent share in national healthcare workforce averages of nurse practitioners.⁸

Mental and Behavioral Health

- Asian health services psychologists represented 5.8 percent of the NHSC LRP participants, exceeding their 4.1 percent share in the national healthcare workforce averages of health services psychologists.⁹
- Hispanic or Latino health services psychologists represented 20 percent of the NHSC LRP participants, exceeding their 3.5 percent share in the national healthcare workforce averages of health services psychologists.¹⁰

Oral Health

- Black or African American dentists represented 13 percent of the NHSC LRP and SP participants, exceeding their 1.4 percent share in the national healthcare workforce averages of dentists.¹¹
- Hispanic or Latino dental hygienists represented 20 percent of the NHSC LRP participants, exceeding their 10.5 percent share in the national healthcare workforce averages of dental hygienists.¹²

Based on self-reports of the 2,523 NHSC scholars (i.e., those in school, pursuing post-graduate training, or awaiting placement in an NHSC-approved service site), 22 percent are Black or African American, 16.8 percent are Asian or Pacific Islander, 2.3 percent are American Indian or Alaska Native, and 14.1 percent of

² Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the healthcare workforce. *Health Aff (Millwood)*. 2002 Sep-Oct; 21(5): 90–102 (<http://content.healthaffairs.org/content/21/5/90.full>).

³ U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2010–2012), Rockville, Maryland; 2014 (<https://bhwh.hrsa.gov/sites/default/files/bhwh/nchwa/diversityushealthoccupations.pdf>).

⁴ Association of American Medical Colleges, Diversity in Medicine: Facts and Figures, 2019. (<https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>).

⁵ Ibid.

⁶ Ibid.

⁷ U.S. Department of Labor, Bureau of Labor Statistics Labor Force Characteristics by Race and Ethnicity, 2020, November 2021, Report 1095.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

NHSC scholars self-reported as Hispanic or Latino. Black or African American NHSC scholars exceeded national student enrollment averages in dentistry, medicine, physician assistant, and nursing disciplines.¹³ Hispanic or Latino NHSC scholars exceeded student enrollment averages in dentistry, representing 15.7 percent of the Corps' dental participants, compared to their 9.0 percent share of the national student enrollment.¹⁴ American Indian and Alaska Native NHSC scholars exceed national student enrollment averages in dentistry, medicine, physician assistant, and nursing disciplines.¹⁵

QUESTIONS SUBMITTED BY SENATOR BRIAN SCHATZ

Question. I am concerned we are facing a cliff for digital health when the public health emergency ends. Last month you said that when it comes to telehealth we cannot let the “old way of business get in the way”. I agree, and so do 61 of my colleagues who have cosponsored my CONNECT for Health Act. HHS's current authority to expand Medicare's coverage of telehealth expires 151 days after the public health emergency ends. Unless Congress acts to ensure permanent expansion of Medicare coverage authorities, we will go back to the dark ages with very limited access to telehealth. During the pandemic, you also waived requirements for other communication technology-based services that CMS could amend without additional authorities needed from Congress. Finally, CMS provided robust guidance to states to increase access to telehealth for individuals in Medicaid and CHIP during the pandemic.

What are the factors you are considering for when this public health emergency could be declared over?

What is CMS's plan regarding the pandemic flexibilities granted for communication technology-based services, such as remote physiologic monitoring, remote therapeutic monitoring, and virtual check-ins?

How is HHS continuing your work with states beyond the public health emergency to ensure that individuals enrolled in Medicaid and CHIP have the same access to telehealth services as those with commercial insurance?

Answer. During the COVID-19 public health emergency, telehealth has been a reliable resource, allowing healthcare providers to reach patients directly in their homes to ensure access to care and continuity of services. The Biden-Harris Administration is committed to supporting a temporary extension of broader telehealth access under Medicare beyond the declared COVID-19 Public Health Emergency (PHE) in order to study its impact on utilization of services and access to care. Telehealth, including audio-only telehealth, can greatly expand access to services for individuals who may not have access to broadband or technology to support 2-way audio-video. This is particularly true in rural and underserved areas, and among older populations.

The Administration is also expanding access to mental health and beneficiary-centered care under Medicare through greater use of telehealth and other telecommunications technologies to provide behavioral healthcare, among other services. Medicare beneficiaries can access care directly in their homes thanks to recent statutory amendments (CAA, 2021), and using audio-only technology where appropriate based on the patient's needs thanks to changes in regulations, including in CMS's CY 2022 Physician Fee Schedule (PFS) final rule, that allow payment for certain behavioral health services via audio-only telephone calls.

In addition, the President's fiscal year 2023 Budget includes a proposal to remove statutory limits on the list of practitioners that are authorized to receive direct Medicare payment for their mental health services, which would expand access to mental health services in Medicare, especially in rural and underserved areas with fewer mental health professionals or in communities more likely to receive care from the referenced practitioners.

CMS has released numerous resources to help states identify opportunities for increasing the use of telehealth services within Medicaid and CHIP. For example, CMS developed Medicaid & CHIP Telehealth toolkit to help states accelerate adoption of broader telehealth coverage policies in Medicaid and CHIP during the COVID-19 PHE. This toolkit provides states with statutory and regulatory infrastructure issues to consider as they evaluate the need to expand their telehealth ca-

¹³ American Dental Association, 2018–2019 Survey on Dental Education: Academic Programs, Enrollments, and Graduates. Association of American Medical Colleges Total U.S. Medical School Enrollment, 2020–2021. American Association of Colleges of Nursing, 2021. 35th Physician Assistant Education Association Annual Report, 2019.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

pabilities and coverage policies. The toolkit also includes a compilation of frequently asked questions and other resources available to states. CMS also released a supplement to the toolkit to provide additional support to state Medicaid and CHIP agencies in their adoption and implementation of telehealth as they begin to plan beyond PHE flexibilities. States may use this supplemental toolkit to help think through how they will explain and clarify which policies are temporary or permanent, when flexibilities will expire, which services can be accessed through telehealth, which providers may deliver those services, the modality they may use to deliver telehealth services, and the circumstances under which telehealth can be reimbursed. Several state profiles are included in this toolkit.

Question. Healthcare workforce shortages are at critical levels in many parts of the country. In addition to workforce training and retention programs, state licensure portability can be an important strategy to increase access to care. As states have begun rescinding licensure waivers, providers are confronting a state patchwork that impacts some from effectively practicing across state lines.

Keeping patient safety in mind, what authority do you need to enhance licensure portability and reciprocity and address regulatory restrictions for providers?

Answer. HRSA's Office for the Advancement of Telehealth supports the Licensure Portability Grant Program under the authority of Section 330L of the Public Health Service Act. States establish their licensure requirements for healthcare providers. However, the Licensure Portability Grant Program assists providers with cross-state licensure by providing funding to work with state licensure boards to create multi-state licensure compacts. Through this program, HRSA provides support to the Federation of State Medical Boards (FSMB) and the Association of State and Provincial Psychology Boards (ASPPB). The FSMB created the Interstate Medical Licensure Compact (IMLC), which offers a voluntary, expedited pathway to licensure for qualified physicians to practice in multiple states, including physicians participating in Medicare and Medicaid. The ASPPB created the Psychology Interjurisdictional Compact (PSYPACT) to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries.

Question. Please list and describe the state policies that HHS helped to enact and/or implement through its Licensure Portability Program.

Answer. The purpose of the Licensure Portability Grant Program is to provide support for state professional licensing boards to carry out programs under which licensing boards of various states cooperate to develop and implement state laws and related policies that will reduce statutory and regulatory barriers to telemedicine, such as creating multi-state licensure compacts. Since states establish their licensure requirements, HHS does not have the authority to change state policies.

Question. What resources would be needed to ramp up HHS's efforts to support state licensure portability?

Answer. The two grantees supported through the Licensure Portability Program, the FSMB and ASPPB, have developed several tools to facilitate access to inter-state telehealth services. These include the Interstate Medical Licensure Compact (36 states, Guam, and the District of Columbia), the Provider Bridge (www.ProviderBridge.org), the Psychology Inter-jurisdictional Compact, also known as PSYPACT (33 states), and the Licensure Project (www.LicensureProject.org). Together, these tools support a range of clinicians, including physicians, physician assistants, nurses, occupational therapists, physical therapists, psychologists, and social workers. Resources could be used to continue the use of tools such as www.ProviderBridge.org and www.LicensureProject.org, expand on efforts to get more states to join the compacts, and support new grantees through the Licensure Portability Program, which would expand the types of healthcare disciplines that are included in the Licensure Portability Program.

HHS is committed to continuing to work within the confines of the law to strengthen the healthcare workforce and connect skilled providers with communities in need including through the use of telehealth. Medicare defers to state law with regard to licensure issues.

Question. Remote patient monitoring (RPM) allows providers to track patients' health metrics and empowers individuals to effectively manage their conditions at home. These tools can improve access to care and health outcomes. Through its Physician Fee Schedule rulemaking, CMS has eliminated some barriers to coverage and payment for RPM services. However, some policies may not adequately address the 77 percent of older adults with at least two chronic conditions who are disproportionately low-income and from minority communities, and could benefit from multiple technologies.

How is HHS enabling the use of technology, such as remote physiologic monitoring and remote therapeutic monitoring, for Medicare beneficiaries who have comorbid chronic health conditions, e.g., diabetes, hypertension, obesity, depression?

Answer. CMS is committed to ensuring our beneficiaries receive high-quality, coordinated care that helps them manage their health. Care coordination and tools such as telehealth and other virtual services can be particularly beneficial for those with one or more chronic health conditions. The COVID-19 public health emergency (PHE) has highlighted that telehealth and other communications technologies can be a reliable resource that allows healthcare providers to reach patients directly in their homes in order to ensure access to care and continuity of services.

In recent years, we have engaged in efforts to update and improve care management and coordination services within the physician fee schedule including chronic care management services, which involve patients with at least two chronic conditions. We also established payment for remote therapeutic monitoring services which can be used to monitor a variety of chronic and acute health conditions.

The Biden-Harris Administration is also committed to supporting a temporary extension of broader telehealth access under Medicare beyond the COVID-19 Public Health Emergency declaration in order to study its impact on utilization of services and access to care. Telehealth, including audio-only telehealth, can greatly increase access to services for individuals who may not have sufficient bandwidth or technology to support 2-way audio-video, particularly in underserved areas and among older populations.

Question. The Native Hawaiian Health Care Improvement Act (NHHCIA) was enacted in furtherance of the Federal trust responsibility of the U.S. government to provide resources to raise the health status of Native Hawaiians. By statute, Papa Ola Lokahi is identified as the single administrative entity responsible for carrying out specific functions. In this capacity, Papa Ola Lokahi must utilize its community expertise to administer the program and work with the five mandated Native Hawaiian healthcare systems to ensure delivery of culturally appropriate care that improves the health status of Native Hawaiians. The NHHCIA does not list among the Secretary's responsibilities the role of identifying a grantee through a competitive application or evaluation process. Instead, the Secretary is obligated to execute a grant or contract with Papa Ola Lokahi and to evaluate its performance.

How is HHS applying its special obligations under Federal trust responsibility to administer the NHHCIA grants?

Answer. In fiscal year 2021, HRSA released a Notice of Funding Opportunity to make available appropriated funding authorized by the Native Hawaiian Health Care Improvement Act for a service grant to Papa Ola Lokahi for activities described in the NHHCIA, including coordination of healthcare programs and services provided to Native Hawaiians, and service grants to 5 certified community-based Native Hawaiian Health Care Systems (NHHCS) to provide a full range of services identified by the legislation and tailored to fit the needs of their respective island communities.

Question. How is HHS applying culturally appropriate standards aligned with the specific goals of the NHHCIA to hold Papa Ola Lokahi and the Native Hawaiian healthcare systems accountable for raising the health status of Native Hawaiians?

Answer. The most recent Notice of Funding Opportunity (NOFO) identifies that funding is intended to improve the provision of comprehensive disease prevention, health promotion, and primary healthcare services for Native Hawaiians. The requirements outlined in the NOFO hold Papa Ola Lokahi and the Native Hawaiian healthcare systems accountable for reporting the following: progress towards goals that align with the NHHCIA, strategies used to overcome challenges encountered in meeting those goals, and changes in the needs of the target population and service area. Clinical quality measures focus on progress made by NHHCS towards health needs pertinent to the target population and are aligned with standardized measures in HRSA's Uniform Data System for the Health Center Program. HRSA monitors POL and the five NHHCS through annual progress reports, regular monitoring calls, the annual submission of performance data, as well as operational site visits. HRSA continues to ensure that this oversight is culturally appropriate.

Question. How is HRSA collaborating with and leveraging the Indian Health Service's expertise in the Federal trust relationship to administer the NHHCIA and evaluate grant performance?

Answer. HRSA collaborates with IHS on reporting data methods and effective community engagement. HRSA also continues to explore new ways to improve the administration and evaluation of this grant funding.

Question. If the final Supreme Court decision for *Dobbs v. Jackson Women's Health Organization* results in the same legal decision as the leaked draft opinion, Americans will lose their constitutional abortion rights protections. After Texas passed its six-week abortion ban, President Biden stated his administration would take a "whole-of-government approach" to abortion rights. During your opening testimony you noted HHS would "double down on our authorities". I appreciate this

commitment, and greater action is needed by HHS to meet this moment. In a major step last December, the FDA revised its Risk and Evaluation Mitigation Strategy (REMS) for mifepristone, removing the in-person dispensing requirement. This decision was consistent with the legal action Dr. Graham Chelius of Kauai took against HHS when he recognized that his patients had to fly to Oahu to obtain a drug safer than Tylenol or Viagra. While I applaud FDA for its revised REMS, I am concerned that it retained unnecessary requirements.

What is FDA's rationale for maintaining its Patient Agreement Form requirement when in 2016, FDA staff recommended removal of this requirement stating it is duplicative of information and counseling provided to patients under standard informed consent practices and professional guidelines?

Answer. As part of FDA's 2021 review of the Mifepristone REMS Program, which involved a detailed analysis of a significant amount of data, FDA concluded that the Patient Agreement Form remains necessary to assure the safe use of mifepristone for medical termination of early pregnancy. This form documents that the prescriber has counseled the patient on the use of mifepristone, what the serious risks are, and what to do if the patient experiences an adverse event. FDA's review of the published literature suggests that the removal of the in-person dispensing requirement may result in an increase in the number of providers becoming certified prescribers. The Patient Agreement Form is an important part of standardizing the medication information on the use of mifepristone that prescribers communicate to their patients, and provides the information in a brief and highly understandable format.

Question. FDA justifies mifepristone's provider certification requirement by noting medical professionals' lack of familiarity and experience with medication abortion. Simultaneously, it is within your authority to strengthen the workforce and increase training for providers. What is HHS's plan to increase the number of providers with the necessary skills to deliver appropriate care?

Answer. Last January, the Secretary launched an HHS-wide Task Force on Reproductive Healthcare Access to protect and bolster access to sexual and reproductive healthcare. This includes looking to ways to expand access to safe and legal abortion care, permissible under the law, and includes working to increase information and engagement with patients and providers to help ensure care. We are continuing to evaluate and look at our authorities and programs and services and will continue to keep you apprised of our thinking on this critical issue.

Question. Is FDA considering modifying its REMS for mifepristone, including its requirement that drug manufacturers must certify prescribing clinicians and pharmacists, and the rule that patients must sign an agreement that they understand drug risks?

Answer. To determine whether a modification to the Mifepristone REMS Program is warranted, in 2021 FDA conducted a comprehensive review of the published literature, other relevant safety data (including adverse event data), and information provided by advocacy groups, individuals, and the applicants. Based on this review, FDA concluded that mifepristone will remain safe and effective for medical termination of early pregnancy if the in-person dispensing requirement is removed, provided all the other requirements of the REMS are met, and pharmacy certification is added.

Accordingly, on December 16, 2021, FDA sent REMS Modification Notification letters to the applicants, notifying them that a modification is necessary and must include removal of the in-person dispensing requirement and the addition of pharmacy certification. Following receipt of these letters, the applicants prepare proposed REMS modifications and submit them to FDA. Once those submissions are approved, the REMS modifications will be effective.

Question. Is the administration considering challenging state laws that contradict the mifepristone REMS?

Answer. Last January, the Secretary launched an HHS-wide Task Force on Reproductive Healthcare Access to protect and bolster access to sexual and reproductive healthcare. This includes looking to ways to expand access to safe and legal abortion care, permissible under the law, and includes working to increase information and engagement with patients and providers to help ensure care. We are continuing to evaluate and look at our authorities and programs and services and will continue to keep you apprised of our thinking on this critical issue.

Question. Does HHS have a plan to increase awareness of medication abortion—including its safety and efficacy—particularly among communities whose access to care is limited? Can you please describe this plan? What resources are needed to execute?

Answer. Last January, the Secretary launched an HHS-wide Task Force on Reproductive Healthcare Access to protect and bolster access to sexual and reproductive healthcare. This includes looking to ways to expand access to safe and legal abortion

care, permissible under the law, and includes working to increase information and engagement with patients and providers to help ensure care. We are continuing to evaluate and look at our authorities and programs and services and will continue to keep you apprised of our thinking on this critical issue

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. One of the most pressing issues West Virginia faces is shortages across the healthcare sector. Nurses, specialists, you name it, we likely don't have enough of them. As we continue to address the COVID-19 pandemic, hospital capacity remains a big issue, especially in rural areas of the state that already faced significant access to care issues. In West Virginia, there are about 7,000 licensed hospital beds, but only enough staff to operate 5,000 of them. That is why Senator Manchin pushed to include \$8.5 billion in the American Rescue Plan specifically to assist rural healthcare providers, including with staffing expenses.

What can the Department do to help ensure places like West Virginia can offer healthcare professionals the resources and tools they need to continue providing care?

Answer. HRSA is focused on workforce needs in rural areas generally and hospital capacity in rural areas specifically. In fiscal year 2022, HRSA will be awarding new programs under the Public Health Workforce Training Network Program to expand the public health capacity by supporting healthcare job development to help to address workforce shortages in rural areas. Additionally, several of HRSA's rural community-based programs offer non-categorical funding that allows applicants to propose and build a program in response to an area of need. HRSA has funded many programs that focus on workforce development through the Rural Health Network Development, Rural Health Care Coordination, Rural Health Care Services Outreach, and Delta States Rural Development Network grant programs. The fiscal year 2023 President's Budget also supports a new pilot program to enable Rural Health Clinics (RHCs) to strengthen their workforce and bring critical services to rural communities. The request will fund approximately 18 Rural Health Clinics.

HRSA supports education and training to West Virginians through grant programs focusing on training primary care providers, nurses, preventive medicine and addiction specialist physicians, and physician assistants. These healthcare providers are training in hospitals and community-based organizations to provide care to rural and medically underserved communities. In addition, trainings support community-based collaboration, technology, medically underserved communities, oral health, minority health, geriatric health, behavioral health focused on substance use disorder and primary care integration. Course delivery modes include: classroom-based, self-paced distance learning, real-time/live distance learning, online webinars, and hybrid trainings with workshops and clinical rotations.

HRSA will continue to provide resources and tools to assist the health care workforce provide quality care. Demonstrated efforts are shown through the following grant programs:

- The National Health Service Corps (NHSC) increases access to care in underserved areas by supporting qualified healthcare providers dedicated to working in underserved communities. The NHSC received supplemental funds through the American Rescue Plan Act to support the nation's COVID-19 response and to help address primary care provider need. In fiscal year 2021, there were 242 NHSC clinicians serving in West Virginia.^{16,17}
- The Primary Care Training and Enhancement—Physician Assistant Rural Training (PCTE–PAR) Program develops and implements longitudinal clinical rotations in primary care in rural areas. The program also supports the training and development of preceptors in rural areas. In fiscal year (FY) 2022, West Virginia University and Marshall University were awarded PCTE–PAR Program grants.
- The Nurse Corps Program received supplemental funds through the American Rescue Plan Act to support our Nation's COVID-19 response and to help address nursing staffing. In fiscal year 2021, Nurse Corps awarded three nursing scholarships in West Virginia and 14 Nurse Corps loan repayment awards.

¹⁶Bureau of Health Workforce Clinician dashboards. (n.d.). Retrieved June 9, 2022, from <https://data.hrsa.gov/topics/health-workforce/clinician-dashboards>.

¹⁷Bureau of Health Workforce Clinician dashboards. (n.d.). Retrieved June 9, 2022, from <https://data.hrsa.gov/topics/health-workforce/clinician-dashboards>.

—The Behavioral Health Workforce Education and Training (BHWET) Program aims to increase the supply of behavioral health professionals while also improving distribution of a quality behavioral health workforce.

In fiscal year 2021, West Virginia University was awarded a BHWET Program for Professionals grant. The purpose of their proposed Rural Integrated Behavioral Health Training (RIBHT) program is to prepare Master of Social Work students for behavioral health practice, with a focus on integrated and rural service delivery.

Marshall University was also awarded a BHWET Program for Professionals grant between AY 2017–2021. The primary focus of the project is to increase the number of training slots that provide experience in integrated behavioral health within the primary care setting for trainees from programs that have previously not offered such training opportunities. These programs include the Master's program in Psychology with Clinical and School emphasis, the Masters in Counseling, and the Psychiatry residency program. Specific attention is given to understanding the unique needs of rural and underserved populations in West Virginia and Appalachia in general and how those needs may impact both behavioral and physical health.

Question. Last month, the Administration released its National Drug Control Strategy. This strategy lays out the steps the Administration, in coordination with Federal agency staff across the government, will take to address the drug epidemic, which Senator Manchin has said time and time again continues to grow in West Virginia and across the nation. Prevention and early intervention are listed in the National Drug Control Strategy as a priority, as they should be. In 2020, the Substance Abuse and Mental Health Services Administration issued its annual report on substance use. The report found that 158,000 people ages 12 to 17 started using prescription pain relievers for the first time in 2020. While this a decline from previous years, youth substance use needs our full attention before we lose the next generation of leaders to the drug epidemic.

What efforts are underway at HHS to address substance use by our youngest and most vulnerable populations?

Answer. SAMHSA oversees grant programs that utilize evidence-based programs and promising practices to address substance use by youth ages 12 to 17, among other efforts.

For instance, SAMHSA's Enhancement and Expansion of Treatment and Recovery for Adolescents, Transitional Aged Youth, and their Families (Youth and Family TREE) grant program supports substance use disorder (SUD) treatment specifically for youth, young adults, and their families with these conditions. Many of SAMHSA's programs include elements that address youth and young adult SUD issues.

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) program aims to implement screening, brief intervention, and referral to treatment services for individuals of varying age groups and across different settings. The program includes a focus on screening for underage drinking, opioid use, and other substance use among youth and young adults in primary care and other health settings that serve this population (e.g., pediatric healthcare providers, Children's Hospitals, federally Qualified Health Centers (FQHCs)).

Grants to Expand Substance Misuse Treatment Capacity in Family, Juvenile, and Adult Treatment Drug Court programs support courts that employ the treatment drug court model to provide SUD treatment (including recovery support services, screening, assessment, case management, and program coordination) to youth and young adults involved in the court system or their parents who are at risk of having dependency petitions filed against them.

The Sober Truth on Preventing Underage Drinking Act (STOP Act) program works to prevent and reduce alcohol use among youth and young adults ages 12–20 in communities throughout the United States. STOP Act grant recipients serve as a catalyst for increased citizen participation and greater collaboration among all sectors and organizations of a community to foster a long-term commitment to reducing alcohol use among youth. Grant recipients disseminate timely information to communities regarding state-of-art practices and initiative that have proven to be effective in prevention and reducing alcohol use among youth. By being deeply rooted in the community, grant recipients utilize town halls to gain feedback from communities and utilize that feedback to implement change and enhance local community initiatives and strategies.

The Strategic Prevention Framework—Partnership for Success (SPF-PFS) program works to prevent the onset and reduce the progression of substance use and its related problems while strengthening prevention capacity and infrastructure at the community and state level. Utilizing a data-driven approach, grant recipients identify communities of high need and at-risk populations of focus, including youths. Grant recipients utilize community coalition building strategies to advance sub-

stance use prevention efforts across the community and develop prevention messaging and other prevention strategies to ensure the dissemination of these messages and strategies.

Additionally, SAMHSA has state level programs that also include services for youth. SAMHSA's State Opioid Response (SOR) program provides resources to states and territories, to continue and enhance the development of comprehensive strategies focused upon preventing, intervening in, and promoting recovery from issues related to opioid use, and increasingly stimulant use. The Tribal Opioid Response (TOR) program provides dedicated resources to perform these activities in Tribal communities. Both programs aim to address the overdose crisis by increasing access to the three FDA-approved medications for the treatment of OUD, reducing unmet treatment need, and reducing opioid-related overdose deaths through the provision of prevention, harm reduction, treatment, and recovery support for OUD (including prescription opioids, heroin and illicit fentanyl and fentanyl analogs) and stimulant use disorder as so elected by states.

A key component of SOR/TOR grantees' substance use prevention strategy is the implementation of Evidence Based Practices (EBPs). For prevention, EBPs are approaches and strategies shown to be effective in reducing the impact of social and population-based substance use concerns.

Examples of EBPs that SOR grantees are implementing include Botvin Life Skills Training; Strengthening Families Program for Parents and Youth ages 10–14; Project Success; and Sources of Strength, Positive Action. All of these strategies focus on preventing the initiation of substance use for at-risk youth. SOR grantees also use funds to support interventions through Teen Courts, Recovery High Schools, Peer Mentor Programs, and Clubhouses. Between fiscal year 20 and fiscal year 2021, approximately 7 percent of individuals receiving treatment and recovery support services with SOR funds were under the age of 24 at the time-of-service delivery.

The Substance Abuse Prevention and Treatment Block Grant (SABG) Program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity to prevent SUD, provide treatment and promote recovery for those with SUD. Under the SABG program, grantees have the discretion to identify adolescents with SUDs and/or mental health disorders and children/youth at risk for behavioral health disorders as priority populations. Between fiscal year 2018–fiscal year 2021, the SABG program served 330,192 clients ages 17 and under and 729,024 clients ages 18–24.

In addition to directly supporting services for youth and young adults across the SUD intervention, treatment, and recovery support continuum, SAMHSA believes that education of the workforce and young people themselves is needed to have an impact in this area. SAMHSA has taken concrete steps to educate providers and those who use substances on the harms of opioid use (prescription and synthetic). SAMHSA supports a broad range of training and technical assistance resources that reach the specialty behavioral health treatment community, general healthcare professionals including students, and the general public. Providing education on the impact of using opioids empowers these audiences to educate individuals (youth and adults) on the risks and harms of using opioids. In addition, reaching youth and young adults with evidence-based information on avoiding exposure to harmful substances puts knowledge directly into the hands of those who may be at highest risk and their peers. This work is augmented through cross-agency collaboration. SAMHSA representatives regularly meet with other agencies to foster synergy in the expansion or improvement of SUD treatment, and how public education might be augmented.

The National Institute on Drug Abuse (NIDA), part of the NIH, supports research to understand and address substance use and its consequences across the lifespan, including among vulnerable children and adolescents. Research findings indicate that substance use and other drug-related harms are more likely to occur in the presence of specific risk factors, such as adverse social determinants of health, and less likely to occur among certain protective factors, like healthy family and peer relationships and financial stability. Prospective, longitudinal studies like the HEALthy Brain and Child Development (HBCCD)¹⁸ and the Adolescent Brain Cognitive Development® (ABCD)¹⁹ studies will help us better understand the specific brain, cognitive, social, and emotional factors that underlie healthy and unhealthy development from the prenatal period through young adulthood. These studies will contribute immeasurably to future substance use prevention strategies.

¹⁸ <https://heal.nih.gov/research/infants-and-children/healthy-brain>.

¹⁹ <https://heal.nih.gov/research/infants-and-children/healthy-brain>.

Because most opioid and other substance misuse begins during adolescence and young adulthood, this is a critical period for prevention. Older adolescents and young adults are at the highest risk for initiation of opioid use, opioid misuse, opioid use disorder (OUD), and death from overdose, and there is a need for evidence-based interventions to prevent OUD. With funding from the Helping to End Addiction Long-term® Initiative (NIH HEAL Initiative®), NIDA leads studies on effective strategies to identify and reach at-risk individuals in various settings, such as schools, healthcare, justice, and child welfare systems. For example, one study is testing a video game opioid use prevention intervention for older teens in school-based health centers (UH3DA050251-03).²⁰ Another study utilizes a convenient smartphone application to engage high-risk youth in a mindfulness-based intervention to help them reduce or quit their substance use (UH3DA050189-03).²¹ Other NIDA-supported studies are aimed at improving the uptake and reach of existing evidence-based prevention interventions across settings, developing tailored approaches for diverse populations, and improving our understanding of the mechanisms of action for effective prevention approaches. NIDA also supports research to expand effective screening approaches for pregnant and postpartum women and school-age children in healthcare settings (NOT-OD-22-106²² and NOT-OD-22-107)²³ and, through its NIDAMED initiative, translates research findings into evidence-based resources and tools for clinicians to screen for problematic substance use (Screening for Substance Use in the Pediatric/Adolescent Medicine Setting).²⁴

Finally, monitoring real-world substance exposure among youth is also critical for informing prevention efforts. NIDA's Monitoring the Future study, an annual survey of substance-related behaviors, attitudes, and values of Americans from adolescence through adulthood, and the Population Assessment of Tobacco Health (PATH) Study, a national longitudinal study of tobacco and health, are helping us to better understand the landscape of adolescent substance use to better target interventions to prevent and reduce youth substance use.

Question. The 340B Drug Pricing Program is essential for providing access to safe and affordable medications for West Virginians. Senator Manchin has consistently advocated for the Department of Health and Human Services to safeguard this essential program and ensure that pharmaceutical companies cannot blatantly disregard the statutes they agreed to. We are hearing about practices that undercut this program by pharmacy benefit managers, or PBMs, known as white bagging or brown bagging, which puts patients' safety at risk and can dramatically raise the out-of-pocket costs for patients. This can also force patients to forgo treatment all together, all so PBMs can receive rebates from the manufacturers.

What is the Department doing to clamp down on these practices?

Are you monitoring this issue?

How can we as legislators help our constituents who are falling victim to these bad practices?

Answer. We are aware of the practices of pharmacy benefit managers under the 340B Drug Pricing Program (340B Program) that you reference. While there is no statutory provision in the 340B statute prohibiting the pharmacy benefit management programs from utilizing this approach, these practices are counter to the intent of the Program, which allows safety net providers to stretch scarce Federal resources and ensure that the safety net has access to discounted drugs for its patients. By pursuing this policy, pharmacy benefit management programs may make it cost prohibitive for certain covered entities to participate in the 340B Program and reduce services to their patients. We look forward to working with you on this issue and to continue to support the important work of the 340B program.

Question. Each year, the Secretary of Labor is required to submit a report regarding compliance with mental health parity laws. Mental health parity laws generally prohibit restrictions on mental health services that are more restrictive than those for all medical and surgical benefits. Secretary Becerra, in January, your Department, along with the Department of Labor and the Department of Treasury, released a report showing that health insurers for the most part are failing to deliver parity for mental health and substance use disorder benefits to beneficiaries. Senator Manchin's office has heard from several constituents who work in the mental health and substance use disorder workforce that mental health parity laws are simply not being followed. What's worse, mental health parity laws are not really

²⁰ <https://reporter.nih.gov/search/q7GOLosA3kSsoyk3nLnCtQ/project-details/10408897>.

²¹ <https://reporter.nih.gov/search/q16mokkSkSYJFFKEUseMA/project-details/10441666>.

²² <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-22-106.html>.

²³ <https://grants.nih.gov/grants/guide/notice-files/NOT-OD-22-107.html>.

²⁴ <https://nida.nih.gov/nidamed-medical-health-professionals/science-to-medicine/screening-substance-use/in-pediatric-adolescent-medicine-setting>.

being enforced. The bad actors aren't seeing any consequences for their actions, which are limiting patient access to mental health and substance use disorder services.

What is the Department doing to ensure mental health parity laws are being enforced?

Answer. Although SAMHSA has no direct enforcement role in the implementation of Mental Health Parity and Addiction Equity Act (MHPAEA), it has been a valued collaborator, partner, and leader on parity. SAMHSA has actively supported MHPAEA implementation by working closely with other agencies such as the Centers for Medicare & Medicaid Services and Departments of Labor and Treasury, as well as the Office of National Drug Control Policy. For instance, in partnership with the Department of Labor, the HHS and SAMHSA developed new, free informational resources that inform Americans of their rights under law on coverage for mental health benefits. The following resources are available on SAMHSA's website:

- “Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits,” an updated trifold pamphlet explaining mental health parity, detailing what it means to the consumer, and listing the protections the parity law provides.
- “Understanding Parity: A Guide to Resources for Families and Caregivers,” which provides an overview of parity geared toward parents, family members or caregivers with information and tools to help them obtain behavioral health services for children or family members in their care.
- “The Essential Aspects of Parity: A Training Tool for Policymakers,” which provides state regulators and behavioral health staff an overview of mental health and substance use disorder parity and how to implement and comply with the Federal parity law regarding employee-sponsored health plans and group and individual health insurance.

We are committed to working with our Federal and state partners to ensure that health plans and insurance companies are accountable for delivering comprehensive care that includes protections on mental health and substance use disorder parity. Non-compliance, both intentional and unintentional, is a widespread problem, and additional investments are needed to conduct enforcement activities on an appropriate scale. While CMS has some enforcement authority, states are the primary enforcers of mental health parity for health insurance issuers in the small group and individual markets.

In the 2022 MHPAEA Report to Congress, the Departments of HHS, Labor, and the Treasury (the Departments) highlighted their recent emphasis on greater Mental Health Parity and Addiction Equity Act (MHPAEA) enforcement and discussed the significant resources dedicated to supporting these efforts. The Departments provided examples, including how the Departments requested comparative analyses of plans' and issuers' nonquantitative treatment limitations (NQTLs), which is a process provided by the Consolidated Appropriations Act, 2021, and the impact of the corrections.

In addition, HHS, together with the Departments of Labor and the Treasury, intends to release additional rulemaking on the MHPAEA. There have been a number of changes related to MHPAEA since issuance of the final regulations, including the 21st Century Cures Act, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and the Consolidated Appropriations Act, 2021. This rule would propose amendments to the 2013 final rules (78 FR 68239) and incorporate examples and modifications to account for this legislation and previously issued guidance.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Title 42

Question. Has the Department of Health and Human Services been asked to provide or provided any vaccines to the Department of Homeland Security for efforts to vaccinate illegal immigrants at the Southern border?

If yes, how many?

Answer. No.

Question. If no, where is DHS procuring vaccines from and is it from manufacturers directly? And if it is, is it part of a HHS contract?

Answer. HHS defers to the Department of Homeland Security for information on their procurements.

Question. On March 30, 2022, DHS released a Fact Sheet entitled DHS Preparations for a Potential Increase in Migration. It states that “DHS has also been providing the COVID-19 vaccines to noncitizens in ICE custody since summer 2021.”

It goes on to state that “Beginning March 28, 2022, DHS expanded those efforts to cover migrants in CBP custody, so as to further safeguard public health and ensure the safety of border communities, the workforce, and migrants.” What role is HHS playing in this decision?

Has HHS provided any funding to support the mass vaccination of illegal immigrants either in CBP or ICE custody?

Answer. HHS has allocated \$48 million from CDC ARP funding via Interagency Agreement with DHS to support certain vaccine related services (e.g., vaccine event adverse reporting, inventory, coordination with state/local Federal agencies) associated with DHS/CBP’s migrant vaccination programs.

Question. How many Public Health Service Corps members are currently deployed to the Southern border?

Answer. Operation Artemis consisted of 71 unique missions, with a total of 938 separate deployments occurring to support. A total of 805 unique officers deployed, with some officers deploying multiple times to meet the 938 deployments.

Question. What are the costs associated with their deployment?

Answer. The average cost per officer to support a deployment is \$8000, totaling an estimated \$7,504,000 to include officer travel, per diem, rental vehicles, and miscellaneous expenses.

Question. What is their role and/or what mission are they supporting?

Answer.

—USPHS deployed a flag officer, RADM Richard Childs, as the officer in charge of Operation Artemis, due to the significance of the operation and to ensure dedicated leadership personnel.

—Officers provided administrative support, facility and engineering support, and clinical support on these deployments. Clinical support included: COVID-testing, nursing case management, COVID vaccination administration, general clinical evaluation and care, pharmacological management, infectious disease support, behavioral health management, and clinical coordination of services across multiple agencies for unaccompanied children and their families.

—Some of the roles in which officers were deployed to support these missions included: Incident Commander, Site Lead, Chief Medical Officer, Chief Nurse Officer, Safety Officer, Force Health Protection, Nurse/Medical/Quality Control/Engineering/Pharmacy/Mental Health Officers to name the most common.

Question. Are they providing vaccinations to illegal immigrants in DHS custody?

Answer. Officers did provide vaccinations to unaccompanied children to prevent the spread of COVID-19 and other communicable diseases.

Question. What is the policy for treating illegal immigrants in the Department of Homeland Security’s custody with COVID-19 therapeutics if they test positive while in custody and what is HHS’ role in this activity?

Answer. CDC does not provide treatment or therapeutics for COVID-19. CDC provides technical assistance and guidance to the Department of Homeland Security to implement COVID-19 mitigation procedures in DHS facilities. For more information regarding implementation of these procedures, please contact DHS.

Aduhelm Decision

Question. In the last 7 years, this Subcommittee has written bills that have more than quintupled funding for Alzheimer’s research. That is how critical of an issue it is to address. FDA has finally approved a drug to treat mild-to-moderate Alzheimer’s disease last year. But last month, CMS made a historic decision to limit coverage only to those participating in an NIH or FDA trial. And, interestingly, CMS made a distinction between drugs approved through FDA’s traditional drug approval process and those that receive accelerated approval. I don’t believe that this distinction has ever been applied to a FDA-approved treatment before.

I recognize that there is a lot of controversy around Aduhelm, its data, its price, and potentially its approval. But putting that aside, I am concerned that CMS, and ultimately HHS, has made a critical error by making a coverage decision that affects not only

Aduhelm, but all other monoclonal antibody treatments coming down the pike. Further, the decision calls into question FDA’s entire accelerated approval process and by doing so, clearly undermines the scientific decisions made by FDA. Can you address what this CMS decision means for the future of FDA’s accelerated approval process?

Answer. The agency is committed to using expedited programs to bring medicines to underserved populations with serious conditions and unmet medical need when the science supports the decision within the statutory authorities given to FDA by Congress. Our decision regarding Aduhelm exemplifies that commitment. It is important to distinguish between FDA’s and CMS’ role. The standard for Medicare

coverage is not the same as the standards for FDA approval of a drug. Our role is to determine if drug is safe and effective. The agency cannot speak for CMS. We continue to see sponsors pursue accelerated approval.

Ensuring the availability of innovative interventions for people is a shared priority for both the Centers for Medicare & Medicaid Services (CMS) and the U.S. Food and Drug Administration (FDA). Underpinning both agencies' work is the unwavering commitment to use reliable data to ensure that effective treatments are made available to patients. The FDA's decision to approve a new medical product is based on a careful evaluation of the available data and a determination that the medical product is safe and effective for its intended use. CMS can conduct its own independent review to determine whether an item or service should be covered nationally by Medicare, including examining whether it is reasonable and necessary for use in the Medicare population.

The final National Coverage Determination (NCD) ensures access to and coverage for Aduhelm and other drugs in the anti-amyloid monoclonal antibody class that receive accelerated approval. The decision also supports innovation and certainty of coverage by creating a long-term coverage pathway for new drugs in this class that obtain FDA traditional approval, without requiring a new NCD.

The work of both agencies is critical to ensure that medical products are available to people across the country. We recognize the impact these decisions have on people with serious and life-threatening conditions and their loved ones. We share a common goal of wanting to advance the development and availability of innovative medical products. The agencies remain committed to using our distinct set of authorities to ensure the continued availability of medical products that meet our respective standards to care for the people we serve.

In issuing this NCD, HHS is not making any statement about coverage of accelerated approval drugs. This decision is specific to the anti-amyloid monoclonal antibody class of drugs. HHS looks forward to continuing our work on the innovative Cancer Moonshot initiative. All Americans are invited to share perspectives and ideas, and organizations, companies, and institutions to share actions they plan to take as part of this mission at whitehouse.gov/cancermoonshot.

Question. How does the decision on Aduhelm affect other Alzheimer's monoclonal antibody therapies that are under development?

Answer. NIH notes that the decisions issued by the FDA and Centers for Medicare & Medicaid Services (CMS) are regulatory decisions, and NIH defers to these agencies on such matters.

Supply Chain

Question. What is the Department's plan for investing in supply chain resiliency for active pharmaceutical ingredients (API), particularly those for essential medicines?

Answer. The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) made a \$354 million investment in Phlow, a consortium of organizations that will expand domestic manufacturing of raw materials and active pharmaceutical ingredients for drugs. This effort includes support for continuous manufacturing. The efforts will target drugs on the FDA drug shortage list that have become even more critical during the COVID-19 response. I will be happy to keep you and your staff informed of activities related to this initiative.

Question. Is the Administration leveraging existing manufacturers and their ability to expand US capacity in the short term (i.e., within 1–2 years)?

Answer. With our initial award to PHLOW, we immediately began supporting efforts to enhance domestic capacity immediately.

In addition, we have been supporting efforts to strengthen the overall domestic manufacturing base to ensure we are better positioned and prepared for whatever comes next. Within HHS/ASPR, we are working to institutionalize efforts to support domestic manufacturing efforts. Specifically, we are integrating and organizing supply chain situational awareness and industrial analysis, domestic industrial base expansion, and supply chain logistics. Bringing these pieces together will strengthen our industry partnerships and support our work to establish and maintain resilient supply chains. A new office within ASPR will pull together several lines of effort across—PPE, Durable Medical Equipment, Testing and Diagnostics, API, etc. While the new office won't necessarily manage every program within that space—SNS, BARDA and H-CORE will continue in key roles—the new office will be a driving force in ensuring coordination of ASPR's efforts to expand the industrial base and solidify the nation's supply chains.

Question. How much funding has been obligated or committed for this activity?

Answer. Specific to the Phlow contract, an initial award of \$354 million was issued. Phlow is a consortium of organizations that will expand domestic manufacturing of raw materials and active pharmaceutical ingredients for drugs.

Question. Does the current investment include a plan for warm based manufacturing capabilities and a vendor managed model that would allow for these newly manufactured APIs to support the underlying healthcare marketplace both during and outside of public health emergencies?

Answer. Current investments are focused on generating highly distributed continuous manufacturing capacities for APIs and finished drug products allowing the U.S. to build resilient supply chains for drug substances and drug products, both during and outside of public health emergencies.

COVID-19 Education Campaign

Question. The HHS congressional justification references a commitment to use local broadcasters and local newspapers for the COVID-19 education campaign, but does not provide additional details on how the Department will do so. What steps will the Department take to ensure that local broadcasters and newspapers, especially in small and rural communities, play a role in the ongoing educational campaign on COVID-19?

Answer. Since onset, the Campaign has committed to using local broadcasters and local newspapers to supplement broad-reaching national outreach. Doing so has allowed for consistent surround-sound presence to adults across America, with a layer of focused messaging directed to the critical audiences. How the campaign has executed local media buys to reach Americans where they live and from the channels they trust most:

The Campaign greatly prioritizes placing paid advertising via local media outlets, and specifically on local television, local cable, local radio, local newspapers and local websites. These run consistently in 20+ markets per month (in some months up to 100 markets) directed to different Campaign audiences.

These local buys run as a supplement to the Campaign's foundation of national ads on broadcast and cable television (and sometimes national radio).

Importantly, national, and local media outlets that are at least 50 percent owned by Minorities are prioritized, provided they provide efficient outreach and are qualitatively suitable for Campaign messages.

As one example, the Campaign designed a hyper-local campaign to reach Black and Hispanic residents of Milwaukee, WI with an invitation to visit a regional Community Vaccine Clinic. The four-week buy included ads on:

- Radio:* WJMR-FM (Urban Adult Contemporary), WNOV-AM/FM (Urban/Talk/Community) WKKV-FM-(Urban Contemporary) WJYI-FM-(Contemporary Christian/Christian preaching), WDDW-AM/FM (Regional Mexican) and WJTI-FM (Regional Mexican)
- Print:* Milwaukee Community Journal, Milwaukee Courier, Milwaukee Times, Journal Sentinel Community NOW papers (targeted to specific zip codes), Urban Milwaukee, El Conquistador, Hispanic Reflections, Spanish Journal, La Comunidad News.
- OOH:* Hyper-local poster boards within highly populated B/AA and Hispanic communities and zip codes. Highly visible billboards on heavy traveled roads and highways. Mobile targeted ads, geo-targeted around vaccine clinic(s). DOOH (malls, office buildings, gas stations, fitness centers, etc.)
- Digital:* Urbanmilwaukee.com, sherpardexpress.com, Onmilwaukee.com, bizjournal.com, milwaukeeens.com for programmatic placements. Site direct partners i.e. Nextdoor.
- Social:* Facebook, Instagram, Twitter (geotargeted to Milwaukee metro area)
- SEM:* Google, Bing, Yahoo, Duck Duck Go (geotargeted to Milwaukee metro area)

In order to continue to ensure that local broadcasters and newspapers, especially in small and rural communities, play a role in the ongoing educational campaign on COVID-19, it is critical to keep Campaign messages in very local programming (including news, regional entertainment and sports):

The campaign has made a dedicated effort to invest paid media dollars in media channels that are located in and trusted by rural populations. The “We Can Do This” campaign has had a dedicated rural audience effort with tailored creative and media buys across efforts to increase first doses for “movable middle” adults, parents with unvaccinated children, and encouraging booster doses.

In addressing rural audiences, the campaign has focused on the more than 46 million Americans who live in “micropolitan” or “noncore” counties according to the National Center for Health Statistics 2013 Urban-Rural classification scheme. On a monthly basis, the campaign has identified heavy-up markets for additional local

media purchases, and concentrations of population in the media market that reside in rural counties has been a factor when determining audiences.

Percentage of the paid budget spent on local paid—ideally compared to industry benchmarks

—Of the Campaign’s entire budget, approximately 70 percent is allocated to the placement of paid advertising. More than half of these dollars (51 percent) are directed locally in one of two ways, either through direct purchase of space with community media outlets or through national channels’ reach into specific locations.

In addition to collaborating with thousands of local media outlets to run paid advertising, we have also engaged in partnerships and relationships with community-based organizations. Many of the organizations with whom we work allow us to affect hyper-local, highly vulnerable populations who may not otherwise be reached with critical information about how, where, and why to get vaccinated. For example, we’re working with:

- National PTA activating 34 local PTAs in priority markets to host events and conduct outreach to parents of children eligible to get vaccinated. Since the start of the partnership, PTA has conducted a total of 86 pop-up vaccine clinics and vaccinated (first shot or booster) 2,050 people.
- The Cobb Institute of the National Medical Association has been hosting a series of “Stay Well Community Health Fair and Vaccine” events in priority markets targeted at reaching Black and African American families. Since the start of the partnership, they have hosted sixteen events, 1,475 individuals have been vaccinated or been given booster shots at these events.
- Eighteen Asian American, Native Hawaiian, and Pacific Islander organizations across the country to conduct in-person and digital outreach. From November 2021 to June 2022, we reached over 3,000,000 people. Some of the organizations include, The Asian American Pacific Community Health Organization, Asian and Pacific Islander Vote, and The National Association of Pasifika Organizations.
- In partnership with Copa Univision, we attended a community sport event in Dallas, TX on June 4–5, to share COVID–19 information with over 800 Latino families participating at the amateur soccer event. The Campaign will participate in three other Copa Univision events in Houston, Chicago, and New York.
- National Day Laborer Organizing Network (NDLON) has been reaching migrant workers and farm workers with key information about vaccines through in-person events and radio. The organizations will also share new videos produced in five different indigenous languages.
- Vaccine Hunters distributed 2,274 Campaign materials at six canvassing sites and hosted 48 vaccination clinics in Maryland to reach Spanish-speaking Latino people. The organization has already vaccinated 2,426 people.
- Working with the National Diaper Bank and Alliance for Period Supplies to distribute campaign information among 200 local banks across the country. These will include fact sheets, drafted press release, postcards, and other materials in diaper and period supply boxes.
- The United Methodist Health Ministry Fund posted seven video testimonials reaching an online audience of more than 200,000 and hosted a webinar for 82 Kansas faith-based, healthcare and childcare providers as well as published an op-ed in Topeka reaching more than 31,000 print and 500,000 online subscribers.
- The National Rural Education Association created three video testimonials with teachers from Missouri, Iowa and Northern California reaching more than 50,000 online viewers; shared information with 300 educators in Victoria, TX at a state conference; published a podcast with a pediatrician from West Virginia with 3,400 downloads; and published a social media toolkit and newsletter for their national network of rural educators and state directors with a reach of more than 100,000.

Question. Please provide details on obligations to date to local broadcasters and newspapers for education campaigns from both the COVID–19 supplemental funds and the American Rescue Plan, broken out by bill, year, and agency.

Answer.

Fiscal Year 2020

Local Radio	\$8,512,770
Fiscal Year 2020 Total	\$8,512,770

Fiscal Year 2020—Funding Source

IAA with the CDC funded by CARES Act appropriation to CDC, Public Law 116–136, 134 Stat. 281, 554–55.

Fiscal Year 2021

Local Newspapers	\$11,136,940
Local Radio	\$14, 526,430
Local Television	\$4,428,756
Fiscal Year 2021 Total	\$30,092,126

Fiscal Year 2021—Funding Source

CARES Act appropriation to CDC, Public Law 116–136, 134 Stat. 281, 554–55.

American Rescue Plan (ARP) Public Law 117–002.

Fiscal Year 2022

Local Newspapers	\$7,482,218
Local Radio	\$14,916,933
Local Television	\$11,082,786
Fiscal Year 2022 Total	\$33,481,938

Fiscal Year 2022—Funding source

CARES Act appropriation to CDC, CARES Act, div. B, title VIII, Public Law 116–136, 134 Stat. 281, 554–55.

American Rescue Plan (ARP) Public Law 117–002.

HRSA Poison Control

Question. I remain concerned that the Department has failed to address the issue of misdirected calls to poison control centers, as required under the Poison Center Enhancement Act that passed in 2019 as part of the fiscal year 2020 appropriations bill. It is my understanding that poison centers in 12 states and the District of Columbia have more than 10 percent of their calls misrouted to the wrong poison center. Critical medical treatment can be delayed when this occurs.

The Poison Center Enhancement Act requires the Secretary of HHS to coordinate with the FCC within 18 months of enactment to ensure calls are routed to the proper poison center based on the location of the caller to the “extent technically and economically feasible.” From what I can tell little progress has been made on this issue. Please provide an update on this issue, as well as a plan of action to improve, if not solve, this growing problem.

Answer. HRSA recognizes the importance of proper routing of the Poison Help Line calls.

HRSA is engaging with our internal and external partners to identify technologically feasible solutions to address the longstanding issue associated with caller’s area codes versus geographical location being used for call routing. We are currently engaged with Verizon (the toll-free vendor), an industry technology solutions organization (ATIS), the American Association of Poison Control Center (AAPCC), and FCC to identify potential technology-based solutions to the call routing issue. Verizon has submitted a formal issue statement to ATIS to initiate an industry review of potential methods to improve the routing information wireless providers over 4G mobile networks; this issue statement was accepted by ATIS and is currently under review. HRSA also conducted individual calls with several vendors to further stimulate telecommunication contractors to propose solutions.

We are committed to continuing to work with industry on a solution to this important issue.

COVID-19 Commercialization

Question. Products are able to go into the commercial market once they receive FDA approval. For COVID-19 related products that have FDA approval, like COVID-19 vaccines for adults, when will the Department transition from being the sole purchaser of these products?

Answer. To date in the COVID-19 response, HHS has supported efforts to ensure that vaccines are available to all states and communities. As of April 1, 2022, HHS has procured approximately 2 billion doses of vaccine and 10.4 million therapeutics and has provided these resources to states and territories at no cost. As Congress has not provided the resources requested for these efforts, the Department is thinking through courses of action to manage the transition away from Federal acquisition. There are a number of potential issues that need to be considered related to licensure, access, and coverage, which may require possible statutory or regulatory changes to resolve. Additional funding is required to ensure that there is a smooth transition and that challenges are addressed as we move forward with shifting vaccines to the commercial market.

COVID-19 Tests

Question. What is the Department's funding plan for COVID-19 testing manufacturers?

Answer. The Administration has been working closely with domestic suppliers and manufacturers since the very beginning. From its first days in office, the Administration has used the Defense Production Act (DPA), industrial mobilization, and advance market commitments to accelerate production of tests. The Administration has also invested billions of dollars in industrial base expansion and procurement of a large quantity of tests from a variety of domestic manufacturers, including Abbott, Quidel, Orasure, and others, as part of the COVIDTest.Gov initiative, and other testing initiatives. We also continue to find ways to maximize any level of support we can provide, including through existing contracts for tests for Long-Term Care Facilities, federally Qualified Health Centers, other Community Health Centers, food banks, and schools. However, as we have been saying for the past months, we need the additional requested funding to provide ongoing support and avoid further production cuts and job layoffs during this time. Without additional funding, there are risks that we will not have the testing capacity we need during a future surge.

Question. Earlier this year, the Department purchased 1 billion at-home tests to be distributed to Americans. The majority of those tests were purchased from Chinese manufacturers. Should a spike in cases cause the Department to purchase additional at-home tests, is there a plan in place to make these purchases from domestic manufacturers?

Why were domestic manufacturers not used for the 1 billion at-home tests the Administration purchased in January 2022?

Answer. When the Administration began offering COVID-19 tests, at no cost, to any person who requested such tests, the intention was to increase the number of tests available without impacting the supply of tests in the commercial market and without impairing existing state/territorial contracts for the procurement of tests. However, from November 2021 to February 2022, we saw a strained domestic manufacturing and supply chain for COVID-19 tests due to an increase in cases. During this timeframe, domestic capacity was not large enough to produce the number of tests required to achieve this initiative. To avoid further straining the domestic market and to further increase access to free tests for the American public, the Administration made the decision to purchase tests from international manufacturers for the larger test initiative. Since the market has stabilized, the Administration has once again shifted to purchasing domestic tests. Our goal is to continue to prioritize the purchase of tests domestically, but we must continue to provide stability and predictability to the domestic market.

Question. As of May 4, testing companies have not received additional volume commitments, but have been provided guidance from the Department to ramp up to maximum capacity. Will these domestic manufacturers receive a concrete order from the Department?

Answer. As we have been saying for the past months, we need the additional requested funding to be able to provide ongoing support to domestic manufacturers in order to avoid production cuts and job layoffs. We have already heard from companies that they have reduced their production capacity by as much as 85 percent compared with maximum production capacity and laid off thousands of workers. We

need the additional requested funding from Congress to avoid further reductions and ensure we have sufficient testing supply and capacity in the event of another surge.

Question. What is the Department's plan for warm-basing domestic testing manufacturing?

Answer. The ability of manufacturers to continue to produce at high levels requires a commitment by the Federal government. Tests purchased by consumers on the retail market tend to ebb and flow as cases rise and fall. Given this, the Federal Government serves as the only real backstop that can guarantee purchases for domestic manufacturers. The Administration will continue to emphasize the need for Congress to provide the requested funding for these purposes. Our inability to fund warm basing within domestic testing manufacturing risks us not having the testing capacity we need in the event of a fall or winter surge.

988 and Behavioral Health Crisis Services

Question. The Substance Abuse and Mental Health Services Administration (SAMHSA) submitted the "Report to Congress on 988 Resources" (Report to Congress), which was required by the National Suicide Hotline Designation Act of 2020, more than 8 months after it was due. The new three-digit lifeline is set to launch in July this year, and the budget requests an increase of nearly \$600 million for fiscal year 2023. SAMHSA has known about the July 2022 launch date for some time, yet SAMHSA's delay puts Congress in a difficult position to provide a fivefold increase or else appear to shortchange this critical effort. Further, the fiscal year 2023 funding will not be available for 988 for months after the launch, and that is a best case scenario.

While the Report to Congress outlines projected annual resources to sustain 988, the fiscal year 2023 budget does not provide any detail as to how SAMHSA would allocate \$696.9 million. While appreciated, the Report to Congress is not a budget document. Please provide a breakout of funding for the fiscal year 2023 request and a detailed description of each activity for the 988 and Behavioral Health Crisis Services, along with the allocation method for each activity.

Answer. First, it is important to note that July 2022 and the transition to 988 and the impacts on volume are as yet unknown. SAMHSA is projecting resource needs based upon the best available current data, and will continue to provide ongoing assessments to respond to potential alternate scenarios. These ongoing assessments may alter projected resource needs outlined below.

The fiscal year 2023 Budget Request for 988 and Behavioral Health Crisis Services is \$696.9 million. The budget proposes an historic investment in the 988 program to ensure there is sufficient funding to support crisis response. The proposed funding will play an essential role in advancing the crisis system to meet the once-in-a-lifetime opportunity of 988 by:

Increasing crisis center capacity (\$545 million): This funding will enhance local capacity through partnerships in behavioral health crisis response—Local center capacity is critical to ensuring that individuals in crisis receive responses that are tailored to the service system where they are located and that services across the continuum are linked and coordinated. We expect the greatest resource needs in supporting 988 response across the national crisis back up centers (Federal) and local crisis centers (combined Federal and non-Federal). SAMHSA's budget projections are based on volume expectations at an \$82 cost per contact and volume estimates that project 7.6 million contacts in fiscal year 2023. Given current estimates of local capacity and non-Federal funding sources to support local response, SAMHSA expects a Federal resource need of \$545 million. This funding shores up our crisis centers around the country to ensure that they have the ready workforce available to staff and answer calls, chats and texts for help and strengthens partnerships that decrease law enforcement response to individuals in crisis.

Strengthening network operations (\$117 million): As the network continues to scale, additional funding will be required for the Lifeline administrator and centralized network functions, including data and telephony infrastructure; standards, training, and quality improvement; evaluation and oversight.

Funding will also be required to sustain and expand technology to promote access for marginalized populations. The fiscal year 2023 investment further increases the capacity and performance of these key network infrastructure components and functions to the standard required for the projected contacts anticipated in fiscal year 2023 and support collaborative efforts with partner organizations to improve local routing of contacts.

Sustaining the 988 & Behavioral Health Crisis Coordination Office (\$10 million): The 988 transition will require continued extensive coordination at the Federal, state, and local levels. Coordination activities led at a Federal level include technical

assistance to states, and crisis centers; strategic planning, performance management, evaluation, and oversight; and formal partnerships, convenings, and cross-entity coordination.

Supporting public awareness with targeted 988 national messaging (\$25 million): The 988 code will provide a universal, easy-to-remember, three-digit phone number and connect people in crisis with life-saving resources. As 988 is implemented, SAMHSA anticipates the need and additional costs to educate the public on services covered by 988, and the differences between 988 and 911. This funding would permit continuation of focused work on populations known to be at high risk of suicide, building upon formative research processes that were launched in fiscal year 22. This funding is not for a larger scale public awareness campaign, but is targeted, foundational work needed to educate the public and local communities on the function of 988.

Question. The Report to Congress indicates that \$560 million would be needed to strengthen local crisis call center capacity from Federal and non-Federal funding. How does the budget request account for non-Federal resources? Please provide an estimate and description of non-Federal resources.

Answer. SAMHSA is working with its partners to track state-level legislative and non-legislative activity aimed at supporting local crisis capacity. To date, only four states have passed legislation with corresponding 988 state cell phone fees, including Colorado, Nevada, Washington, and Virginia. Other states have passed appropriation legislation not connected to cell phone fees, some have ordered commissions without any specific funding allocation, and many states have either legislation in progress or no current plans for legislative activity. Some states have also looked to Medicaid and payer reimbursement to support crisis center development though this is in very early stages in most areas. SAMHSA expects that it will take time for most states to develop sustainable and comprehensive mechanisms to support 988.

Organ Procurement and Transplantation Accountability

Question. The HHS budget documents appear to be sending a mixed message with regard to the Administration's position on holding Organ Procurement Organizations (OPOs) accountable for poor performance. The fiscal year 2023 HHS Budget in Brief document includes a section called "Remove Restrictions on the Certification of New Entities as Organ Procurement Organizations and Increase Enforcement Flexibility," which proposes flexibility to recertify poor performing OPOs that lose certification because of failure to meet certain criteria. This narrative runs counter to the Final rule "Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations" (42 CFR Part 486), which will bring much needed standardization to how OPOs measure performance and ensure all OPOs are performing at high quality standards. What is intended by this budget narrative and why is it proposed in light of the Final rule 42 CFR Part 486?

What is the status of implementation of 42 CFR Part 486 and what guidance has CMS provided to OPOs regarding its implementation?

Answer. Organ procurement organizations (OPOs) are vital partners in the procurement, distribution, and transplantation of human organs in a safe and equitable manner for all potential transplant recipients. The role of OPOs is critical to ensuring that the maximum possible number of transplantable human organs is available to individuals with organ failure who are on a waiting list for an organ transplant. HHS is dedicated to improving health equity and access in the organ procurement and transplantation system, including by holding OPOs accountable for their performance.

In December 2020, CMS published "Medicare and Medicaid Programs; Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations". This rule finalized new outcome measures OPOs are required to meet for re-certification and was published with the intention of increasing donation and organ transplantation rates by replacing the previous outcome measures with new transparent, reliable, and objective outcome measures that are used to make better certification decisions and incentivize better performance. At the end of the re-certification cycle, each OPO will be assigned a tier ranking based on its performance for both the donation rate and transplantation rate measures, as well as the re-certification survey. The highest performing OPOs will be assigned in Tier 1 which means the donation and transplantation rates of the top 25 percent of OPOs, and automatically recertified for another 4 years. OPOs with rates that are below the top 25 percent will be in either Tier 2 or 3. Tier 2 OPOs are not automatically recertified but they will have to compete to retain their donation service area (DSA). Tier 3 OPOs are the lowest

performing OPOs and will be decertified and lose their service area. CMS believes that increasing competition between the OPOs will incentivize them to maximize their performance and consequently increase the number of organs available for transplantation.

OPOs will be held accountable for the new measures for recertification purposes in 2026. While CMS will conduct activities for OPO recertification in 2026, the timeline for OPOs to implement needed improvements occurs much earlier than 2026. OPOs will be notified of their performance on the new outcome measures at the end of each 12-month period of the 4-year recertification cycle, which starts in 2022. OPOs will be accountable to this requirement when they receive their first results in the next re-certification period. The target data for this first report is spring of 2023. By identifying the performance of OPOs annually, poor performing OPOs can appropriately change and adopt effective practices that improve their performance in donation and make more organs available for transplantation.

The President's fiscal year 2023 Budget includes a proposal that would certify new entities as organ procurement organizations and recertify certain organ procurement organizations that do not meet the criteria for recertification based on outcome measure performance, but which have shown significant improvement during a re-certification cycle. The proposal will provide the flexibility CMS needs to avoid organ procurement disruptions due to the certification status of certain organ procurement organizations and provide these organizations with an incentive to maximize performance even if they do not believe they could satisfy the outcome requirements at the next recertification.

Question. I was pleased to see HRSA released a Request for Information regarding the Organ Procurement and Transplantation Network (OPTN), seeking ways to improve and strengthen the OPTN ahead of the fiscal year 2023 Request for Proposal. Throughout the last 4 years, the OPTN contractor United Network for Organ Sharing (UNOS) has been exposed for its regional bias and inability to effectively improve the organ procurement and transplantation system. For example, records that UNOS fought vigorously to keep hidden from the public reveal UNOS colluded against certain regions of the country when it issued the liver allocation policy in December 2018. Further the National Academies of Science, Engineering, and Medicine (NASEM) revealed an astounding number of organs continue to unused, and NASEM made several recommendations related to the OPTN contract and HHS oversight to improve accountability, improve policymaking, and modernize the transplantation network. How is HHS planning to update the OPTN contract to hold the contractor accountable for system improvements?

Will HHS break up the OPTN contract to separate the policymaking functions from the IT functions?

Answer. HRSA recognizes that the Organ Procurement and Transplantation Network (OPTN) contract is critical to the oversight and accountability of the organ donation and transplantation system and intends to be appropriately deliberative about decisions impacting the effectiveness and efficiency of the system. As you note, HRSA issued a Request for Information (RFI) to solicit feedback about opportunities to strengthen the OPTN. In particular, the RFI sought feedback on the ways to address many of the National Academies of Science, Engineering, and Medicine findings and recommendations in its report titled Realizing the Promise of Equity in the Organ Transplantation System. HRSA released the RFI to better support HRSA's efforts to increase accountability in OPTN operations, modernize performance of the OPTN IT system and related tools, and improve engagement with donors and patients. It specifically focuses on opportunities to strengthen equity, access, and transparency in the organ donation, allocation, procurement, and transplantation process. In addition, it also sought stakeholder input on the governance, finance, IT, data collection, policy, and operational components of the OPTN. HRSA is appreciative of the response to the RFI and is actively reviewing this important feedback to inform the development of the next contracting cycle. We look forward to continuing to engage with Congress as we develop the next contracting cycle and continue to identify strategies for modernization and accountability across the organ procurement and transplantation system.

Provider Relief Fund (PRF)

Question. Hospitals and providers that opened their doors in 2020 and 2021 have not had equitable access to the PRF, despite experiencing some of the same challenges during the COVID-19 pandemic as established healthcare providers. What has the Administration done to ensure equitable access to the PRF dollars Congress provided for this subset of providers?

Answer. As part of the Administration's ongoing commitment to equity, and to support providers with the most need, HHS included new elements in Phase 4 of

the Provider Relief Fund (PRF). Rather than paying the same percentage of losses for all providers as in Phase 3, PRF Phase 4 reimburses smaller providers for their operating revenues net expenses at a higher rate compared to larger providers. That means, new providers who just opened their doors and have \$10 million or less in annual patient care revenues in 2020 would receive 45 percent of their adjusted quarterly losses, compared to 25 percent or 10 percent for medium and large providers.

In addition, HHS allocated approximately 25 percent of the \$17 billion allocation to Phase 4 Bonus payments based on the amount and type of services to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) patients. HHS used a similar methodology for the \$8.5 billion in ARP Rural payments, making payments based on the amount and type of services provided to Medicare, Medicaid, and CHIP patients who live in rural areas, as defined by the Federal Office of Rural Health Policy. Bonus payments relied on claims submitted from January 1, 2019 through September 30, 2020 in order to capture both pre-pandemic care, as well as care delivered during the pandemic. This allowed providers that opened their doors in the first three quarters of CY 2020 to be eligible for additional funds.

Question. How many hospitals and healthcare providers opened their doors in 2020, 2021, or 2022? Can HHS please provide a breakout by provider type, year, and an estimate of the emergency relief funding that these providers have requested and received from the PRF?

Answer. Attached, please find the Phase 3 and Phase 4/ARP Rural payments to new provider in 2020 by self-selected provider type.

Please note, new providers in 2021 and 2022 were not eligible for PRF or ARP Rural payments. Furthermore, the application portals for Phase 3 and Phase 4/ARP Rural did not collect providers' emergency funding requests. The data attached are Quarterly Losses, which are calculated based on changes in operating revenues and expenses pre-pandemic and COVID-19, as reported by applicants. For new providers where there is no comparable pre-pandemic time period, the revenue loss was estimated using the revenues reported by the provider and the average loss rate for that category of provider.

Attachment Q 4B: How many hospitals and health care providers opened their doors in 2020, 2021, or 2022? Can HHS please provide a breakout by provider type, year, and an estimate of the emergency relief funding that these providers have requested and received from the PRF?

Table 1. Phase 3 Quarterly Losses¹ and Payments by Provider Type² for All Paid Providers and All Paid New Providers in 2020³

Applicant Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total Adjusted ¹ Quarterly Losses (QL)	Total Payments Issued ¹	Apps (#)	Total Adjusted QLP ¹	Total Payments Issued
Ancillary Services - Chiropractors	1,289	\$26,430,000	\$26,210,000	53	\$890,000	\$670,000
Ancillary Services - Dental Service	24,215	\$2,643,350,000	\$1,769,769,000	1,157	\$85,700,000	\$63,270,000
Ancillary Services - Diagnostics	588	\$323,790,000	\$182,370,000	33	\$6,700,000	\$5,150,000
Ancillary Services - Eye and Vision Service Providers	2,441	\$291,780,000	\$171,680,000	86	\$4,380,000	\$3,500,000
Ancillary Services - Other Ancillary Service Providers	1,244	\$251,630,000	\$105,760,000	56	\$990,000	\$710,000
Ancillary Services - Respiratory, Developmental, Rehabilitative and Restorative Service Providers	459	\$49,890,000	\$34,360,000	24	\$1,830,000	\$1,130,000
DME / Suppliers	151	\$4,378,000	\$2,640,000	3	\$0	\$0
Emergency Medical Service Providers	472	\$465,150,000	\$198,290,000	23	\$2,440,000	\$1,430,000
Facilities - Acute Care Hospital	771	\$23,375,320,000	\$8,528,410,000	28	\$96,700,000	\$28,410,000
Facilities - Assisted Living Facilities	3,639	\$590,860,000	\$388,510,000	394	\$15,310,000	\$11,210,000
Facilities - Hospice Providers	49	\$15,240,000	\$4,430,000	11	\$100,000	\$50,000
Facilities - Inpatient Behavioral Health	359	\$169,360,000	\$125,030,000	33	\$1,650,000	\$1,130,000
Facilities - Nursing Homes	359	\$299,400,000	\$97,910,000	43	\$2,350,000	\$2,400,000
Facilities - Other Inpatient Facilities	294	\$197,530,000	\$80,170,000	18	\$1,380,000	\$840,000

¹ The application portal for Phase 3 did not collect providers' emergency funding requests. The data attached are Quarterly Losses, which are calculated based on changes in operating revenues and expenses pre-pandemic and COVID-19, as reported by applicants.

² The list of provider types changed slightly between Phase 3 and Phase 4/ARP Rural.

³ These data reflect providers that were new in 2020 only. There are no PRF or ARP Rural payments associated with activities that occurred in 2021 or 2022, as a result no providers, including new providers, have received funds based on 2021 and 2022 revenues.

⁴ In Phase 3, HRSA employed several pre-payment cost containment safeguards to ensure that information was accurate and legitimate and that HRSA made payments equitably. Approximately, 27% of applications' Quarterly Losses were adjusted.
⁵ These data do not include providers that did not receive a payment, either because the provider had reached their maximum Phase 3 payment or because the provider was on an exclusion list.
⁶ The aggregate Quarterly Losses for providers in the "Other" category were positive (i.e., they did not have losses). However, providers still received payments because the Phase 3 payments were calculated based on the greater of 2% of annual patient care revenues and 88% of quarterly losses.

Applicant Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total Adjusted ⁴ Quarterly Losses (QL)	Total Payments Issued ⁵	Apps (#)	Total Adjusted QL ⁶	Total Payments Issued
Facilities - Residential Treatment Facilities	202	\$16,150,000	\$38,060,000	10	\$360,000	\$260,000
Home and Community - Home and Community-based Support Providers	2,390	\$265,970,000	\$206,510,000	214	\$3,060,000	\$3,230,000
Home and Community - Home Health Agencies	2,243	\$299,580,000	\$190,100,000	209	\$6,320,000	\$5,010,000
Home and Community - Other Services	872	\$65,420,000	\$127,570,000	71	\$1,080,000	\$860,000
Other ⁶	3,857	-	\$877,340,000	254	\$12,820,000	\$10,270,000
Outpatient and Professional - Ambulatory Surgical Center	1,464	\$893,120,000	\$546,240,000	45	\$14,830,000	\$12,280,000
Outpatient and Professional - Behavioral Health Providers	6,730	\$429,730,000	\$393,050,000	715	\$6,390,000	\$5,210,000
Outpatient and Professional - Multi-specialty Practice	2,458	\$3,987,020,000	\$2,426,070,000	126	\$23,890,000	\$15,710,000
Outpatient and Professional - Other Outpatient Clinic	2,562	\$746,340,000	\$494,170,000	164	\$19,740,000	\$14,960,000
Outpatient and Professional - Other Single Specialty Practice	10,185	\$1,934,550,000	\$1,254,130,000	447	\$37,830,000	\$27,600,000
Outpatient and Professional - Pediatrics Practice	1,913	\$335,790,000	\$228,180,000	55	\$1,490,000	\$1,060,000
Outpatient and Professional - Pediatric Medicine and Surgery Practice	430	\$29,320,000	\$16,680,000	15	\$430,000	\$320,000
Outpatient and Professional - Primary Care Practice	4,781	\$1,011,260,000	\$664,760,000	262	\$9,630,000	\$7,540,000
TOTAL	76,417	\$38,718,340,000	\$19,189,330,000	4,549	\$358,270,000	\$224,230,000

Table 2. PRF Phase 4 and ARP Rural: Quarterly Losses⁷ and Payments by Provider Type⁸ for All Providers Paid and New Providers in 2020 Paid⁹

Provider Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total QL	Total Payments Issued or Attempted	Apps (#)	Total QL	Total Payments Issued or Attempted
Ancillary Services - Chiropractors	2,288	\$83,640,000	\$42,670,000	30	\$510,000	\$240,000
Ancillary Services - Dental Service Providers	16,744	\$1,399,480,000	\$656,900,000	351	\$6,690,000	\$3,510,000
Ancillary Services - Diagnostics	677	\$237,760,000	\$118,640,000	14	\$2,240,000	\$1,390,000
Ancillary Services - Eye and Vision Service Providers	2,226	\$189,470,000	\$114,460,000	26	\$250,000	\$390,000
Ancillary Services - Other Ancillary Service Providers	957	\$244,690,000	\$105,110,000	15	\$380,000	\$190,000
Ancillary Services - Pharmacy	923	\$24,050,000	\$14,140,000	85	\$140,000	\$520,000
Ancillary Services - Respiratory, Developmental, Rehabilitative and Restorative Service Providers	943	\$110,980,000	\$46,980,000	26	\$320,000	\$150,000
DME / Suppliers	737	\$14,600,000	\$43,360,000	9	\$10,000	\$20,000
Emergency Medical Service Providers	1,292	\$593,850,000	\$310,240,000	22	\$4,190,000	\$1,730,000
Facilities - Acute Care Hospitals	2,977	\$27,361,180,000	\$10,165,220,000	18	\$7,240,000	\$16,000,000
Facilities - Assisted Living Facilities	4,405	\$1,971,370,000	\$655,620,000	175	\$17,350,000	\$5,900,000
Facilities - Hospice Providers	431	\$106,610,000	\$93,310,000	13	\$120,000	\$190,000
Facilities - Inpatient Behavioral Health Facilities	391	\$302,200,000	\$137,740,000	20	\$1,680,000	\$1,450,000
Facilities - Nursing Homes	8,018	\$7,666,870,000	\$2,209,430,000	261	\$134,430,000	\$66,000,000
Facilities - Other Inpatient Facilities	444	\$403,480,000	\$167,520,000	6	\$1,100,000	\$900,000

⁷ The application portal for Phase 4/ARP Rural did not collect providers' emergency funding requests. The data attached are Quarterly

Losses, which are calculated based on changes in operating revenues and expenses pre-pandemic and COVID-19, as reported by applicants.

⁸ This table does not include Phase 4 applicants who are pending adjudication or receiving no payment due to the deduction of remaining Phase 3 prior payments.

⁹ These data reflect providers that were new in 2020 only. There are no PRF or ARP Rural payments associated with activities that occurred in 2021 or 2022, as a result no providers, including new providers, have received funds based on 2021 and 2022 revenues

Provider Type	Providers Paid			2020 New Providers Paid		
	Apps (#)	Total QL	Total Payments Issued or Attempted	Apps (#)	Total QL	Total Payments Issued or Attempted
Facilities - Residential Treatment Facilities	404	\$155,610,000	\$70,100,000	13	\$920,000	\$510,000
Home and Community - Home and Community-based Support Providers	3,438	\$660,360,000	\$353,220,000	137	\$17,730,000	\$4,390,000
Home and Community - Home Health Agencies	4,235	\$823,120,000	\$468,530,000	169	\$2,330,000	\$1,810,000
Home and Community - Other Services	1,133	\$253,630,000	\$125,720,000	48	\$350,000	\$250,000
Other	2,392	\$1,843,470,000	\$621,480,000	62	\$1,730,000	\$810,000
Outpatient and Professional - Ambulatory Surgical Center	1,876	\$614,450,000	\$279,900,000	16	\$930,000	\$590,000
Outpatient and Professional - Behavioral Health Providers	5,199	\$665,130,000	\$399,070,000	228	\$1,130,000	\$920,000
Outpatient and Professional - Federally Qualified Health Center	424	\$450,890,000	\$226,150,000	-	-	-
Outpatient and Professional - Multi-specialty Practice	2,772	\$3,782,330,000	\$1,370,160,000	62	\$3,350,000	\$1,520,000
Outpatient and Professional - Other Outpatient Clinic	2,951	\$638,390,000	\$397,110,000	74	\$5,070,000	\$2,520,000
Outpatient and Professional - Other Single Specialty Practice	9,375	\$1,925,360,000	\$943,750,000	144	\$12,290,000	\$4,750,000
Outpatient and Professional - Pediatrics Practice	2,082	\$567,710,000	\$255,760,000	30	\$1,260,000	\$580,000
Outpatient and Professional - Podiatric Medicine and Surgery Practice	766	\$44,980,000	\$26,170,000	9	\$200,000	\$90,000

Outpatient and Professional - Primary Care Practice	4,873	\$830,560,000	\$383,200,000	140	\$4,130,000	\$1,860,000
Outpatient and Professional - Rural Health Clinic	379	\$77,640,000	\$60,880,000	14	\$290,000	\$140,000
TOTAL	85,752	\$50,290,720,000	\$20,862,540,000	2,217	\$228,360,000	\$119,320,000

Substance Use Harm Reduction

Question. Thank you for your prompt response to my letter in February on HHS' harm reduction grant. As many in Congress were, I was concerned that HHS was on the precipice of providing Federal funding to purchase crack pipes. After the controversy that funding announcement stirred up, what did HHS do to ensure these grants will not go toward purchasing illegal drug paraphernalia, like syringes and crack pipes?

Answer. In the Notices of Award, SAMHSA included terms and conditions explicitly restricting funds from directly or indirectly purchasing or promoting the use of drug paraphernalia, including pipes/pipettes in safer smoking kits. Syringes to prevent and control the spread of infectious disease are allowed for purchase. Harm reduction programs that use Federal funding must adhere to Federal, state, and local laws, regulations, and other requirements related to such programs or services. A comprehensive program monitoring and oversight plan is being implemented to ensure that funds are not misused. Please see the Notice of Funding Opportunity for more information: <https://www.samhsa.gov/sites/default/files/grants/pdf/fy22-harm-reduction-nof.pdf>.

Question. Drug overdose trends are a cause for alarm. In my time as the lead Republican on this Subcommittee, we have increased funding by \$4 billion toward addressing the opioid crisis, which suffered a setback during the pandemic. There's no doubt we need to continue to address this crisis. I'm concerned, however, with the push to expand overdose prevention activities and similar harm reduction activities at the expense of primary prevention activities. Since 2019, in a bipartisan manner, this Subcommittee has explicitly funded harm reduction activities through the Center for Substance Abuse Treatment. This was done to not undercut programs that are focused on primary prevention of substance use and to ensure people who suffer an overdose have access to treatment, yet SAMHSA has blatantly ignored Congressional intent. This willful disregard for Congressional intent is inexcusable and a cause for concern. Why did SAMHSA continue to fund the administration of "Grants to Prevent Prescription Drug/Opioid Overdose," "First Responder Training for Opioid Overdose Reversal Drugs," and "Improving Access to Overdose Treatment" out of the Center for Substance Abuse Prevention, after Congress specifically moved the programs to the Center for Substance Abuse Treatment in 2019?

Will you work with us to make sure both the administration and funding for harm reduction activities align with congressional intent?

Answer. Since 2019 and up to the present time, SAMHSA has followed Congressional guidance and funded PDOA, FRT, and IAOT out of CSAT. However, in recognition that the most effective harm reduction strategies are implemented across the behavioral health continuum, CSAP subject matter experts have been heavily involved in the administration of these programs. This management approach has not been implemented at the expense of SAMHSA's primary prevention efforts but have enhanced the effectiveness of behavioral health services and interventions across the continuum of care.

Unfortunately, traditional primary prevention programs are not always effective in preventing substance misuse and/or overdose deaths. CSAP programs that expand beyond primary prevention utilize data that targets trends and themes associated with overdose deaths and increased substance use. Including indicated and selective prevention activities such as psychosocial supports in CSAP programs is critical to connecting at risk individuals to support services and treatment services that are funded by CSAT. Funding multiple types of prevention programs that utilize evidence-based approaches saves lives.

SAMHSA's Behavioral Health Continuum:

Promotion: These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.

Prevention: Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse, and illicit drug use.

Treatment: These services are for people diagnosed with a substance use or other behavioral health disorder.

Maintenance: These services support individuals' success and include long-term treatment, continuing care, and recovery support.

Question. It has been reported that the Biden Administration is considering support for safe injection sites. These sites allow drug users to consume illicit drugs under medical supervision and are against the law. The Associated Press reported in February that the Department of Justice is "talking to regulators about 'appropriate guardrails'" for such sites. What is the status of these discussions and is HHS or SAMHSA involved?

What are the "appropriate guardrails" that are under discussion?

Answer. SAMHSA is not involved in safe injection sites. Given the legal status, we have and continue to refrain from involvement.

Unaccompanied Children

Question. In fiscal year 2021, the Department had the largest number of referrals of unaccompanied children ever. It spent almost \$7 billion on the program, including almost \$4 billion transferred from funding that was supposed to be spent on COVID-19 activities. fiscal year 2022 referrals to date are almost 40 percent higher than they were at this time in fiscal year 2021, and Congress has provided \$8 billion to care for unaccompanied children this fiscal year. However, for fiscal year 2023, the Administration only requested \$4.9 billion in discretionary funding for the program. Why do you think the Department will be able to cut \$3.1 billion in costs when referrals of UACs and program costs have gone up the past 2 years?

Answer. The Administration requested a \$4.9 billion discretionary appropriation for fiscal year 2023 as well as two mandatory appropriations. With the funding provided by the discretionary appropriation, ACF will continue to effectively care for children referred by the Department of Homeland Security (DHS), ensure facilities meet FSA standards, and work to expand post-release services to all children released from ORR care. The Budget also proposes mandatory appropriations for a contingency fund, recognizing the unpredictable fluctuations in program needs, and a fund for UC legal representation. Additionally, the number of permanent shelter beds will increase, reducing the amount of funding needed for more expensive temporary shelter beds. Approximately 75 percent of budget costs go directly to care for unaccompanied children (UC) in ORR shelters. Other services for UC such as medical care and family unification services, including background checks, make up approximately 20 percent of the budget. Administrative expenses to carry out the program total approximately 5 percent of the budget. The UC program will keep the appropriations committees apprised of changes to program costs as needed.

Question. As I mentioned in my opening statement, I'm concerned about the impact of the termination of the Title 42 Order. Even though unaccompanied children

have been exempted from the order since January 2021, the Department of Homeland Security is projecting a large increase in illegal border crossings which will likely include unaccompanied children. What are your plans to handle a surge in UACs? Can the program support a surge at the level requested in the President's budget?

If not, why wouldn't you provide Congress with a budget request that reflects the actual costs of the program?

Answer. ORR will continue to care for children referred by DHS and ensure their safety and well-being. However, this program's costs are inherently unpredictable and challenging to budget for with any degree of certainty. Despite this uncertainty, we have an obligation to provide appropriate services to all unaccompanied Children.

HHS's mission is to care for UC until they are safely released to a vetted sponsor or leave ORR custody following an immigration judge's order of removal, turn 18 years of age, or obtain legal immigration status in the United States. The number of children referred by DHS in ORR care can fluctuate, which is why ORR continuously reviews capacity needs throughout the year.

These estimates are based on historic data and DHS predictions and consider several factors such as UC referral numbers, trends, projections, and COVID-19 infection rates and impact on staffing and bed availability. These estimates further inform program costs in real-time and impact budget numbers accordingly.

Because of the inherent uncertainty in the UC program, it is extremely challenging to fund it through the conventional annual appropriations process. For this reason, the 2023 Budget would establish a mandatory contingency fund, which would provide additional resources when there are unexpected surges in the number of unaccompanied children requiring care.

HHS/ORR continuously plans for increases in migration. This includes projecting influx capacity needs, expanding bed capacity, adding more beds through entering into cooperative agreements with existing grantees, and adding new grantees to ORR's network of facilities. Associated program costs are included in the current budget proposal before the committee. ACF maintains regular dialogue with the appropriations committees and will continue to keep

Members and staff apprised of changes in funding needs.

Question. The budget proposes, again, a contingency fund for the UAC program. This has never been an effective way to manage the program, as witnessed in an fiscal year 2017 CR when the Democrats forced the inclusion of \$200 million in funding for a contingency fund, its threshold trigger was set too high, and that funding was wasted. Knowing that, why would the Department propose a contingency fund again? It appears that it is simply a budget gimmick.

Answer. We do not view the contingency fund as a gimmick. Instead, we view it as a reasonable way to deal with the inherent uncertainty in the UC program, allowing the program to have a reliable source of funding to activate new shelter capacity to handle unexpectedly high UC referrals.

ACF analyzed the previous iteration of the contingency fund and designed this proposal accordingly to be more effective and operational. We concur that the threshold trigger in the fiscal year 2017 CR was set too high. ORR took that miscalculation into account and designed the current proposal to be more efficient. Specifically, the fund would pay out \$27 million for each increment of 500 referrals above a threshold of 7,500 UC referrals per a month, which is a historically high level of monthly referrals.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

Question. Review Choice Demonstration for Inpatient Rehabilitation Facility services

The inpatient rehabilitation facility review choice demonstration, or IRF RCD, is slated to begin in Alabama at some point, perhaps later this year. What steps has HHS/CMS taken to identify qualified auditors who have experience caring for IRF patients, given the increased auditing that will occur under IRF RCD? We have about 20 rehabilitation hospitals and hospital-based inpatient rehabilitation units in Alabama, and this IRF RCD program is going to be a big challenge for them. Will HHS/CMS commit to collaborate with them so that the RCD doesn't become an overwhelming burden of paperwork and claim denials? If so, what actions will the Department and agency take to minimize the administrative burden and promote access to care?

Answer. The proposed Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD) would allow the agency to better understand the scope and causes

of improper payments and work with IRFs to reduce documentation errors. This would allow CMS to focus on the prevention of improper or fraudulent IRF claims and assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among IRFs providing services to Medicare beneficiaries. Additionally, the proposed IRF RCD would offer IRFs provisional assurance of payment and would reduce the burden of audits and associated appeals while protecting beneficiary access to care in a timely manner.

This proposed demonstration would not create new clinical documentation requirements; rather, it would only require submission of the same information providers are currently required to maintain. IRFs would have flexibility as they can choose their path to demonstrate compliance with Medicare requirements. IRFs would initially select, for the first 6 months, between two review choices: 100 percent pre-claim review or 100 percent post payment review. Providers who select pre-claim review may resolve any documentation issues and resubmit their requests an unlimited number of times prior to submitting the claim for payment. IRFs that have a high pre-claim review affirmation rate or post payment review claim approval rate would have additional options from which to choose, including relief from most reviews which will offer providers the flexibility to choose a review option that would work for them based on their resources and financial needs. No matter which choice is selected, beneficiary access to treatment will not be delayed.

To ensure consistency in operations and to eliminate potential contractor variation in medical review, we will ensure there is vigorous oversight of demonstration operations, including quality assurance and accuracy reviews of Medicare Administrative Contractor (MAC) review decisions to ensure they are reviewing in accordance with CMS policies. The MAC reviewers will undergo training to ensure consistency before beginning the reviews. The MACs involved in the demonstration regularly perform Medicare reviews on behalf of CMS and will be following all applicable statutes and regulations that are in effect when the demonstration is implemented. Both the MAC and CMS will monitor the reviewers' accuracy throughout the demonstration. In addition, CMS medical staff will conduct reviews on a selection of pre-claim review requests and claims to ensure the MAC decisions are accurate and consistent across reviewers.

QUESTIONS SUBMITTED BY SENATOR JERRY MORAN

Question. Mr. Secretary, Congress has provided bipartisan support to help extend the reach of state and Federal programs to serve more families and improve the overall quality of care. I was pleased to support significant funding increases for the Child Care Development Block Grant and Head Start in particular in the fiscal year 2022 omnibus. I am also a cosponsor of the Child Care and Development Block Grant Reauthorization Act of 2022, which would build on the bipartisan Child Care and Development Block Grant program to provide greater support to working families to afford child care.

Can you please speak to how additional funding for CCDBG will help low- and middle-income families be able to continue to access and afford high- quality child care?

Answer. In fiscal year 2020, the CCDF program served 1.49 million children and 900,300 families despite minimal or even inadequate funding. The number of children served has steadily declined over the last decade from a high of 1.7 million children in fiscal year 2010. Only about 15 percent of federally eligible children receive child care subsidies. Moreover, almost all states establish child care provider payment rates that fail to reimburse providers for the full cost of quality child care, which reduces parent choice, inhibits supply, and contributes to high staff turnover and low wages. In turn, states are forced to limit eligibility, enforce waitlists, charge unaffordable family co-payments, and establish payment rates that fail to reimburse providers for the full cost of quality child care. CCDF needs significantly more resources to ensure that additional families have access to child care, improve the quality of care, increase wages, and strengthen the child care sector.

Question. During the Senate Appropriations Subcommittee hearing on May 4th, you committed to fully stocking the biodefense and pandemic response supplies maintained by the Strategic National Stockpile. It is also imperative that the Stockpile is maintained with products manufactured in the U.S. and not depend on China as we did when COVID-19 first arose. I'm troubled to learn that HHS has cancelled 3 contracts to manufacture gowns for the Strategic National Stockpile in the past 6 months. We've also been told there are currently zero sterile surgical gowns in the Stockpile. However, your fiscal year 2023 budget does note that you have a target of 265M gowns and that procurements are in process.

Can you confirm for me specifically how many sterile surgical gowns are currently in the Strategic National Stockpile and what are your plans to procure additional U.S.-made sterile surgical gowns to meet your stated targets?

Answer. The SNS currently holds approximately 60 million deployable isolation gowns.

While SNS has made progress in building its inventory of gowns, holding more than 12 times the amount held at the beginning of the COVID-19 response, the progress has been exclusively to the inventory of isolation gowns rather than surgical gowns. SNS currently holds fewer than 1000 surgical gowns. SNS previously signaled its intention to procure domestically manufactured surgical gowns to help close the gap between current holdings and the COVID-19 target of 265 million gowns.

QUESTIONS SUBMITTED BY SENATOR JOHN KENNEDY

Question. Secretary Becerra committed to “robust enforcement” during his confirmation hearing before the Senate HELP Committee (2/23/21) to become the Secretary of the Health and Human Services Department. Despite this commitment and widespread non-compliance, HHS has failed to meaningfully enforce the hospital price transparency rule.

A recent national survey found an overwhelming bipartisan majority, 87 percent of Americans, support the requirement for hospitals to post prices, and nearly 79 percent want critical measures like transparency in coverage to be implemented immediately without further delay.

A comprehensive study published February 2022 by Patient Rights Advocate, reviewed 1,000 hospitals nationwide and found only 14.3 percent of hospitals are compliant with the HHS rule that went into effect over 1 year ago.

Mr. Secretary, first can you tell the Committee how many hospitals, as of today’s hearing, have received warning letters and/or corrective action plans for non-compliance?

Of the letters that went out to non-compliant hospitals, can you please tell me how many responded?

Mr. Secretary, can you also tell me how many hospitals, who again have had over 15 months to comply, have been issued a civil monetary penalty?

When do you expect to issue your first civil monetary penalty for non-compliance?

Can you commit to this committee, Congress, and the American people that your Department will immediately post both compliant and non-compliant hospitals on your website and begin issuing fines to non-compliant hospitals?

Answer. CMS is committed to ensuring consumers have the information they need to make fully informed decisions regarding their healthcare. Hospital price transparency helps Americans know what a hospital charges for the items and services they furnish.

The hospital price transparency final rule was published in November 2019 and became effective January 1, 2021. The final rule implements section 2718(e) of the Public Health Service Act (as added by the Affordable Care Act) and requires each hospital, for each year, to establish, update, and make public a list of the hospital’s standard charges for items and services provided by the hospital. The final rule superseded guidance issued by CMS in 2015 and 2019. The rule requires hospitals to make public five types of ‘standard charges:’ gross (chargemaster) charges, discounted cash prices, payer-specific negotiated charges, and the minimum and maximum de-identified negotiated charges.

The final rule also specified methods by which CMS may monitor hospitals’ compliance with the requirements, including evaluating complaints made to CMS, reviewing analyses sent by third parties regarding hospital noncompliance, and auditing hospitals’ websites. Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

- (a) Provide a written warning notice to the hospital of the specific violation(s).
- (b) Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements.
- (c) Impose a civil monetary penalty not in excess of \$300 per day on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS’s request to submit a corrective action plan or comply with the requirements of a corrective action plan.

We expect hospitals to comply with these requirements and are enforcing these rules to make sure Americans have information regarding what the hospital will

charge for their healthcare in advance. Prior to the effective date, CMS developed a dedicated hospital price transparency website found here: <https://www.cms.gov/hospital-price-transparency>. This website includes resources to help hospitals comply with the rule in addition to a method for consumers to contact CMS and submit specific complaints related to hospital noncompliance.

In January 2021, we began proactive audits of hospital websites as well as review of complaints submitted to CMS via the hospital price transparency website. In April 2021, we issued the first set of warning letters to noncompliant hospitals. These letters list specific areas of deficiencies identified through CMS compliance review and request hospital action to remedy the deficiencies. We intend to continue to send warning letters on a rolling basis as we identify noncompliant hospitals through our proactive audits and review of complaints. Hospitals that fail to submit a corrective action plan or comply with the requirements of a corrective action plan will be subject to a civil monetary penalty. In the event CMS issues a civil monetary penalty (CMP), CMS will identify the hospital and display the hospital's name on a CMS website.

In November 2021, in the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC), CMS increased the civil monetary penalties that will apply to noncompliant hospitals. The final rule set a minimum CMP of \$300/day for smaller hospitals with a bed count of 30 or fewer, and a penalty of \$10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of \$5,500. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be \$109,500 per hospital, and the maximum total penalty amount would be \$2,007,500 per hospital. This approach to scaling the CMP amount retains the original penalty amount for small hospitals, increases the penalty amount for larger hospitals, and affirms the Administration's commitment to enforcement and public access to pricing information. The revised CMP policy took effect January 1, 2022.

Question. I understand that implementing a monumental law, such as the No Surprises Act, takes time. To that extent, I am grateful that the Federal Independent Dispute Resolution (IDR) portal was officially opened in April. However, I am concerned as I have heard from providers who have thousands of claims ineligible for the IDR process. Once the Federal Portal was opened, providers were given 15 business days to submit all claims to IDR where the 30-business day, post Open Negotiation limit had expired. However, this extension does not apply to claims where no Open Negotiation was initiated. This is worrisome as I have heard from providers who did not submit claims for Open Negotiation, as the portal was not open to file for IDR within the required 4 days.

Would the Department of Health and Human Services (HHS) be willing to open a 30-day window for reconsideration of all claims between January 1, 2022 and April 14, 2022, allowing providers to initiate Open Negotiations now that the Federal IDR portal has been established?

Answer. The Federal Independent Dispute Resolution (IDR) system went live on April 15, 2022, and CMS has posted operational guidance for providers and plans on the CMS No Surprises Act website. As described in regulations and operational guidance, a 30-day open negotiation period may begin after a provider or facility receives a payment or denial notice from a health plan or issuer for applicable out-of-network services. At the end of the 30-day open negotiation period, if the health plan or issuer and provider or facility haven't agreed on a payment amount, either party can submit the item(s) or service(s) for review in the IDR process. If the disputing parties experience extenuating circumstances during the IDR process that prohibit them from complying with deadlines to submit information, they may email the Departments at: FederalIDRQuestions@cms.hhs.gov and include the IDR dispute reference number, if known, to receive a Request for Extension Due to Extenuating Circumstances form and instructions for next steps. Consumers, providers, facilities, plans, issuers, and FEHB carriers with questions about the No Surprises Act can call the No Surprises Help Desk at 1-800-985-3059.

Question. According to the No Surprises Act Interim Final Rules, insurers must provide an email and physical address to submit Open Negotiations. However, I have heard from many providers that insurers are inhibiting the flow of claims information by creating unnecessary steps for providers who wish to exchange information on claims and submit open negotiations, such as by withholding the required contact information, withholding information on payment remittances, or by requiring providers to register with various websites.

Will there be proper oversight to ensure these obstructive practices are not occurring, and that proper transparency, as required by law, is taking effect? What will

the Administration to do prohibit these burdensome hurdles impacting Open Negotiations?

Answer. HHS—together with our colleagues at the Department of Labor, Department of the Treasury, and Office of Personnel Management—has been working to implement the No Surprises Act (NSA) and ensure that consumers receive the benefits of the protections included in the law by Congress. We have released regulations and guidance for providers, group health plans, health insurance issuers, and FEHB carriers that explain the requirements related to the processing of claims and the open negotiation process. We will continue to work to provide additional training and technical assistance to help stakeholders understand their obligations and comply with key requirements of the NSA.

We are committed to ensuring compliance with the requirements of the NSA and its implementing regulations. If you are hearing from providers or plans about issues regarding compliance with the requirements of the NSA, they should submit a complaint to the No Surprises Help Desk at <https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing> or by calling 1-800-985-3059.

Question. It was clear that the No Surprises Act was intended to force providers and insurers to move in-network, avoiding the IDR process altogether, creating a smoother process for all parties involved. I am concerned, because in reality, everything I was afraid of happening, is. I have heard from various providers that insurers are using the No Surprises Act as leverage to cut in-network provider contracts in half during negotiations. Others who have established the necessary amount of contracts to establish a “Median In-Network” rate are sending providers notices stating their networks are “closed” to additional providers.

How is HHS addressing the issue of narrowing of networks and these predatory practices?

Answer. Under CMS’s Notice of Benefit and Payment Parameters for 2023 Final Rule, CMS finalized regulatory changes in the individual and small group health insurance markets and establishes parameters and requirements issuers need to design plans and set rates for the 2023 plan year. The rule also includes regulatory standards to help states, the Marketplaces, and health insurance companies in the individual and small group markets better serve consumers.

Under the final rule, CMS finalized changes to ensure that patients have access to the right provider, at the right time, in an accessible location. The rule requires qualified health plans (QHPs) on the federally-facilitated Marketplaces (FFMs) to ensure that certain classes of providers are available within required time and distance parameters. For example, a QHP on the FFMs will be required to ensure that its provider network includes a primary care provider within ten minutes and five miles for enrollees in a large metro county. The rule also sets a standard, starting in the 2024 plan year, requiring QHPs on the FFMs to ensure that providers meet minimum appointment wait time standards. For example, QHPs will be required to ensure that routine primary care appointments are available within 15 business days of an enrollee’s request. Additionally, HHS will review additional specialties for time (i.e., the time it takes the enrollee to get an appointment) and distance (i.e., the distance between the provider and enrollee)—including emergency medicine, outpatient clinical behavioral health, pediatric primary care, and urgent care. OB/GYN parameters will also be aligned with the parameters for primary care.

Additionally, Section 109 of Title I of Division BB of the Consolidated Appropriations Act, 2021, requires HHS, in consultation with the Federal Trade Commission and the Attorney General, to conduct a study of the effects of the No Surprises Act on market concentration, healthcare costs, and access. The first report is due no later than January 1, 2023, and four additional reports shall study the effects of the Act in the four subsequent years.

Question. I understand that medical procedures account for 96 percent of all human exposure to man-made radiation. This can result in severe burns, cataracts, cognitive dysfunction, immunosuppression, and even cancer—in patients and clinicians. While the CDC embraces the guiding principle for radiation safety of “as low as reasonably achievable,” or “ALARA”, it is not aligned with current medical procedures; increased use of high-radiation procedures like fluoroscopy to place stents; extensive clinical data on the dangers of radiation exposure and need for utilizing better precautions; and the latest shielding technologies that can prevent this excessive, avoidable radiation exposure.

How can we address this with appropriate guidance communicated effectively to providers to prevent harm to them and their patients, especially regarding simple changes like appropriate radiation shielding?

Answer. Keeping in mind the diagnostic and potentially life-saving value that these procedures provide to the public, the principles of justification and optimization are essential to the practice of radiation medicine. Are the diagnostic proce-

dures indicated or warranted (justification), and if so, are the procedures of high quality to gain the needed diagnostic information with minimal dose (optimization)? CDC sponsored the National Council on Radiation Protection and Measurements (NCRP) to conduct the most recent estimate of radiation doses to the U.S. population. This NCRP study provided an update to the earlier estimate in 2009 that indicated the sharp increase in average dose to the U.S. population due to the evolving technology and use of these diagnostic tools.

QUESTIONS SUBMITTED BY SENATOR HYDE-SMITH

Question. Local pharmacies and pharmacists have long been a trusted and vital part of our local healthcare community. 9 in 10 Americans live within 5 miles of a pharmacy, and many of those Americans have come to rely on their pharmacy during the pandemic to provide vital access to COVID-related services, including testing, vaccinations, and treatments. Pharmacists were central to combating COVID-19, providing more than 245 million vaccine doses and millions of tests across 20,000+ pharmacies nationwide. However, CMS treats pharmacists differently than other healthcare professionals when it comes to providing these services, and, ultimately, CMS does not have the necessary payment structure to appropriately reimburse pharmacists for these services.

Secretary Becerra, can you please elaborate on the efforts CMS has taken to expand pharmacist provider status/reimbursement during the COVID-19 PHE, and clarify which flexibilities granted to pharmacists can and will be extended beyond the PHE? Specifically, how will pharmacists receive reimbursement for COVID-19 tests and vaccine administration after the PHE?

Answer. Pharmacists are essential parts of our healthcare system and are playing an important role in the response to the COVID-19 public health emergency. Pharmacists may perform certain tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law. In addition, pharmacists can enroll as mass immunizers and bill Medicare for administering Part B vaccines.

We have explicitly clarified that pharmacists fall within the regulatory definition of auxiliary personnel under our regulations. As such, pharmacists may provide services incident to the professional services and under the appropriate level of supervision of the billing physician or practitioner, if payment for the services is not made under the Medicare Part D benefit. This includes providing the services incident to the services of the billing physician or practitioner and in accordance with the pharmacist's state scope of practice and applicable state law.

Question. 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 \$3.5 million, despite the tremendous cost of CKD to society, Medicare, and Medicaid. We must increase awareness and early detection of kidney disease via a national kidney disease awareness public health initiative, which the CKD Initiative at CDC is poised to do with proper funding and community partnership.

Please comment on efforts to expand the Chronic Kidney Disease Initiative to meet this awareness and early detection need.

Answer. The Chronic Kidney Disease (CKD) Initiative currently conducts several activities to promote kidney health, including collaborating with partners to support and enhance the CKD Surveillance System. This system tracks kidney disease and its risk factors over time and monitors progress in prevention, detection, and management.

The CKD initiative works to:

- Increase public awareness of CKD, its risk factors, and complications through scientific publications, provider resources, featured articles, and other educational resources.
- Promote early diagnosis and treatment of CKD by
 - Encouraging providers to use the CKD e-phenotype to detect CKD in people early on, help manage CKD, and help reduce CKD-related complications such as heart disease and kidney failure.
 - Publishing on the state-level awareness of CKD in the U.S.
 - Sharing information for the public on prevention and risk management, and how to take care of your kidneys.
- Conduct surveillance, epidemiology, health outcomes, and economic studies in partnership with other offices at CDC, other government agencies, universities, and national organizations.

CDC is committed to the CKD Initiative, and its important work has been highlighted in HHS' Advancing American Kidney Health Initiative. In the fiscal year 2022 Omnibus, the CKD Initiative received an increase of \$1 million dollars from fiscal year 2021 funding (total of \$3.5 million). While continuing the current work of the CKD Initiative, CDC is using the funding increase to:

- Study the effects of youth-onset type 2 diabetes on kidney structure, function, and complications to identify novel and specific targets for CKD prevention and treatment.
- Update the CKD cost effectiveness studies to include new data, treatments, and numerous advances in our understanding of CKD and its causes, progression, and treatment.
- Expand the analytical capacity of the CKD Surveillance System, including analysis of large datasets and incorporating new indicators of the social determinants of health and CKD morbidity at the national, state, and county levels.
- Examine trends in incidence of end stage kidney disease, diabetes complications, and impact on high-risk populations.

Question. There have been recent positive changes to clinical practice in the diagnosis of kidney disease, namely the adoption of new equations for estimating GFR that do not include race as a modifier.

What else is NIDDK doing to elevate kidney-specific research and interventions to eliminate racial and ethnic disparities in kidney care? Specifically, can you comment on investments in research initiatives that bridge existing deficits in CKD management and treatments to reduce incidence and progression, increase the number of CKD clinical trials related to kidney disease (including efforts to enhance participation of under-represented populations), identify strategies to improve the delivery of evidenced-base care in under-represented populations, and address issues related to kidney patients' quality of life?

Answer. Addressing disparities in kidney disease outcomes is a major research priority for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Recognizing that new approaches are needed, the Institute held a workshop in February 2022 aimed at helping design interventions to address structural racism in kidney health disparities. An important outcome of this effort is a forthcoming initiative, recently approved by the NIDDK's Advisory Council, inviting clinical trials to develop and implement these and other interventions in hopes of providing new, evidence-based solutions to overcome disparities in chronic kidney disease and end stage renal disease (also known as ESRD or kidney failure) care and outcomes.

The NIDDK is also determined to improve care and reduce disparities in management of advanced kidney disease. For example, ESRD disproportionately affects African Americans and can severely affect quality of life, particularly for the roughly half of ESRD patients who experience severe pain. The Hemodialysis Pain Reduction Effort (HOPE) clinical trial is exploring non-opioid methods of pain management and improving quality of life, with a focus on heavily affected communities. The trial is engaging participants as partners in the research process and study management to strengthen the science—efforts that have also helped accelerate recruitment of new participants.

A variation in the APOL1 gene that is more common in people of African descent than in other populations is one factor accounting for kidney disease disparities among African Americans. However, it is not yet well understood how APOL1 variation might affect outcomes for kidney donors or recipients. The APOL1 Long-term Kidney Transplantation Outcomes Consortium is currently addressing these vital questions, while employing a ground-breaking patient-engagement effort that served as a model for HOPE and other studies. Another factor that worsens disparities in outcomes for people with ESRD is the relative lack of access to transplanted kidneys for communities of color. The NIDDK and the Patient Centered Outcomes Research Institute are therefore working together to fund the System Interventions to Achieve Early and Equitable Transplants (STEPS) Study, an intervention designed to improve access to transplantation for African Americans through healthcare system change.

Question. Studies indicate that we could have over one million people in kidney failure and need a transplant by 2030. Yet, each year, thousands of recovered kidneys go un-transplanted, while every day, 12 people die waiting for a kidney transplant. Recently there has been additional scrutiny into our organ procurement and transplantation system, yet no major policy proposals have been announced to improve this appalling failure of care. Organ Procurement Organizations are the sole stakeholders in the transplant ecosystem responsible for recovering and transporting deceased organs without legitimate oversight and accountability to ensure quality assurance and performance improvement. Transplant centers desperately

need financial incentives to accept less than perfect kidneys and care for complex transplant patients. People of color and underserved communities face numerous hurdles in being referred for a transplant evaluation.

What is HHS planning to do to reduce organ discards, improve transplantation, and minimize racial and ethnic disparities in transplantation access?

Answer. Organ procurement organizations (OPOs) are vital partners in the procurement, distribution, and transplantation of human organs in a safe and equitable manner for all potential transplant recipients. The role of OPOs is critical to ensuring that the maximum possible number of transplantable human organs is available to individuals with organ failure who are on a waiting list for an organ transplant. HHS is dedicated to improving health equity and access in the organ procurement and transplantation system, including by holding OPOs accountable for their performance.

In December 2020, CMS published “Medicare and Medicaid Programs; Organ Procurement Organizations Conditions for Coverage: Revisions to the Outcome Measure Requirements for Organ Procurement Organizations”. This rule finalized new outcome measures OPOs are required to meet for re-certification and was published with the intention of increasing donation and organ transplantation rates by replacing the previous outcome measures with new transparent, reliable, and objective outcome measures that are used to make better certification decisions and incentivize better performance. The revised measure will encourage OPOs to pursue all potential donors, even those who are only able to donate one organ. CMS estimates that if every OPO were to meet or exceed this measure, we could have approximately 5,600 more organs per year to transplant.

HRSA is committed to an equitable and timely organ donation and transplant system. This spring, HRSA issued a Request for Information (RFI) to solicit feedback about opportunities to strengthen the Organ Procurement and Transplantation Network (OPTN). In particular, the RFI sought feedback on the ways to address many of the National Academies of Science, Engineering, and Medicine findings and recommendations in its report titled *Realizing the Promise of Equity in the Organ Transplantation System*. HRSA released the RFI to better support HRSA’s efforts to increase accountability in OPTN operations, modernize performance of the OPTN IT system and related tools, and improve engagement with donors and patients. It specifically focuses on opportunities to strengthen equity, access, and transparency. HRSA is appreciative of the response to the RFI and is actively reviewing this important feedback to inform the development of the next contracting cycle. We look forward to continuing to engage with Congress as we develop the next contracting cycle and continue to identify strategies for modernization and accountability across the organ procurement and transplantation system. In addition, HRSA is collaboratively working with its CMS colleagues on an End Stage Renal Disease Treatment Learning Collaborative (ETCLC) project designed to capture and share best practices and processes to increase transplants and reduce discards. The ETCLC focuses on kidney transplants, which make up approximately 85 percent of the total waiting list. Improvements in this area will have a broad impact on the system. HRSA is committed to the critical work of continuously improving the organ donation and transplantation system, and looks forward to continuing to work with you on this issue.

QUESTIONS SUBMITTED BY SENATOR PATRICK LEAHY

Question. Due to a long-standing Federal policy known as the ‘institutes of mental disease’ (IMD) exclusion, states are prohibited from claiming Federal Medicaid funds for in-patient mental health services delivered to eligible individuals residing in hospitals or institutions of more than 16 beds. While the exclusion was originally intended to ensure that maintained primary financial responsibility for inpatient psychiatric care and reduce the Federal cost share, it has no clinical rationale and inhibits access to critical services for Medicaid beneficiaries. This includes individuals suffering from substance use disorders, which has hit an all-time high during the COVID-19 pandemic. Many states such as Vermont are facing a critical shortage to appropriate and timely mental healthcare that results from a lack of funding for in-patient psychiatric beds.

What would be the fiscal cost over 10 years to repealing the IMD exclusion?

How can Congress work with the agency to overcome the barriers caused by the IMD exclusion and increase access to much needed in-patient mental health treatment?

Concurrently, how will the President's budget be used to incentivize and help states develop and provide community-based services for individuals suffering from mental health disorders?

Answer. The Biden-Harris Administration is committed to expanding access to affordable care, including inpatient psychiatric and substance use disorder care when appropriate. While the Medicaid statute prohibits states from receiving Federal financial participation for services delivered to most individuals residing in an IMD, CMS has worked within the confines of the law to provide states with flexibility to increase access to these services. For example, CMS has approved Medicaid section 1115 demonstrations that allow state Medicaid programs to pay for services provided to adults with serious mental illness/serious emotional disturbance or substance use disorder who are short-term residents in an institution for mental disease (IMD). Similarly, managed care organizations (MCOs) are permitted to reimburse up to 15 days per month of treatment in IMDs as an in-lieu of service—that is, a service that is not included under the state plan, but is a clinically appropriate, cost-effective substitution for a similar, covered service.

When appropriate, the Biden-Harris Administration also supports strengthening home and community-based services (HCBS) as an alternative to institutionalized care, in order to ensure that people have access to safe options that work for them. People are happier and healthier when they live in their community, and living in one's own home and community usually costs less than care in an institution. The department is working hand-in-hand with states to ensure they have the time and support they need to strengthen their home care systems. HHS recognizes the importance of HCBS which allow millions of Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. HHS looks forward to working with Congress to improve this access.

Question. The COVID-19 pandemic has exacerbated a youth mental health crisis in our country. A recent NIH-funded study revealed that since the start of the pandemic, there has been an increase in the number of suicides among youth 10-to-19 years of age. In the past year, nearly 200 Vermont children have sought care for mental health related issues at emergency rooms. Many of these children had to wait an average of over 24 hours before they were seen for care. Rural states like Vermont also face significant barriers to meeting the demand for mental healthcare, the most prevalent being the shortage of behavioral healthcare clinicians. I strongly support proposed investments in school-based mental healthcare, early childhood intervention, community mental health centers, and the 988 suicide prevention and crisis support line to start to address these issues.

How will the agency use the proposed investments for youth mental health to ensure that rural areas can adequately train, recruit and retain behavioral healthcare providers that are pediatric specialists?

Answer. SAMHSA oversees multiple grant programs that support training pediatric behavioral healthcare providers.

SAMHSA's Infant and Early Childhood Mental Health grant program helps to address the national shortage of mental health professionals with infant and early childhood expertise by training early childhood providers and clinicians to identify and treat behavioral health disorders of early childhood. In fiscal year 2021, grantees trained 4,003 clinicians and early childhood providers on evidence-based mental health treatments for infants and young children. The Mental Health Awareness Training grant program trains individuals, including primary care and specialty healthcare providers, how to respond to individuals with mental disorders appropriately and safely. The Certified Community Behavioral Health Clinic Improvement and Advancement grant program includes a staff training requirement as part of the overarching goal of enhancing and improving community behavioral health systems.

SAMHSA also supports technical assistance centers that provide, among other things, training to pediatric healthcare providers. These centers include the Suicide Prevention Resource Center, National Child Traumatic Stress Network, and Mental Health Technology Transfer Center Network.

To strengthen the mental health and substance use disorder workforce, the fiscal year 2023 budget provides an investment of \$397 million for HRSA's Behavioral Health Workforce Development Programs, which is \$235 million above fiscal year 2022 enacted level. This funding will increase training of new behavioral health providers, including a track for health support workers such as peer support specialists and community health workers and place an emphasis on team-based care. In order to promote inclusive and equitable behavioral healthcare for youth, this investment will support a special focus on the knowledge and understanding of children, adolescents, and youth at risk for a mental health disorder, Serious Emotional Disturbance, or substance use disorder. The Behavioral Health Workforce Development Pro-

grams includes \$225.8 for Behavioral Health Workforce Education and Training (BHWET) Programs. In fiscal year 2023, the BHWET Programs seek to establish and expand field placements, internships, and experiential sites for behavioral health professionals and paraprofessionals to train, especially among children- and youth-focused community-based partners who are able to conduct trainings in school-based settings. A special focus is placed on the knowledge and understanding of children, adolescents, and transitional-aged youth at risk for a mental health disorder, Serious Emotional Disturbance (SED), and/or substance use disorder.

The Budget also includes increases in Primary Care Training and Enhancement and Nurse Education, Practice and Retention to expand behavioral health services into primary care.

In fiscal year 2022, HRSA received \$5 million for a pediatric specialty loan repayment program under which participants will be employed full-time for a specified period, of not less than 2 years, in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral healthcare, including substance use disorder prevention and treatment services. Program participants will be required to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population.

The fiscal year 2023 President's Budget proposes \$10 million for the Pediatric Mental Health Care Access (PMHCA) program, which has played an important role in helping to increase access to specialized mental health providers and build provider capacity for children in rural areas. The PMHCA program promotes behavioral health integration in pediatric primary care through new or expanded statewide or regional pediatric mental healthcare telehealth programs. These networks of specialized pediatric mental healthcare teams provide tele-consultation, training, technical assistance, and care coordination to assist pediatric primary care providers.

Through the PMHCA Program, pediatric primary care providers are able to diagnose, treat and refer children to the care they need for behavioral health concerns. Telehealth technologies promote long-distance clinical healthcare, clinical consultation, and patient and provider education, helping address challenges in accessing behavioral health clinicians who treat behavioral concerns in children and adolescents.

The number of primary care providers enrolled in the PMHCA Program increased from 1,963 in fiscal year 2019 to 4,511 in fiscal year 2020. Authorization for the PMHCA program expires at the conclusion of fiscal year 2022.

In addition, the fiscal year 2023 President's Budget includes \$57.3 million, a \$3 million increase over fiscal year 2022 enacted, for HRSA's Autism and other Developmental Disorders program. Among other programs, this investment supports the Developmental-Behavioral Pediatrics Training Program (DBP) that trains Fellows in developmental behavioral pediatrics to address the broad range of behavioral, psychosocial, and developmental concerns that pediatric primary care providers see. The program also supports practitioners' ability to provide proven interventions to children's behavioral and developmental concerns, including for individuals with autism spectrum disorder and other developmental disabilities. In fiscal year 2020, the DBP Training Program trained over 1,400 DBP Fellows, medical students and pediatric residents. DBP graduate survey results show that 5 years following completion of the program, 100 percent of DBP Fellows demonstrated leadership, worked in an interdisciplinary manner, and worked with maternal and child health populations, including those considered to be underserved. The proposed fiscal year 2023 increase will help support the DBP program, as well as the Leadership Education in Neurodevelopmental and Other Related Disabilities (LEND) Training program to address unmet needs and disparities in evaluation, diagnosis, and treatment. For DBP, funding will allow expansion of the DBP program including increased fellowship opportunities for existing awardees.

Finally, the fiscal year 2023 President's Budget supports the Child and Adolescent Health Promotion Services Program, referred to as the Bright Futures Program. This program supports quality health promotion and preventive services for all children, adolescents, and young adults through evidence-driven, strengths-based clinical guidance. This includes the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care ("Periodicity Schedule"), which includes preventive services that group health plans and health insurance issuers must cover without cost sharing. The Periodicity Schedule recommends several mental and behavioral health screenings be conducted during well visits. This program serves providers across the country, including those in Health Provider Shortage Areas (HPSA), Medically Underserved Areas (MUA), and providers who serve patients from historically marginalized backgrounds.

Question. Vermont, like many other states, is currently facing a severe nursing shortage. The State has forecasted 6,244 vacancies within the nursing professions

within the next 2 years, largely caused by an aging workforce and mental burnout that has been accelerated by the COVID-19 pandemic. There is also an inadequate number of nursing educators to train the next generation of nurses.

How can HHS help states to build and bolster resilient nursing pipelines and nurse training programs?

Answer. CDC makes essential workforce and training resources accessible across the globe through the Department of Health and Human Services, CDC, and state and local health departments. CDC's fellowships are a pathway for training and recruiting the next generation of public health leaders, including nurses.

With short-term ARP funds, CDC is working with the Corporation for National and Community Service (CNCS) to place members onsite at public health departments to help meet current staffing needs for the COVID response. This is one component of a longer-term program to support ongoing public health staffing needs and future surge staffing needs for emergencies. While meeting immediate staffing needs, the Public Health AmeriCorps, established jointly between CNCS and CDC will also include a goal of creating a pathway of entry level, future public health professionals, including nurses. The joint venture between AmeriCorps and the CDC received 122 applications representing community organizations from 41 of 50 states. Funding decisions and notices of awards from AmeriCorps were released in April 2022. For more information: <https://americorps.gov/newsroom/press-release/americorps-cdc-award-more-60-million-public-health-americorps-programs-part>.

CDC is providing \$3 billion in grants to state, territorial, and local jurisdictions. CDC plans has posted the notice of funding opportunity, and awards will be made in 2023. Funding will support hiring, retention and training of public health workers, particularly from the communities they are intended to serve, and will permit the funding of a broad range of public health workers, including nurses and public health nurses and other community health professionals.

The nursing pipeline is supported and enhanced through HRSA programs:

- The Nurse Corps Scholarship and Loan Repayment Programs assist in the recruitment and retention of nurses while reducing the financial barrier to nursing for all levels of professional nursing students and increase the pipeline of nurses by supporting nurses and nursing students committed to working in communities with high need. Additionally, the Nurse Corps program supports nurse faculty who will train the next generation of nurses. In fiscal year 2023, HRSA anticipates funding scholarship and loan repayment awards.
- Another challenge for advancing and growing the nursing field is recruitment and training of nurse faculty. To address this issue, in fiscal year 2023, HRSA will also support the Nurse Faculty Loan Program (NFLP), which provides funding to accredited schools of nursing to establish and operate a student loan fund and provide loans to students enrolled in advanced education nursing degree programs who are committed to becoming nurse faculty. In exchange for completion of up to 4 years of post-graduation full-time nurse faculty employment in an accredited school of nursing, the program authorizes cancellation of up to 85 percent of the student loan.
- An additional area of focus in our nursing work is recruiting and training nurses who are underrepresented in the nursing profession. The Nursing Workforce Diversity (NWD) Program supports nurse training for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses).
- The fiscal year 2023 Budget Request also would support the Advanced Nurse Education Program at \$105.6 million, \$20 million above the fiscal year 2022 enacted level. The Budget includes an increase of \$20 million for grants to grow and diversify the maternal and perinatal health nursing workforce by increasing and diversifying the number of Certified Nurse Midwives with a focus on practitioners working in rural and underserved communities.
- The Scholarships for Disadvantaged Students (SDS) Program dedicates 16 percent of its total budget to providing scholarships to educate and train bachelor and graduate-level nurses and nurse midwives from disadvantaged backgrounds to address nursing shortages in rural and underserved communities. The SDS Program currently funds 25 bachelor and graduate-level nursing schools across the United States and its territories.

SUBCOMMITTEE RECESS

Senator MURRAY. The committee will next meet in Dirksen 138, Wednesday, May 17, at 10 a.m. for a hearing on the Biden Administration's budget request for the National Institutes of Health. The committee is adjourned.

[Whereupon, at 11:10 a.m., Wednesday, May 4, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, May 17.]

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

TUESDAY, MAY 17, 2022

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

The subcommittee met at 10:02 a.m. in room SD-138, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.
Present: Senators Murray, Durbin, Reed, Baldwin, Blunt, Moran, Kennedy, Braun, and Rubio.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

STATEMENT OF LAWRENCE TABAK, D.D.S., PH.D., ACTING DIRECTOR

ACCOMPANIED BY:

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

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

JOSHUA GORDON, M.D., PH.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

RICHARD HODES, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING

NORA VOLKOW, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

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 2023 budget request for the National Institutes of Health.

Senator Blunt and I will each have an opening statement. Then I will introduce our witnesses. And after their testimony, Senators will each have 5 minutes for a round of questions.

While we were unable to have this hearing fully open to the public, or media for in-person attendance, live video is available on our committee website. If you are in need of accommodations, including

closed captioning, you can reach out to the Committee or the Office of Congressional Accessibility Services.

Every day across my Home State of Washington, researchers at the Fred Hutch Center, University of Washington, Washington State University, Seattle Children's hospital, and so many other world-class institutions are working around the clock and making ground-breaking discoveries.

Discoveries that don't just drive innovation and economic growth, but also bring families, cures, and treatments, and hope for the future, discoveries that saves lives, discoveries that don't just drive innovation and economic growth, but also bring families cures, and treatments, and hope for the future.

I am pleased to say this budget request shows the administration understands the tremendous importance of supporting our Nation's biomedical research community, and continuing our tradition of global leadership here, especially as in the past few years, have been such a stark reminder of how the investments we make in research today pay off down the road.

The rapid development of safe, effective COVID vaccines was made possible by research into mRNA vaccines we funded, in response to Ebola and other viruses, and by a biomedical research enterprise that has been built over decades.

And today, thanks to the vaccines and therapeutics that NIH (National Institutes of Health) researched to help develop, COVID deaths and hospitalizations are the lowest we have seen in 2 years. However, we are not out of the woods yet when it comes to this pandemic. There is still the threat of new, more deadly variants, especially right now when caseloads are inching up again, but our communities' resources have largely been spent down.

We need to defend the hard-won progress we have made, and that means passing emergency COVID funding, so our communities have the tests, and treatments, and vaccines, and tools they need to keep families safe.

This is really urgent. So I am going to keep fighting to make sure we get it done. And in addition to providing our communities the resources they need to fight this pandemic, I hope we are able to come together this year, as we have so many times in the past, to continue providing our researchers what they need to help us to fight COVID-19, and so many other challenges.

Challenges like: Developing better tests, making next-generation vaccines that are effective against all COVID variants, and understanding long COVID, and how we support the millions of people who are living with it; and challenges like the mental health crisis this pandemic has made so much worse, especially for young people, or overdose deaths which have been skyrocketing due to the rise of fentanyl.

Recently, our Nation lost a record 107,000 people to overdose deaths in a single year, and in Washington State, opioid deaths increased by two-thirds in 2021. This crisis is tearing a hole in so many communities, so many families, it is truly heartbreaking, and we have to pull out all the stops to get this under control.

That is why I am working on bipartisan legislation to strengthen programs that help our first responders, healthcare professionals,

and others on the front lines. And why I want to make sure we continue investing in research here like this budget proposes.

Of course the measure of success against any disease is not how much we invest to fight it; it is how much we are helping patients. For example, when it comes to Alzheimer's disease, that is exactly what we need to be focused on, for patients fighting this disease the stakes are intensely personal. They are fighting to hold onto cherished memories with loved ones, and a feeling of control over their daily lives, and the weight of that fight falls on their family members, friends, and caregivers.

With so much at stake in their lives, these families deserve to know the research projects they are depending on are being thoughtfully designed and prioritized for meaningful outcomes and results. This is really important for me, especially when we have increased funding for Alzheimer's research six-fold since 2015; when the 2025 target date that is established in the National Alzheimer Project Act is just around the corner, and when there are so many other terrible diseases families are desperate for NIH to put more resources into as well.

Another important undertaking is the launch of the Advanced Research Projects Authority for Health, which aims to break the mold for how cutting-edge research is conducted, speed up the discovery and development of medical treatments, and support projects that have the potential to transform medicine.

I worked hard to provide resources to establish ARPA-H (Advanced Research Projects Agency for Health) in our bipartisan funding bill earlier this year, and I am working hard right now to pass the Prevent Pandemics Act to set it up for long-term success.

That requires striking a balance to ensure ARPA-H can complement NIH's expertise while still operating independently to nimbly seize opportunities to accelerate innovation and breakthroughs.

I am focused on getting that balance right, so I will be asking more about why so much of the NIH budget increase, requested by the administration, goes towards ARPA-H when it is yet to bring on a staff and what that means for the other NIH institutes and centers.

Of course at the end of the day, innovation isn't 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 this work is to our families, we can't afford to have this agency's potential limited, or its success threatened by bias, discrimination, or harassment in the workplace.

We have to do more to address harassment in the biomedical research community, as well as address the fact that the number of researches of color is too low, and even clinical trials often fail to be adequately representative.

These are real problems with real consequences for research, and I have been pressing for progress on this for years. So I have been glad to see NIH working to examine barriers to diversity among its researchers, address how its practices have reimbursed structural biases and discrimination, and implementing a new policy, as secured in this committee that requires those that receive NIH grants to notify the agency when a Principal Investigator is removed, even temporarily, for sexual harassment or bullying.

But more work remains to be done to remove racism, discrimination, and harassment from research. And I will continue to follow our progress here.

Finally, before I turn over to Senator Blunt, I just want to take a moment to note that this will be the last NIH hearing we have with him, and to say how grateful I am, Senator Blunt, for all the work with you on this issue over the years.

It has been really great to have a partner across the aisle who really understands why these investments are so important to families, in Washington State, Missouri, across the country, and who is really willing to sit down and work in a bipartisan way to make sure we are delivering for folks back home.

So thank you so much, Senator Blunt. And I will turn it over to you.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Well, thank you, Chair. I appreciate the work we have done together. As you said, this is in my, in all likelihood, last NIH hearing. And as I have started to look back on the time I have spent in the Senate, one of the things I think will have the most long-term impact is what we have done together for NIH research.

You have been a great partner in that effort. We have worked closely with Chairman DeLauro, and Congressman Cole, in the House, who chaired that subcommittee, and they both chaired the committee during the 8 years we have been doing this work together. The entire committee, of course, was involved, but I would particularly like to mention Senator Durbin and former Senator Alexander, who were right there at the beginning of trying to see what we could do to change a trajectory that, really, was not good.

And of course, Dr. Tabak, thank you for you, and the directors being here with us today; and I think all of you would remember when I became chairman nearly 8 years ago, NIH funding was stagnant, and had been for about a decade, but over the past 7 years, working together, we have increased that funding by nearly 50 percent.

It was a period of time that, looking back, the NIH, not only could count on sustained funding, but also having a substantial increase every year. And I am hopeful and confident that Senator Murray's continued partnership in that commitment will let us do that again this year. And I hope we are able to, successfully, work together and have a bill before the end of the year.

I am disappointed that this budget request reduces funding for 12 of the 27 institutes, including the National Cancer Institute, and the National Institute of Allergy and Infectious Diseases. The latter, of course, was demonstrated over and over again how important it was during COVID. There are very few increases, frankly, that are proposed in this request, the increase in CURES is coincidental, and that this fiscal year 2023 year has that number already built in.

The only significant increase, as the Chair has pointed out, at NIH this year, would be an increase of \$4 billion for ARPA-H. Now, I am a supporter of ARPA-H, I am a supporter of the Secretary's decision to have it associated with NIH. But a \$4 billion increase for ARPA-H, and no increase for NIH would really verify

the worst concerns that people have had, about ARPA-H as a competitor to our ongoing research, as opposed to finding a way where the government can and should be willing to take on more financial risks, to become a real partner in targeted research outcomes, that have a specific short-term goal in mind, and to help us reach that goal. That doesn't mean we should jeopardize research challenges as big as cancer, and Alzheimer's disease, or as small as hearing aids, as we look to build, frankly, on the goal of doing more of what we were able to do in the pandemic.

I was also surprised that the budget request failed to take more of the lessons learned from the pandemic into consideration, instead of embracing more high-risk, high-reward science, and focusing on projects with instant impact which proves so successful with programs like RADx (Rapid Acceleration of Diagnostics), it appears that the budget got bogged down with political priorities that don't quite fit the agency's long-standing mission.

This is clearly illustrated with a request for a new Center for Sexual Orientation and Gender Identity, yet virtually no additional money for the Cancer Moonshot. NIH is clearly in a period of transition. If there is one lesson to be learned from the COVID-19 pandemic, it is that our Nation's success depends on medical research infrastructure, across the country, supported by NIH.

Now is not the time to abandon that goal, now is the time, in fact, to make it even stronger. And I hope the original, or the eventual budget that we propose to our colleagues in the Senate, and to the whole Congress, will reflect that determination, to make NIH stronger across the board rather, than the way this budget proposal looks at NIH.

And Chair, thank you for your comments. And thank you for the chance to speak, and for holding this hearing.

[The statement follows:]

PREPARED STATEMENT OF SENATOR ROY BLUNT

Good morning. Thank you, Dr. Tabek and the other Institute Directors, for being here today.

This is my last NIH hearing. As I've started to look back on my Senate career, one of my proudest accomplishments is realigning the priorities within the Labor/HHS bill to focus on medical research.

When I became Chairman nearly 8 years ago, NIH funding was stagnant. And it had been that way for nearly a decade. But over the past 7 years, NIH funding has increased nearly 50 percent, and NIH could count on sustained funding and a substantial increase each year. I am hopeful, with Senator Murray's continued partnership and commitment, we will continue this legacy in my last Labor/HHS bill this year.

I am disappointed, however, that Dr. Tabek has to defend a budget that is nearly indefensible. This is a budget request that reduces funding for 12 of the 27 Institutes, including the National Cancer Institute and the National Institute of Allergy and Infectious Diseases, the latter of which demonstrated its importance during the COVID pandemic. The very few and modest increases that are proposed in the budget request were likely only accomplished because CURES funding significantly increases in fiscal year 2023—a mere coincidence that was not determined by the Administration.

The only significant increase NIH receives this year in the budget request is an increase of \$4 billion for ARPA-H. I am a supporter of ARPA-H and particularly the Secretary's decision to house it within NIH. ARPA-H has the ability to translate what we learned during COVID—that the government can and should be willing to take more financial risks to become a real partner in research outcomes—and expand that model to other research challenges as big as cancer and Alzheimer's disease to as small as hearing aids.

However, no matter how much I support the goal of ARPA-H, it cannot be the sole focus of NIH's budget request. And it cannot displace other scientific priorities or be funded at the expense of other critical research efforts.

I am also surprised that the budget request failed to take more of the lessons learned during the pandemic into consideration to move the agency forward. Instead of embracing more high-risk, high-reward science and focusing on projects with instant impact, which proved so successful with programs like RADx, it appears that the budget got bogged down with political priorities that don't quite fit the agency's longstanding mission. This is clearly illustrated with a request for a new Center for Sexual Orientation and Gender Identity, yet virtually no additional funding for the Cancer Moonshot.

NIH is clearly in a period of transition. The long-time Director has left and we are coming out of a pandemic that has been nearly the sole focus of the agency for the past two-and-a-half years. I hope NIH takes this opportunity to review its current mission and consider whether it aligns with where you want it to be and where you want it to go.

If there is one lesson learned from the COVID-19 pandemic, it is that our nation's success depends on the medical research infrastructure across this country supported by NIH. Now is not the time to abandon it. Now is the time to make it even stronger.

Thank you.

Senator MURRAY. Thank you. I will now introduce our witnesses. We have Dr. Lawrence Tabak, he is the Acting Director of the National Institutes of Health; Dr. Anthony Fauci is the Director of the National Institute of Allergy and Infectious Diseases; Dr. Gary Gibbons is the Director of the National Heart, Lung, and Blood Institute; Dr. Joshua Gordon is the Director of the National Institute of Mental Health; and Dr. Nora Volkow is the Director of the National Institute on Drug Abuse.

Welcome to all of you, and thank you for being here today.

Acting Director Tabak, you may deliver your opening remarks.

SUMMARY STATEMENT OF DR. LAWRENCE TABAK

Dr. TABAK. Thank you, Chair Murray, Ranking Member Blunt, and distinguished subcommittee members. I am honored to be here today with my colleagues representing the NIH. This is a time for NIH and the entire biomedical research community to reexamine all of our efforts. During the COVID-19 pandemic, we were driven by the urgency of the moment.

NIH must learn from this experience, and seize the opportunity to define a new normal. As acting director, I am committed to new strategies, new voices, and a renewed focus on the future.

Now is the time to reflect on what worked and did not work to address COVID and to shape new strategies. Your sustained investment in NIH research set the stage for the new mRNA technology, and immunogen design that were key to the development of safe and effective vaccines in an unprecedented timeline. Since these vaccines became available, it is estimated more than two million American lives were saved, and more than 17 million hospitalizations were averted.

Now we need continued support for a wide range of biomedical fields, including the behavioral and social sciences, to identify and successfully implement better ways of responding to the short- and long-term health effects of COVID-19, to prepare for future pandemics, and to ensure equitable protection of our diverse population.

And it is not just about vaccines. Our Rapid Acceleration of Diagnostics, our RADx Initiative, fueled the development of many

new approaches for COVID-19 testing that are being used in the communities.

To help ensure that such benefits were shared with of those disproportionately affected by the pandemic, we initiated efforts like RADx Underserved Populations, and the NIH Community Engagement Alliance. These experiences, along with other NIH-led efforts focus on COVID treatment development, demonstrate the extraordinary value of public-private partnerships.

The NIH can build upon the momentum of the COVID response, and apply it to other challenges through the Advanced Research Projects Agency for Health, ARPA-H. Thanks to your inclusion of key authorities, and funding in the Omnibus, NIH is beginning to frame the basic administrative infrastructure for ARPA-H. This is a key first step in creating a permanent home for the strategic partnerships that are so urgently needed to address cancer, diabetes, Alzheimer's, and many other diseases.

But we can't stop there. In addition to new strategies, biomedical research needs new voices. A growing body of evidence demonstrates that inclusion of diverse perspectives yields better outcomes. In the clinical setting medical teams provide—diverse medical teams provide more accurate diagnoses and improve health for patients while building trust.

We do better science when we have a diversity of scientists, from different backgrounds and communities, scientific fields in various career stages. NIH continues to prioritize, fund and empower early-stage investigators so they can succeed as independent researchers.

In 2021, we reached an all-time high of early-stage investigators, funded 1,513. The passion and commitment of our scientists is matched by the voices of people living with a wide range of diseases and conditions. Conversations with patients and their advocates are sometimes difficult, but those are often the discussions that teach us the most.

From the AIDS (Acquired Immunodeficiency Syndrome) advocacy groups of the 1980s, to today's groups for autism, ME/CFS (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome), long COVID, and many others, these voices have refused to be ignored, and ultimately, all of us benefit.

This is a moment for renewed focus on the future. I spent a lot of time encouraging early-stage scientists, but I also like to think about the importance of engaging elementary school-aged children, like those my wife has taught, for over 40 years.

During the pandemic, exposure to the importance of science has become a big part of many of their lives. Past pandemics have inspired young people to become scientists, but the images they saw were usually of older men who looked pretty much like me. Hopefully, today's kids are seeing more scientists who look like them.

Still, we need to do better. Our Nation needs all the bright minds we can find, and I hope you will continue to work with the NIH to make this happen.

Thank you for your time. And my colleagues and I welcome your questions.

[The statement follows:]

PREPARED STATEMENT OF LAWRENCE A. TABAK, D.D.S., PH.D.

Good morning, Chair Murray, Ranking Member Blunt, and distinguished Members of the Subcommittee. I am Lawrence A. Tabak, D.D.S., Ph.D, the Acting Director of the National Institutes of Health (NIH). It is an honor to appear before you today.

I am grateful for the committee's long-standing support for NIH. Whether it is cancer immunotherapy or sickle cell therapies or COVID-19 vaccines, NIH's successes would not have been possible without the investment made by this committee.

The fiscal year 2023 President's Budget will support science that helps tackle many critical national challenges: from initiatives to address health disparities, fight the rising tide of addiction, and transform nutrition science. The budget will also build upon the initial investment in the new Advanced Research Projects Agency for Health (ARPA-H).

ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH

The President's Request proposes \$5 billion to fully operationalize ARPA-H¹ in fiscal year 2023. This new agency will be a key component to drive transformational innovation in health research and we are grateful for your support. At the direction of the Secretary, we are working to create an ARPA-H that is free to innovate and take risks, an ARPA-H that leverages NIH infrastructure, and an ARPA-H that has unfettered and frequent access to all of the brightest minds across all research fields—from biomedicine to sociology to mathematics. In alignment with the DARPA model, ARPA-H will recruit term limited, visionary program managers who will use its catalytic platform to take on critical challenges in conjunction with traditional and nontraditional partners across academia, government, and industry. ARPA-H will use directive approaches that will provide quick funding decisions to support projects that are results- and use-driven and time-limited, and identify emergent opportunities through advanced systematic horizon scans of academic and industry efforts.

ARPA-H projects would be bounded in time, typically a few years with longer periods allowed for efforts that are highly complex, and with the understanding that a significant fraction of projects will not reach their goals, a necessary outcome when conducting ambitious, innovative research. To determine which bold questions should be undertaken and to evaluate proposed programs and projects, ARPA-H would adopt approaches similar to those utilized by DARPA, such as the "Heilmeier Catechism,"² a set of principles that assesses the challenge, approach, relevance, risk, duration, and metrics of success. It will be critical for ARPA-H to engage with the broader biomedical community, including patients and their caregivers, researchers, industry, community groups, and others, to understand the full range of problems and the practical considerations that need to be addressed for all groups and populations.

CANCER MOONSHOT

The President's Cancer Moonshot^{SM 3} aims to accelerate progress in cancer research and make additional therapies available to more patients. Established in 2016, the Beau Biden Cancer Moonshot was a bold action on behalf of cancer patients. The President's Budget includes \$216 million to the National Cancer Institute for Cancer Moonshot.

Prominent, ongoing Moonshot priorities include immunotherapy, childhood cancer, cancer prevention and early detection, and cancer implementation science. For example, several Moonshot initiatives focus on rare pediatric cancers, including research on the fusion of genes that yield novel "fusion oncoproteins" that drive some childhood cancers. Additionally, Federal agencies, led by NIH, will develop a focused program to expeditiously study and evaluate multicancer detection tests, as we did for COVID-19 diagnostics, which could help detect cancers early, when there may be other, more effective, treatment options for patients. Finally, implementation science strives to maximize the use of proven cancer prevention and early detection strategies and to incorporate them into standards of care, which is an urgent need among underserved, rural, and minority populations.

¹ <https://www.nih.gov/arpa-h>.

² <https://www.darpa.mil/work-with-us/heilmeier-catechism>.

³ <https://www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative>.

HEALTH DISPARITIES

A key area where NIH hopes to build upon investments made by this committee in fiscal year 2022 is in the agency-wide effort to reduce health disparities. In the wake of a pandemic that disproportionately affected communities of color, this year's President's Budget will enlist most of our Institutes and Centers (ICs) in developing and testing interventions to reduce health disparities that have been appropriately tailored to the breadth of clinical and community services found in diverse settings and contexts.

Importantly, the health disparities research agenda will be aided and informed by the NIH UNITE Initiative,⁴ composed of actively engaged representatives from across all 27 NIH ICs and the Office of the Director. This initiative was launched with the goal of identifying and addressing structural racism within the NIH-supported and the greater biomedical research community through development and implementation of new policies, procedures, and practices. To gain a better understanding of stakeholders' concerns, NIH issued a public Request for Information in March 2021, which captured over 1,100 responses from researchers, external partners, and members of the public. Responses will inform efforts to improve the culture and advance structural change in biomedical research.

NIH has recently launched several more initiatives to improve the health of racial and ethnic minorities and other populations who experience health disparities. One of the funding opportunities will commit \$60 million over the next 5 years to support transformative research to address health disparities and advance health equity.⁵ NIH will also commit \$30 million from 25 Institutes, Centers, and offices to support observational research that will define the role of structural racism and discrimination (SDR) in causing and sustaining health disparities, and intervention research that will address SDR to improve minority health or reduce health disparities.⁶ Finally, NIH will provide approximately \$24 million for the Transformative Research to Address Health Disparities and Advance Health Equity at Minority Serving Institutions initiative, which is designed to support research projects with the strongest potential to have a profound effect on health disparities research.⁷

MENTAL HEALTH

With the fiscal year 2023 President's Budget Request, NIH intends to direct increased attention towards mental health. Mental illnesses are the fifth leading cause of disability in the United States, accounting for 6.6 percent of all disability-adjusted life years in 2019. In addition, suicide rates for youth have risen over the past 2 decades in the United States; in 2019, an estimated 6,488 youth ages 10 to 24 died by suicide. Despite advances in the treatment of depression and other serious mental illnesses, there remain few evidence-based interventions that rapidly reduce suicide risk within healthcare settings. NIH is supporting research projects that focus on testing the safety, efficacy, and feasibility of several of the newest antidepressant interventions—intravenous ketamine and intranasal esketamine (medications known to rapidly reduce depressive symptoms in hours or days) as well as transcranial magnetic stimulation (TMS; a noninvasive treatment that uses magnets to activate specific parts of the brain)—to rapidly reduce suicidal thoughts and behaviors in adults and adolescents.^{8,9}

In response to the pandemic, which exacerbated mental illness throughout the country, NIH launched a project to support research focused on the social, behavioral, and economic impacts of COVID-19, which supports research on the secondary effects of the pandemic, such as financial hardship, reduced access to healthcare, and school closures.¹⁰ The fiscal year 2023 President's Budget requests \$2.2 billion for the National Institute of Mental Health (NIMH), that includes targeted increases of \$25 million to expand research on the impact of the COVID-19 pandemic on mental health, \$5 million to undertake studies of the impact of social media on mental health, and \$5 million to inform mental health treatment ap-

⁴ <https://www.nih.gov/ending-structural-racism/unite>.

⁵ <https://grants.nih.gov/grants/guide/rfa-files/RFA-RM-21-021.html>; <https://grants.nih.gov/grants/guide/rfa-files/RFA-RM-21-022.html>.

⁶ <https://grants.nih.gov/grants/guide/rfa-files/RFA-MD-21-004.html>.

⁷ <https://grants.nih.gov/grants/guide/rfa-files/RFA-RM-21-022.html>.

⁸ <https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified>.

⁹ <https://www.nimh.nih.gov/news/research-highlights/2021/nimh-addresses-critical-need-for-rapid-acting-interventions-for-severe-suicide-risk>.

¹⁰ <https://covid19.nih.gov/news-and-stories/covid19-ripple-effects>.

proaches, service delivery, and system transformation in support of the Administration's mental health initiatives.

MATERNAL MORBIDITY AND MORTALITY

Even during a global pandemic, NIH has continued to focus on other long-standing yet urgent public health needs. The Centers for Disease Control and Prevention estimates 700 women die each year in the United States of pregnancy-related deaths, 60 percent of which are preventable, and over 50,000 experience severe pregnancy-related morbidity each year.

To address this alarming trend, NIH established the Maternal Morbidity and Mortality Task Force,¹¹ an NIH-wide collaboration. The Task Force coordinates the Implementing a Maternal health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative,¹² which invests in studies to promote an integrated understanding of biological, behavioral, sociocultural, and structural factors that contribute to maternal morbidity and mortality and engages communities in the development of solutions to address the needs of pregnant and postpartum individuals. IMPROVE plans to launch a national network of Maternal Health Research Centers of Excellence that will incorporate local community needs and perspectives to expand and complement existing research efforts by developing, implement and evaluating community tailored interventions to address health disparities in severe maternal morbidity (SMM) and maternal mortality (MM). Through this strategy, IMPROVE will build an evidence-based approach to reducing SMM/MM and its associated health disparities. To support this key initiative, the fiscal year 2023 President's Budget requests \$30 million for IMPROVE. In addition, the request also includes \$3 million for the Eunice Kennedy Shriver National Institute of Child Health and Human Development to support research on mitigating the effects of COVID-19 on pregnancies, lactation, and post-partum health with a focus on individuals from racial and ethnic minority groups.

OPIOIDS AND PAIN RESEARCH

Since early in the pandemic, studies have found increases in the use of many kinds of illicit drugs, including fentanyl, cocaine, heroin, methamphetamine, and cannabis. The NIH Helping to End Addiction Longterm (HEAL) Initiative,¹³ launched in 2018, is a cross-agency program spanning basic, translational, and clinical research on opioid and stimulant misuse and addiction, and pain. HEAL Initiative funds are being used to accelerate the development and availability of longer-acting formulations of existing opioid use disorder (OUD) therapies (e.g., buprenorphine and methadone) and novel immunotherapies (e.g., vaccines) that could block the effect of opioids in the brain to help people with OUD and decrease the incidence of overdose.

The HEAL Initiative is building the Integrative Management of chronic Pain and OUD for Whole Recovery (IMPOWR) network¹⁴ to develop effective treatment interventions for people who experience both chronic pain and OUD. The IMPOWR network consists of clinical research centers that collaborate to develop effective interventions, best models of care for delivery of services, and sustainable implementation strategies for a variety of patients with co-occurring chronic pain and OUD or opioid misuse, with an emphasis on highly vulnerable groups.

In 2020, this committee directed NIH to expand HEAL to address methamphetamine use and we are making progress toward this goal. For example, NIH-funded research on immunotherapies for stimulant use disorders led to the development of a monoclonal antibody called IXT-m200 that targets methamphetamine.¹⁵ This treatment has received Fast Track designation from the Food and Drug Administration and is now being studied in emergency department settings in people with methamphetamine overdose.¹⁶ It is the first novel, investigational treatment for methamphetamine addiction ever to advance in the medication development process to a Phase 2 clinical trial. In order to continue to respond to these evolving chal-

¹¹ <https://www.nih.gov/research-training/medical-research-initiatives/improve-initiative/trans-nih>.

¹² <https://www.nih.gov/research-training/medical-research-initiatives/improve-initiative>.

¹³ <https://heal.nih.gov/>.

¹⁴ <https://heal.nih.gov/research/clinical-research/integrative-management-chronic-pain>.

¹⁵ <https://nida.nih.gov/news-events/nida-notes/2020/02/part-2-immunotherapies-new-tool-to-treat-methamphetamine-addiction>.

¹⁶ <http://intervexion.com/2016/01/intervexion-therapeutics-announces-fast-track-designation-of-ixt-m200-for-treatment-of-methamphetamine-addiction/>.

allenges, the fiscal year 2023 President's Budget includes total funding of \$2.6 billion in this research area across NIH's ICs.

Importantly, NIH seeks to involve many more of our ICs in this initiative, particularly with respect to research addressing pain. The fiscal year 2023 President's Budget Request will expand research into effective therapies that don't involve the brain or the central nervous system by involving researchers from many Institutes and Centers like the National Institute on Dental and Craniofacial Research (NIDCR),¹⁷ which I led for a decade prior to becoming the Principal Deputy Director of NIH. As a dentist, I know that there is no group of clinicians who have more to contribute or more to gain from identifying better pain management approaches. For example, researchers have identified clinical signs and symptoms that can help predict whether temporomandibular disorder pain will linger and turn into chronic pain. Research at the National Center on Complementary and Integrative Health¹⁸ proposes to investigate the role of the brain in pain processing and control, and how factors such as emotion, attention, environment, and genetics affect pain perception.

NUTRITION RESEARCH

The complexity of human nutrition, combined with the impact of diet on chronic diseases that were a contributing factor to the excess deaths of the pandemic, demands that cutting-edge data science and system science methods be employed to move nutrition science into the 21st century. To reflect the high priority NIH places on innovative, multidisciplinary nutrition research, in 2021 the NIH Director moved the Office of Nutrition Research (ONR)¹⁹ to the Office of the Director. Dedicated funding is critical to ensure that the ONR can operate effectively as a cross-cutting NIH entity and to accomplish the goals of the plan. The fiscal year 2023 President's Budget requests \$97.2 million for the NIH Office of the Director to support ONR.²⁰

Within this amount, one new collaborative project proposed is Reducing Nutrition Health Disparities through Food Insecurity and Neighborhood Food Environment Research. This research will use precision regional implementation science and pragmatic research approaches to test strategies to ensure food security and access to healthy food, which are intended to prevent disparities in a variety of diet-related diseases and conditions, such as cardiovascular disease, obesity, diabetes, and cancer. Elucidating the role of these social conditions on diet and nutritional status could help address and prevent diet-related health disparities and promote health equity.

This kind of population and system science will be an important complement to the Nutrition for Precision Health program²¹ (awarded in January 2022 to recruit 10,000 diverse participants to study how a person's nutritional status, metabolism, microbiome, genetics, and environment affect health) and the \$50 million Artificial Intelligence for Chronic Disease initiative (first funded in fiscal year 2021, the initiative leverages machine learning and data science tools to untangle the complex underlying causes of chronic diseases and look for early treatments).

NIH BUILDINGS AND FACILITIES

NIH strives to ensure that its facilities are safe and enable scientists to discover new diagnostics, therapies, and cures. As part of this effort, the President's Budget proposes \$300 million for NIH's Buildings and Facilities appropriation. These funds are meant to begin addressing the backlog of life and safety repairs that totaled over \$1 billion in the 2019 report by the National Academies of Science, Engineering and Medicine on the condition of NIH's facilities on the Bethesda Campus. A key aspect of NIH's strategy is to sustain the condition of existing facilities to prevent premature deterioration and the curtailment of research, including the physical plant, building structures, utility systems, roads, and grounds at all NIH sites. These projects will help to ensure the continued efficient and effective performance of NIH's real property assets to meet ongoing and projected research requirements and to offset the deterioration and obsolescence caused by age and use.

The President's Budget request also proposes a modification to the language governing repairs, which is intended to move NIH's property stewardship beyond maintenance and repairs to more proactive efforts like the modernization at NIH's re-

¹⁷ <https://www.nidcr.nih.gov/>.

¹⁸ <https://www.nccih.nih.gov/>.

¹⁹ <https://dpcpsi.nih.gov/onr>.

²⁰ <https://officeofbudget.od.nih.gov/pdfs/fiscalyear23/ics/27%20-OD%20FY%202023%20CJ%20Chapter.pdf>.

²¹ <https://commonfund.nih.gov/nutritionforprecisionhealth#:~:text=The%20goal%20of%20the%20NIH,prevention%20and%20treatment%20of%20disease>.

search hospital, replacement of obsolete, temporary, and fragmented research facilities, improvement of facilities that advance computational and data science, and improvement of the energy and water efficiency of buildings. To achieve this will take time, so NIH looks to leverage prioritization processes currently in place to focus on the projects that are of the most need to our organization.

CONCLUSION

A healthier nation is a more productive nation and a vibrant research community is a pillar of an economically sound nation. With your support, NIH looks forward in fiscal year 2023 to continue the tradition of catalyzing major break throughs over decades, bettering the human condition through rigorous and innovative science. My colleagues and I look forward to answering your questions.

Senator MURRAY. Thank you very much. And I realized it as I was going through the list of panelists in front of us, I skipped Dr. Richard Hodes, is the Director of National Institute on Aging. Welcome to you as well.

We will now begin a round of 5-minute questions of our witnesses, and I ask my colleagues to please keep track of the clock and stay within your 5 minutes.

DRUG OVERDOSE

Dr. Volkow, I want to start with you. As I mentioned in my opening remarks, across the country overdose deaths continue to rise dramatically. Last year they spiked in my home State of Washington by 30 percent, and much like the rest of the country, were really driven by fentanyl.

This is really a national crisis, so we have got to be using every tool that we have to support our communities, including fentanyl strips, which Secretary Becerra mentioned at his hearing here a few weeks ago. The research I have seen indicates that those strips which are used to detect fentanyl in drugs, are an effective overdose prevention tool, but they require several steps to use them, including chipping off some of the pill to be able to test it.

Can you tell us what the research shows about the effectiveness of those test strips? And really, are they easy to use? Can you talk a little bit about that?

Dr. VOLKOW. Thanks very much for that question. And indeed the fentanyl test strips have been tested for sensitivity and specificity, and the data shows, actually, high sensitivity, and there are only a few fentanyl analogs that are not detected.

Having said that, the fentanyl test strips were developed for testing drug use in urine, so for patients that are being monitored; and so now this is a new application, and as a result of that there can be problems on how it is implemented.

Overall, patients that have used the fentanyl test strips report positive outcomes, and actually in terms of identifying drugs that may put them at higher risk. The research is now ongoing to try to determine what are the optimal guidelines on how to use them, number one; but number two, if the results were positive, what is it that an individual should do in case that they still want to consume them.

As you know there are still multiple problems in terms of making these fentanyl tests available throughout the United States, and there is interest on actually determining and getting approvals for some of these tests by the Food and Drug Administration, so they

can be utilized in healthcare settings, which is not possible at this moment.

OVERDOSE PREVENTION

Senator MURRAY. Well, are there overdose prevention strategies that you and HHS (Department of Health and Human Services) hope to roll out in the coming months? Talk to me a little bit about what we are doing in terms of prevention.

Dr. VOLKOW. Prevention strategies that have been shown to be widely effective is perhaps one of the most important ones, is widespread distribution of Naloxone, and that becomes actually, in some instances, a challenge if the Naloxone is not available for those that use them.

Another harm-reduction practice that has generated a lot of attention, is the extent to which, because the drug supply is so extremely dangerous these days, in which safe injection sites could be viable for patients that otherwise may be at high risk of overdosing. And while the data is still preliminary in the United States, in other countries they have shown that in certain settings they can be quite effective. So there is interest on evaluating them.

There is also interest in the community to test other products that may serve as harm reduction, for example, the use of kratom, which is sold as tea, and that contains a drug—a molecule that has the effects that are similar to those of buprenorphine, but could be utilized also for decreasing withdrawal or depression. So these are more novel, and we don't have sufficient data, but those are things that are being discussed.

ALZHEIMER'S DISEASE

Senator MURRAY. Okay. Thank you.

Dr. Hodes, it is said that science is a marathon, not a sprint. However, Congress has really approached investing in research to treat and cure Alzheimer's disease and related dementias, with really a sense of urgency. We have poured resources into this research, \$17 billion since 2015 to really supercharge the discovery process with a goal of finding a treatment or cure by 2025.

And I am concerned that NIH isn't positioned to meet that deadline. Given the sheer scale of Federal investment, what is NIH doing to deliver meaningful and measurable outcomes that assess its progress towards finding effective treatments?

Dr. HODES. Thank you for that critical question. And let me answer it very briefly in terms of process, and then with some examples of meaningful accomplishments during this time. As you know, we have counted on critical input from the national and global research communities, advocates, et cetera, with our annual summits, all of which feed into a careful identification of milestones, that is the goals and targets which are necessary to meet our most important needs.

I want to take a moment just to thank the staff of this committee for the interactions we have had over the past year to help us focusing these milestones into meaningful, quantifiable outcomes, and making them transparent and available.

To touch on just some of the examples of the important advances, I would point starting with our clinical trials. So for example, in

pharmacological trials, there are currently eight studies targeting amyloid, or not, which are Phase 3, in their latest stages capable of identifying definitive, positive outcomes, meaningful outcomes, clinically which are due over the next years to reveal their answers.

There are some 62 early-phase clinical trials, and a variety of targets, three-fourths of them not amyloid, and these are the results of basic science, which has found more and more potential targets. So the clinical trials, or investment in them, are critically important, and you alluded as well, to the burden on the families, and those living with dementia, that is also an area of clinical research, clinical trials, And we now are funding a large number of trials studying interventions for care and care providing, which will be producing their results.

The National Academy has identified two of those generated with NIH funds that are ready for dissemination, being disseminated with further evidence. Happy to elaborate as time allows, but these are some of the examples of accomplishments, and of our important process to continue being accountable to ourselves, to you, and to the public for making the best use of these very critical funds to accomplish the highest of the priorities.

Senator MURRAY. Well, thank you. And I think transparency is really important. The deadline is around the corner, and we have put out a lot of money for this, and need to know, as Congress, how those investments are going.

So I look forward to working with you. And Senator Blunt will look forward to working with you on that as well.

Senator BLUNT. Thank you, Chair.

UNDIAGNOSED DISEASE NETWORK

Dr. Tabak, during the time you were Deputy Director, the seven hearings we had with Dr. Collins, who was the Director at the time, I think every single time he talked about the importance of NIH bringing hope to millions. I want to talk a little bit about the proposed ending of funding for the Undiagnosed Diseases Network.

We have one of those in St. Louis; Chair Murray has one in Seattle. I had somebody reach out to me a couple of weeks ago, Michele Herndon, from Affton, Missouri. She was concerned because her son, Mitchell, who had suffered from a series of health issues that doctors couldn't diagnose, had benefitted from one of the centers.

In fact, by late-high school, he was in a wheelchair, his hearing was gone, and his eyesight was gone. They were losing hope, but after they sought treatment at the Undiagnosed Disease Network in St. Louis, they found a neurological condition so rare, that it didn't even have a name.

In fact, Mitchell lost his battle. The condition he had now carries his name, the Mitchell syndrome. But Michele and her family were comforted by the fact that they finally knew what this long struggle had been about. This year's budget cuts the Undiagnosed Diseases Network, and closes all 12 of its clinical sites.

She was concerned about that. I am too. I think there is some discussion where they may graduate in some way to where they continue to exist. I think it would be a problem to walk away from

that. Not everybody can come to NIH in Bethesda. And if you don't have the site within some reasonable distance of where you are, you are unlikely to get this service. Do you want to talk about why that decision was made to stop funding these 12 sites?

Dr. TABAK. We certainly agree that the diagnostic services provided by the Undiagnosed Diseases Network are extremely valuable to patients and to their families. The challenge that we face is there does come a point where the diagnoses become a part of standard care, versus a research question, but finding that right balance is something that we continue to work through.

All the cases that are enrolled presently will continue to undergo comprehensive evaluation. We will establish a Data Management and Coordinating Center to draw upon the experience of all of the centers that are participating in this program. But really, we would like to work with you, going forward, to come up, perhaps, with a better solution in the mid- and long-term.

Senator BLUNT. Good. Well, let us continue to work on that. I mean, really you can't have standard care if you are still discovering things that needs to be looked at as an option. Mitchell syndrome is Mitchell syndrome only because he was the first, and may be the only diagnosed person so far, that ever had that. And that is going to fall outside of standard care definition, I think. So let us continue to work on that.

RADX

Is Dr. Gordon available? Let me ask him, on RADx, Dr. Gordon, in the mental health area, and in the RADx example of, again, NIH itself, partnering directly with others to try to find a rapid solution. Do you think that a Shark Tank RADx kind of option would be a possibility, as you look for biomarkers in mental health?

Dr. GORDON. I think that is a great idea, Senator Blunt. I appreciate your support of that initiative, and NIMH (National Institute of Mental Health) as well. We have funded a number of small businesses, as well as a number of academics, who have come up with really wonderful ideas for biomarkers that can help guide clinical decisionmaking. Something that we desperately need in psychiatry to help speed treatments and make sure the people who need treatment, get the right treatment from the get-go.

And one of the ideas for it, we have been thinking about is using the RADx example where you had, essentially, a competition between a number of different companies in RADx, it was for tests for COVID. But the idea is to apply something like that to the biomarker space for mental health.

And we think now is the right time to do that, and so we are talking with our colleagues at NIBIB (National Institute of Biomedical Imaging and Bioengineering), who ran the RADx competition, and trying to figure out how we can do that for biomarkers for mental health.

Senator BLUNT. Very good. I would encourage that. I think every single home test for COVID comes out of the RADx experience, and again, if you have got people that have ideas that can come to you, and see which of those you should partner with; I think that would be a great step in the right direction.

Thank you, Chair.

Senator MURRAY. Senator Reed.
 Senator REED. Thank you, Madam Chairman.

SUICIDE

Dr. Gordon, we are in the midst of a significant spike in suicides, particularly among children, which is very disturbing, and we know some of that is a result of the pandemic, but I am just interested in what research at NIH is pursuing this issue, to recognize warning signs. How is that research being operationalized, and put out to practitioners, particularly, and to families? And then the other point would be, we have a new national hotline, 988, are you in any way, sort of trying to coordinate, or work with that, or study that?

Dr. GORDON. The answer to both those questions is, yes, we are deeply involved in making sure that our research informs practitioners both in the clinic and at the State level when we are talking about 988.

Let us talk about youth suicide first. NIMH has funded a number of research programs in identifying individuals at risk, particularly the young, and in getting to evidence-based care. One quick example, the NIMH Intramural Program developed a screening questionnaire called the ASQ (Ask Suicide-Screening Questions) that has been disseminated to primary care practices, and pediatric emergency rooms throughout the country, and really it is being used nationwide.

We also have funded a number of research projects, looking at school-based identification and prevention measures as well, and we do our best to make sure that they are out there.

We also work with Federal partners, like the Substance Abuse and Mental Health Services Administration, or SAMHSA, and there we are working with them, especially around the 988, looking, to try to make sure that States that are implementing the follow-ups to 988, are aware of evidence-based approaches to mental health crises.

For example, the proper utilization of mobile crisis teams that are trained in responding to individuals in mental health crises is one evidence-based approach that has been proven over and over again to work. So yes, and we continue to work in both of those areas. Thank you.

Senator REED. All right. Thank you, Dr. Gordon.

LONG HAUL COVID

Dr. Fauci, the issue of long-haul COVID has been dominating the news lately. Can you describe how NIH is tracking these cases? Are there common elements to them? Are there treatments showing any promise? Where are we in the process of tackling?

Dr. FAUCI. Yes. Thank you very much for that question, Senator. I will begin the answer, and then I will hand it over to Dr. Gibbons, who is also very much involved in this.

Senator REED. Thank you.

Dr. FAUCI. As you well know, this is a real phenomenon, and the epidemiology of it is still being worked out, I mean, the range of people anywhere from 5 percent to up to 30 percent of people have

the persistence of symptoms that are not thoroughly explainable by any pathogenic process that we have been able to identify.

We put together large cohorts that are now being followed, both to understand the actual prevalence, incidence, as well as the pathogenesis.

With regards to treatment, Senator, it is very difficult to do any treatment for it when you don't know exactly what the pathogenic mechanisms are, and that is the reason why we are putting so much effort into trying to find out just what is going on. Is it immune activation? Is it persistence of virus? Not necessarily replication competent virus, but maybe particles of virus such as the nucleotides.

But let me hand it over to Dr. Gibbons who could also tell you a bit about that.

Senator REED. Thank you.

Dr. GIBBONS. You know, I only add to Dr. Fauci's comments, that we are indeed setting up the recovery—researching COVID to enhance recovery effort. It is moving with a great sense of urgency given the suffering of the patients with long COVID. There are a number of elements that have launched effectively. One is to create an electronic health record, a base set of cohorts. They are derived from 60 million records of patients across the country.

A diverse body of patients, of which, between four and five million have COVID, and that provides an opportunity to track those individuals electronically, and digitally, and longitudinally, to see who develops long COVID, who does not, that can inform, as Dr. Fauci mentioned, our understanding of the prevalence, as well as the risk factors, as well as the long-term effects, chronically.

It is already starting to show preliminary evidence that is suggestive of—potentially the ability of vaccination to prevent the development of long COVID. Similarly, they were seeing signals that are telling us that the severity on the acute COVID has bearing on your susceptibility to develop long COVID.

Similarly, we are seeing trends towards, who is most affected. And again it is identifying people of color, African-Americans and Latinos as a high-prevalence group, developing long COVID that really hasn't come to the fore as much; and so we are learning as we go and develop this program. Thank you.

CHILDHOOD CANCER STAR ACT

Senator REED. Thank you very much. Just a final point, if I may. We have to reauthorize the STAR (Childhood Cancer Survivorship, Treatment, Access, and Research) Act. It is the best thing we have done in a long time, with respect to childhood cancer.

And I think you would agree, Dr. Tabak? Just a nod of the head is sufficient.

Dr. TABAK. Yes.

Senator REED. Thank you. Thank you, Madam Chair.

Senator MURRAY. Senator Kennedy.

Senator KENNEDY. Thank you, Madam Chair.

Dr. Tabak, what the National Institutes of Health has done, and continues to do is nothing short of extraordinary, I mean, it is really breathtaking. And I want to thank you and your colleagues for doing that.

We have all been to pandemic school for the last several years, and I want to use the few minutes I have to explore what we have learned.

COVID RELATED SCHOOL CLOSURES

Dr. Fauci, whether you asked for it or not, you have sort of been the government's face on the response to the pandemic. Looking back, and I recognize that hindsight is crystal clear, but looking back, do you think it was worth it, do you think the benefits were greater than the costs of closing down our elementary and secondary schools?

Dr. FAUCI. I think it is difficult to give a definitive answer to that. I know in the very beginning when we had really no other protection prior to vaccinations that were available to contain, somewhat, the spread of the virus. One of the things that was felt to be important would be to protect children as well as the rest of the population.

Right now we have felt, more than just recently, that it is very important to keep the children in school for the simple reason that we know of the deleterious effects, both psychologically, mentally, and developmentally in children, to keep them out of school. But you have to have a delicate balance between protecting the children from getting infected, and perhaps bringing the——

Senator KENNEDY. Did we strike the proper balance?

Dr. FAUCI. You know, I believe that we have. It is very tough to tell. I think only time will tell whether that is the case, because there is indication that has been deleterious effects on children, but we believe from a public health standpoint, that at the time it was the right decision.

Senator KENNEDY. Well, can I ask you this Doctor. And I realize, I am not asking—I am not saying, or offering judgment of what was done at the time. I am asking what we have learned. Let us suppose we have a substantial increase in prevalence of the coronavirus next week, God forbid.

Dr. FAUCI. Right.

Senator KENNEDY. Would CDC (Centers for Disease Control and Prevention) recommend shutting down the elementary and secondary schools?

Dr. FAUCI. It is very difficult for me to speak for the CDC, but knowing the fact that we——

Senator KENNEDY. Would you recommend it?

Dr. FAUCI. Right now, I would do everything we can to keep the children in school, and not shut down the school. And that has always been my strong recommendation, to the extent possible, not to keep the children out of school.

Senator KENNEDY. But yet we did shut down.

Dr. FAUCI. But to keep them safely in school, by getting children that are available to be vaccinated, vaccinated.

Senator KENNEDY. Right.

Dr. FAUCI. To get the children who are eligible to be boosted, vaccinated, and to surround the children with teachers and personnel in the schools who are vaccinated. That is the best way to protect the children while keeping them in school.

Senator KENNEDY. Okay. Let me ask you this. In hindsight, knowing what you know now, had you known it then, did we do the right thing in shutting down society? Would we have been better off saying: No, we are going to protect the vulnerable, the elderly, the people who are immunocompromised, and we are going to isolate them but have the rest of American society, churches, businesses, universities, schools go on about their business, while at the same time providing them guidance about how to protect themselves?

Dr. FAUCI. Well, it is a complicated question, I will try and give as simple an answer as possible. I think there is a misperception about who the vulnerable are. There are many, many more vulnerables in society, and there is a misperception that the only vulnerables—

Senator KENNEDY. Yes. But I am about to run out of time. Let us assume we can agree on a definition.

Dr. FAUCI. I don't think you can. I think that society is very heterogeneous, and it isn't a question of shutting down completely, Senator, because we never shut down completely. If you do shut down a society you do it for a purpose, and the purpose is, at that period of time when you are protecting people from interaction, that you get as many people vaccinated as you possibly can.

Senator KENNEDY. Let me stop you at that.

Dr. FAUCI. To shut down—

Senator KENNEDY. I am going to run out of time. Let me ask you one last question.

Dr. FAUCI. Sure.

Senator KENNEDY. What would you do differently today?

Dr. FAUCI. Right now I would hope that we would get many more people vaccinated.

Senator KENNEDY. No. But what would you do when you did it, in hindsight, if you knew then what you know today?

Dr. FAUCI. It depends on when we got the vaccine. Do you mean before the availability of vaccine? Before the availability of vaccine, when we had no other situation, I would try to protect people by making sure that they masked, and kept themselves separated from this congregate, indoor settings, that is what I would do, in the absence of a vaccine.

But right now I think it is important, looking forward, we still only have 66 percent of the total population vaccinated, and less than half of those are boosted. I think we can approach what we are likely going to be seeing, and are seeing now, with an increase in surges, with the possibility of a surge in the fall and winter.

One of the real things we can all do as a Nation, is pull together and try to get our people vaccinated, and those who are eligible to be boosted, boosted. That would solve a lot of the problems that you are referring to.

Senator KENNEDY. Okay. Thank you. Thank you all.

Senator MURRAY. Thank you. Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair.

SUBSTANCE ABUSE EPIDEMIC

Welcome, Dr. Tabak. I am posing the first question to you for an update on research efforts to better respond to the substance-use

epidemic, by way of context. As you well know, the substance-use epidemic continues to ravage communities across Wisconsin, and across the United States, and an increasingly dangerous role is played by synthetic opioids, such as fentanyl, as well as psychostimulants, like methamphetamine.

So I believe it is vital that we invest in sustained research into substance-use disorders to prevent deaths, treat patients, and make our communities safer. If you could describe recent research efforts, including what is happening with the HEAL Initiative, the Helping to End Addiction Long-Term Initiative, I would appreciate that.

Dr. TABAK. If I may, to turn to Dr. Volkow, who is our expert in this field.

Senator BALDWIN. Absolutely.

Dr. VOLKOW. Thanks very much for the question. And our research is actually going from the basic to help develop medications with new targets, to help develop formulations that can be—actually lead to better outcomes. To epidemiology research to understand the changing face of the overdose crisis, which now, as you are mentioning, is no longer just limited by our overdoses from prescription opioids, but encompasses overdoses from fentanyl, methamphetamine, and cocaine, to the implementation research that can help us determine what are the optimal models of care that we can deploy in community, and to take advantage of infrastructure.

So for example, research is ongoing to determine how the health care system can be involved in the prevention and treatment of substance-use disorders, and how can we bring treatments to justice settings, like prisons, and jails, and upon release, and maximize the possibility of these individuals to get healthcare, to the involvement of community, so that we can actually integrate the effort between healthcare, justice, and communities.

Through the HEAL Initiative, we have been able to accelerate significantly. Also, another area that has been neglected, overall, which is the need to better treatments for the management of severe pain, and if we do not address the need of patients suffering from severe pain, we keep them as very, very vulnerable, to seeking out much more dangerous drugs, out in the illicit market.

And finally, we need to also ask ourselves: What is it in the United States that is making Americans so vulnerable to the use of these drugs? And that is relevant to prevention, because if we do not understand it, then we cannot do interventions to actually protect those that because of circumstances alien to them, are actually at much higher risk to taking drugs, and ultimately develop addiction or overdosing.

Senator BALDWIN. I appreciate your response.

INVESTMENT IN RESEARCH

Dr. Fauci, the U.S. was able to bring a COVID-19 vaccine to the public in really record time. And I am grateful for the work of so many that made that possible; including several who are in this room.

Unfortunately, the next pandemic, driven by an unknown disease X will come. And I believe we can't wait. We should invest in the development of novel antivirals, and vaccines, and diagnostics for

unknown threats from priority viral families, now, so that we are better prepared in the future.

Can you explain how the investments we have made over time at NIH and across the Federal Government, made the COVID-19 vaccines and medical countermeasures possible? And how would sustained investments to develop responses to viral families of concern make us better prepared?

Dr. FAUCI. All right. Thank you very much for that question, Senator. Yes, it is very, very clear that the investment in basic and clinical biomedical research for at least a few decades, and maybe more, prior to the realization that we are dealing with a new, historic pandemic, allowed us to do something that was completely unprecedented.

Two examples of that are the work that was done on what we call vaccine platforms, the mRNA vaccine which was fundamental, basic research, on how to get the mRNA molecule to actually serve as a platform for vaccine.

Work at the NIH, in our own campus, as well as NIH-funded investigators throughout the world, also worked on what is called immunogen design to do work that led to the ability to stabilize the optimal immunogen, in this case it was the spike protein, which allowed us to go from the realization of a new pathogen, on January 9-10, 2020, getting into Phase 1 trial, in 65 days and 11 months data, having a safe and effective vaccine.

We did that because of the investment you are referring to. Right now, looking forward, we have what is called a Prototype Pandemic Preparedness Plan, which means you do just what I believe you are alluding to. You develop a number of families. There are about 20 families that are the high risk, of those there are about 7 families of viruses that if you do the fundamental work of looking at the commonalities among them, and develop diagnostic tests, assays, immune correlates, and do that now.

And if we don't get the resources now, Congress has been very generous to us up to now, but if we don't get the resources we need, we are not going to be able to do the kind of preparedness, not only for vaccine, but also for targeted development of antivirals, which we did so successfully with HIV (human immunodeficiency virus), and did quite successfully right now.

But we have programs that are not going to get off the ground unless we get funding. So fundamental basic, and clinical research are the core of everything that is going to protect us in the future. Thank you.

Senator MURRAY. Senator Braun.

FUTURE COVID LOCKDOWNS

Senator BRAUN. Thank you, Madam Chair. So I am going to have two questions, and I would like Dr. Tabak and Dr. Fauci to answer each of the two questions. I am going to start with this one.

So in navigating through the entirety of what we did to fight COVID, clearly, the most expensive feature of the navigation would have been lockdowns. We did that out of uncertainty, we had no idea, you know, how that was going to work.

Even in the business I ran, you had early dust ups, where you would get a case and clear out a warehouse. And we quickly under-

stood you do not throw caution to the wind, and you take the basic information that we all had to deal with, and you took it seriously, you put protocols in.

Let us look at lockdowns. It costed us trillions of dollars, and we are paying for that now, with super-high inflation. You know, I think I am interested in, when Johns Hopkins comes out with a study that said basically that didn't have any impact on mortality, and I don't know that that study addressed what mortality might have been impacted, in terms of deferring other healthcare. Can we take lockdowns off the table in terms of what we do in the future? Dr. Tabak, and then Dr. Fauci.

Dr. TABAK. I can't say, because I don't know what that future holds for us. If you have a pathogen that is very virulent, very infectious—

Senator BRAUN. Let us assume it is in the same modality as what we have been navigating through over the last couple 3 years.

Dr. TABAK. I think the initial presentation of the virus was one that was devastating. It killed a lot of people.

Senator BRAUN. What about the study that Johns Hopkins did, because we are always saying, pay attention to the science?

Dr. TABAK. I am not familiar with that study, sir.

Senator BRAUN. Dr. Fauci.

Dr. FAUCI. Senator that is a very good question. If you are going to lock down, you have got to use it temporarily for a reason to prepare you to be able to un-lock down, and get the public prepared for that.

Right now, looking forward, I don't see the need of lockdown in the future unless something really, very, very unusual happens. And the reason is, that what we really need to do, is we need to get our population vaccinated, and we need to get them boosted. That would completely obviate the need to lock anything down.

So right now if you ask me the question, looking forward, do I see, even if we do get a new variant, I think the vaccinations that we have, have enough cross-reactivity and our ability, with proper resources, to make variant-specific boosts, I don't see lockdown in the future. Lockdown is a temporary thing, to get you to be able to move quickly to save lives.

Senator BRAUN. That is good to hear, because in that kind of moment of uncertainty, I don't think we could afford to do it again. I hope the Biden administration is listening to that.

VACCINE MANDATES

The other question; and I led the effort on it; is when we took this and distilled it down to, you either get a vaccine or you lose your job. And thank goodness, we did marshal bipartisan support that said that didn't make sense, Supreme Court used that as a cue, you know, in terms of what they did to abrogate that.

So in the future, will we heed what the Supreme Court said, and that you wouldn't calculate, even though don't disagree that vaccines are an important tool, along with therapeutics, and preventative? Would you push to do the same thing that we almost did, that would have been the second calamity to occur? In terms of what it would have cost the economy, and probably not benefit from a result that would have been measurable?

Dr. Tabak, and then Dr. Fauci.

Dr. TABAK. As you know the vaccination is the single most effective preventive measure, and so to the extent that the law allows, you would want to continue to act——

Senator BRAUN. But would you recommend that we go down that path again, down to 100 employees in a business, to where you said, either get it, or lose your job.

Dr. TABAK. That is a policy call, sir. I don't make those calls.

Senator BRAUN. Dr. Fauci.

Dr. FAUCI. Again, it is a policy call. I would hope that we would marshal everybody, you know, both sides of the aisle, to get out there and encourage everybody to get vaccinated, and if they did, we wouldn't even have to address that question. I don't like mandating things. I don't like punishing people for not doing something.

But I would hope that they would realize, if you look at the data, and you just made an appropriate statement, Senator, a moment ago, about following the science; if you look at the data, of the differences in vaccinated versus unvaccinated people, and hospitalizations, and death, it is striking what it is.

So as a public health person, I would say why don't we all pull together to get people vaccinated. We won't have to worry about, essentially, putting what appears to be and is in fact a penalty if you don't.

Senator BRAUN. And I think the key to that navigation is to pay attention to the data, and the science, not the political science.

Dr. FAUCI. Right, exactly.

Senator BRAUN. Thank you.

Dr. FAUCI. Thank you.

Senator MURRAY. Thank you. Senator Rubio.

Senator RUBIO. Thank you. Thank you all, for being here.

GENDER TRANSFORMING CARE

Dr. Tabak, let me start with this question. You know, we have recently seen that the—not just the Biden administration, but the Biden administration, and others in the policy realm, have been actively promoting and supporting the use of things like, puberty blockers, and hormone therapy for young boys and girls. I want to sort of limit my question to minors, for what they have termed gender transforming care.

That is not an FDA-approved use of puberty blockers and hormone therapy I don't believe in any people, but especially in minors. So as the NIH is America's medical research agency, what work have we done at NIH, what work has been done to determine if this non-FDA-approved use of these medicines, this off-label use of these medicines is appropriate for minors seeking gender transforming care?

Dr. TABAK. So NIH funds a small number of observational studies to gather the data on the effects of treatments that transgender youth and their parents have chosen. And there are also a small number of studies that describe the health issues and risks, including HIV that are unique to these transgender youth. But all of the research in this space is observational. We do no interventional work.

Senator RUBIO. I guess, my question is before—one thing is a decision made by an adult, right, and especially given the irreversible nature of some of these treatments, isn't there some wisdom in the notion that before policymakers are out there promoting the off-label use of medications that lead to permanent changes, that there be some more research done on its impact, you know, 5, 10, 15, 20 years from now?

Dr. TABAK. So as you know, transgender youth are more vulnerable to depression, anxiety, engaging in self harm, and so it is important that we examine and evaluate the potential effects of these treatments.

Researchers are observing longer term psychological impact of these protocols, and so by looking at individuals, transgender youth, with and without histories of puberty suppression, we will be able to better answer the types of questions that you are posing.

Senator RUBIO. Yes. I guess my—that is my point. My point is, we don't know what its long-term implications are when we weight the costs and the benefits. The FDA (Food and Drug Administration) hasn't approved this, and yet we have policymakers promoting it. And I think that is an important point.

I mean, clearly, we don't want anybody harming themselves, and things of this nature, but we don't know what—these policy decisions are being made on the basis of observational guidance, and by your own admission, without any sort of long-term trajectory on its holistic impact.

COVID TRAVEL RESTRICTIONS

Dr. Fauci, I am running into something that is pretty interesting. I believe the United States is the only major Western country that now requires its citizens to test negative for COVID before they can get on an airplane and reenter the country. I believe that is accurate.

And on the other hand, we are hearing now that, for example, Title 42, which is a COVID-era policy should be lifted because we have reached the point now where COVID is manageable, or at a level where we no longer need Title 42. And we obviously know we have a problem in our southern border where every day people are entering the country, illegally, and many are not even being tested for COVID. And even if they are, they are being allowed to stay, and most certainly would under Title 42.

I don't understand. How do we tell American citizens, if you test positive, even if it is a dead virus that has been in your system for 10 days, because you can test positive days after you are no longer infectious, and you can't enter your own country? But people—if you arrive illegally, whether you test positive or not, if you say the magic words for “asylum” you get to stay in the country.

And this is a real-life scenario. I know people that are abroad, they test positive, they are not sick; maybe they were sick a week ago. And they can't afford to continue to pay for hotel rooms, and staying overseas until they can finally score a negative test.

Has the time come for us to lift this, in your view; you know, having been so integral in our COVID response? Are we at a point now where American citizens should be allowed to return to their country without testing negative?

Dr. FAUCI. You know, I am not—thank you for the question. It is an important question. I don't have the answer to that. I mean, we work with our CDC colleagues to continue to examine the feasibility of that, and the desirability of that. I think the idea of having an immigration issue mixed with a public health issue for the general population; I think those probably should be separated.

Senator RUBIO. Well, except they are interrelated, because they both involve groups of people entering the United States. One group is citizens of the country entering legally, the other group, frankly, are people that are not entering legally. The group that is not entering legally, even if they test positive, if they are even tested, get to stay; the American citizen can't reenter their own country until they produce a negative test.

And my point is, if we have reached the point in COVID, where we no longer need Title 42 as a COVID restriction for illegal entry, why do we still need travel restrictions for American citizens for legal entry into their own country? That is the genesis of the question. That is where I think the link is the—it sort of seems to be at odds with it.

Dr. FAUCI. Yes.

Senator RUBIO. All right. Thank you.

UNIVERSAL COVID VACCINE

Senator MURRAY. Thank you. Dr. Fauci, you talked a little about this. But I wanted to go back through it again. I am really pushing for Congress to pass additional emergency COVID funding to make sure that our communities have the tests, and the treatments, and vaccines they need to keep their families safe.

And I understand your Institute is supporting research on the development of these next-generation vaccines that could protect against multiple variants. What can you tell us about the progress of that research? And what does NIH need to see it to completion?

Dr. FAUCI. Well, thank you for that question. Well, the progress has been substantial. To get what we call "universal", and that is probably too broad a term, is to get a vaccine that works against multiple variants of SARS-CoV-2 is the first step.

And that would be something where you get a vaccine that either is directed against the common component of all of the variants, or has each of the components of the variants, for example, in a nanoparticle with a mosaic or multiple components to it.

We have studies that are, right now, gone from preclinical, namely, in an animal model, into a human study, and the results actually look very promising. The next step would be to get a vaccine that not only is against all variants of SARS-CoV-2, but against all of those group of variants, including, what we call, sarbecoviruses, which overlap with the viruses that we see in many bats, which almost certainly are the original source of these viruses, that have jumped species and gone into humans.

The work is going along very, very well. We are getting a number of investigators, both people who have been established in the field, and new investigators, but we can't continue it, Madam Chair, without additional resources.

And that is really one of the things that is very, very difficult for us, because the scientific opportunity is there, and we really feel

that we do have this, not only as an aspirational goal, but we will be able to get to that goal of getting a vaccine that would protect us against both known and unknown variants. So we are excited about the science of it, but we can't continue without additional resources.

INTERAGENCY WORK WITH BARDA

Senator MURRAY. To have resources, right. And how is your Institute working with BARDA (Biomedical Advanced Research and Development Authority) to accelerate innovation in the next-generation vaccine development, particularly for COVID-19 vaccines?

Dr. FAUCI. Well, we have had a long-standing collaboration and cooperation with BARDA now for quite a long period of time. And the way that works is that we do the fundamental, basic research, and proof of concept, and very often get involved, not only in the preclinical, but in the early trials, whereas, BARDA partners with a pharmaceutical company to do the advanced development of these concepts.

So it is a partnership that has really worked very, very well, and hopefully we will be able to continue that, again with the need for new resources.

Senator MURRAY. Okay. Thank you.

Dr. Gordon, I want to come back to you. You have had several questions about mental illness, not surprising. It is a huge issue for America today. And I know that despite the best efforts of researchers, like yourself, in the past 30 years, we have seen dramatic increases in mortality, morbidity, and healthcare costs related to mental illness; and that is actually before factoring in the effects of this pandemic, and the opioid crisis.

MENTAL HEALTH DIAGNOSIS ISSUES

And on top of it all, diagnosis is really difficult. And medications don't always work, and can have awful side effects. So I know Senator Blunt asked you about using RADx, as one possible approach, but what are the greatest barriers to accurate diagnosis?

Dr. GORDON. Well, frankly, one of the greatest barriers to accurate diagnosis, Senator, is that our diagnoses are not terribly good, in terms of describing what is going on in the brain. And so we need a better individualized approach, not just to diagnosis, but really being able to make informed clinical decisions in cooperation with our patients.

Well, the clinical issue really isn't, does this individual have depression, or schizophrenia, or bipolar disorder, although those diagnoses can be sometimes hard to differentiate in the individual patients.

The bigger clinical question is: For this patient with depression, are they going to benefit most from a medication, or which type of medication? Or are they going to benefit most from psychotherapy, or a brain stimulation treatment?

We have a number of different research projects that are aimed at trying to make those kinds of clinical decisions with the aid of technology, with the aid of increased attention to details in the patients' behaviors, and cognitions. And that approach I think is

going to take advantage of things like big data. So we need to collect lots and lots of information about—well characterized patients.

And then we need to make careful experiments to try to determine when that information helps us describe that patient better. So it is really about precision medicine in psychiatry, moving it forward in a number of different fronts, from grants, to academic organizations. And as I mentioned also before, small business grants that are really paying off. So we should see some progress, hopefully in the future, near future.

Senator MURRAY. So I assume it is fair to assume that solving this diagnosis puzzle, will really open doors for better treatments?

Dr. GORDON. It would open doors to transforming how we decide with our patients what treatments to use. It would really change psychiatry. Right now, as a psychiatrist, if I want to help someone with depression, our only discussion is about which side effects they don't want. And so we try to avoid one medication or another. As opposed to which medication, or which treatment that I have to offer is going to work better for them. So yeah, it would really transform things.

Senator MURRAY. Okay. Thank you. Senator Blunt.

Senator BLUNT. Thank you, Chair.

ADUHELM

Dr. Hodes, I have been watching the FDA decision on Aduhelm, the Biogen drug, as well as the CMS (Centers for Medicare & Medicaid Services) handling of that. I think that decision is going to have some pretty long-term consequences, particularly the CMS decision, and other companies will be following. Biogen has already made some pretty dramatic decisions, based on the CMS view that only the people in a trial could benefit from the emergency approval, by FDA.

Would you talk a little bit about both of those things? First the FDA approval process, what merit do you see in that emergency approval process? And then, what concerns do you have or not have about CMS then deciding that it would only be available to a few people?

Dr. HODES. Thank you for the question. Well, of course FDA and CMS have their regulatory responsibilities, and we defer to those. But we do work very closely particularly on the science involved in these implications; so as many, or all of you may know, the decision by FDA was what was called an accelerated approval of Aducanumab, Aduhelm, based on its ability to clear amyloid from the brain, and by brain scans.

Without compelling evidence of clinical effectiveness, and that was the rub. And in fact, the FDA decision required that the sponsors, Biogen, Eisai, then conduct a randomized, controlled trial to look if—to determine if there was, in fact, clinical outcome.

It was in that setting that CMS said that for widespread coverage it would require randomized, controlled clinical trial. It made the distinction, though, about the future of such drugs. Any drug that received an approval based on clinical outcome, based on FDA decision and judgment, would have broader coverage without requirement for another randomized clinical trial.

But any in which there was no demonstrated evidence of effectiveness on clinical outcomes, would require that kind of outcome before they went further. Again, those are regulatory decisions.

Senator BLUNT. So it sounds like, to me, the FDA decision was really a CMS; or at least just the decision to continue the trial. That may not have been what FDA thought it was doing, but that is what CMS decided it was doing?

Dr. HODES. No. FDA, again, by requiring that—for maintenance even of the accelerated approval, that a clinical trial, a randomized trial, be carried out, was also saying there needed to be a continuation.

You asked, importantly I think, what the impact of this will be on other studies, other agents. There are currently three companies, Roche, Lilly, and Eisai—Biogen, which have ongoing clinical trials of other antibodies to amyloid, they have all received a breakthrough designation last year from the FDA. They are all expected to produce their results in the next few months. So above all, I think we all share hope and optimism that will see effective clinical outcomes there.

For NIH, I think the implications are clear. We need to support the most rigorous and continuing research toward amyloid and other targets, the kind of research that will give clear-cut, definitive answers about clinically important outcomes. And that is certainly our part in this consortium.

VACCINE AND THERAPEUTIC DEVELOPMENT

Senator BLUNT. Well, Dr. Fauci, while we are talking about the accelerated approvals, or not, during COVID, obviously NIAID (National Institute of Allergy and Infectious Diseases) shepherded both successful vaccines and therapeutics, through the approval process during the pandemic. I am concerned that once the pandemic is officially behind us that both vaccine and therapeutic research and development will be subjected to normal development processes that, in what we have learned in the last year-and-a-half may not be the structure that we should use. Would you talk about that a little bit?

Dr. FAUCI. Senator, are you referring to the fact that we should not slow down the acceleration of approvals when we are out of the pandemic phase?

Senator BLUNT. I am asking that, or if there should be some “new normal” approval process, now that we have had, I think two vaccines, and 20 treatments developed through those partnerships?

Dr. FAUCI. Yes. I am not sure I understand the question. It is my fault. Are you saying that, should we continue the normal standard of approval, which would take much longer than the emergency-use authorization? Is that the question you are asking?

Senator BLUNT. That is the question.

Dr. FAUCI. Yes. Yes, I think we should go through the normal approvals, and if we are in an emergency situation again, we absolutely should use the EUA (Emergency Use Authorization) approach which has fared us very well. But when we get behind us the outbreak, I think the normal approval process, which is pretty much expedited pretty well by the FDA, should continue.

Senator BLUNT. All right. Thank you, Chairman.

Senator MURRAY. Senator Kennedy.

TITLE 42 RECISSION

Senator KENNEDY. Thank you, Madam Chair. Did the Biden administration ask any of you whether it was safe to rescind Title 42?

Dr. TABAK. We have had no discussions about that, sir.

Senator KENNEDY. You haven't done?

Dr. TABAK. I have not. No.

Senator KENNEDY. How about you, Dr. Fauci?

Dr. FAUCI. No. I have not.

Senator KENNEDY. How about you, Dr. Gibbons?

Dr. GIBBONS. No, No, sir.

Senator KENNEDY. How about you, Dr. Gordon?

Dr. GORDON. No.

Senator KENNEDY. Dr. Hodes?

Dr. HODES. No, sir.

Senator KENNEDY. Dr. Volkow?

Dr. VOLKOW. No.

Senator KENNEDY. Well, the Biden administration says it is safe, that under the science it is okay. Who did the administration rely on, to suggest that rescinding Title 42 is in the interest of public safety?

Dr. FAUCI. That was a CDC decision. The Title 42 is a CDC decision.

Senator KENNEDY. Do you agree with it, Dr. Fauci?

Dr. FAUCI. Well, I think that the immigration policy should be separated from the public health—

Senator KENNEDY. No. And I don't want to get you involved in immigration policy; but people are people, physiology is physiology.

Dr. FAUCI. Right.

Senator KENNEDY. And one is the susceptibility of the virus has nothing to do with their country of origin or immigration status.

Dr. FAUCI. Right.

Senator KENNEDY. And what I am asking you, purely from a public safety standpoint.

Dr. FAUCI. Right. Yes.

Senator KENNEDY. Is it safe to rescind Title 42?

Dr. FAUCI. I think given the level of infection at the time, which is right now, that I think that the CDC decision was a reasonable decision.

Senator KENNEDY. Does anybody disagree with that? Do you all agree with that? Let me get you, of record.

Dr. Gibbons?

Dr. GIBBONS. Yes. I concur with Dr. Fauci on that.

Senator KENNEDY. Dr. Gordon?

Dr. GORDON. I don't have the expertise to concur or not concur.

Senator KENNEDY. Okay. Dr. Hodes?

Dr. HODES. I would also say I don't have the expertise to weigh on this.

Senator KENNEDY. Dr. Volkow?

Dr. VOLKOW. I don't have the expertise.

Senator KENNEDY. Okay. All right; thank you very much.

Senator MURRAY. Senator Moran.

ARPA-H PRIORITIES

Senator MORAN. Thank you, Chairman Murray. I don't have the benefit of knowing what has been asked and answered. So I will ask questions. Recently the ARPA-H proposal would initially focus—this is for Dr. Tabak—would initially focus on three diseases: cancer, Alzheimer's, and diabetes, and be housed under NIH.

Congress and NIH already invest significantly into research and development to these three diseases. How can NIH conduct proper oversight to ensure NIH, through its current work, isn't simply being replicated?

Dr. TABAK. I think those three diseases are meant to be illustrative and not restrictive. In terms of the larger issues that you raise, as you know, NIH does a rather extensive portfolio analyses, and the expectation would be that there will be a crosstalk between the new agency, and the NIH to avoid, as you put, you know, the potential for duplication.

ALZHEIMER'S DISEASE TREATMENTS

Senator MORAN. This is again for you, Dr. Tabak. In recent National Coverage Determination, CMS indicated it would support FDA and NIH, by covering drugs for Medicare beneficiaries, participating in randomized, controlled trials. I would interpret that to mean that there is a path to coverage through NIH studies for participants qualifying trials, related in the FDA-approved Alzheimer's disease treatments. Is that an assessment that—and I am not—if that is an accurate assessment? Or how would you elaborate?

Dr. TABAK. If I may turn to Dr. Hodes, who is the expert in that space.

Senator MORAN. Dr. Hodes.

Dr. HODES. I think that is a very accurate statement. Thank you.

Senator MORAN. Good. And that is a good development, right? Dr. Hodes shook his head, yes.

Dr. HODES. Yes, sir.

NCI BUDGET REDUCTION

Senator MORAN. Let me talk a moment, in the absence of Dr. Sharpless, I will let you all direct who should answer my question. The NIH 2023 budget request suggests \$199 million cut to the NCI (National Cancer Institute), a 2.9 percent cut from the current fiscal year. I assume that that will be explained as those dollars being picked up in ARPA-H. What is the rationale for the significant funding pivot to ARPA-H at the expense of NCI?

Dr. TABAK. So at the time the budget was prepared, the only baseline that the administration had to work with was a continuing resolution level. We are fortunate that the Congress, in the Omnibus, provided us with substantially more resources than were in the continuing resolution. And we certainly look forward to working with you as the 2023 appropriations process works through.

Senator MORAN. So there is room—there is no particular insistence that that is the right ratio between the funding of one ARPA-H, and the normal appropriations process for NCI?

Dr. TABAK. I think it is more than a reflection of using a baseline that was available at the time.

Senator MORAN. Well, the \$16.9 billion increase for NCI in fiscal year 2022, allowed the NCI to increase the funding allocated toward competitive cancer grants. It is one of the reasons we continue to advocate for higher NCI funding, is to improve NCI's ability to award those competitive cancer grants.

In recent years NCI could only fund about one in eight research grant applications. Dr. Sharpless indicated, in front of the subcommittee, that that was a great concern to him, as it is to me. If NCI funding is not boosted above the fiscal year 2022 levels, can competitive grants be prioritized and expanded?

Dr. TABAK. It would be very difficult to do that in the absence of additional funding.

Senator MORAN. Doctor, thank you, both of you. Thank you all.

AUTOIMMUNE DISEASE RESEARCH

Senator MURRAY. Dr. Tabak, last week the National Academy has issued its review of NIH's autoimmune research portfolio, and the authors found that much of the work that that agency does in this area is really extraordinary. But that NIH doesn't do the best job coordinating, or setting priorities, or focusing on innovation, or evaluating its autoimmune research portfolio.

The authors' findings really echo an earlier 2010 National Academy Study on women's health research, and to address these problems, they recommended the creation of an Office of Autoimmune Disease Research within the Office of the Director, to facilitate collaboration and coordination.

Given the importance of this research for communities across the country, it is critical that NIH does the best possible job facilitating it. Do you have concerns with establishing this office?

Dr. TABAK. Senator, the report, as you know, was released last week, and we are still reviewing the specifics of it. In reviewing the top line messages, among the things they suggest that we do, develop an agency-wide strategic plan, make sure that investments that we make align with those strategic plans, coordinate both within and outside the agency, do evaluation, do reports to the Congress.

At first glance, I think these are things that we could probably do without the creation of a new office, but I certainly, you know, would be willing to work with you, and other members of the committee, going forward, as we sort through the specifics of the report, and get a better understanding of the rationale behind their specific recommendation.

Senator MURRAY. Okay. I would like to work more with you on that. I think this is extremely important. I want to make sure we are addressing it in the correct way, and I want to talk to you more about that.

Dr. TABAK. Thank you.

Senator MURRAY. Senator Blunt.

EARLY STAGE INVESTIGATORS

Senator BLUNT. Thanks Chair. I think my last question today will start with Dr. Tabak, but anybody that wants to talk about it.

One of the things we were most concerned about 8 years ago was the fact that young researchers were leaving the field. That the pool of money, not only wasn't increasing, but it was about 22 percent less in the research buying power, than it had been.

What are we doing right now to keep young researchers in the field, and try to see that they get their first grant, and that there is not an obstacle based on numbers of first grants to getting that second grant?

Why don't you start, Dr. Tabak? And if anybody else wants to talk about what you are doing to keep young researchers engaged I would be pleased to hear that.

Dr. TABAK. We have prioritized the funding of early-stage investigators; back in 2013 we only supported 600 such individuals, last fiscal year, 1,513. That has come as a result of the Institute and Center leadership prioritizing applications from these individuals. We have also created certain mechanisms that would incentivize and enable early-stage investigators.

So for example, we have the so-called Katz Early Stage Investigator Award, in which no preliminary data is accepted. This is important, it basically liberates a new investigator from his or her post-doctoral or graduate school experience, and they are able to think, you know, as boldly as possible in preparing an application.

We also have the NIH Director's New Innovator Award Program which is attracting early-stage investigators from very broad biomedical fields. And so when you take these things together, I think we are making good progress in ensuring the entrée into the system of biomedical research.

But let me turn to my colleagues to see if anybody else wishes to comment.

Dr. GIBBONS. If I might add to Dr. Tabak's comments. There are two areas for the NHLBI (National Heart, Lung, and Blood Institute) that we are particularly focusing on. As evident in these hearings, a critical element is the translation of basic science understanding into clinical science and clinical medicine, and clinician scientists are critical to making those transitional leaps that are so important to public health.

And this is an area, quite frankly, where there is a paucity of early-stage investigators, in a critical pipeline. And so we have special awards for them to get their first RO1, in particular, to launch their careers as early-stage clinical investigators.

I would also add the diversity of that early-stage investigator pool is critical, and recognizing the supportive efforts to expand that diversity is, again, another high priority which we have programs, specifically, designed to do that, like our PRIDE Program. Over.

Senator BLUNT. Anybody else?

Dr. HODES. I had to reinforce the points made. And note that we also try to track outcomes of our programs, including training, career development. So for example, with the expanded research around Alzheimer's and related dementia's research, since 2015 through the present, fully a third of the investigators awarded have been new and early-stage investigators who have had no prior, major NIH research. And we think this is an important reflection

of our ability to recruit. And now we will see about retaining them into the research workforce.

Dr. VOLKOW. And I was just going to make a comment, because Dr. Tabak alluded to it, and an area that is crucial is to ensure that we get the brightest interested in science; so going after younger kids, and teaching them, and giving the opportunity to see what science is all about, is a way that you can ensure that you will have the throughput then, to get investigators.

Senator BLUNT. Thank you, Chair.

Senator MURRAY. Thank you. Senator Moran.

Senator MORAN. I will just take this moment, Chairman Murray, to thank you and Senator Blunt, for your leadership, and the success that we have had in numerous years, now in a row, in the support for the National Institutes of Health.

I have been a ranking member of this committee with Senator Harkin. You both have been ranking members, and chairmen and woman of this committee during a period of time in which we were capable, in a bipartisan way, of increasing the investment in fighting the diseases and afflictions that Americans and people around the globe suffer from.

And not knowing what our committee schedule is into the future, this may be the last time we have Senator Blunt here with the NIH crew. And I take this moment to thank him, in particular, for his efforts that have been recognized around the country, and certainly in our home States of Kansas and Missouri, of making a tremendous difference in the efforts to find the cures and the treatments to reduce the afflictions that we face in the world, of our well-being, of our health.

And so to you, to Senator Blunt, particularly today, thank you for that leadership. I am pleased that the world is in a better position, and that Americans have a greater chance of fighting these diseases, and there is a lot more hope than there used to be.

Senator MURRAY. Thank you. Thank you for those comments. I think we all agree.

That will end our hearing today. And I want to thank my fellow committee members for a thoughtful conversation.

I want to thank Doctors Tabak, Fauci, Gibbons, Gordon, Hodes, and Volkow. Thank you all for joining us today to share your expertise.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due May 27, at 5:00 p.m.; the hearing record will 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. LAWRENCE TABAK

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. The budget request concentrates most of its proposed spending increase in ARPA-H, even though that agency has yet to hire anyone. If Congress funded ARPA-H at \$5 billion as the budget proposes, what impact would that have on N-

I–H’s 27 institutes and centers? While Congress’s work on the ARPA–H authorization continues, there’s broad agreement that it should not be based in Bethesda with the rest of NIH and that its staff should be recruited from outside the agency. Given the transformative role ARPA–H is supposed to play by supporting high-risk, high-reward research, I believe NIH should rely on outside expertise to recruit the right staff to stand up the agency.

Who is handling ARPA–H’s hiring? Is it NIH or an outside firm?

When does NIH expect to have a permanent director on-board?

Answer. HHS is in the process of standing up ARPA–H and developing plans for its operations and functions, including recruiting an innovative group of people to help launch the important work of the agency. HHS is bringing onboard staff in key support functions—acquisitions, budget/finance, and strategic resources. Program managers will be recruited after an inaugural director is on board. The Secretary is also seeking to identify an interim leader prior to the appointment of an inaugural Director. Ideally, this acting deputy director would have considerable experience in government—specifically familiarity with the “ARPA” model, broad technical and management experience across several disciplines, and a proven record innovating around experimental platforms and tools to facilitate discovery, quantification, and validation of fundamental measures in science.

Meanwhile, the White House is currently looking for candidates for President Biden to appoint as an ARPA–H Director who will be responsible for administration and operation of ARPA–H and who will report to Secretary Becerra. The ideal candidate would be an extraordinary leader with a vision and proven track record for driving transformative change in health and biomedicine, a strong private sector background, and experience in academia or government, as well as a proven ability to build partnerships.

Question. Congress provided significant funding for research into long-COVID with the goal of understanding this complex condition and developing potential treatments.

When does NIH expect to exhaust its existing balances of long-COVID funding and what steps would it take if faced with a shortfall?

Answer. Funds for the Researching COVID to Enhance Recovery (RECOVER) initiative are being used to implement the necessary in-depth and national scale approach to understanding, preventing, and treating the post-acute sequelae of SARS–CoV–2 infection (PASC), including Long COVID. The National Institutes of Health (NIH) has either obligated or has planned/outyear RECOVER activities for all of the \$1.15 billion funding provided by Congress. Working on an accelerated schedule, NIH has obligated approximately \$674.5 million as of May 17, 2022. The balance will be utilized in planned obligations to cover fiscal year 2022 and outyear spending for RECOVER studies.

Our understanding of the complexity and broad range of conditions encompassed in PASC has evolved substantially since the time of the original appropriation, and it is clear that we need to further accelerate and expand our existing efforts and capacity to test a wider range of interventions and develop assays for the diagnosis and monitoring of patients with PASC.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

ARPA–H

Question. I am a supporter of ARPA–H. At last year’s NIH hearing I spent the majority of my statement highlighting that ARPA–H is the right idea at the right time because, as we learned so well during COVID–19, NIH can take a larger, more involved role in public-private partnerships without overstepping the bounds of the role private industry should play. Since that time, Congress has passed an Omnibus appropriations bill that included \$1 billion to establish ARPA–H. In addition, the HHS Secretary has established ARPA–H at NIH, but with direct reporting to the Secretary’s office. Dr. Tabak, can you explain why it is important to have ARPA–H under the NIH umbrella, and specifically how this will help get ARPA–H established and working on research programs faster?

Answer. On April 15, 2022, Secretary Becerra transferred ARPA–H to the NIH as notified in the Federal Register published April 20, 2022. The Secretary indicated that, following presidential appointment, the ARPA–H director will report directly to the Secretary and be delegated all the necessary authorities to administer ARPA–H.

The Secretary’s decision to transfer ARPA–H to NIH is critical to accelerating ARPA–H’s establishment and reducing the use of funding for redundant functions using critical infrastructure provided by NIH. Broadly, ARPA–H’s mission aligns

with NIH's, in that both agencies strive to improve health through research. Through close collaboration between ARPA-H and NIH, along with other Federal, and public or private entities, ARPA-H will ensure it reaches all people with better health solutions faster. ARPA-H benefits from drawing closely upon NIH's role as a global leader in biomedical research, including its knowledge, expertise, and ongoing activities. Setting up ARPA-H within NIH will avoid unnecessary duplication of scientific and administrative effort. As a part of NIH, ARPA-H is benefitting from and leveraging the use of several electronic systems to quickly establish its functional areas, provide for a more seamless start up, and avoid building functionality from scratch that already exists.

Question. ARPA-H is in the process of being stood up. Can you provide the Committee with additional details on:

What qualifications you are looking for in a Director?

Answer. President Biden will appoint an inaugural Director with the requisite experience to lead this new agency. An ideal candidate would be an extraordinary leader with a proven track record and vision for driving transformative change in health and biomedicine, a strong private sector background, and experience in academia or government. In addition, the candidate should have a proven ability to build partnerships.

Question. When do you expect a Director to be in place?

Answer. The White House manages the search, nomination, and announcement, of all presidential appointees.

Question. How many program managers are you looking to hire?

Answer. ARPA-H will recruit and hire program managers based on the organization's priorities and the funding available. Decisions will be made when the inaugural ARPA-H Director is appointed.

Question. What are the qualifications for the location for an ARPA-H headquarters and when will that decision be announced?

Answer. HHS is in the process of standing up the new agency and is developing plans for its operations and functions. Currently, no commitments as to the physical location of ARPA-H have been made.

Question. Will there be an official location search similar to how locations for other agencies outside of Washington, DC were chosen? Like the recently relocated National Institute of Food and Agriculture?

Answer. Currently, no commitments as to the physical location of ARPA-H have been made. We will continue to engage in a thoughtful process.

Question. When do you expect scientific programs to begin?

Answer. Scientific programs are expected to begin after the appointment of an inaugural director and the recruitment and hiring of the first program managers.

Question. How will ARPA-H be structured to ensure that biomedical researchers at universities have an opportunity to be program managers when typical sabbaticals from research institutions last 2 years, which is less than the typical three year program manager term?

Answer. Program managers are expected to be appointed for a single three-year term with the possibility of a single renewal, but shorter terms could be negotiated. In a circumstance where a program manager's home institution recalled the researcher prior to the end of an appointment, ARPA-H would anticipate working with the institution for a mutually agreeable solution.

Question. Will ARPA-H encourage researchers to publish outcomes of their ARPA-H research in medical publications? This is currently atypical at DARPA.

Answer. DARPA and ARPA-H operate in two different ecosystems. DARPA funds performers to benefit the Department of Defense in execution of its mission. ARPA-H's goal is for new technologies, capabilities, and platforms to benefit everyone and improve everyone's health potential. Where appropriate, ARPA-H performers will be encouraged to publish their findings or otherwise make them widely available.

Question. Will ARPA-H run clinical trials? If so, what will be the process to test/approve treatments or vaccines with FDA?

Answer. Scientific programs are expected to begin after the appointment of an inaugural director and the recruitment and hiring of the first program managers. A potential area of focus is to improve clinical trials to speed the generation of research results and recruit more inclusive trial participants so that those results are more representative of the patient population. ARPA-H will seek opportunities to work closely with other Federal agencies and the private sector on these issues.

Question. More specifically, how do you envision the partnership between ARPA-H and FDA?

Answer. See Answer above.

Question. How do you ensure the FDA approval process does not hinder the urgency ARPA-H will need?

Answer. Operating within the Federal Government, ARPA-H anticipates the benefit of forming close relationships, collaborations, and agreements with other Federal agencies, either formal or informal. In either case, the intent remains the same—to work closely with other Federal agencies to engage them early in the program development process and collaborate to promote synergistic goals.

Question. Are you concerned that FDA will hinder the fast moving nature of the agency because of their slow approval process?

Answer. ARPA-H anticipates partnering with the FDA through collaborative integration and involvement of FDA staff, where appropriate, in relevant programs from their inception. These collaborations would be developed to be mutually beneficial from ARPA-H's and FDA's perspective.

Question. Will ARPA-H have an advisory board? If so, who will comprise it? If not, why not?

Answer. This would be decided by the inaugural Director.

Universal Flu Vaccine

Question. In response to the COVID-19 pandemic, the US was able to work through public-private partnerships to develop several vaccines within less than a year. While this was a much needed triumph, I assume, Dr. Fauci, it also greatly increases expectations that we can develop vaccines for other diseases using the mRNA model or the processes used for developing a COVID vaccine. What did you learn from COVID-19 vaccine research and development that can now be applied to the development of other vaccines, particularly a universal flu vaccine?

Answer. The development of vaccines for COVID-19 was greatly accelerated by the development of vaccine platform technologies as well as advances in structural biology that allowed for the stabilization of the SARS-CoV-2 spike protein and its incorporation into the mRNA vaccine platform. Research advances that have supported the development of COVID-19 vaccines, including current efforts to develop the next generation of COVID-19 vaccines, will support ongoing efforts to develop universal influenza vaccines by further validating and advancing the vaccine platforms and technologies on which they are based. For example, advances in mRNA vaccine platforms, including the successful development of mRNA-based COVID-19 vaccines, have shown the utility of this vaccine platform, especially in situations where rapid development of vaccines is crucial or where traditional vaccine technologies have not yet proven successful. Several mRNA-based vaccine candidates for seasonal influenza are currently undergoing clinical testing. The National Institute of Allergy and Infectious Diseases (NIAID) also is sponsoring clinical studies of three novel mRNA-based HIV vaccines. Evaluation and development of the mRNA vaccine platform across a number of diverse virus families will further aid our efforts to develop tools and resources for responding to the next pandemic threat.

NIAID also will build on the advances made for COVID-19 vaccines using other vaccine platforms, many of which are already in use for the development of universal influenza vaccines. NIAID Vaccine Research Center investigators have created a nanoparticle-based pan-coronavirus vaccine candidate designed to elicit antibodies targeted to the spike protein of multiple different coronaviruses. This mosaic nanoparticle-based approach—based on the universal influenza vaccine concept known as FluMos—is currently undergoing preclinical testing in an animal model. Separately, NIAID-supported scientists provided proof of principle that self-assembling mosaic nanoparticles displaying receptor binding domains of multiple coronaviruses in the Sarbecovirus subgroup (including SARS-CoV-2) can induce protection in mice when challenged with another Sarbecovirus. These advances in nanoparticle vaccine technology will help inform similar strategies for development of a universal influenza vaccine. In addition, NIAID intramural investigators are evaluating inactivated whole virus vaccine candidates for a broadly protective beta-coronavirus vaccine based on related efforts to develop a universal influenza vaccine. Development and testing of this approach for beta-coronaviruses will provide valuable insights into the development of broadly protective inactivated whole virus vaccines for influenza and other viral families. NIAID also is supporting studies through its vaccine adjuvant program to compare different classes of adjuvants and identify the most efficacious vaccine formulations. The identification of vaccine adjuvants that promote cross-protective and durable immunity in vulnerable populations would complement ongoing efforts to develop universal influenza vaccines as well as vaccines for other pandemic threats.

In late 2021, NIAID announced four awards to fund multidisciplinary, collaborative teams to conduct research on pan-coronavirus vaccine candidates and help accelerate pan-coronavirus vaccine development. The teams will incorporate advances in coronavirus biology and immunology; immunogen design; and innovative vaccine and adjuvant technologies to discover, design, and develop vaccine candidates to

protect against multiple SARS-CoV-2 variants and other coronaviruses. NIAID expects that these efforts not only will advance the development of pan-coronavirus vaccines, but also will complement similar activities undertaken by NIAID intra- and extramural researchers, including at the Collaborative Influenza Vaccine Innovation Centers (CIVICs) and the NIAID-supported Vaccine and Treatment Evaluation Units (VTEUs) to develop universal influenza vaccines. In addition, NIAID-supported research to better understand the immune response to SARS-CoV-2 infection and vaccination, including the role of antibodies and T cells, will further advance our understanding of the human immune system and may provide valuable insights into new strategies for developing and evaluating broadly protective vaccines for other pandemic threats, including influenza.

Long COVID

Question. Dr. Tabak, there are a lot of unknowns about long COVID—what the causes are, why it affects only some, even what the defined set of symptoms are—and that opens up a lot of research avenues. But there is also a sense of urgency that should not be lost and NIH must stay focused on finding ways to help those who suffer, which could be as many as 30 percent of the population that has had COVID-19.

At the end of 2020, Congress provided \$1.15 billion for research on long COVID. Using this funding, NIH started the RECOVER program, which in the intervening months has received a lot of criticism. Concerns have been raised about NIH's lack of urgency and whether it is focused too much on open-ended research questions as opposed to testing treatments and moving therapeutics to clinical trials. Can you address these concerns and specifically highlight why NIH chose to create a large observational study as opposed to focusing on testing therapeutics and other possible treatments?

Answer. Researching COVID to Enhance Recovery (RECOVER) program's national longitudinal observation study is enrolling thousands of diverse participants including adult, pregnant, and pediatric populations from over 200 sites across the country, to fully understand the incidence, prevalence, clinical signs, and symptoms of the various forms of post-acute sequelae of SARS-CoV-2 infection (PASC) and risk factors for their development. Of note, RECOVER is particularly attentive to ensuring inclusion of those typically underrepresented in biomedical research and those from the populations disproportionately affected by COVID-19. The clinical data and specimens from this study are necessary to provide the robust evidence base for development of diagnostics, clinical monitoring strategies, as well as therapeutics. Moreover, the data collected through this study will inform an understanding of and strategies to address ethnic and racial disparities in PASC, impact on pre-existing conditions, and mental health effects.

Key data and findings from RECOVER's observational study have ensured that NIH is now better poised to test currently available treatments and agents to address symptomatology while simultaneously continuing efforts to fully understanding the full spectrum of diagnosis for the pathobiology of PASC—efforts that have not occurred in research of other post-viral conditions. For example, with knowledge gained through the observational study and other elements of RECOVER, potential clinical trial interventions could explore pathways to determine if there are viral responses that might generate some sort of reaction (e.g., pro-inflammatory) that can be treated or to determine if there are other types of disorders producing metabolic aspects that can be therapeutic targets.

Clinical trials to identify safe and effective treatments as well as preventive strategies for PASC are a priority for NIH. NIH is addressing symptoms/symptom clusters and underlying mechanisms of pathobiology of PASC by establishing a dedicated Clinical Trials Data Coordinating Center to implement and manage multiple interventions, as well as issuing a solicitation for well-designed clinical trials testing a range of interventions. Clinical trial development is being informed through a consultative process with engagement of patient, practitioner, and research communities regarding symptoms/symptom clusters, outcome measures, and interventions. The first trials are anticipated to be launched by Fall of 2022.

The RECOVER initiative is also leveraging real-world data derived from the electronic health records (EHRs) of over 60 million adult and pediatric patients accessible through the National COVID Cohort Collaborative (N3C), the PEDSnet consortium, and the National Patient-Centered Clinical Research Network (PCORnet).^{1,2,3}

¹ <https://ncats.nih.gov/n3c>.

² <https://pedsnet.org/>.

³ <https://pcornet.org/network/>.

RECOVER electronic health records (EHR) to better define PASC in all its forms, to discover and understand factors that influence the likelihood of developing PASC in adults and children, to understand PASC treatment strategies as quickly as possible, and to identify high priority approaches to address PASC in the populations most affected. While this work is ongoing, the RECOVER EHR studies have recently completed their initial set of analyses at national scale and are publishing results on several key clinical and public health issues including: PASC cardiac complications;⁴ development of new onset diabetes as part of PASC; impact of COVID-19 vaccination and viral variants on PASC; manifestations of PASC in children and adolescents; and racial, ethnic, and socioeconomic disparities in PASC.

The RECOVER pathobiology studies being launched soon will identify mechanisms underpinning clinical phenotypes and symptomatic manifestations and understand the pathology in multiple organ/systems that has led or will lead to clinically significant health problems. Analyses of clinical data and biospecimens from the longitudinal studies will contribute to our understanding of the cause(s) of PASC, help identify biomarkers, enable risk stratification, contribute to the development of new therapeutic targets, and will help inform the design of PASC clinical trials.

A systematic and standardized autopsy study at scale is underway now to comprehensively identify the effects of SARS-CoV-2 infection on organs/tissues throughout the body for the purpose of understanding the pathobiology of PASC and informing development of diagnostics, clinical monitoring, and potential treatment and prevention strategies.

Osteopathic Medicine

Question. Dr. Tabak, Colleges of Osteopathic Medicine educate nearly a quarter of U.S. physicians, but only compromise a small portion of NIH grants and are underrepresented on NIH study sections and advisory boards. How will NIH work with Colleges of Osteopathic Medicine to increase their representation on NIH panels and through funding opportunities?

Answer. The National Institutes of Health (NIH) is dedicated to strengthening and diversifying the biomedical research workforce. This includes fostering opportunities for physician-scientists with osteopathic medical degrees, a group of researchers NIH recognizes as being underrepresented in the biomedical workforce. As part of this effort, NIH continues to address recommendations described in a 2014 report focused on the physician-scientist workforce from the NIH Advisory Committee to the Director.⁵ As the report notes and NIH agrees with, “findings which lead to advances in practice are driven largely by the work of investigators with a variety of degrees [including D.O.s], of whom those with clinical training contribute essential knowledge and skills.”

Physicians with a Doctor of Osteopathic Medicine (D.O.) degree represent an important component of the medical community. They straddle the complementary, integrative health, and allopathic medical communities and have historically been connected to the National Center for Complementary and Integrative Health (NCCIH), one of NIH’s Institutes and Centers (ICs), through the practice of osteopathic manipulation. Osteopathic manipulation is a full-body system of hands-on techniques to alleviate pain, restore function, and promote health and wellbeing. This promising intervention is of interest to NCCIH, and the Center makes every effort to ensure that D.O.s have representation on its advisory council. NCCIH currently has two members with a D.O. degree on its 18-member council.⁶

NCCIH along with other NIH ICs has specific opportunities for clinician-scientists, which includes D.O.s, who conduct research across a wide range of complementary and integrative health approaches. Examples of such programs include, but are not limited to:

- Mentored Clinical Scientist Research Career Development Awards.⁷
- K12 career development award program.⁸
- Academic Research Enhancement Award (AREA) program.⁹

Act for ALS

Question. Last year, Congress passed a bill I cosponsored, ACT for ALS, that establishes a grant program to address neurodegenerative diseases, and specifically ALS. The fiscal year 2022 Omnibus passed in March provided \$25 million to establish the program. Dr. Tabak, I know NIH had concerns about this bill when it was

⁴ <https://www.cdc.gov/mmwr/volumes/71/wr/mm7114e1.htm>.

⁵ acd.od.nih.gov/documents/reports/PSW_Report_ACD_06042014.pdf.

⁶ www.nccih.nih.gov/about/nccih-member-roster.

⁷ researchtraining.nih.gov/programs/career-development/K08.

⁸ researchtraining.nih.gov/programs/career-development/k12.

⁹ grants.nih.gov/grants/funding/r15.htm.

passed. Can you discuss the concerns and the challenges to this research so we can address them moving forward?

Answer. The National Institutes of Health (NIH) strongly supports investing in the unique and specific research needs of the Amyotrophic lateral sclerosis (ALS) community. ALS and other rare and fatal neurodegenerative diseases inflict immense suffering on people living with these diseases and their families, and there is an urgent need to develop effective therapies and cures. NIH is enthusiastic about partnering with others to catalyze new approaches capable of bringing us closer to developing effective interventions to prevent, diagnose, mitigate, treat, or cure ALS.

NIH is supportive of the ACT for ALS provisions that have the main intent of broadly enhancing research and development for ALS and other rare neurodegenerative diseases, including the HHS Public-Private Partnership for Rare Neurodegenerative Diseases, and the U.S. Food and Drug Administration (FDA) action plan and grant program for research on ALS and other rare neurodegenerative diseases. NIH has major capabilities in administering grant programs in ALS research. NIH's primary concerns with the legislation have been with the grant program for research utilizing data from expanded access to investigational therapies for ALS authorized in section 2 of the legislation. NIH's concerns continue to be that (1) the creation of the expanded access grant program fails to place appropriate focus on the real and pernicious challenges impeding the development of effective ALS therapies, namely, the desperate need for a real understanding of disease mechanisms to allow for the development of effective treatments; (2) supplying investigational therapies, especially those unproven to have tangible improvements for patients, is beyond the NIH mission to advance our fundamental knowledge to improve health; (3) programs supplying investigational drugs have the potential to drive patients away from enrolling in placebo-controlled trials that are desperately needed to actually produce new and effective treatments for ALS patients; and (4) few small businesses would qualify for the program as defined by the statute, thus limiting the diversity of the investigational drugs that could be in the grant program. The final amended legislation addressed some of NIH's concerns by requiring entities to conduct research enrolling patients ineligible for other ALS clinical trials. However, NIH's principal concerns still hold true, and we strongly emphasize that investments in mechanistic disease research and therapy development are critical for the breakthroughs needed to develop transformative therapies for ALS.

Regarding the research component of the expanded access provision in the ACT for ALS, we remain concerned that the expanded access data obtained from persons with ALS on whom there is no research-grade data preceding an intervention, and for whom there is not a matched control group (gender, age, time from onset, rapid vs. slow course, etc.) with which to compare is unlikely to yield valuable scientific information. Even in instances where some reliable data would be gleaned, the information is unlikely to be transformative or rapidly accelerate ALS research. Except for an investigational drug that is so potent that it stops progression, any other finding would be impossible to ascribe to anything other than chance. As section 2 of the ACT for ALS Act specifies that investigational drugs in the expanded access grant program are confined to those in phase 3 clinical trials, a highly potent therapy would be first identified in the randomized controlled phase 3 trial. As of the date of the hearing, NIH has begun implementing the expanded access grant program. A request for applications was published on May 12, 2022.¹⁰

NIH places a high priority on research that will lead to the development of interventions for ALS and has increased funding for ALS research from \$52 million in fiscal year (FY) 2016 to \$120 million in fiscal year 2021. This increase is primarily due to the rise in research on Alzheimer's disease and related dementias, which supports research on those mechanisms and conditions that cause both dementia and ALS, rather than reflecting an increase in research on ALS alone. In addition to a broad array of research projects to understand the genetic and environmental causes of ALS and to elucidate the cellular and molecular mechanisms by which the disease progresses, in fall of 2021 NIH funded four exciting projects¹¹ through the Accelerating Leading-edge Science in ALS (ALS2) initiative, part of the NIH Common Fund's Transformative Research Awards, which aims to dramatically advance our understanding of what triggers ALS and what drives the rapid progression of this disease. NIH is also supporting several large natural history and biomarkers studies to improve our understanding of the disease process and to identify biomarkers that will predict when people at risk for ALS might get the disease, which would allow them to begin treatment early, perhaps even before symptoms appear. NIH-

¹⁰ grants.nih.gov/grants/guide/rfa-files/RFA-NS-22-071.html.

¹¹ www.ninds.nih.gov/news-events/directors-messages/all-directors-messages/spurring-innovative-research-toward-als-cures-through-accelerating-leading-edge-science-als-als2.

supported preclinical research projects are testing a range of therapeutic targets and agents, including gene therapies and small molecule drugs, in experimental models of ALS, including animals or cells/tissues, to treat inherited and sporadic forms of ALS. Several promising industry-funded clinical trials are based upon NIH-supported basic and preclinical research findings.

NIH is preparing for the future of ALS research by initiating a strategic planning process to identify the highest priorities for research that will lead to the discovery of effective interventions for the diagnosis, treatment, management, prevention, or cure of ALS. The process is engaging researchers, clinicians, advocates, people affected by ALS, multiple NIH institutes, and other Federal agencies, and has multiple opportunities for the general public to contribute to the process. Draft priorities will be presented for public comment at a public workshop on October 26–27, 2022.¹²

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

Question. Dr. Tabak, the fiscal year 2023 budget request does not continue its support for the Undiagnosed Diseases Network as it graduates from the Common Fund. The University of Alabama at Birmingham runs the Undiagnosed Diseases Network in partnership with Harvard and it has been a valuable resource to which to refer challenging cases and also is a network of strong collaborators to help researchers tackle those cases. More than that, it is a national resource for Americans who have an undiagnosed disease or disorder with no other place to turn.

Why is there not a plan in place to retain the Network and its clinical sites around the country?

Answer. The Undiagnosed Disease Network (UDN) was always planned for 10 years—the maximum period of support for Common Fund programs. In Phase II of the program (starting in 2018), the UDN was tasked with developing a framework to continue its mission after expiration of Common Fund support, ensuring sustained clinical utility for decades to come. For the final year of the program, the National Institutes of Health (NIH) will provide supplements and extensions to the UDN extramural clinical sites, Coordinating Center, and some Cores to ensure that all participants accepted by the end of the ninth year are evaluated as the program transitions to a larger, self-sustained network. Some sites have committed to continue enrollment during this period, and NIH is exploring means to enable other sites to continue to enroll new patients as well. The intramural Undiagnosed Disease Program, housed within the NIH Clinical Center and currently supported as a UDN clinical site, will continue to receive support and oversight from multiple NIH Institutes and Centers (ICs).

Multiple NIH ICs released a notice of intent to publish a funding announcement to support a Data Management and Coordinating Center to provide infrastructure and research support for a new network of clinical sites. Clinical sites with the appropriate infrastructure, expertise, and resources needed to conduct the clinical evaluation and DNA sequencing of participants enrolled at their sites can apply for designation as a Diagnostic Center of Excellence. Diagnostic Centers of Excellence will have access to resources of the Data Management and Coordinating Center.

NIH is committed to the successful transition of UDN and welcomes the opportunity to work with Congress to identify the best path forward. NIH's long-term vision is to see an expanded Network continue to make important scientific discoveries while improving clinical practice for undiagnosed patients—regardless of geographic location or socioeconomic status.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. I am pleased to be the lead sponsor along with Senator Reed of the Childhood Cancer STAR Act. As we know, cancer remains the most common cause of death by disease among children in the United States. By the age of 50, more than 99 percent of the children who survived their initial cancer diagnosis will have had a chronic health problem, and 96 percent have experienced a severe or life-threatening condition caused by the toxicity of the treatment that initially saved their life. Thanks to the STAR Act, the NCI has supported new research into improving the quality of life of childhood cancer survivors.

¹² www.ninds.nih.gov/about-ninds/strategic-plans-evaluations/strategic-plans/amyotrophic-lateral-sclerosis-als.

Could you advise the Committee on how much of the \$30 million Congress has provided for the STAR Act each year has been invested in this research and how many new research projects you have been able to support with the STAR Act fund?

Answer. The National Cancer Institute (NCI) appreciates your and Senator Reed's leadership, and the Subcommittee's continued support for childhood cancer research, including support for the Childhood Cancer STAR Act. Each year, the Subcommittee has appropriated \$2 million of the \$30 million authorization to support the Centers for Disease Control and Prevention (CDC) in their implementation of STAR Act provisions focusing on enhancing CDC cancer registry efforts (Section 102 of the Act). NCI has used the remaining \$28 million of STAR Act funding to support new biobanking research efforts (Section 101) and to continue to conduct and support survivorship research projects (Section 202), as well as evidence reviews focused on childhood cancer survivorship (Section 203) in partnership with the Agency for Healthcare Research and Quality (AHRQ). These initiatives are supported through a variety of mechanisms, including but not limited to new research grants. Efforts in each of NCI's three areas are summarized below.

1. Biobanking Projects:

NCI is committed to making progress for children and adolescents and young adults (AYAs) with cancer, survivors, and their families, and biobanking efforts have long been a part of this mission. In accordance with the goals of the STAR Act, NCI provided supplemental funding to the Children's Oncology Group (COG) Biobank in 2019 to support immediate enhancements. NCI subsequently funded six supplemental projects, which are listed below, starting in 2020 to bolster and expand the current programs. The supplements included projects to increase collection of diagnostic, relapse, and autopsy specimens, as well as specimens from childhood cancer survivors enrolled in NCI's Childhood Cancer Survivor Study (CCSS). Pediatric cancers are classified as rare cancers, and these efforts will increase sample availability to researchers and clinicians in an effort to advance research and improve patient outcomes, especially for children with the rarest cancer subtypes.

- Rare Tumor Populations Biobanking (COG):* For rare cancers for which COG does not have open clinical trials, tumor tissue collection options are limited. This program expanded in fiscal year (FY) 2021 and supports tumor tissue and blood collection for specific groups of patients for which current tumor tissue collection is lacking or inadequate, with priority for tumor types with high risk of treatment failure. This initiative also collaborates closely with the Childhood Cancer Data Initiative (CCDI) to analyze tumor tissue to obtain a clinically relevant molecular profiling through the CCDI Molecular Characterization Protocol. The data helps this Protocol support characterization of tumors for rare cancers, with an initial emphasis on Central Nervous System (CNS) tumors as well as soft tissue sarcomas.
- Tumor Specimens from Patients at Relapse (COG):* 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. One area of focus is the collection of relapse specimens from children with rhabdomyosarcoma.
- Rapid Autopsy Specimen Collection (COG):* NCI and COG continue to work with patient organizations to support rapid autopsy collection of tumor samples from children and AYAs who have died of their disease. Foundations and families within the pediatric brain tumor community have been leaders in such programs, and we hope 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 help other families.
- Pediatric MATCH Diagnostic Specimen Collection (COG):* This effort collects diagnostic samples for children and AYAs who have already submitted samples at relapse through NCI's Pediatric MATCH Trial and enables molecular characterization to identify the changes in gene mutations and gene expression that occur between diagnosis and relapse. This in-depth characterization aims to inform development of more relevant treatments.
- Biobanking I—Specimen Collection of Subsequent Cancers (CCSS):* The development of subsequent malignant neoplasms (SMN) is associated with significant morbidity and mortality for survivors of childhood cancer. The CCSS has prioritized collection of SMN somatic tissue specimens (tissue blocks, scrolls, slides) from survivors with confirmed cases of subsequent malignancies. The re-

sults help design treatment protocols and interventions that will result in an increase in survival, while minimizing harmful late effects. This research is also used to develop and expand programs for early detection and prevention of late effects in children and adolescent cancer survivors.

—*Biobanking II—Specimen Collection to Study Chronic Health Conditions (CCSS)*: This project will enhance the CCSS as a resource for future biologic and genetic evaluations to better understand the causes of chronic health conditions in survivors of childhood cancer.

Many of the STAR Act supplement projects are still collecting samples and have contributed to many new NCI research projects. Childhood cancer researchers have requested and used biospecimens from STAR Act funded supplement projects for 11 new research projects, with 10 of these projects supported by NCI (in addition to the STAR Act investments described here) and one supported by the Cancer Prevention and Research Institute of Texas. Biospecimens will continue to be available for researchers in the coming years with continued support. Along with increasing the number of greatly needed samples, these projects also address other concerns and barriers to biobanking and provide opportunities to mitigate these challenges. Through implementation of the STAR Act biobanking provisions, NCI continues to support progress towards better understanding pediatric cancers. Additional details about each of these biobanking projects will be provided to Senators Capito and Reed, and their colleagues, in the biobanking report required in Section 101 of the STAR Act, which is anticipated to be transmitted to Congress in June 2022.

2. Survivorship Research Grants:

NCI also continues to conduct and support childhood and AYA cancer survivorship research that advances additional goals of the STAR Act. NCI issued a new request for applications (RFA) in March 2020, titled “Research to Reduce Morbidity and Improve Care for Pediatric, and Adolescent and Young Adult (AYA) Cancer Survivors” (RFA-CA-20-027/028), which builds upon a previous RFA, “Improving Outcomes for Pediatric, Adolescent and Young Adult Cancer Survivors” (RFA-CA-19-033), to continue to address survivorship research areas emphasized in the STAR Act.

NCI funded seven projects in response to RFA-CA-19-033 in fiscal year 2020, and 10 projects in response to RFA-CA-20-027/028 in fiscal year 2021. An additional final round of awards is expected to be finalized in the coming weeks. Commitments for these 5-year awards will extend to fiscal year 2026, pending availability of appropriations. Projects supported through the first two rounds of awards in fiscal year 2020 and fiscal year 2021 are described in more detail in the tables below.

These efforts aim to improve care and health-related quality of life for childhood and AYA cancer survivors, through mechanistic, observational, and intervention research projects that focus on six key domains: (1) disparities in survivor outcomes; (2) barriers to follow-up care; (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.

RFA-CA-19-033: Improving outcomes for Pediatric, Adolescent, and Young Adult Cancer Survivors	Tumor Types	Late/Long Term Effect(s)
Project Title, Principal Investigator, Institution, Grant Type		
Using Information Technology to Improve Outcomes for Children Living with Cancer ¹³ PI: Dr. Jin-Shei Lai (Northwestern University at Chicago), U01	All	Disease and treatment-related symptoms
A Randomized Trial of a Mobile Health and Social Media Physical Activity Intervention Among AYA Childhood Cancer Survivors ¹⁴	All	Sedentary behavior

PI: Dr. Nina Kadan-Lottick (Yale University), U01

Utility of Memantine in Preventing Cognitive Dysfunction in Children Receiving Cranial Radiotherapy ¹⁵ PI: Dr. Nadia Laack (Mayo Clinic), U01	Primary brain tumors	Cognitive dysfunction after cranial radiotherapy
A web-based patient-reported symptom monitoring and self-management portal for AYA breast cancer survivors ¹⁶ PI: Dr. Ann Partridge (Dana-Farber), U01	Breast cancer	Symptoms, unmet needs, concerns
Telehealth based exercise intervention to improve functional capacity in survivors of childhood cancer with significantly limited exercise tolerance ¹⁷ PI: Dr. Kirsten Ness (St. Jude), U01	All	Reduced exercise capacity, impaired physical dysfunction
An Interactive Survivorship Program to Improve Healthcare Resources [INSPIRE] for Adolescent and Young Adult (AYA) Cancer Survivors ¹⁸ PI: Dr. Karen Syrjala (Fred Hutchinson), U01	All	Emotional distress; adherence
Implementation of a Provider-Focused Intervention for Maximizing HPV Vaccine Uptake in Young Cancer Survivors receiving Follow-Up Care in Pediatric Oncology Practices: A Cluster-Randomized Trial ¹⁹ PI: Dr. Wendy Landier (University of Alabama), U01	All	Elevated risk of HPV-related complications and malignancies
RFA-CA-20-027/028: Research to Reduce Morbidity and Improve Care for Pediatric, and Adolescent and Young Adult (AYA) Cancer Survivors	Target Population	Topic Area
Project Title, Principal Investigator, Institution, Grant Type		
Predicting and Preventing Chemotherapy-Induced Cardiotoxicity in African American Children PI: Drs. Paul W Burridge and Yadav Sapkota (Northwestern University at Chicago), R01	African American, doxorubicin-treated childhood cancer survivors ²⁰	Cardiotoxicity
Bridging Information Divides and Gaps to Ensure Survivorship: The BRIDGES Randomized Controlled Trial of a Multi-level Intervention to Improve Adherence to Childhood Cancer Survivorship ²¹ PI: Dr. Nina S Kadan-Lottick (Yale University), R01	Childhood cancer survivors and primary care providers	Follow-up care
Social Genomic Mechanisms of Health Disparities Among Adolescent and Young Adult (AYA) Cancer Survivors ²²	Non-Hodgkin's lymphoma and Hodgkin's lymphoma survivors	Social determinants of health

PI: Dr. Bradley Jay Zebrack (University of Michigan at Ann Arbor), R01

SALSA—Study of Active Lifestyle Activation ²³ PI: Dr. Eric Jensen Chow (Fred Hutchinson Cancer Research Center), R01	Childhood cancer survivors	Cardiovascular disease
Individual, Cultural, and Area-Based Factors Associated with Survivorship Care Among Asian/Asian American Childhood Cancer Survivors ²⁴ PI: Drs. Kimberly Ann Miller and Joel E Milam (University of Southern California), R01	Asian and Asian American childhood cancer survivors	Follow-up care
Optimization of a mHealth Physical Activity Promotion Intervention with Mindful Awareness for Adolescent and Young Adult Cancer Survivors ²⁵ PI: Drs. Siobhan Marie Phillips and David Victorson (Northwestern University at Chicago), R01	Childhood and AYA cancer survivors	Quality of life
Pilot Test of an mHealth Intervention for Reducing Alcohol Use Among Rural Adolescent and Young Adult Cancer Survivors ²⁶ PI: Drs. Carolyn Lauckner and Laurie McIlouth (University of Kentucky), R21	Rural AYA cancer survivors	Alcohol consumption
Treatment-Specific Genetic Risk Scores for Late Effects Prediction in Childhood, Adolescent, and Young Adult Cancer Survivors ²⁷ PI: Drs. Cindy Im and Yan Yuan (University of Alberta), R21	Childhood cancer survivors	Risk for chronic conditions
Remote Monitoring of Cardiac Function in Childhood Cancer Survivors PI: Dr. Saro Armenian (Beckman Research Institute/City of Hope), R21	Anthracycline-exposed, long-term childhood cancer survivors ²⁸	Cardiac dysfunction
Caregiving for Young Adults with Cancer in Latino Families: Understanding Healthcare Engagement and Family Wellbeing ²⁹ PI: Dr. Michael A Hoyt (University of California-Irvine), R21	Latino AYA cancer survivors and their families and providers	Caregiving

¹³ reporter.nih.gov/search/owLPDXpgCU-iBbBTXwB1Qg/project-details/10247641
¹⁴ reporter.nih.gov/search/WCYrRYvZjUyxTUSKqGtHRA/project-details/10464453.
¹⁵ reporter.nih.gov/search/hhFq_KlhjUK_3mrhwe8lzw/project-details/10020353.
¹⁶ reporter.nih.gov/search/6iqMWMtbbk2QCXUdJKPFW/project-details/10079364.
¹⁷ reporter.nih.gov/search/vD2lwK9vOkCEXKq0gt1xIA/project-details/10075046.
¹⁸ reporter.nih.gov/search/ouCqFYfadUaDvFDHKRpQvQ/project-details/10080015.
¹⁹ reporter.nih.gov/search/JL500raCfUSRsLG_1qNHUg/project-details/10076219.
²⁰ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10275329.
²¹ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10274932.
²² reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10272690.
²³ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10285925.
²⁴ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10275095.
²⁵ reporter.nih.gov/search/SzDDxi0b_UWciL8xp_2iEw/project-details/10278744.
²⁶ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10273171.
²⁷ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10273416.
²⁸ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10274206.
²⁹ reporter.nih.gov/search/tuBqAK_RUKcGDcJFdrNqg/project-details/10269806.

3. *Childhood Cancer Survivorship Evidence Reviews, with AHRQ:*

NCI entered into an Inter-Agency Agreement with AHRQ to support its work to implement Section 203 of the STAR Act, focused on identifying best practices in survivorship care, through AHRQ Evidence Reviews on Childhood Cancer Survivorship. A summary of the progress is provided below.

4. *Disparities and Barriers to Pediatric Cancer Survivorship Care:*³⁰

This report was posted on the AHRQ website for public comment in October 2020, with simultaneous peer review. The final report was published in March 2021. The NCI used the findings of the report to provide funding through 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 (supported by NCI in addition to STAR Act investments). 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.

5. *Models of Care That Include Primary Care for Adult Survivors of Childhood Cancer:*³¹

This report was posted on the AHRQ website in June 2021 for public comment, with simultaneous peer review. The report was published in February 2022. NCI and AHRQ are widely disseminating this report to raise awareness of the role that primary care providers play in the care of adult survivors of childhood cancers. 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.

6. *Transitions of Care from Pediatric to Adult Services for Children with Special Healthcare Needs:*³²

The systematic review is anticipated to be posted on AHRQ’s website in May of 2022. Similar to the other two reports, 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 PATRICK LEAHY

Question. The COVID–19 pandemic has adversely affected clinical cancer care and profoundly impeded progress in the provision of essential clinical trials for cancer patients, with rural populations particularly hard hit. Vermont is currently one of seven states eligible for the NIH Institutional Development Award (IDeA) that does not have an NCI-designated facility. Therefore, Vermont has faced reduced access to cancer clinical trials relative to more urban areas. Because access to clinical trials directly correlates with improved quality of cancer care, this reduced access leads to poorer outcomes for Vermonters diagnosed with or at risk for developing cancer. Many of these IDeA states that lack NCI-designated centers have medical schools that would be capable of conducting clinical trials.

How will the NIH better support cancer care and clinician investigator training in predominately rural IDeA states that lack an NCI-designated cancer center?

Answer. The National Cancer Institute (NCI) leads, conducts, and supports cancer research across the nation and is committed to helping all people live longer, healthier lives. Ensuring equitable access to cancer care and clinical trials across the country is a top priority for NCI. This objective was also recently reaffirmed as one of the goals identified in the next phase of the Cancer MoonshotSM, which includes NCI efforts to continue to support and enhance enrollment of underrepresented populations to cancer clinical trials, as well as cancer control research in persistent poverty areas.³³ In addition, NCI and the National Institute of General

³⁰ effectivehealthcare.ahrq.gov/products/pediatric-cancer-survivorship/research.

³¹ effectivehealthcare.ahrq.gov/products/childhood-cancer-survivorship-care/research.

³² effectivehealthcare.ahrq.gov/products/transitions-care-pediatric-adult/protocol.

³³ www.whitehouse.gov/ostp/news-updates/2022/03/17/fact-sheet-white-house-announces-initial-steps-for-reignited-cancer-moonshot/.

Medical Sciences (NIGMS) have recently issued several funding opportunity announcements (FOAs), discussed in more detail below, focused on promoting cancer research in rural communities, including communities in Institutional Development Award (IDeA) states and those that are not home to an NCI-designated cancer center.

NCI-designated cancer centers are a cornerstone of the NCI's cancer research efforts across the country, and many centers have large catchment areas that cross state lines. For example, the Dartmouth Cancer Center includes the entire states of Vermont and New Hampshire as part of its service area.³⁴ Greatly extending the reach of the NCI-designated cancer centers are several key extramural networks that support the majority of NCI-supported clinical trials: the National Clinical Trials Network (NCTN), the Experimental Therapeutics Clinical Trials Network (ETCTN), and the NCI Community Oncology Research Program (NCORP). The NCTN primarily conducts later-phase cancer treatment and imaging trials, while ETCTN conducts early phase cancer treatment trials. Research groups within these networks hold annual meeting sessions on topics related to underrepresented populations, and each of these groups has a patient advocate committee to provide input on developing and conducting trials. The ETCTN also recently launched the Create Access to Targeted Cancer Therapy for Underserved Populations (CATCH-UP.2020) program to enhance access via clinical trials to targeted cancer therapy for minority/underserved populations.³⁵

The NCORP includes 25 states with large rural populations³⁶ and expands the reach of the NCTN, bringing cancer research to people in their own communities. NCORP provides infrastructure for conducting studies on cancer control and prevention, cancer care delivery research, and screening, treatment, and quality of life evaluations embedded in treatment trials. The NCORP includes seven research bases and 46 community sites across the United States, including 14 minority/underserved community sites, and this locally based infrastructure includes approximately 1,000 component and subcomponent sites (e.g., hospitals, cancer centers, oncology clinics) through which patients can enroll in NCTN and NCORP clinical trials.

Even in IDeA states without NCI-designated cancer centers or NCORP grantees (such as Vermont, Rhode Island and West Virginia), NCI has active trial sites reaching rural patients. These sites are not required to have an NCORP grant or be associated with a designated cancer center to become a "member site" for an NCTN/NCORP group. Many academic sites are members even if they are not a designated cancer center, and community sites are eligible to be full members. These full member sites also have affiliated sites throughout the state or region where patients can be enrolled. In Vermont, for example, there are approximately 55 NCI-supported trials open to patients with a treatment site within the state,³⁷ and more than 230 Vermont patients enrolled in either NCORP or NCTN trials over the past 5 years. The top enrollment site was the University of Vermont Medical Center/College of Medicine in Burlington.

Clinicians from these NCTN/NCORP member sites can fully participate in the NCTN/NCORP groups, contribute to scientific development, and develop expertise in clinical investigations. Dozens of these investigators enrolled patients to NCTN and NCORP trials over the past 5 years, including more than 30 investigators with enrollments in Vermont and more than 60 investigators with enrollments in West Virginia. Investigator involvement in these NCI-sponsored programs provides critical opportunities for rural patients and produces valuable research findings. For example, Dr. Robert Ward of Rhode Island Hospital is a co-author on research showing that improved screening methods for women with dense breasts are needed because of their increased risk of breast cancer and of failed early diagnosis by screening mammography,³⁸ work that was funded by an NCORP breast cancer screening study.

NIGMS-supported research is also benefitting cancer patients in rural communities through IDeA Networks for Clinical and Translational Research (IDeA-CTR),³⁹ such as the Northern New England Clinical and Translational Research (NNE-CTR) Network,⁴⁰ which includes participating and collaborating healthcare,

³⁴ gis.cancer.gov/ncicatchment/.

³⁵ ctep.cancer.gov/initiatives/Programs/etctn_catch-up2020.htm.

³⁶ ncorp.cancer.gov/news/2019-08-19.html.

³⁷ clinicaltrials.gov/ct2/results?cond=cancer&term=&cntry=US&state=US%3AVT&city=&dist=&Search=Search&recrs=a&type=Intr&fund=0.

³⁸ doi.org/10.1001/jama.2020.0572.

³⁹ grants.nih.gov/grants/guide/pa-files/PAR-14-303.html.

⁴⁰ reporter.nih.gov/project-details/10205083.

educational and research institutions in Maine, Vermont, and New Hampshire. The IDeA-CTR awards support state-wide or multi-state regional networks of clinical and translational research, which build research infrastructure, develop investigators, and support research activities that address health conditions prevalent in populations of IDeA states. Since cancer affects individuals nationwide as well as in IDeA states, all 12 IDeA-CTRs invest in cancer research by supporting pilot research projects. These projects include mechanistic, translational, clinical, and prevention studies.

Recognizing that more research is needed to identify the best strategies for providing care to rural populations, NCI and NIGMS are currently providing funding for projects selected through three targeted FOAs:

1. Improving the Reach and Quality of Care in Rural Populations:⁴¹ This funding opportunity focused on strategies for delivering and improving the quality of cancer care in rural areas among low-income and/or underserved populations. Over the two funding rounds, nine research projects were funded, including research focusing on financial toxicity and navigation, survivorship, telehealth, community-based patient navigation for cancer screening, palliative care, and symptom management.

2. Social and Behavioral Intervention Research to Address Modifiable Risk Factors for Cancer in Rural Populations:⁴² This funding opportunity focused on research to develop, adapt, and test individual-, community- or multilevel interventions to address modifiable risk factors for cancer in rural populations. Three research projects have been funded after the first round, focusing on tobacco control in rural American Indian households, increasing physical activity, and utilizing telehealth options for treatment of obesity.

3. IDeA Clinical Research Resource Center:⁴³ Increasing the number of clinical trials and complex observational studies in IDeA states is a pressing need that requires continued efforts to strengthen clinical research capacity and maximize the use of existing resources through innovative approaches. The IDeA Clinical Research Resource Center (I-CRRC) funding opportunity aims to 1) strengthen communication and develop collaborations between health research institutions in IDeA states and clinical trial sponsors; and 2) develop clinical research coordinators with the knowledge and skills to manage clinical trials and complex observational studies.

NCI is committed to serving patients across the country, including those in rural areas who face disparities in incidence and mortality rates that can be attributed in part to barriers in accessing health services. NCI will continue to fund research and support efforts to improve access and better address the unique needs of these communities.

QUESTIONS SUBMITTED TO DR. ANTHONY FAUCI

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Question. Dr. Fauci, there has been limited evidence that antiviral therapies to treat COVID-19, like Paxlovid, may relieve symptoms from long COVID. The theory is that long COVID may be caused by the virus persisting in parts of the body for months. What are your thoughts on this and what work is NIH doing in this space to determine if therapeutic treatments may relieve or even cure long COVID?

Answer. While most people recover quickly and fully from infection with SARS-CoV-2, some experience ongoing or new symptoms or other health effects after the acute infection has resolved, referred to as post-acute sequelae of SARS-CoV-2 infection (PASC). An understanding of the underlying mechanisms of PASC will be crucial as we work to identify and test therapeutics. The National Institutes of Health (NIH) supports research to inform estimates of PASC prevalence as well as to understand the pathogenic mechanisms underlying the wide range of observed symptoms and the risk factors for developing PASC. This includes the examination of whether particular symptoms associated with PASC may be caused by the persistence of virus or viral particles in parts of the body. NIH has launched the Researching COVID to Enhance Recovery (RECOVER) Initiative,⁴⁴ a trans-NIH effort that aims to understand, prevent, and treat the post-acute sequelae of SARS-CoV-2 infection. The NIH RECOVER Initiative complements ongoing studies supported by the National Institute of Allergy and Infectious Diseases (NIAID) to better un-

⁴¹ grants.nih.gov/grants/guide/rfa-files/RFA-CA-19-064.html.

⁴² grants.nih.gov/grants/guide/rfa-files/RFA-CA-20-051.html.

⁴³ grants.nih.gov/grants/guide/pa-files/PA-22-150.html.

⁴⁴ <https://recovercovid.org/>.

derstand the various post-acute manifestations of COVID-19 and will engage more than 100 researchers at more than 30 institutions to build a diverse national study population and support large-scale studies in this critical area, as well as clinical trials of potential treatments for PASC. The knowledge gained through these collective efforts will help inform the identification of effective treatments for PASC, including those evaluated through RECOVER.

Question. How many clinical trials are funded by NIH that are testing treatments for long COVID?

Answer. The highly diverse symptomology of PASC observed in patients across the lifespan strongly suggests that PASC, rather than being a singular condition, is likely multiple clinical conditions that vary across the lifespan and demographic groups. This has important implications for the research approach to PASC—namely, multiple diverse diagnostic, treatment, and prevention strategies will be needed for the range of PASC conditions and patient populations. This will require an appropriately diverse portfolio of sufficiently scaled and powered clinical studies to generate high-quality data that can inform clinical and public health practices.

Toward this end, the NIH RECOVER Initiative, described above, is preparing to launch clinical trials to identify safe and effective treatments to enhance recovery of patients with persistent symptoms and identify interventions which, if initiated early, could prevent end-organ and systems damage and other sequelae. RECOVER has established a dedicated Clinical Trials Data Coordinating Center to implement and manage multiple interventions addressing symptoms/symptom clusters and underlying mechanisms of pathobiology of PASC. RECOVER also issued a solicitation for clinical trial proposals testing a range of interventions to address symptoms/symptom clusters and underlying mechanisms of pathobiology. RECOVER will test a variety of therapeutic strategies. The first trials are anticipated to be launched by the Fall of 2022. As understanding of underlying mechanisms leading to post-acute sequelae of SARS-CoV-2 infection improves through the RECOVER and other research activities, additional candidate interventions will be evaluated and selected for testing.

Question. How many of these trials are beyond a phase I trial?

Answer. The RECOVER Initiative plans to launch Phase IIb–III PASC clinical trials that leverage fit-for-purpose design strategies to maximize rigor, efficiency, and flexibility. Initial trials will likely focus on interventions that have shown promise in other recovery contexts and on current hypotheses regarding pathogenesis. As our understanding of underlying mechanisms leading to PASC improves through RECOVER and other research activities, additional candidate interventions will be evaluated and selected for testing.

Question. There have been recent reports of individuals taking Paxlovid, and then their symptoms return after their treatment is complete. Do you know why that may happen?

Answer. NIH scientists, in collaboration with the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA), are looking into possible ways to better understand the phenomenon of COVID-19 rebound after Paxlovid treatment. NIH currently does not have studies underway, but the agency is actively discussing potential studies to learn more about who this is affecting, how often it is occurring, and if a longer regimen would be more effective in certain cases. For additional information on what is currently known about the case reports of patients developing symptoms again after completing a course of Paxlovid, please refer to “FDA Updates on Paxlovid for Health Care Providers”⁴⁵ and the “CDC Health Alert Network Health Advisory on COVID-19 Rebound After Paxlovid Treatment”.⁴⁶

Question. How much of the \$1.15 billion appropriated has been obligated?

How much of this funding has been obligated or committed for clinical trials?

Answer. In December 2020, Congress provided \$1.15 billion in NIH funding, available for obligation over 4 years, to support research into the long-term effects of SARS-CoV-2. With this funding, NIH launched Researching COVID to Enhance Recovery (RECOVER) in February 2021. As of May 17, 2022, \$674.5 million has been obligated. Of that amount, \$137 million has been obligated to the launch of clinical trials, including the establishment of the Clinical Trials Data Coordinating Center.

The remaining funding will be distributed during the final 2 years of the RECOVER Initiative to support outyear activities of these ongoing clinical research studies, including (but not limited to): longitudinal clinical follow up of adult and pediatric patients enrolled in the cohort studies, autopsy studies, central research

⁴⁵ <http://www.fda.gov/drugs/news-events-human-drugs/fda-updates-paxlovid-health-care-providers>.

⁴⁶ <http://www.emergency.cdc.gov/han/2022/han00467.asp>.

services, pathobiology research, mobile health platform, data repositories, clinical biospecimen collection and repositories, Electronic Health Record/Other Real World Data studies, as well as support for NIH management of the RECOVER initiative through specialized administrative and technical expertise.

Question. What work is NIH doing related to long COVID to address the most burdensome of symptoms or the most severe cases?

Answer. The National Institutes of Health (NIH) has designed and launched Researching COVID to Enhance Recovery (RECOVER),⁴⁷ a major research effort of national scale to improve understanding of Post-Acute Sequelae of SARS-CoV-2 infection (PASC), including Long COVID, and to inform the development of safe and effective diagnostic, treatment, and preventive strategies. RECOVER includes a longitudinal study designed to have inclusive and diverse participant enrollment that is representative not only of the U.S. population generally, but of the population of sub-groups most severely affected by coronavirus disease 2019 (COVID-19). RECOVER also includes electronic health records (EHR) studies of over 60 million patient records; a systematic and standardized autopsy study at scale; a mobile health platform to enable broader and deeper engagement of participants; pathobiology and mechanistic studies and development of animal models; and clinical trials. Importantly, RECOVER is patient-centered and engages patients at every level of the Initiative, from local studies to protocol development, to overall governance of the Initiative.

NIH RECOVER is preparing to launch clinical trials to test treatment and preventive strategies for Long COVID. This includes creating a portfolio of prioritized interventions that:

- Address symptoms/symptom clusters of high priority to patients
- Will test a broad range of interventions
- Address current nascent hypotheses regarding the pathogenesis of Long COVID
- Have sufficient scientific rationale, appropriate safety profiles, technical merit, and feasibility
- Would be available/accessible to most patients
- Are ready to launch in the short term

To identify which Long COVID symptoms have the highest impact on patients' quality of life, RECOVER is taking a broad consultative approach with engagement of patient, practitioner, and research communities. For example, both patient participants in the RECOVER longitudinal cohort studies and a national sample (non-RECOVER) of patients are periodically surveyed regarding their symptoms and the burden posed by them; and interviews and focus groups with highly affected communities and the RECOVER National Community Engagement Group and patient representatives are periodically conducted for in-depth insights into patient perceptions of the burden of Long COVID symptoms. The input from these engagement activities is informing RECOVER clinical trial design, including the selection of interventions, to ensure that RECOVER clinical trials address the most burdensome symptoms of Long COVID.

QUESTIONS SUBMITTED TO DR. GARY GIBBONS

QUESTIONS SUBMITTED TO PATTY MURRAY

Question. Our country has lost over a million people to COVID-19 and countless more have been infected by this virus. And people of color have faced the worst of this crisis. Studies show that people of color are more likely to be hospitalized for COVID, and while some recover quickly and completely, others have persistent symptoms that linger for months. That's why, in December 2020, we appropriated more than \$1 billion in supplemental funding for NIH to study long-COVID.

What updates can you share about NIH's RECOVER Initiative and what we have learned about long COVID and how it impacts different communities?

What are the challenges you're facing in terms of recruitment for RECOVER's clinical trials, and how is NIH ensuring that they have diverse representation?

Answer. The National Institutes of Health (NIH) launched the Researching COVID to Enhance Recovery (RECOVER) initiative to better understand and ultimately to prevent and treat the broad array of post-acute symptoms of SARS-CoV-2 (PASC), commonly called Long COVID. At the center of RECOVER is a longitudinal observational study that is currently recruiting adults and children from other ongoing studies of COVID, Long COVID clinics, and other cohorts—many of which

⁴⁷ recovercovid.org.

have a history of including people from communities disproportionately burdened by disease.

The RECOVER research initiative is meant to significantly expand both our knowledge about the full clinical spectrum of symptoms, long term outcomes, and underlying biology of Long COVID, as well as our ability to develop safe and effective therapeutic interventions. It funds multi-disciplinary biomedical, clinical, and epidemiological studies, many focused on untangling the complex social and biological factors that cause higher rates of hospitalization and Long COVID in communities of color.

RECOVER studies highlight diverse participation and community engagement, and include clinical trials, clinical studies that leverage cohort data and specimens, a patient registry, pathobiology studies, a mobile health platform, and electronic health record (EHR) studies. Clinical cohort institutions were selected for RECOVER studies that have a proven track record in reaching communities hardest hit by the pandemic. For example, RECOVER includes the Institutional Development Award (IDeA) clinical research network, which supports research in states that historically have had low levels of NIH funding. Their clinical coordinating center is one of the main hubs for the adult cohort study. In addition, a Research Centers in Minority Institutions (RCMI) program awardee is also serving as a hub for the study.

As of May 2022, NIH has enrolled more than 5,000 people and is close to RECOVER's target recruitment of 6,000. Participants are undergoing testing at 46 sites in 23 states, along with the District of Columbia and Puerto Rico. Twenty-seven percent of enrollees live in federally designated medically underserved areas. Thirty-six additional sites will come online before the end of 2022. The completion dates for reaching target enrollment are January 2023 for adults and May 2023 for children.

Other research efforts are helping to increase understanding of Long COVID. For example, a recent study published in *The Lancet Digital Health*,⁴⁸ describes how researchers used Artificial Intelligence (AI) technology to comb through an EHR database of more than 13 million people to identify characteristics of people with Long COVID and those likely to develop it.

While recruitment into the RECOVER longitudinal observational study is progressing steadily, researchers are facing challenges. Strong competition for people with biomedical research skills has hindered core and site hiring and led to delays in opening local sites and study implementation. The enrollment of study participants—including those who are currently infected with COVID-19, those with Long COVID symptoms, and those who were previously infected but show no Long COVID symptoms (to act as control cases)—is still challenging. Participating in studies, which may require taking time off from work, is an economic barrier. The recent decline in the number of cases of acute SARS-CoV-2 infection, milder symptoms associated with Omicron variants that make people less likely to seek medical attention, and the rapid expansion of home testing makes it difficult to identify and recruit acute cases. In addition, the extremely high transmissibility rates of recent variants means that many people have been re-infected, which reduces the ability to find people who have never been infected.

Increasing enrollment rates in communities disproportionately affected by SARS-CoV-2 infection is a critical goal for RECOVER; NIH is therefore monitoring the diversity of enrollment closely. One of the challenges is limited awareness in some communities about Long COVID. Another is establishing trust among people with a history of mistrust in the biomedical research establishment and the Federal Government. This impedes RECOVER's ability to establish sufficient enrollment in clinical studies that produce enough high-quality data to provide the evidence base necessary to guide clinical practice and public health policy.

The NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities initiative was launched to establish a research approach to ensure the participation of black and brown communities in vaccine research trials that were then underway.⁴⁹ CEAL now bolsters RECOVER recruitment by working with research teams in 21 locations across the country to address misinformation, foster trust in science and research, and ensure inclusive participation in NIH research. Strategies include local media and social media outreach, search engine optimization (SEO) tactics, local community outreach and education, and using SARS-CoV-2 testing programs and point-of-care settings as recruitment platforms. Through trusted mes-

⁴⁸ [www.thelancet.com/journals/landig/article/PIIS2589-7500\(22\)00048-6/fulltext](https://www.thelancet.com/journals/landig/article/PIIS2589-7500(22)00048-6/fulltext).

⁴⁹ covid19community.nih.gov/.

sengers in communities hit hardest by the pandemic, CEAL and its community partners are helping increase diversity in Long COVID research.

Question. Many patients with long-COVID have been diagnosed with a blood circulation disorder known as postural orthostatic tachycardia syndrome, or POTS. Symptoms associated with POTS include lightheadedness, fainting and an uncomfortable, rapid increase in heartbeat.

Has NIH determined the rough proportion of long-COVID patients whose symptoms include POTS?

Answer. Dysautonomia refers to a disorder of autonomic nervous system function. The autonomic nervous system controls many of the unconscious and involuntary bodily processes such as heart rate, blood pressure, and breathing. Postural orthostatic tachycardia syndrome (POTS) is a relatively common dysautonomia in which moving to an upright position can trigger an excessive increase in heart rate (tachycardia) and other symptoms such as light-headedness, shortness of breath, chest pain, and palpitations. Other common symptoms not necessarily linked to posture include headache, fatigue, exercise intolerance, and impaired sleep, digestion, and concentration. While the cause of POTS is unknown, low blood volume, dysregulation of the autonomic nervous system, autoimmunity, and viral infection may all play a role, each perhaps leading to distinct subtypes of POTS. It is likely that POTS has multiple underlying mechanisms resulting in subtypes of POTS that need to be identified and characterized.

Symptoms of the post-acute sequelae of SARS-CoV-2 infection (PASC) may overlap with those experienced by persons suffering with POTS/dysautonomia. Research on the biological causes of PASC and potential treatments pose a unique opportunity to possibly discover the key pathophysiology underlying several disorders suspected to be the sequelae of a viral illness in a significant subset of those affected, such as POTS/dysautonomia and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).

The Researching COVID to Enhance Recovery (RECOVER)⁵⁰ Initiative seeks to better understand, treat, and prevent PASC, including Long COVID, and to understand how SARS-CoV-2 can lead to long-lasting and widespread effects such as fatigue, decline in some cognitive abilities, pain, sleep disorders, and dysautonomia, among others. RECOVER is a patient-centered study of national scale with diverse participation and community engagement. RECOVER has multiple scientific aims, including to understand the clinical spectrum and the biology underlying recovery over time, and to define distinct sub-phenotypes of Long COVID. It includes multiple sub-studies: longitudinal observational clinical cohort studies with thousands of diverse participants across the lifespan, ancillary clinical studies leveraging the cohort data and specimens, pathobiology studies, analyses of electronic health records, and clinical trials. We expect RECOVER studies will advance understanding of other conditions believed to be triggered by infection, which will include COVID-19 related cases of POTS/dysautonomia and ME/CFS. We also expect that RECOVER studies will reveal the proportion of Long COVID patients that meet the criteria for POTS/dysautonomia and ME/CFS. RECOVER study teams and oversight bodies include experts in those conditions.

What work is NIH supporting to understand the underlying causes of POTS?

Answer. The National Institutes of Health (NIH) has supported a wide range of POTS-related grants and currently funds research examining the autoimmune basis of POTS and the autonomic pathophysiology of POTS. In addition, NIH intramural researchers are investigating possible associations between PASC and POTS/dysautonomia⁵¹ through comprehensive testing of the extended autonomic system in patients experiencing PASC.

At the direction of the Senate Appropriations Committee, the National Institute of Neurological Disorders and Stroke (NINDS) and the National Heart, Lung and Blood Institute (NHLB), with participation by Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), jointly convened a workshop in July 2019 to discuss the state of the science and gaps in the current understanding of POTS. NINDS and NHLBI prepared and submitted a Report to Congress⁵² based on workshop discussions between leading experts in POTS research and care, officials from the three sponsoring Institutes, and patient advocates.⁵³

⁵⁰ recovercovid.org/.

⁵¹ <https://reporter.nih.gov/project-details/10491027>.

⁵² https://www.nhlbi.nih.gov/sites/default/files/media/docs/NIH%20RTC%20on%20POTS_Final.signed.pdf.

⁵³ [chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nhlbi.nih.gov/sites/default/files/media/docs/NIH%20RTC%20on%20POTS_Final.signed.pdf](https://www.nhlbi.nih.gov/sites/default/files/media/docs/NIH%20RTC%20on%20POTS_Final.signed.pdf).

In addition, in April 2021, NHLBI posted an article⁵⁴ about research in this field, and NINDS and NHLBI issued a Notice of Special Interest,⁵⁵ “Stimulate Research on the Diagnosis, Treatment, and Mechanistic Understanding of Postural Orthostatic Tachycardia Syndrome (POTS),” to encourage researchers to submit proposals designed to answer fundamental questions about POTS.^{56,57} The grant applications submitted in response to the Notice are currently under review, which evaluates the scientific and technical merit of research applications. NIH peer review process, which evaluates the scientific and technical merit of research applications.

In addition, NHLBI is leading an NIH-wide workshop on sex/gender-specific COVID-19 outcomes on June 16–17, 2022. The workshop will include a presentation and discussion of autonomic hemodynamic disorders, including POTS, in PASC and the need for better understanding of the underlying pathophysiology and development of specific treatment approaches. NIH continues to encourage investigator-initiated research grant applications on POTS.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. Dr. Gibbons, I have a question about pulmonary fibrosis, or PF, a complex and deadly lung disease that affects over 250,000 people in the U.S. I am especially concerned about this disease because we have a lot of coal miners in West Virginia, and workers who are exposed to coal dust and silica are at higher risk of developing PF. Diagnosing this disease is complex, and by many estimates often takes over 2 years. In far too many cases, patients already have advanced PF by the time they receive a diagnosis.

What research is the NHLBI currently funding to address the serious problem of late diagnosis in PF?

Answer. Currently, Pulmonary Fibrosis (PF) has no cure, and for some forms of PF, such as Idiopathic Pulmonary Fibrosis (IPF), median survival is 3–5 years from diagnosis. Some studies show an association between coal and silica dust and the development of PF.

Current efforts by the National Heart, Lung, and Blood Institute (NHLBI) to address PF include the Institute’s Prospective Treatment Efficacy in IPF using genotype for N-acetylcysteine (NAC) Selection (PRECISIONS) study, a five-year study aiming to enroll 200 IPF patients. PRECISIONS will use genetic testing to identify patients likely to respond to the antioxidant NAC. The first PRECISIONS clinical trial will explore the effectiveness of precision medicine for IPF. NHLBI recently funded a cohort of currently unaffected but at-risk individuals who have more than two close family members with PF, which could demonstrate how genetics and family exposure could affect risk disease risk.

The Lung Health Cohort, in partnership with the American Lung Association, follows 4,000 healthy millennials (aged 25–35) to identify early risk factors (e.g., lifetime air pollution, potentially noxious inhalation exposures) and signs of lung disease, including IPF, to allow earlier and effective intervention. In 2021, NHLBI-funded researchers identified gene expression signatures in the blood of PF patients. This research may reveal new therapeutic targets and help monitor and predict disease course.

NHLBI is supporting collaborative projects to establish a set of model systems that reproduce essential IPF disease-defining features to advance understanding of the IPF pathogen from onset through disease progression. These projects will also provide a platform for identifying and testing novel treatment therapies. By developing several model systems in parallel, scientists could identify common fibrosis pathways.

QUESTIONS SUBMITTED TO DR. JOSHUA GORDON

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. We understand NIMH is working to eliminate disparities in youth mental health by the year 2030.

⁵⁴ <https://www.nhlbi.nih.gov/news/2021/decoding-mysteries-postural-orthostatic-tachycardia-syndrome>.

⁵⁵ <https://grants.nih.gov/grants/guide/notice-files/NOT-HL-21-008.html>.

⁵⁶ <https://www.nhlbi.nih.gov/news/2021/decoding-mysteries-postural-orthostatic-tachycardia-syndrome>.

⁵⁷ <https://grants.nih.gov/grants/guide/notice-files/NOT-HL-21-008.html>.

What specific areas of research are needed in order for NIMH to meet this ambitious goal?

Answer. As detailed in the September 2021 National Institute of Mental Health (NIMH) Report to Congress “Addressing Youth Mental Health Disparities,” NIMH is prioritizing research to address and reduce mental health disparities among underserved and underrepresented youth by 2031. To meet this goal, NIMH will encourage a full and diverse range of research—including basic science, translational science, and services and implementation research—focused on addressing the needs of youth across race, ethnicity, culture, language, gender identity, sexual orientation, geography, and social determinants of health (e.g., education, economic stability, quality of housing, access to healthcare). These research efforts will aim to identify ways to decrease risk, increase resilience and protective factors, improve access to and utilization of high-quality evidence-based care, and improve outcomes of treatment and services among populations negatively impacted by mental health disparities.

NIMH previously published information about the research needs that guide the activities of NIMH Divisions, Offices, and Teams that support mental health disparities research across the lifespan.⁵⁸ Additionally, in December 2021, NIMH, the National Institute on Minority Health and Health Disparities, and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) hosted an expert conference to further inform research efforts specifically on youth mental health disparities. This conference included a diverse group of expert panelists to assess the state of the science and the short- and longer-term research priorities related to improving mental health treatment, services, and outcomes for youth and adolescents from communities that experience health and related disparities.⁵⁹

Specific areas of research that NIMH aims to support include:

1. Understanding structural social determinants of mental health (e.g., housing instability, family income, community resources, neighborhood characteristics, work or school environments, and structural racism), how they can be modified, and how they drive risk of, resilience to, and protection from the development of mental illnesses.
2. Identifying and understanding contextualizing factors, including environmental and historical factors, their impact on biology, emotion, cognition, and behavior, and how they mediate mental health disparities.
3. Assessing how local, state, and Federal policies, laws, and regulations impact social determinants of mental health, mental health service delivery, and outcomes among youth from populations impacted by mental health disparities.
4. Characterizing variation in biological and genomic processes within and among diverse populations historically underrepresented in genetics research.
5. Conducting longitudinal studies and other research focused on understanding and measuring how childhood experiences confer resilience to or risk for mental illnesses and suicidal thoughts and behaviors in youth from populations impacted by mental health disparities.
6. Improving the specificity of biomarkers and the accuracy of culturally appropriate diagnostic assessments (including risk calculators) for youth from populations impacted by mental health disparities.
7. Developing and validating culturally appropriate preventive interventions, including systems-level approaches (e.g., in classrooms, schools, communities) for youth and parents from populations impacted by mental health disparities.
8. Optimizing existing evidence-based approaches to minimize bias in diagnosis and treatment, and to improve continuity of care and mental health outcomes for youth from populations impacted by mental health disparities.
9. Addressing co-occurring mental illnesses in youth with intellectual and developmental disabilities, including youth with intersectionality with other high-risk groups.
10. Improving the implementation and availability of mental health prevention and treatment interventions and services, as well as programs to support youth and family functioning, within youth-serving institutions (e.g., educational settings, community-based after-school programs, faith-based programs, child welfare programs, juvenile justice settings).
11. Using innovative assessment and analytic methods to examine sub-populations and low base-rate behaviors (e.g., death by suicide) and to address complex, multi-modal datasets.

⁵⁸ www.nimh.nih.gov/about/organization/od/odwd/nimhs-approach-to-mental-health-disparities-research.

⁵⁹ www.nimh.nih.gov/news/events/2021/2021-youth-mental-health-disparities-conference-identifying-opportunities-and-priorities-in-youth-mental-health-disparities-research-summary.

12. Developing, testing, and implementing prevention and treatment interventions that are relevant to communities impacted by health disparities across a broad range of ages (e.g., infancy through young adulthood).

13. Engaging collaborative teams that include community partners to ensure that the outcomes and interpretation of research reflect the priorities of the population participating in the research.

14. Developing targeted interventions by examining risk and resilience within populations impacted by youth mental health disparities.

QUESTIONS SUBMITTED TO DR. RICHARD HODES

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Aduhelm Decision

Question. Dr. Hodes, I've been watching with interest, as I suspect you have as well, the decisions FDA and CMS have made regarding the new Alzheimer's treatment, Aduhelm. What are your thoughts about CMS' decision to require only patients in a clinical trial to receive the first approved Alzheimer's drug in more than a decade? And how does that decision affect other NIH Alzheimer's clinical trials?

Answer. The National Institutes of Health (NIH) notes that the decisions issued by the U.S. Food and Drug Administration (FDA) and Centers for Medicare and Medicaid Services (CMS) are regulatory decisions, and NIH defers to these agencies on such matters. To date, the impact of the aducanumab (the generic name for Aduhelm) coverage determination on NIH clinical trials has been minimal. NIH will continue to press forward with its robust and diverse research portfolio in the area of therapy development, building on the advancements we have achieved thus far. We will continue to evolve our understanding about Alzheimer's and to develop more ways to detect, treat, and prevent this disease.

Question. Perhaps what is most concerning about the decision CMS made on Aduhelm is that it impacts not only this specific treatment, but all other monoclonal antibody treatments coming down the pike. Can you address what this CMS decision means for the future of NIH's clinical trials process for new Alzheimer's treatments?

Answer. NIH notes that the decisions issued by FDA and CMS are regulatory decisions, and NIH defers to these agencies on such matters. These decisions underscore the need to further advance our knowledge and support a broad range of therapies for Alzheimer's and related dementias. In fact, nearly three-quarters of National Institute on Aging (NIA)-funded Alzheimer's and related dementias drug trials in early phases (phase I or phase II) are for targets other than amyloid proteins. NIH will continue to advance its robust and diverse research portfolio in therapy development, building further on the significant achievements thus far to effectively prevent, detect, and treat these devastating diseases.

Question. Dr. Hodes, I know you had initial concerns about how CMS' decision may pull patients away from other NIH clinical trials and toward an Aduhelm trial instead, simply so they could have access to the new drug. Has that fear been realized and how have you worked to combat it?

Answer. These concerns have not been realized. To date, the impact of the aducanumab coverage determination on NIH clinical trials has been minimal.

Overactive Bladder

Question. Dr. Hodes, overactive bladder affects more than 38 million Americans, and is more common with aging and in women. Recent studies on anticholinergic medications, which are commonly prescribed drugs to treat overactive bladder, have shown that these medications have a negative impact on cognition and may lead to the development of Alzheimer's disease and related dementia. Given the potential adverse impact on the nation's elderly that will only increase as our population ages, is NIA studying these medications or working collaboratively with other Institutes to determine the safety and efficacy of anticholinergic medications, and any association they may have with cognitive decline and Alzheimer's disease and related dementia?

Answer. Overactive bladder occurs when the bladder is triggered to empty at the wrong time, leading to a sudden urge to urinate that a person may have difficulty suppressing. The symptoms of overactive bladder include urinary frequency, urinary urgency, and urge incontinence.

The National Institute on Aging (NIA) supports studies on a range of issues related to the causes, prevention, and treatment of overactive bladder. This includes research on the safety of long-term use of anticholinergic medications commonly pre-

scribed to treat overactive bladder and the associated risk of cognitive impairment and dementia. For example, NIA is supporting a clinical trial testing whether discontinuing use of anticholinergics improves cognition and lowers the risk of Alzheimer's disease and related dementias.⁶⁰ NIA is also funding a clinical trial to test a mobile app that integrates a personalized anticholinergic risk calculator, targeted multimedia such as videos and blogs to educate users regarding anticholinergics, and a conversation starter to help a patient self-initiate ending anticholinergic prescriptions with a healthcare provider.⁶¹ This trial will explore the impact of the app on prescription anticholinergic exposure among older adults and on cognitive function and quality of life. Other research studies currently funded by NIA seek to assess severe adverse events associated with the interaction of cholinesterase inhibitors used to treat Alzheimer's with anticholinergic medications;⁶² test mechanisms of neurotoxicity from anticholinergics;⁶³ evaluate extended cognitive, urinary, and functional trajectories in older incontinent women without pre-existing dementia who use anticholinergic medication;⁶⁴ utilize a novel model to investigate anticholinergic drug induced dementia;⁶⁵ improve how older adults living with dementia, their caregivers, and clinicians make decisions about using anticholinergic medicines;⁶⁶ and test electronic health record-based tools that engage caregivers to help primary care providers reduce medication overload and deprescribe medications that can worsen cognitive burden in patients with mild cognitive impairment, Alzheimer's disease, and related dementias.⁶⁷ In addition, a recent NIA-supported study found that exposure to strong anticholinergics increased the risk of transitioning from normal cognition to mild cognitive impairment.⁶⁸ Another recent NIA-funded study that evaluated adverse outcomes of anticholinergic medicines in patients with dementia and overactive bladder⁶⁹ found an increased risk of mortality associated with non-selective antimuscarinic (a subtype of anticholinergic drugs) medications in older adults with dementia.⁷⁰

The National Institutes of Health (NIH) is committed to continuing to fund research to improve the lives of people living with overactive bladder and will continue to fund research towards prevention of cognitive impairment in this, and other, areas.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. Alzheimer's disease has certainly been in the news recently. While, there is plenty to discuss on Adulhelm and decisions regarding its coverage, I am interested in the role it can play in moving the science forward.

What is on the horizon to better understand Alzheimer's disease and how we can prevent/slow its progression?

Answer. Thanks to the increased investment in Federal funding for Alzheimer's and related dementias, the National Institutes of Health (NIH) has been able to embark on an ambitious research agenda and continues to make significant progress in discovering approaches that may prevent, diagnose, and treat these complex diseases.

Understanding Alzheimer's and related dementias: Roughly 10 years ago, we knew of just 10 genetic areas associated with Alzheimer's disease, and 20 years ago, we knew of only 4. That number has grown to more than 70 associated genetic areas today. These advances are already informing new pathways for potential prevention and treatments. For example, NIH-supported research involving a Colombian family with more than 6,000 living members led to the identification of a gene variant that may protect against the development of Alzheimer's.⁷¹ Studies to understand how this gene and others may protect against Alzheimer's suggest new possibilities for treatment options, which NIH is exploring further.

⁶⁰ reporter.nih.gov/search/Shaj-qYerkm0U6DRn1S6tg/project-details/10129872.

⁶¹ clinicaltrials.gov/ct2/show/NCT04121858.

⁶² reporter.nih.gov/search/pZSsBABfW0K-DPFCtVqRcQ/project-details/10212709.

⁶³ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/10168318.

⁶⁴ reporter.nih.gov/search/0lm26jQsukuQXix5r-QvGw/project-details/10343015.

⁶⁵ reporter.nih.gov/search/0lm26jQsukuQXix5r-QvGw/project-details/10258975.

⁶⁶ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/9926791.

⁶⁷ reporter.nih.gov/project-details/10370471.

⁶⁸ www.ncbi.nlm.nih.gov/pmc/articles/PMC6036636/.

⁶⁹ reporter.nih.gov/search/-xMveMuhZUWqFIMIntQeIw/project-details/9377896.

⁷⁰ pubmed.ncbi.nlm.nih.gov/32026255/.

⁷¹ <https://www.nia.nih.gov/news/unique-case-disease-resistance-reveals-possible-alzheimers-treatment>.

In addition, NIH funds research beyond genetics to understand the biological mechanisms associated with dementia. For example, National Institute on Aging (NIA) intramural researchers have identified several biological pathways linked to abnormal brain metabolism in people with Alzheimer's disease and related dementias.⁷² These researchers also identified 15 promising candidate drugs that have already been shown safe and effective for other conditions and are screening these for potential use in treating dementia. By studying drugs approved by the Food and Drug Administration (FDA) for other conditions, researchers may be able to accelerate the drug discovery process for Alzheimer's and related dementias.

Diagnostics: In the early 2000s, researchers could only confirm an Alzheimer's disease diagnosis via autopsy. NIH support has been instrumental in developing ways to image and visualize aggregations of specific proteins like amyloid and tau—the hallmarks of Alzheimer's—in the brain, making a diagnosis possible in living persons. NIH continues to advance new, less invasive ways of detecting these proteins. For example, NIH small business innovation research funding helped researchers at C₂N Diagnostics validate the PrecivityAD™ test, a more affordable and less invasive alternative to traditional Alzheimer's tests like brain scans.⁷³ This blood biomarker test is now available to some doctors who are sending blood samples to C₂N's lab to analyze blood for amyloid. In May 2022, the FDA granted marketing authorization for the first test for the early detection of amyloid plaques using cerebrospinal fluid.⁷⁴ The clinical study of this test utilized cerebrospinal fluid samples made available by the Alzheimer's Disease Neuroimaging Initiative, a key component of NIH-supported Alzheimer's research infrastructure.

These tests are poised to transform Alzheimer's diagnostics and clinical trial recruitment. For example, because they can be done without the need for expensive PET scanners and radioactive diagnostic agents, they can be used in a much broader range of clinical settings, such as community health centers, thereby removing a potential barrier to participation in clinical trials.

Clinical Trials: In 2015, NIH funded 38 clinical trials to treat and prevent Alzheimer's and related dementias. In 2022, NIH is supporting more than 400 trials, approximately half covering dementia treatment and prevention, and the other half covering care interventions for persons living with these diseases.⁷⁵ The growth of NIH's clinical trial portfolio, which includes a diverse range of promising therapeutic approaches, is directly attributable to increased appropriations. In fact, the number of therapeutic targets for drug candidates in NIH-supported trials has more than doubled from 2015 to 2022. This is particularly evident in early phase (phase I or phase II) trials, where more than three-quarters of the drug trials currently supported by NIH are for targets other than amyloid proteins in the brain.

Some of these clinical trials will share results soon. The Exercise in Adults With Mild Memory Problems (EXERT) trial,⁷⁶ which tests the effects of aerobic exercise on cognition in adults with Alzheimer's, will report topline results in August 2022. In December 2022, the PEACE-AD trial,⁷⁷ which evaluates the drug Prazosin to treat severe agitation in adults living with Alzheimer's who require full-time caregiving, will share topline results. In addition, the DISCOVER Study⁷⁸ testing the drug Posiphen® in adults diagnosed with Alzheimer's is expected to report results late this year or in early 2023.

Prevention: We now know there are several risk and resilience factors that may play a role in the development of dementia. One example is blood pressure control. Recent NIH-supported studies showed that intensive high blood pressure control significantly reduces the occurrence of mild cognitive impairment, a precursor to dementia in some individuals. NIH has taken steps to share these findings with the public through efforts like the Mind Your Risks® campaign.⁷⁹

In addition, a recent analysis of data from two NIA-funded longitudinal study populations, the Chicago Health and Aging Project (CHAP)⁸⁰ and the Memory and Aging Project (MAP),⁸¹ found that adhering to a combination of healthy behaviors

⁷² <https://www.nia.nih.gov/news/nia-study-identifies-fda-approved-drugs-may-also-be-helpful-dementia>.

⁷³ <https://www.nih.gov/news-events/news-releases/nih-small-business-funding-boosts-alzheimers-science-advances>.

⁷⁴ <https://www.fda.gov/news-events/press-announcements/fda-permits-marketing-new-test-improve-diagnosis-alzheimers-disease>.

⁷⁵ <https://www.nia.nih.gov/research/ongoing-AD-trials>.

⁷⁶ <https://clinicaltrials.gov/ct2/show/record/NCT02814526>.

⁷⁷ <https://clinicaltrials.gov/ct2/show/NCT03710642>.

⁷⁸ <https://www.clinicaltrials.gov/ct2/show/NCT02925650>.

⁷⁹ www.mindyourrisks.nih.gov/.

⁸⁰ www.alzrisk.org/cohort.aspx?cohortid=15.

⁸¹ www.alzrisk.org/cohort.aspx?cohortid=60.

was associated with a lower risk of Alzheimer's, including in individuals with genetic risk factors for the disease.⁸²

The behaviors included engaging in regular physical activity, avoiding smoking, practicing light-to-moderate alcohol consumption, eating a high-quality diet, and engaging in cognitive activities. Practicing four or all five of these behaviors was associated with up to a 60 percent reduction in Alzheimer's risk.

The finding that behavioral choices appear to have an impact on the development of Alzheimer's even in individuals with a higher genetic risk is encouraging in terms of the promise of nondrug therapies in the search for effective treatments. To this end, NIH continues to support research to identify the best ways to help prevent dementia, including more than 130 clinical trials on nondrug interventions like exercise, diet, and sleep.⁸³ NIH also supports research on how to help people adopt and sustain these healthy behaviors over a lifetime.⁸⁴

QUESTIONS SUBMITTED TO DR. NORA VOLKOW

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Opioids Research

Question. Dr. Volkow, since fiscal year 2018, NIH has been provided \$500 million in dedicated funding annually for opioids and stimulant research. However, according to data released last week by the CDC, opioid overdoses continue to rise, with deaths up nearly 50 percent in the past 2 years. What research has NIH produced to move the needle on overdoses?

Answer. The National Institute on Drug Abuse (NIDA) shares your concerns about rising rates of drug overdoses and mortality. In the past few years, this crisis has been driven largely by increasing availability of potent synthetic opioids such as fentanyl and increases in combined opioid and stimulant use. NIDA supports robust multi-pronged efforts to stem the overdose crisis, including research on drug use and overdose prevention interventions, emerging patterns of substance use, harm reduction approaches, development of medications for opioid and stimulant use disorders, and the impact of coronavirus disease 2019 (COVID-19) on substance misuse and comorbidities.

Adolescence and young adulthood are periods of particularly high risk for drug initiation and the development of addiction. Through its prevention research portfolio and through the HEAL Prevention Initiative,⁸⁵ NIDA is developing and testing strategies to prevent drug use risk in youth overall and specifically to prevent opioid initiation, misuse, and use disorder, in populations including American Indian/Alaska Natives, youth with justice system involvement, and youth experiencing homelessness. This research will also address the sustainability and cost of these interventions. Through one project, researchers have developed a patient education program to prevent diversion of stimulants prescribed for attention-deficit/hyperactivity disorder.⁸⁶ Initial evidence showed reductions in patients' disclosure of their prescription to friends, their intent to share, and being approached to share.⁸⁷

In 2020, NIDA expanded its National Drug Early Warning System (NDEWS), which monitors patterns of drug use, morbidity, and mortality. By analyzing counterfeit pills seized by law enforcement, NDEWS established that such pills are a growing source of fentanyl.⁸⁸ This suggests that many fentanyl exposures are unplanned, and that overdose risk could be reduced with simple tools like fentanyl test strips (FTS). NIDA supports studies on FTS use and research to improve FTS technology. NIDA's Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs also support innovative technologies to surveil drugs in community wastewater to monitor changes in drug use as well as the emergence of new drugs. These tools are valuable for assessing the impact of prevention and treatment interventions and helping to tailor resource allocation.

⁸² pubmed.ncbi.nlm.nih.gov/32554763/.

⁸³ www.nia.nih.gov/research/ongoing-AD-trials.

⁸⁴ www.nia.nih.gov/research/blog/2021/12/tis-season-healthy-habit-research.

⁸⁵ heal.nih.gov/research/new-strategies/preventing-opioid-use-disorder.

⁸⁶ <https://reporter.nih.gov/project-details/9980049>.

⁸⁷ Molina BSG., Kipp, HL., Joseph, HM., et al. Stimulant diversion risk among college students treated for ADHD: Primary care provider prevention training. *Acad Pediatr.* 2020; 20(1): 119–127.

⁸⁸ Palamar, JJ., Ciccarone, D., Rutherford, C., et al. Trends in seizures of powders and pills containing illicit fentanyl in the United States, 2018 through 2021. *Drug Alcohol Depend.* 2022;1:234.

In alignment with the National Drug Control Strategy, one of NIDA's priorities is to expand research on harm reduction, which focuses on reducing the risk of overdose and other harms associated with drug use. Through the NIH Helping to End Addiction Long-term® (NIH HEAL Initiative®), NIDA is establishing a new network to develop, test, and implement harm reduction strategies and assess the impact of state and local harm reduction policies.⁸⁹ NIDA research is also evaluating the implementation of peer-based opioid overdose education, naloxone distribution, and social support interventions and their impact in African Americans⁹⁰ and veterans.⁹¹

Through its Clinical Trials Network (CTN), NIDA has helped create an arsenal of medications for opioid use disorder (MOUD) that are effective in reducing overdose. NIDA supported development of naloxone, and more recently, Kloxxado, a nasal spray containing high-dose naloxone that was approved by the U.S. Food and Drug Administration (FDA) in 2021.⁹² NIDA continues to fund research aimed at treating opioid and stimulant use disorders and overdose with nearly 90 compounds at various stages along the drug development pipeline, including longer-acting overdose reversal agents; and since 2019, NIDA's Pharmacotherapies Development Program has ushered twenty-four investigational new drug (IND) applications and eight IND exemptions through the FDA's IND process. One of the most promising preclinical projects underway is optimizing, characterizing, and testing the efficacy of a novel compound for reversing opioid-induced respiratory depression involving fentanyl and fentanyl analogs, alone and in combination with methamphetamine.⁹³ Researchers are also studying the unique physiological and pharmacological effects of co-intoxication with fentanyl and methamphetamine in animal models and testing the ability of CS-1103 to normalize these effects.⁹⁴ Unfortunately, NIDA-funded research also shows that MOUD are underutilized.⁹⁵

NIDA funds research to overcome barriers to MOUD use in diverse settings, including prisons and jails. For example, one recent study found that 6 months after Rhode Island implemented a comprehensive OUD screening and treatment program at its corrections facilities, the state saw a 12.3 percent reduction in fatal overdoses overall and a 60.5 percent reduction among the recently incarcerated.⁹⁶ With support from the NIH HEAL Initiative, the HEALing Communities Study⁹⁷ and the Justice Community Opioid Innovation Network (JCOIN)⁹⁸ are expanding research efforts to increase MOUD use; test the effectiveness and adoption of new prevention interventions and medications; and together, use real-world evidence to address the needs of vulnerable populations.

Stimulant misuse and overdose, primarily involving methamphetamine, have also continued to rise and often co-occur with opioid misuse. Unlike the case for OUD, there are no clinically proven medications for methamphetamine use disorder (MUD), but NIDA has supported progress on this front. Recent findings from a clinical trial demonstrated that treating MUD with naltrexone, a type of MOUD, in combination with bupropion, an antidepressant with stimulant effects, for six weeks helped patients reduce their meth use and improved other symptoms, such as depression⁹⁹ (Trivedi, et al. 2021).

NIDA-funded research also helped establish that contingency management (CM) is effective for reducing misuse of opioids, stimulants, and other substances; in CM, patients are given incentives for reducing their drug use or engaging in treatment. NIDA funding led to the first FDA-authorized mobile apps for intended to help increase retention in outpatient treatment programs for SUD.¹⁰⁰ These cognitive behavioral therapy apps are intended to be used in conjunction with CM and other tools and strategies to reduce drug craving. Ongoing studies seek to improve these

⁸⁹ RFA-DA-22-046: HEAL Initiative: Harm Reduction Policies, Practices, and Modes of Delivery for Persons with Substance Use Disorders (R01 Clinical Trial Optional).

⁹⁰ https://reporter.nih.gov/search/pXhkeRP_10CxXi3NjmRQig/project-details/10354090.

⁹¹ https://reporter.nih.gov/search/pXhkeRP_10CxXi3NjmRQig/project-details/10298478.

⁹² https://reporter.nih.gov/search/pXhkeRP_10CxXi3NjmRQig/project-details/10298478.

⁹³ <https://reporter.nih.gov/search/Zmse6nG00kKHYS5M4qW/project-details/10227069>.

⁹⁴ https://reporter.nih.gov/search/51gwUKe_70eDNuM13Y1IOQ/project-details/10433799.

⁹⁵ Xu, KY., Mintz, CM., Presnall, N., et al. Comparative Effectiveness Associated With Buprenorphine and Naltrexone in Opioid Use Disorder and Cooccurring Polysubstance Use. *JAMA Netw Open*. 2022 May 2;5(5).

⁹⁶ Green TC., Clarke, J., Brinkley-Rubinstein, L., et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry*. 2018 Apr 1;75(4):405–407.

⁹⁷ <https://heal.nih.gov/research/research-to-practice/healing-communities>.

⁹⁸ <https://heal.nih.gov/research/research-to-practice/jcoin>.

⁹⁹ <https://pubmed.ncbi.nlm.nih.gov/33497547/>.

¹⁰⁰ <https://peartherapeutics.com/products/reset-reset-o/>.

apps and apply them in new ways, such as at-home initiation of MOUD (3R44DA042652).¹⁰¹

While these advances are moving the needle, the COVID-19 pandemic has exacerbated the overdose crisis. Nearly 15 percent of U.S. adults initiated or increased substance use to cope with pandemic-related stress,¹⁰² and drug overdose rates among adolescents doubled during the pandemic, after a decade of stability.¹⁰³ While Federal drug regulatory and healthcare agencies implemented policy changes to expand treatment access for people with SUD, pandemic restrictions still caused disruptions in treatment.¹⁰⁴ NIDA has supplemented many of its studies and programs during the pandemic, including the Adolescent Brain Cognitive Development SM Study (ABCD study®), to better understand the risks of pandemic-related substance misuse and identify possible ways to intervene, and to evaluate the impact of pandemic-related policy changes.

Question. During the COVID-19 pandemic, NIH stepped up and embraced the sense of urgency by creating programs like RADx, which was a Shark Tank-style program to develop more COVID tests. How can we incorporate that model into the urgent needs related to the opioid epidemic?

Answer. Addressing the addiction and overdose crisis requires innovation, and often, those in a position to develop solutions are not even aware of their potential to help. Therefore, NIDA uses the Federal government's small business innovation research (SBIR) and small business technology transfer (STTR) programs and novel, fit-for-purpose, funding authorities to help biotech startups develop innovative solutions that translate addiction science into healthcare and consumer products.¹⁰⁵

Under the statutory authority of the America Creating Opportunities to Meaningfully Promote Excellence in Technology, Education, and Sciences (COMPETES) Reauthorization Act of 2010, NIDA's annual "\$100,000 for Start a Substance Use Disorders (SUD) Startup" is a Shark Tank-style challenge that supports research ideas that are intended to be the foundation for the development of successful new startups.¹⁰⁶ Each year, this challenge provides ten winners with \$10,000 each and technical mentoring from NIDA biomedical entrepreneurship experts. This enables the winners to test the premise that their research idea can be fostered into a biotech startup that will eventually contribute to the pool of innovative small businesses that can successfully compete for NIDA's SBIR and STTR funding. Sound Life Sciences and Prapela were discovered and selected through this challenge. Sound Life Sciences used this award to build a startup around a novel app that turns a user's smartphone into a portable respiratory monitor capable of detecting changes in breathing associated with an overdose. If an overdose is detected, it will sound an alarm, provide instructions, and summon emergency services to the user's location.¹⁰⁷ Prapela developed a hospital bassinet pad that delivers gentle, random vibrations to treat newborns who were exposed to opioids before birth. The bassinet pad may help improve newborns' breathing and heart rate and may also be useful in infants with breathing issues due to premature birth.¹⁰⁸

Other innovative products grew out of the NIDA Market Fair, a Shark Tank-style funding solicitation strategy. NIDA staff pitched ideas for potential funding concepts to "Sharks" who were experts in product development and policy from other NIH Institutes and other Federal agencies. The best ideas were rapidly selected and developed into funding opportunities for small business applications. The Shark Tank-style selection of concepts for development assured that there was a need and a market, which, in turn, attracted the companies best suited to develop specific products. Biobot Analytics developed a wastewater testing and analysis method to detect community exposure to opioids that can inform local opioid response efforts; this company was also able to pivot and provide critical data on the presence of SARS-

¹⁰¹ <https://reporter.nih.gov/project-details/10153370>.

¹⁰² Czeisler, ME., Lane, RI., Petrosky, E., et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69(32):1049–1057.

¹⁰³ Friedman, J., Godvin, M., Shover, CL., et al. Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. *JAMA.* 2022;327(14):1398–1400.

¹⁰⁴ Meadowcroft, D. and Davis W. Understanding the Effect of the COVID-19 Pandemic on Substance Use Disorder Treatment Facility Operations and Patient Success: Evidence From Mississippi. *Subst Abuse.* 2022;16:11782218221095872.

¹⁰⁵ <https://nida.nih.gov/research/nida-research-programs-activities/nida-challenges-program>.

¹⁰⁶ <https://nida.nih.gov/research/nida-research-programs-activities/nida-challenges-program/2021-start-sud-startup>.

¹⁰⁷ <https://www.soundlifesci.com/>.

¹⁰⁸ <https://www.prapela.com/>.

CoV-2 in communities.¹⁰⁹ AppliedVR developed RelieVRx™, an FDA-authorized virtual reality-based tool to treat people with chronic low back pain by helping them learn how to better cope with pain.¹¹⁰

The goal is to reduce the need for opioids for many different pain indications and reduce the associated risk of developing an opioid use disorder (OUD). Workit Health® is an app that uses video chat and messaging technology to bring trained experts directly to those with SUDs via a phone or computer.¹¹¹ The company is working to develop a chat bot to improve patient engagement and is continually working to expand its services to treat additional disorders and co-occurring conditions. Woebot, developed by Woebot Health™, is a smartphone-based mental health chatbot intended to use artificial intelligence and language processing technology to deliver personalized cognitive behavioral therapy for people with SUDs.¹¹² Woebot is being expanded for use in additional mental health indications. In addition, We the Village provides online support for families or friends of someone who is struggling with substance use or has a SUD.¹¹³ The online support includes a course that aims to teach people communication and support skills and an online Q&A to help people share what they've learned, with the overall aim of helping loved ones reduce substance use and get treatment. These and other innovative products developed through NIDA support demonstrate that pairing sound science with biotechnology entrepreneurship has great potential benefit for those with addiction or at risk for overdose.

QUESTIONS SUBMITTED BY SENATOR SHELLEY MOORE CAPITO

Question. The release last week of the preliminary 2021 overdose statistics was a grim reminder of how much work we still have to do. Last Friday, I spoke with a mother who had recently lost her daughter to fentanyl laced methamphetamine. She shared that while the first responders had tried to use Narcan, since meth was the primary drug in her system it was ineffective.

How is research progressing for an overdose reversal drug similar to Narcan for meth/stimulant overdoses?

Answer. Unprecedented increases in drug overdose deaths in the last 8 years have been driven mainly by fentanyl, alone and in combination with other drugs. Co-involvement of stimulants in fentanyl-involved overdose deaths as well as increases in overdose deaths involving stimulants without any opioids are particularly concerning the National Institute on Drug Abuse (NIDA).¹¹⁴ The rate of methamphetamine-involved overdose deaths increased by 810 percent from 2013 to 2021, and the rate of cocaine-involved overdose deaths increased by 398 percent.¹¹⁵ There are currently no U.S. Food and Drug Administration (FDA)-approved medications to treat stimulant use disorder or stimulant overdose, but NIDA research is underway to better characterize stimulant overdoses and to develop treatments for overdoses involving stimulants, alone or in combination with opioids.

Researchers have developed an antibody against methamphetamine (IXT-m200) that binds the drug in blood and keeps it from entering the brain in animal models and is safe for use in healthy humans. As a next step, NIDA is funding a study in emergency department patients with methamphetamine intoxication to test the efficacy of the antibody in alleviating methamphetamine overdose symptoms.¹¹⁶ NIDA-funded researchers have developed a small molecule (CS-1103) intended to act like a sponge and clear drugs from the body; they are testing its ability to clear either fentanyl¹¹⁷ or methamphetamine.¹¹⁸ Researchers are also studying the unique physiological and pharmacological effects of co-intoxication with fentanyl and methamphetamine in animal models and testing the ability of CS-1103 to normalize

¹⁰⁹ <https://biobot.io/>.

¹¹⁰ <https://www.relievr.com/>.

¹¹¹ <https://www.workithealth.com/>.

¹¹² <https://woebothealth.com/new-rct-shows-woebot-reduced-problematic-substance-use-occasions-by-one-third/#:~:text=In%20short%3A%20Woebot%20significantly%20reduced%20substance%20use%20occasions,a%20total%20score%20of%20%3E%2F%3D%20on%20the%20CAGE-AID%29.>

¹¹³ <https://wethevillage.co/>.

¹¹⁴ <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>.

¹¹⁵ cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

¹¹⁶ [https://reporter.nih.gov/search/Zmse6nG00kKHYseah5M4qw/project-details/10269933\(5U01DA053043\)](https://reporter.nih.gov/search/Zmse6nG00kKHYseah5M4qw/project-details/10269933(5U01DA053043)).

¹¹⁷ [https://reporter.nih.gov/search/Lv70TeON70-p34mvyTTKXg/project-details/10390959\(2R44DA052957\)](https://reporter.nih.gov/search/Lv70TeON70-p34mvyTTKXg/project-details/10390959(2R44DA052957)).

¹¹⁸ [https://reporter.nih.gov/search/ufwTgufCYka3Auu_FIsAng/project-details/10425422\(5U01DA053054\)](https://reporter.nih.gov/search/ufwTgufCYka3Auu_FIsAng/project-details/10425422(5U01DA053054)).

these effects.¹¹⁹ Other research underway is a preclinical project to optimize, characterize, and test the efficacy of a novel compound for reversing opioid-induced respiratory depression involving fentanyl and fentanyl analogs, alone and in combination with methamphetamine.¹²⁰

In addition to the studies described above, NIDA is currently supporting research on nearly 90 compounds aimed at treating opioid and stimulant use disorders and overdose at various stages along the drug development pipeline. NIDA also issued funding opportunity announcements to solicit additional research to develop new medications to prevent and treat stimulant use disorders and overdose co-involving opioids and stimulants,¹²¹ to develop pharmacotherapeutics and other medical therapeutic and diagnostic devices for opioid use disorder and stimulant use disorders,¹²² and to understand the mechanisms underlying the toxic effects of using opioids and stimulants together.¹²³

SUBCOMMITTEE RECESS

Senator MURRAY. And this committee will next meet in Dirksen 138, Tuesday, May 24, at 10 a.m., for a hearing on the Biden Administration's Budget Request for the Department of Education.

The committee is adjourned.

[Whereupon, at 11:29 a.m., Tuesday, May 17, the subcommittee was recessed, to reconvene at 10 a.m., Tuesday, May 24.]

¹¹⁹ https://reporter.nih.gov/search/51gwUKe_70eDNuM13Y1IOQ/project-details/10433799 (3U01DA053054).

¹²⁰ <https://reporter.nih.gov/search/Zmse6nG00kKHYseah5M4qw/project-details/10227069> (5U01DA051373).

¹²¹ NOT-DA-22-049: Notice of Special interest (NOSI): Medications Development for Stimulant Use Disorders.

¹²² RFA-DA-23-021: Developing Regulated Therapeutic and Diagnostic Solutions for Patients Affected by Opioid and/or Stimulants use Disorders (OUD/StUD) (R43/R44—Clinical Trial Optional).

¹²³ NOT-DA-20-007: Notice of Special Interest (NOSI): Preclinical and Clinical Studies of the Interactions of Opioids and Stimulants.

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

TUESDAY, JUNE 7, 2022

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

The subcommittee met at 10:32 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Patty Murray (chairman) presiding.

Present: Senators Murray, Reed, Shaheen, Schatz, Baldwin, Manchin, Blunt, and Braun.

DEPARTMENT OF EDUCATION

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 2023 request for the Department of Education. Senator Blunt and I will each have an opening statement, and then I will introduce our witness. After his testimony, Senators will each have 5 minutes for a round of questions.

We are unable again 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 are in need of accommodations, including closed captioning, please reach out to the committee or the Office of Congressional Accessibility Services.

SCHOOL SAFETY

Mr. Secretary, I know everyone on this committee is focused on what we can do to protect our kids and educators in light of the tragedy at Robb Elementary School in Texas. Those families are in my heart and the need for action is heavy on my mind. And of course, 10 days before the mass shooting at a school in Texas, there was a mass shooting in a grocery store in Buffalo.

Last week there were several more, including one at a health center. And we have also seen mass shootings at movie theaters, concerts, houses of worship. When a mass shooting happens everywhere, this isn't just a school problem, it is a gun problem.

So, while there is much to say about how we can protect our kids from gun violence, we can't fix this by asking educators to be soldiers and bringing more guns into schools. We cannot fix it by turning classrooms into prisons or simply buying more metal detectors. We have to pass common sense gun safety reforms. There is no getting around it. Universal background checks. Assault weapons ban. Red flag laws.

I am ready to work with any Republican to make any kind of meaningful change here, and I hope that after years of blocking progress, they reverse course because as a mother and a grandmother and a former preschool teacher, it is not hard for me to choose between guns and kids. And I don't think that should be a hard choice for anybody.

I believe prioritizing our kids and making sure everyone of them receives a great public education and can pursue higher education is one of the best decisions we can make every time. I am constantly hearing from parents across Washington State who feel the same. That is a belief that got me into politics, and it drives my work every day.

RECENT MAJOR INVESTMENTS

It is why I pushed so hard in our recent bipartisan funding bill to make the largest increase in more than a decade to Title I funding for public schools, and to Pell Grants, and it is why I am glad this budget calls for even more resources to support students from preschool through college and career readiness, and to address inequities in education that harm so many students.

And it is why Democrats worked so hard to pass the American Rescue Plan to help schools get our kids back in the classroom safely, and address students' academic and mental health needs, which were worsened by the COVID-19 pandemic. The fact almost all schools are operating in person today is a clear testament to how useful those resources were.

CHALLENGES TO EDUCATION

But there is more work ahead to address the challenges this pandemic has exposed and exacerbated for families and kids, especially. The childcare crisis is a huge weight on families, on businesses, on our entire economy. I am continuing to push with everything I have got for an investment through reconciliation of the size and scope we need to fix this. If we do that, we can get parents, especially moms, back to work, put more money back in their pockets, and set our kids up for a brighter future.

I have heard from so many parents and educators and students back home also about the mental health challenges our kids are facing. And I have been making sure the Biden Administration hears from them, too, from the students who joined me and Surgeon General Murthy to discuss these challenges earlier this year, to the mental health professionals that sat down with me and Secretary Becerra in Washington State a few weeks ago.

We need to make sure that our kids and everyone in our communities get the help they need. That is why I am working to take action on youth mental health as part of a larger bipartisan package. Another enormous challenge for schools and students is the

learning loss that this pandemic caused. Educators are working tirelessly to reengage students to address their academic needs and tackle the years of disrupted learning.

But it is not easy to get things on track in the wake of a pandemic, especially amid the staffing shortages. And this work is all the more urgent for kids who were already facing the greatest barriers in education, only to face the greatest burdens of this pandemic as well. That includes students of color, students with disabilities, English learners, students from families with low incomes, and students experiencing homelessness.

THE PRESIDENT'S BUDGET REQUEST

So, Mr. Secretary, I am pleased to see that this budget provides a critical boost to our public education system, especially increasing in the Title I program that serves over 60 percent of public schools in the U.S. It prioritizes support for students with disabilities, an issue where States and districts have fought for too long, struggling to fill the gaps in Federal funding.

And it increases support for the more than 5 million English learners and youth, including immigrants. Mr. Secretary, these are worthwhile investments, but there is room for improvement, particularly when it comes to helping students experiencing homelessness. The pandemic has been especially challenging for these kids, and we have to invest in their success. We also need to address the crushing burden of student debt. There is one word that keeps coming up when I talk to people about our student loan system, broken.

So, I applaud the Biden Administration's recent move to provide full debt relief to the over half a million students who were ripped off by Corinthian Colleges. And I know the Department is also moving on long needed fixes to income driven repayment plans and the public service loan forgiveness program like I have been pushing.

For too long, these programs were mismanaged, and the previous Administration simply ignored struggling borrowers who were asking for help. I am glad to see that change under President Biden, but I am not content, and I won't be until we finally have a system that actually works for students and borrowers.

And that means finally seeing this Administration extend the current repayment pause until at least 2023 and provide immediate relief by forgiving some debt for all borrowers while working on creating a student loan system that provides real help, especially to those who need it the most. And of course, we have got to address the root of the problem, higher education is just too expensive. We have got to do everything we can to lower the cost of college.

So, I am really glad this budget supports efforts I pushed for to simplify the Federal Student Aid application process and expand eligibility for those with the greatest need. It increases funding for TRIO and retention and completion grants and increases Pell Grant awards to put the program on a path to doubling the maximum award, a fitting tribute for the 50th anniversary of Pell this year.

But cost is not the only barrier that prevents students from pursuing higher education goals, which is why working to make college more accessible means investing in historically black colleges, tribal colleges and universities, and other minority-serving institutions as well.

Mr. Secretary, I always say a budget is a statement of values, and this budget shows President Biden truly understands the value of ensuring every student in our country gets a high-quality public education.

ACCESS TO FREE PUBLIC EDUCATION

That is no surprise when we have an educator as the first lady. But unfortunately, that stands in sharp contrast to the statements we have seen from some Republicans, like the Governor of Texas, who is planning to challenge the decades old Supreme Court precedent establishing the right to a public education for all children, including undocumented students. That should be shocking and concerning to everyone.

Public education is a foundation of this democracy, and no one should be playing politics with our kids' futures. The last thing any kid needs is a politician making life harder for them because of where they are from or who they are or who they love.

I am focused on what matters most when it comes to education, and that is not banning books, not punishing teachers for teaching history, or targeting gay and Trans teachers and kids who just want to talk about what they did with their family over the weekend, or just be a part of a team with their friends. It is making sure that every child in our country can get an excellent public education that prepares them to succeed in life.

We are talking about the basics here. It is also making sure our students are safe from gun violence, from discrimination, from harassment, and assault. And it is making sure parents have more time to spend on the things they care about most, making it easier for them to be involved at their kids' schools.

PARENTAL INVOLVEMENT AND SUPPORT FOR FAMILIES

Look, I got my start in politics as a parent advocate. I organized thousands of moms and dads to save a preschool program. I served on my local school board. I know how valuable it is to have parents involved, and I know making sure parents can get involved in their kids' education starts with supporting families and delivering good paying jobs, so parents actually have the time to ask their kids about school, affordable childcare and healthcare and guaranteed paid family and medical leave.

Those investments will take stress off the shoulders of parents. And when mom and dad aren't trying to figure out how to afford their kid's insulin, they can spend more time helping them on their homework or just asking them how their day went. These are the issues parents and students back in Washington State are focused on.

They are the issues I am focused on, and it is great to see President Biden is focused on them, too. With that, I will turn it over to Senator Blunt for his opening remarks.

STATEMENT OF SENATOR ROY BLUNT

Senator BLUNT. Good morning, chair, and thank you for having this hearing today. Secretary Cardona, thank you for appearing before the subcommittee today to discuss the Department of Education's fiscal year 2023 budget request.

I appreciate so much of what you are doing at the Department, and in the last year we have gotten a chance to know each other. I don't think we have ever had a conversation that didn't include catching up on your family, and I appreciate your commitment to them and to education.

Before we turn to the budget request, I want to acknowledge the terrible tragedy that occurred at Robb Elementary in Uvalde, Texas, 2 weeks ago. Like many Americans, I am heartbroken for the lives of the 19 students that will go un-lived, of the two teachers that were lost.

No family should ever suffer the loss of a child in this kind of horrific act of violence. The community and many of the families in it will be changed forever because of what happened there. I want to look at what we can do in a bipartisan way, as the chair has mentioned, her commitment in that same vein, to prevent another tragedy like this from occurring.

During my time on this committee, I have worked with my colleagues to provide significant increases to enhance school safety, expand access to mental health support, and restart gun violence research at both NIH (National Institutes of Health) and CDC (Centers for Disease Control and Prevention).

We need to continue working together to ensure everyone who has a mental or behavioral health issue can get the treatment they need and when they need it. I also want to say that people with mental health challenges are more likely to be the victims of a crime than they are to be the perpetrators of a crime.

But clearly, there is a thread through these kinds of horrific events where a better mental health support system would have made a difference and needs to make a difference and needs to be there for all kinds of reasons, and this is one of them. This is my last year in the Senate, and my final Department of Education budget hearing.

As the first person in my family to graduate from college, as a former teacher, as a former university President, I know firsthand the importance of education, both in an individual's life and in improving our country as a whole. As I reflect on my time here working on behalf of Missourians and for our country, I am proud to say I have worked to strengthen our education programs that provide the most opportunities to every American.

In the K-12 space, I have supported programs that provide maximum flexibility for schools to decide how to best use limited resources to address the educational needs of all children and their families. This includes support for key formula programs such as Title I, IDEA (Individuals with Disabilities Education Act), and career technical education State grants.

During my time as the chairman of the committee or now as the top Republican on the committee, we have increased funding for education formula grants by more than \$5.3 billion. That includes

an increase of \$3.1 billion for Title I, and \$2 billion for IDEA. I have been a longtime champion of the charter school program, which supports the expansion of innovative, high quality public schools.

Coming out of the COVID-19 pandemic, now more than ever, parents need to be involved. Parents want to have the flexibility to choose the school that best meets their child's needs. This is evident, frankly, by the increased enrollment at public charter schools as traditional public school enrollment has declined. Given these trends, as you and I have talked about before, I am frustrated that your department is moving forward with what I think are over-reaching charter school program regulations that would create a chilling effect on the expansion of high-quality public charter schools that families so clearly want to have as an alternative. I encourage you to reconsider those regulations.

Those funds were set aside specifically by the Congress to encourage the creation of more charter school opportunities. And your regulations, frankly, make that highly unlikely.

I have also spent the last 7 years focused on prioritizing investment in bipartisan efforts to promote college access, affordability, and competition. With the 50th anniversary of the Pell Grant this year, something the Chair just mentioned, I am proud that we have accomplished a number of things there.

Over the past seven Labor-HHS (Department of Health and Human Services) bills, we have increased the maximum Pell Grant award from \$1,120 to \$6,895. That includes increasing the discretionary portion of the—like I said, from \$1,120—I meant by \$1,120 to \$6,895. This includes increasing the discretionary portion of the maximum Pell Grant award for five consecutive years through Labor-HHS bills, which prior to 2018 had not been increased through the appropriation process for a decade.

With Senator Murray's active help, as at that time the top Democrat on the authorizing committee, as well as the top Democrat on this committee, and Chairman Alexander's assistance as well, who was the chairman of the committee at the time, we also reinstated year-round Pell, a critical tool to help students stay continuously enrolled in school, complete their degree program faster, graduate with less debt, and enter or reenter the workforce more quickly.

I believe that one of the best ways to reduce the student debt burden is to help students identify post-secondary pathways to careers sooner and assist students as they complete their post-secondary education.

Investments through this committee and Pell Grants, programs like TRIO and GEAR UP are and have been crucial to helping students succeed. We built one of the greatest higher education systems in the world, in part because the Federal Government supports it without trying to control it.

I hope we continue to do that by building on the efforts of the past and not completely rewriting a playbook that has produced great results in terms of the quality of higher education in our country. Therefore, I am glad to see that this year's budget did not include the misguided proposal to make community college free.

As you have heard me say before, if you really want to make college expensive, make it free, and have the Federal Government pay

the bill. While this budget request doesn't include any specific student loan proposals, I am alarmed by the potential of what I believe, and what the Speaker of the House and the President have believed and said in the past, would be illegal student loan forgiveness currently under discussion by the Administration.

I don't think I am in the minority when I say that it is really unconscionable that the 85 percent of Americans who do not have Federal student loans would be stuck with the bill for this political giveaway. And if it happens, it is likely to happen between now and Election Day. And even worse, loan forgiveness would disproportionately benefit those who can and should be able to pay back their debt.

This is evidenced by the fact that the top 40 percent of households by income hold almost 60 percent of the student loan debt, while the bottom 40 percent hold less than 20 percent of the outstanding debt. Let me reiterate for you and for my colleagues, student loan forgiveness, as it is currently being considered and discussed, would greatly benefit those who truly are not in need of it.

If limited even to \$10,000 per borrower and individuals making less than \$150,000 per year, the Committee for Responsible Federal Budget estimates that student loan forgiveness would cost at least \$230 billion, and those in the top half of the income scale would receive 71 percent of the benefits.

This is on top of the \$100 billion that it has already cost the American taxpayers to pause student loans for the past 20 months during the COVID-19 pandemic. To put that in perspective, we could fund the Pell Grant program, which is actually, targeted towards low income students for more than a decade at the cost of these misguided, regressive policies.

Finally, student loan forgiveness does nothing to drive down college costs, and in fact it is likely to lead to increased costs and quicker student loan debt accumulation than before, with the expectation that there would be another round of forgiveness in the future. What Americans really need right now is relief from crushing inflation, not more bad policies that will only further drive up inflation.

Even the New York Times editorial board agrees that loan forgiveness is, "legally dubious, economically unsound, politically fraught, and educationally problematic." I hope the Administration will put a pause on this unfair, expensive idea and truly consider who it might be hurting rather than who might be helped.

Mr. Secretary, as we work through the appropriations process and your 2023 budget request, I hope we can set partisan politics aside and pass a bill with meaningful investments to support fair access to quality education for all students.

I look forward to working with the Chair and others on the committee to come up with a product that we can all support before the full committee and before the House. Thank you again, Mr. Secretary, for being here today.

[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 fiscal year 2023 budget request.

Before we turn to the budget request, I want to acknowledge the terrible tragedy that occurred at Robb Elementary in Uvalde, Texas two weeks ago. I am heartbroken for the lives of the 19 students and two teachers that were lost. No family should ever have to suffer the loss of a child to a horrific act of violence.

I want to look at what we can do, in a bipartisan way, to prevent another tragedy like this from occurring. During my time on this Committee, I have worked with my colleagues to provide significant increases to enhance school safety, expand access to mental health support, and restart research into gun violence. We need to continue working together to ensure anyone who has a mental or behavioral health issue can get the treatment they need, when they need it.

This is my last year in the U.S. Senate and my final Department of Education budget hearing. As a first generation college graduate, former teacher and college president, I know firsthand the importance of education, both in an individual's life and in improving our country as a whole. As I reflect on my time in Washington, working on behalf of Missourians and our nation, I am proud to say I've strived to strengthen our education programs that provide the most opportunities to every American.

In the K-12 space, I've supported programs that provide maximum flexibility for schools to decide how to best use limited resources to address the educational needs of all children and their families. This includes support for key formula programs such as Title I, IDEA, and career and technical education state grants.

During my time as the Chairman of this Subcommittee, and now as the top Republican, we have increased funding for education formula grants by more than \$5.3 billion. That includes an increase of \$3.1 billion for Title I and a \$2 billion increase for IDEA.

I've also been a longtime champion of the charter school program, which supports the expansion of innovative, high-quality public schools. Coming out of the COVID-19 pandemic, now more than ever, parents want the flexibility to choose the school that best meets their child's needs.

This is evident by the increase in student enrollment at public charter schools as traditional public school enrollment declines. Given these trends, I'm frustrated that your Department is moving forward with overreaching charter school program regulations that would create a chilling effect on the expansion of high-quality public charter schools that families so clearly want, and I urge you to reconsider those regulations.

I have also spent the last 7 years focused on prioritizing investment in bipartisan efforts to promote college access, affordability, and completion.

With the 50th anniversary of the Pell Grant this year, I am proud of all we've accomplished in strengthening this critical program. Over the past seven Labor/HHS bills, we have increased the maximum Pell Grant award by \$1,120 to \$6,895. This includes increasing the discretionary portion of the maximum Pell grant award for five consecutive years through the Labor/HHS bill, which prior to 2018 had not been increased through the appropriations process for a decade.

We also reinstated Year-Round Pell, a critical tool to help students stay continuously enrolled in school, complete their program or degree faster, graduate with less debt, and enter or re-enter the workforce more quickly.

I believe that one of the best ways to reduce the student debt burden is to help students identify postsecondary pathways to careers sooner and assist students as they complete their postsecondary education. Investments through the Labor/HHS bill in Pell Grants, and other programs like TRIO and GEAR UP, are crucial to helping students succeed.

We have built one of the greatest higher education systems in the world in part because the Federal Government supports it, without trying to control it. I hope we continue to do that by building on the efforts of the past and not completely rewriting the playbook. Therefore, I was glad to see that this year's budget did not include the misguided proposal to make community college "free." As many have said before me, "let's see how expensive college will be when it's free."

While this budget request doesn't include any specific student loan proposals, I am alarmed by the potential for illegal student loan forgiveness currently under discussion by the administration. I do not think I'm in the minority when I say that it is unconscionable that the 87 percent of Americans who do not have Federal student loans would get stuck with the bill for this political giveaway.

And even worse, loan forgiveness would disproportionately benefit those who can and should be able to pay back their debt, evidenced by the fact that the top 40 percent of households by income hold almost 60 percent of the student loan debt, while the bottom 40 percent have less than 20 percent of outstanding debt. Let me reiterate that for you and for my colleagues: student loan forgiveness, as it's cur-

rently being considered and discussed, would largely benefit those who do not truly need it.

Even if limited to \$10,000 per borrower and individuals making less than \$150,000 per year, the Committee for a Responsible Federal Budget estimates that student loan forgiveness would cost at least \$230 billion and those in the top half of the income scale would receive 71 percent of the benefits. This is on top of the \$100 billion that it has already cost the American taxpayer to pause student loan repayments via executive order for the past 20 months during the COVID-19 pandemic. To put that in perspective, we could fund the Pell grant program, which is actually targeted towards low-income students, for more than a decade at the cost of these misguided regressive policies.

Finally, student loan forgiveness does nothing to drive down college costs and, in fact, is likely to lead to increased costs and quicker student loan debt accumulation than before with the expectation of another round of forgiveness to come. What Americans really need right now is relief from crushing inflation, not more bad policies that will only further drive up inflation. Even the New York Times Editorial Board agrees that loan forgiveness is “legally dubious, economically unsound, politically fraught, and educationally problematic.” I hope the Administration will put a pause on this unfair, expensive idea, and truly consider who it might be hurting rather than helping.

Mr. Secretary, as we work through the appropriations process and your fiscal year 2023 budget request, I hope we can set partisan politics aside and pass a bill with meaningful investments that support fair access to quality education for all students.

Thank you again for being here today.

Senator MURRAY. Thank you, Senator Blunt. Our witness today is Miguel Cardona, the Secretary of the Department of Education. Thank you so much for joining us today. We look forward to your testimony, and you may begin.

SUMMARY STATEMENT OF HON. MIGUEL CARDONA

Secretary CARDONA. Thank you, Chair Murray, Ranking Member Blunt, and members of this distinguished subcommittee. Good morning, and again, thank you for having this hearing today. While I will focus on the budget and the priorities of the Department of Education, I must start by sharing that together we must meet this moment.

SCHOOL SAFETY

After attending the wakes of former murdered children and attending the funeral of a teacher, Irma Garcia, who died protecting her students and her husband, Joe, who died of a broken heart, I spoke with teachers from Robb Elementary School in Uvalde, Texas. In between tears, they asked for help.

They asked that we see what they are experiencing so that we could do everything in our power to help them and the millions of students and educators we serve across the country. So today, respectfully, I ask us to do something. Our teachers and educators did everything we asked of them these last 2 years.

Now we must listen to them and act. For the last 2 years, with greater risks to their own lives, our students and teachers rose to the moment and safely returned to school, despite fears and the risks that were associated with it. Now we must do the same. We must rise to the moment, despite whatever fears may exist, to support our students and our teachers.

On May 24, the following schoolchildren and teachers were murdered in one of our schools, Irma Garcia, Eva Mireles, Makenna Lee Elrod, Layla Salazar, Maranda Mathis, Nevaeh Bravo, Jose

Manuel Flores, Jr., Xavier Lopez, Tess Marie Mata, Rojelio Torres, Eliahna Ellie Amyah Garcia, Eliahna Torres, Annabell Guadalupe Rodriguez, Jackie Cazares, Uziyah Garcia, Jayce Carmelo Luevanos, Maite Yuleana Rodriguez, Jailah Nicole Silguero, Amerie Joe Garza, Alexandria Lexi Aniyah Rubio, Alithia Ramirez. We must say their names as we remember the responsibility that we have. Americans are looking to us to solve difficult problems. We should be humbled by this opportunity to make a more perfect union. We need to do better. Our kids deserve better. Let's find a path forward.

Before I start, I want to thank you for confirming key Education Department positions. We are eagerly awaiting confirmation of additional nominees so that the Department can continue its critical work on behalf of students, families, and educators. Today's hearing is about more than the President's proposed investments for education in the fiscal year 2023. It is about the needs of our students and how we can meet them if we work together.

THE PRESIDENT'S BUDGET REQUEST

The priorities in this budget reflect what I have learned during visits to 33 States across America, in my conversations with students, with parents, educators, and leaders in small towns and affluent suburbs and urban and rural communities, including our tribal communities. Addressing opportunity and achievement gaps that were made worse in the pandemic is more important than ever.

This budget focuses on this by investing in our Title I schools and investing in full-service community schools, which provide high poverty communities with easier access to services for health and nutrition, enrichment, education, adult education, and much more. This budget also invests \$1 billion in hiring staff to support the growing mental health needs. Students are six times more likely to access mental health supports in schools versus community settings.

To address the teacher shortage crisis, let's invest an additional \$350 million for recruiting and retaining teachers. I have traveled the country listening to parents. They share their concerns with the recovery—they are concerned with their kids' reading grade—reading at grade level, and they are concerned with getting back to school, not letting politics and division get into the classroom.

Let's work together. The American Rescue Plan got us this far. We went from 46 percent of our schools fully open at the beginning of the Biden-Harris Administration to over 99 percent today. With your investments, let's build more inclusive, affordable pathways to higher education and rewarding careers for all of our students. Let's increase Pell by \$1,775 for fiscal year 2023 so more kids can get to college.

Our budget also calls for investments in community colleges, historically black colleges and universities, Hispanic-serving institutions, tribal colleges, and other inclusive institutions. We are proposing \$200 million for career connected learning, so more underserved students' graduate high school with industry credentials and college credits. Our high school graduates need more options.

Look, education gave me the tools to achieve the American dream. I grew up in a blue collar community. I only had what my public schools offered. I attended a Title I school and graduated from a technical high school. I became a first generation college student. I am a bilingual certified educator who benefited from quality teacher preparation programing and good professional development.

I am a product of the investments in this budget. Education brought me the promise of this country. It made it a life for me. We must renew that promise for today's students and those to come. For the last 2 years, we were tested in ways we could never imagine. Through intentional collaboration and strong leadership, we persevered.

As this moment requires even more of us, we must lead with an even greater sense of urgency. Our students are watching. Let's not let them down. Thank you.

[The statement follows:]

PREPARED STATEMENT OF 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 2023 Budget Request for the Department of Education. This request reflects President Biden's deep belief in the importance of education and the success and well-being of our nation's students. It's my hope that Congress answers the President's call for increased investments at the Federal level that will help our schools continue to recover from the COVID-19 pandemic, address long-standing inequities that have existed in our school systems, and elevate our country's education system to lead the world. Our task is to reimagine and strengthen our entire system of education, from pre-kindergarten through adult education. As we recover from the crisis, let's focus on the opportunities to do just that.

Last summer traveling in Michigan, I met a woman named Ruth who is a middle-aged woman working just to make ends meet. She had a health issue that forced her to go to the hospital during the pandemic, which opened her eyes to a future in the healthcare field. As she told me, "After seeing what our country is going through, I want to live the rest of my life helping others who are going through health issues." Using a Pell Grant, she is returning to school to be a nurse practitioner. My point is that it is never too late to go back to school, and it's never too late to seize the opportunities ahead and we can make it easier for learners of all ages like Ruth to reignite their passions and discover new ones.

FISCAL YEAR 2022 CONGRESSIONAL ACTION

I want to begin by thanking the Members of the Subcommittee—and your staff—who worked so hard to provide a fiscal year 2022 appropriations bill. That bipartisan funding package delivers for our students and families by making essential investments in our schools and building on a cornerstone of the Biden-Harris Administration—keeping equity at the center of all we do. This bill includes an important commitment, shared by President Biden, to significantly increase funding for the Title I program by providing \$17.5 billion in funding, a \$1 billion increase. This is the largest increase for Title I in over a decade and an important first step that we look forward to working with you to build upon. The bipartisan package makes important strides to meet the needs of the whole child, to support effective teaching and learning, and to strengthen and diversify the educator pipeline. The 2022 appropriations bill also makes college more affordable by increasing the maximum Pell Grant by \$400, which is a down payment on the President's call to double Pell and will help more students pursue an education or training beyond high school. The President's 2023 Budget Request builds upon this legislation by increasing investments in our schools with high-poverty rates; helping meet the needs of students with disabilities and multilingual learners; and expanding access to postsecondary education and increasing college completion.

There is one technical detail that I would like the members of this Subcommittee to keep in mind when reviewing our fiscal year 2023 Budget Request. Due to the timing of the passage of the fiscal year 2022 appropriations legislation, the baseline for our fiscal year 2023 request levels was the fiscal year 2021 enacted level and

does not reflect final fiscal year 2022 appropriations action. A comparison of our request with actual fiscal year 2022 levels could suggest that we are proposing a number of decreases for fiscal year 2023, when that is not the case. On the contrary, our goal is to maintain and build on these critical investments. The Administration is excited about the support of Congress and the many increases provided to Department of Education funding in fiscal year 2022. We look forward to working with Congress to provide technical assistance during upcoming fiscal year 2023 appropriations action. The numbers I will be citing in my testimony today will mostly reflect differences between the fiscal year 2022 appropriation and our request.

DEPARTMENT OF EDUCATION FUNDING LEVELS

The President's fiscal year 2023 request calls for a significant increase in Federal support for education from birth through college and career. The proposed discretionary request is \$88.3 billion for Department of Education programs, an increase of almost \$12 billion over the fiscal year 2022 enacted level. The 2023 Budget would make historic investments in the Nation's future prosperity by prioritizing funding for five core themes that are at the heart of this Administration's vision for education in America: 1) Supporting Students Through Pandemic Response and Recovery Over the Long Term; 2) Boldly Addressing Opportunity and Achievement Gaps; 3) Supporting a Talented and Diverse Educator Workforce; 4) Making Higher Education Inclusive and Affordable; and 5) Building Pathways Through Postsecondary Education that Lead to Successful Careers.

SUPPORTING STUDENTS THROUGH PANDEMIC RESPONSE AND RECOVERY

Even with 99 percent of schools open for full-time, in-person learning, many students continue to be affected by the pandemic. We know that in our communities most impacted by COVID, their recovery could take many years. Disruptions caused by the COVID-19 pandemic continue to take a toll on the academic success, and physical, social, emotional, and mental health of students. It has also taken a toll on the well-being of our educators and school staff.

Responding to these needs can often be a challenge for many schools. For example, there continues to be a critical gap, that existed prior to and was only made worse by the pandemic, between the number of school-based health service providers needed and the number of such providers currently serving in our schools, particularly in school districts and schools with high rates of poverty. This is why the Budget includes a \$1 billion investment to bridge that gap through the School-Based Health Professionals program, both by building the pipeline of such professionals and by providing the dedicated funding needed to hire them. We appreciate the additional \$90 million Congress provided to support similar activities in the fiscal year 2022 legislation, and we are committed to building on this investment as more is still needed. The Administration estimates that our requested funding, together with State and local matching funds, would allow LEAs to hire an additional 21,000 school counselors, nurses, social workers, and school psychologists.

Our request further supports students through pandemic response and recovery by including \$468 million to dramatically expand the Full-Service Community Schools (FSCS) program. A 2020 study from the Rand Corporation, *Illustrating the Promise of Community Schools: An Assessment of the Impact of the New York City Community Schools Initiative*, found that community schools in New York City had a positive impact on student attendance, on-time grade progression, high school graduation rates, disciplinary incidents for elementary and middle school students, math achievement, credit accumulation for high school students, shared responsibility for student success at elementary and middle schools, and students' sense of connectedness to adults and peers for elementary and middle school students. Additional studies have found similar outcomes for evidence-based approaches to Full-Service Community Schools. Our request would allow the Full-Service Community Schools program to create an estimated 800 new community schools serving up to 2.4 million additional students, family members, and community members in districts that want to advance this approach.

For districts that may not have the capacity to implement the broader community schools approach supported by FSCS, this request also includes \$25 million for the provision of integrated student supports (ISS), one of the pillars of evidence-based approaches to community schools. ISS grants would help provide access to services that meet the social, emotional, mental and physical health, and academic needs of students and families through cross-agency efforts and partnerships between districts and with community-based organizations.

BOLDLY ADDRESSING OPPORTUNITY AND ACHIEVEMENT GAPS

Even before the pandemic, too many elementary and secondary school students faced daunting barriers to receiving a high-quality education. This budget seeks to remove those barriers by providing the resources needed so that every student can be successful. Core to that effort is Title I, which helps schools provide students from low-income communities the learning opportunities and supports they need to succeed. This budget boosts funding for Title I by \$19 billion over fiscal year 2022 through a mix of discretionary and mandatory funding. This substantial new support for the program, which serves 25 million students in nearly 90 percent of school districts across the Nation, would be a major step toward fulfilling the President's commitment to addressing long-standing funding disparities between under-resourced schools—which disproportionately serve students of color—and their wealthier counterparts. The Budget also includes a first-time \$30 million investment to improve education and outcomes for children and youth in foster care, one of our most vulnerable populations.

The President and I are committed to ensuring that children and youth with disabilities receive the services and support they need to thrive in school and graduate ready for college and career. I am very excited that our request provides an additional \$3.3 billion over 2021 enacted levels—which would be the largest two-year increase ever outside of the American Rescue Plan—for Individuals with Disabilities Education Act (IDEA) Grants to States, with a total of \$16.3 billion to support special education and related services for students in grades Pre-K through 12. The Budget also nearly doubles funding to \$932 million for IDEA Part C grants, which support early intervention services for infants and families with disabilities that have a proven record of improving academic and developmental outcomes. The increased funding would support States in implementing critical reforms to expand their enrollment of underserved children, including children of color, children from low-income backgrounds and children living in rural areas. The increase for Part C includes \$200 million to expand and streamline enrollment of children at risk of developing disabilities, which would help mitigate the need for more extensive services later in childhood and further expand access to the program for underserved children. In addition, our request includes a sizeable increase for the Preschool Grants program. More than 80 percent of children participating in the Preschool Grants program have demonstrated significant improvement in academic, behavioral and social and emotional outcomes, which is consistent with numerous studies that have found that the provision of special education and related services for preschool-aged children significantly improved outcomes in these areas.

Recent results from the National Assessment of Educational Progress continue to show significant achievement gaps remain between English Learners and their peers. This is directly tied to the educational opportunities and resources that are available to support their success.

These barriers to a high-quality education are especially pressing, as many states and school districts have experienced an increase in arrivals of immigrant children, including refugees from countries impacted by war. Accordingly, this Budget includes a significant increase of \$244 million to the English Language Acquisition grants program, for a total fiscal year 2023 funding level of \$1.1 billion. Further, the increased investment proposed for fiscal year 2023 would greatly strengthen the Department's capacity to work with its State and local partners to elevate meeting the needs of English learners in the context of encouraging multilingualism as a necessary skill for success in our globally competitive economy.

SUPPORTING A TALENTED AND DIVERSE EDUCATOR WORKFORCE

The Administration is committed to not only honoring educators but making sure they are treated with the respect and the dignity they deserve. In addition to promoting supportive working conditions and welcoming educators' voices as critical partners to improve education, we must make sure education jobs are ones that people from all backgrounds want to pursue.

For decades, the education sector has faced shortages in critical staffing areas, such as special education and bilingual education, disproportionately impacting students of color and students from low-income backgrounds. The COVID-19 pandemic and tight labor market have made shortages worse. These shortages negatively impact the education students receive and continue to fall hardest on students in underserved communities. For example, teacher shortages in areas such as STEM, Career and Technical Education, and advanced placement and dual enrollment/early college programs can result in these high-quality pathways and opportunities being out of reach for students. In addition to comprehensive investments across several programs to support a diverse and well-prepared pipeline of educators, the Budget

includes \$514 million for the Education Innovation and Research program, including \$350 million focused on identifying and scaling models that improve recruitment and retention of staff in education.

These funds would support innovative efforts to improve resources and support for educators, provide teacher access to leadership opportunities that improve teacher recruitment and retention, and expand the impact of great teachers within and beyond their classrooms.

Other key investments include \$132 million for Teacher Quality Partnership grants to effectively prepare aspiring teachers by supporting pathways into the profession such as high-quality teacher residencies and Grow Your Own programs, that improve educator diversity, effectiveness, and retention; \$250 million for IDEA, Part D, to support the pipeline of special education teachers and personnel; and \$20 million for Augustus Hawkins Centers of Excellence to support teacher preparation programs at Historically Black Colleges and Universities (HBCUs), Tribally-Controlled College and Universities (TCCUs), and minority-serving institutions (MSIs). We are incredibly appreciative that fiscal year 2022 appropriations provided first time funding for the Augustus Hawkins program to support teacher preparation programs at these institutions. Recognizing that school leaders are second only to classroom teachers among school factors that affect student learning, our request includes \$40 million in funding for the reauthorized School Leader Recruitment and Support program to improve the recruitment, preparation, placement, support, and retention of effective principals and other school leaders in underserved schools.

MAKING HIGHER EDUCATION INCLUSIVE AND AFFORDABLE

Too many students today are deciding that a postsecondary education is out of reach. That is unacceptable. To make higher education more inclusive and affordable, the Budget increases the maximum Pell Grant by \$1,775 over the 2022–2023 award year through a mix of discretionary and mandatory funding, helping an estimated 6.7 million students from low- and middle-income backgrounds overcome financial barriers. This historic increase is one piece of the Budget's comprehensive proposal to double the maximum Pell Grant by 2029. The Administration continues to support expanding Federal student aid, including Pell Grant eligibility, to students who are Deferred Action for Childhood recipients—commonly known as DREAMers—and we are committed to working with Congress to advance this goal.

Any approach we take to postsecondary education must put students and families first. Too many people currently see our student aid delivery system as broken, with a few, but notable, bad actors taking advantage of students looking to get ahead and student aid systems that have not kept pace with today's demands. Our request will improve the services we provide students and families to help them pay for college through a historic investment in Student Aid Administration. We are requesting \$2.65 billion to administer the Federal student aid programs in fiscal year 2023, an increase of \$620 million over fiscal year 2022 enacted. Specifically, the increase will allow us to implement customer service and accountability improvements to student loan servicing and ensure the successful transition from the current short-term loan servicing contracts to a more stable long-term servicing environment. The increase is also critical to ensure full implementation of the FAFSA® Simplification Act for the 2024–25 award year.

Of course, access to higher education is just one piece of the puzzle. It is also critical to help students obtain the support they need to be successful, and to provide institutions with resources to ensure their students' success. Just as so many students do not seek education beyond high school, too many start but don't complete their postsecondary degree or certification. The President and I are committed to not only ensuring an education beyond high school is accessible and affordable, but that students are provided equitable access to resources and supports to persist and complete. The Budget supports strategies to improve the retention, transfer, and completion rates of students by creating a Retention and Completion Grant program in the Fund for the Improvement of Postsecondary Education. The Budget also promotes academic success by providing critical resources to support students' basic needs, including a \$30 million increase to institutions providing affordable child care for student parents with low-incomes. The request includes significant increases for Federal TRIO programs and GEAR UP to expand services that promote access and completion in postsecondary education for underserved individuals. The Budget would also enhance institutional capacity at HBCUs, TCCUs, MSIs, and low-resourced institutions, including community colleges, by providing an increase of \$703 million over the 2022 enacted level. This funding includes a \$450 million initiative to expand research and development infrastructure at four-year HBCUs, TCCUs, and MSIs.

BUILDING PATHWAYS THROUGH POSTSECONDARY EDUCATION THAT LEAD TO
SUCCESSFUL CAREERS

While increased funding for student aid and higher education is vitally important, the key to access and affordability really begins before any student applies to college. It begins in high school and even earlier. This is why the President's Request would help create stronger college and career pathways between our Pre-k through grade 12 systems, our two- and four-year colleges and universities, and our workforce partners. We are requesting \$200 million for a new Career-Connected High Schools Initiative within Career and Technical Education National Programs, to provide competitive grants that support partnerships between local educational agencies, institutions of higher education (including community colleges), and employers to support early enrollment in postsecondary and career-connected coursework; work-based learning opportunities; and academic and career-connected instruction across the last 2 years of high school and the first 2 years of postsecondary education. Our request also supports adult learners through a College Bridge Initiative, funded through Adult Education National Leadership Activities, and new grants to support disconnected youth without a high school diploma.

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 19 percent increase for the Office for Civil Rights to protect students, providing a total of \$161 million to advance equity in educational opportunity and delivery at Pre-K through 12 schools and at institutions of higher education.

CLOSING REMARKS

This is our moment to truly reimagine education so that all students can succeed. Thank you again for this opportunity to share more about the President's plan to invest in students of all ages—like Ruth from Michigan—and the schools and institutions that serve them. As I and the President have said before, our budget is a reflection of our values and I look forward to working with you to advance this historic budget request. I am committed to learning more about your individual interests and priorities related to Department of Education programs and activities and 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.

Senator MURRAY. Thank you, Mr. Secretary, for a very compelling opening statement. And I think it is incumbent upon all of us to remember the names of those students that you said out loud and our job here to make sure that students like them across the Nation get the kind of help and support they need from the Federal Government.

STUDENT LOANS

So, thank you very much for that. Let me begin by asking you about the Department's attempts to improve student loan programs, like addressing the longstanding problems in the income driven repayment program and the public service loan forgiveness program, forgiving loans for borrowers ripped off by for profit colleges, including many in my home State.

But there is significantly more work to really fix this, our broken loan system, and make sure that it works for all of our students. I have been very clear that this Administration should extend the current repayment pause until 2023 so you can get all this work done.

I wanted to ask you this morning, what is the Department doing to comprehensively address issues in our student aid system, from students filling out the FAFSA (Free Application for Federal Student Aid), initially applying for the aid, to the borrowers making their last payment or having their balance forgiven?

Secretary CARDONA. Thank you for that question and for an opportunity to share with you. We are really, as was described by your opening comments, addressing a broken system. The system is broken. So as much as there is conversation about student loan forgiveness, we take the work of fixing a broken system very seriously at the Department of Education. What we don't want to do is end up in a situation where 5 years from now, we have the same problems that we have today.

Our FSA (Federal Student Aid) office is really improving services, providing an onramp with better communication, a better support for our borrowers, better communication. We are upgrading systems that haven't been upgraded in 45 years to make the process much more user friendly. The simplification process for FAFSA is underway, as you know, and you have been advocating for. It has to be simpler.

I have met too many students who by 6th, 7th grade decided that college is not for them because their parents are afraid of that process. Imagine the talent we have in this country that is untapped because students are afraid of this process. We have a responsibility at the Department of Education to address, in my opinion, a system that isn't working for students and for borrowers.

And we have done a lot of work to address loan forgiveness for those who deserve it. Like for the public service loan forgiveness, for the thousands of borrowers, 408,000 borrowers that have total and permanent disabilities, who are eligible for loan forgiveness but never got it. We are fixing that. But we are also improving the college scorecard.

We are improving FSA Office of Enforcement. We are doing a lot of things to improve systems that are broken, and part of that is what you brought up, making sure the system works for the borrowers and it is—they can get information quickly and easily.

Senator MURRAY. You recently announced plans for this new student loan servicing solution, unified servicing and data solution. How will that make sure we have better accountability and high quality service for student borrowers?

Secretary CARDONA. Well, what we are going to do is be more engaged in the outcomes of those services. We have very high expectations, and we are going to make sure that we have rigorous standards for those companies that partner with us to engage in. Obviously, we are going to communicate with our borrowers directly and we are going to hear from them on the progress of that.

So, oversight increase, accountability, higher standards, better communication with our partners, and more communication with our students is how we are going to determine if it is working.

OFFICE FOR CIVIL RIGHTS STAFFING

Senator MURRAY. Okay. In my minute left, I just wanted to ask you about the backlog at the Office for Civil Rights. We have rising caseloads, large backlog. So, I was glad to see actually that the President Biden budget requested an increase. But just tell us quickly what is at stake for our students and parents, if the Office of Civil Rights doesn't get a boost in funding?

Secretary CARDONA. Well, we have seen an increase during the pandemic, especially of cases regarding students with disabilities.

And it is our responsibility to make sure that we are serving our students and our families who are concerned that their rights were violated. We need to have additional staff to address this backlog and address the increase in cases.

Senator MURRAY. And that is what that additional boost—

Secretary CARDONA. And that is what the funding request is for.

Senator MURRAY. Okay. Thank you very much. Senator Blunt.

Secretary CARDONA. Thank you.

Senator BLUNT. Thank you, Chair. Mr. Secretary, as you know, one of the things that I have worked on hard, and this committee has too is to get in a situation where we treat mental health like all other 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 psychologist, social workers.

MENTAL HEALTH

In the budget year we are in now, we provided \$111 million for that purpose, which was an increase of \$95 million over the previous year. Can you give me an update on what you hope to do with that \$111 million and how quickly you think we are going to begin to see some results in terms of people available to fill the need you see in schools for these professional services?

Secretary CARDONA. Thank you, Senator. And first of all, thank you for your service over the years as you—this is your last hearing. Thank you for the advocacy on behalf of our students.

Senator BLUNT. Thank you.

Secretary CARDONA. Mental health is significantly—has to be significantly greater in how we educate our students moving forward. There were issues with mental health access before the pandemic, much worse. I am pleased that with ESSER (Elementary and Secondary School Emergency Relief) funds, there has been a 65 percent increase in social workers, 17 percent increase in counselors. But in my conversations across the country, it is not enough, and we need more.

And there needs to be long term funding to make sure that these resources are available for the long term. And you are absolutely right, there is a shortage of school social workers and community social workers. In our budget, we have funds aimed at promoting a partnership between higher education institutions and K–12 institutions to make sure that we are producing social workers.

And we hope to fund programs like that with these funds so that students have access to the supports that they need. Additionally, mental health support also includes access to afterschool programming or engaging with a mentor or having other activities that give students an opportunity to engage in a positive social climate with their peers.

So addressing mental health supports does include increasing social workers and access to community providers, but it also means increasing access to positive peers for our students.

Senator BLUNT. So, Mr. Secretary, the money that was available to schools through the COVID pandemic relief, I think that money could have been used for mental health, maybe in the way you just defined it. Do you see schools doing that? And if they are not doing

it, why do you think they are not using it for those mental health purposes?

Secretary CARDONA. Yes, I do see them using it that way. A Future Ed report confirmed that, you know, a high percentage of staffing is aimed at providing more mental health support. I do believe that they are using it very well. I have seen examples. I remember visiting New Mexico recently and having a circle with about 15 to 20 students, high school students who are really affected by the pandemic.

At least two of the students in that circle lost a parent during the pandemic. And one of the students said the only reason why he is back in school is because of that counselor that brought them back over the summer to connect with them. And the student is doing better now. But he said if it weren't for those supports there, he would not be in school.

I have seen it firsthand, and I know the money is being put to good use, not only with additional social workers, but with programs that reconnect students that have been disengaged or family members that have been disconnected from our schools.

Senator BLUNT. Well, I hope we are encouraging them to use this money that way and to use it in the near term rather than some program way out there. Because just like you said, I think people, the disruption of in-person school and other things has created some significant challenges we didn't have before.

FREE APPLICATION FOR FEDERAL STUDENT AID DATA RELEASE

I am very concerned about the recent news reports that data from individuals completing their free application for student aid was shared with Facebook through the Meta Pixel code. Could you talk to me a little about that?

I think initially the Department did not think that happened, but Richard Cordray, the Student Aid Chief Operating Officer, said it did happen. Could you talk about that?

Secretary CARDONA. Sure. Yes. What we found was in May 2020, during the last Administration, the Department inadvertently activated a more sophisticated advertising tool that did share some information, but not Social Security numbers, dates of birth, or personal financial information.

Once we found that out, we immediately stopped that feature. And we are moving quickly now to investigate this and find out what was shared. And we had two Congressional update meetings already, but we plan on being very open and transparent about this information.

Senator BLUNT. Well, I heard you mention May 2020. Let me just finish my thought out here. Cordray says it was inadvertently shared after FSA engaged in a March 2022 advertising campaign. And it came out later that that information was shared with Facebook as early as January 2022. It could be there is also a January 2020 or May 2020 situation, but I think there are clearly situations in the current year where this material was faced. Thank you, Chair.

Senator MURRAY. Senator Reed.

SCHOOL FACILITIES

Senator REED. Thank you very much, Madam Chairman. And thank you, Mr. Secretary, for your service. In the 2021 State of Our Schools report, it was found that there was an \$85 billion per year gap between what school facilities need to be brought up to standard today, to sophistication and relevancy, versus what money has been committed by the States.

And last month, my colleague and friend Bobby Scott passed in the committee the Reopen and Rebuild American School Act, which I am the co-sponsor over here. And it called for a \$130 billion investment by 10 years by the Federal Government to get these buildings up to speed. And you know yourself, they are closing schools early because of heat in Philadelphia.

Those schools weren't built when air conditioning was a standard feature. In my community of Cranston, Rhode Island, they had to keep the windows open all winter and the kids in coats because the ventilation system and COVID was too much. So, isn't it time we made a significant investment?

I know the President has called for \$2 million to have a coordinating office in your department to help move money around. I know there are funds in the American Rescue Plan, etcetera, but do you think it is time we have a Federal commitment to fixing up these facilities, helping the States?

Secretary CARDONA. Yes, sir. And I think these issues are even more highlighted when we talk about school security. I can tell you, when I served as a principal of an elementary school, a fairly modern elementary school, the cafeteria and the media center were the only air conditioned spaces.

So, in May and June, I had a schedule of teachers rotating through those spaces so that they and their students could get fresh air and could breathe easier. That is how our schools are operating in many places across the country. I can also tell you, Senator, that when I visited schools at the beginning part of my time as Secretary of Education, some schools reopening efforts were impacted by the impacts of deferred maintenance.

Schools that had poor circulation, poor air flow, and their reopening was delayed because of that. We do have to take a very serious look at our schoolhouses and look at it as infrastructure is equity.

Unfortunately, there are different standards in different places, and we have to make sure that our schools are places where children can learn, where our staff want to work, and it is safe for students. And I do believe our efforts are there to look at this, but I do believe a commitment is needed for this to take place.

Senator REED. No, you are actually right. And I think it obviously is an equity issue because you go to places in Rhode Island, Central Falls High School, which is the smallest community in the State, a mile by a mile, mostly Latinos and Latinas.

They have a high school that was built in the 1920s, I am guessing. They are going to build a new high school, but you can see that everywhere. We have, in the United States, an estimated 43 million adults who are low skilled in literacy and 63 million adults who are low skilled in numeracy.

ADULT EDUCATION

And in this modern, sophisticated economy, if you can't read or write, getting a job beyond the local fast food is challenging. Do we have to do more to help adult education in the United States, increase funding?

Secretary CARDONA. Absolutely. I believe not only is it important that we focus on our adult education population because the system didn't work for them the first time around, but we also know that not only for their family, but for their community, it pays economic dividends. You know, their quality of life improves, and their ability to contribute improves. And there are programs out there, especially now with the economy the way it is and the job opportunities that exist.

We need to do a better job connecting them with high paying jobs. That is just quality of life for their family. And as was mentioned in one of the earlier statements, you know, this has a multi-generational approach, right. If the parent has a better paying job, they might have more opportunity to be with their children at home and help them with their homework.

So, I do believe we have a responsibility to improve adult education, and there is an opportunity here for success for these students and for their communities.

PELL GRANTS AND EDUCATIONAL OPPORTUNITY

Senator REED. Well, in the final seconds, I have to mention the 50th anniversary of the Pell Grant. I had the distinction of succeeding Senator Pell. No one could replace him. And if you really wanted to feel good about yourself, you marched in the parade with him and you pretended they were cheering for you.

[LAUGHTER].

Senator REED. It is a very good technique. But we have to do more, I think, than just simply bump up the Pell Grant every year. And Senator Collins and I have the Pass Act, which is a much more comprehensive way to set goals at the State level for attainment to have a systematic sort of from preschool, grammar school, all the way into college so that they are ready—people, young people are ready to go to school. So, I would ask you to look very closely at that, Mr. Secretary. And thank you very much.

Senator MURRAY. Thank you. Senator Manchin.

Senator MANCHIN. Thank you, Madam Chairman. Secretary, it is good to have you here. Thank you for being here and thank you for your service. And next, let me say, on behalf of the great people of West Virginia and my entire State, our deepest sympathy to the families of the children and the teachers who were lost in Uvalde in a horrible tragedy.

SCHOOL SAFETY

Along those lines, school safety has been a major topic of late of what we could have done, what we can do, and what we should do, especially following that tragic shooting in Uvalde. In March 2018, President Trump appointed then Secretary DeVos to lead the Federal Commission on School Safety.

That commission found that while there is no universal school safety plan that will work for every school across the country, the Federal Government does and can play a role in enhancing school safety. So, in your budget, the Department asked for \$129 million to address school safety, national activities, \$23 million increase.

That includes \$24.7 million for new grants under Project Prevent, and just \$2 million for a proposed national clearinghouse on school infrastructure sustainability to help with technical assistance. On school facility construction and improvement, which you might—maybe recommend, you might want to evaluate that and look at that and if that is enough to do the job.

Issues such as self-locking doors, armed security guards, active shooter training for teachers and students, bulletproof windows, and other training have all been discussed as ways to help students improve student safety.

So, my question would be, on the finding of the 2018 school safety report, that was an active shooter preparedness and mitigation, I know the Department has undertaken a review of the report and I am wondering what the status of that review is or has been or where you are in evaluating that and if it has been implemented.

Secretary CARDONA. Yes. You know, we—thank you for that, Senator. We take the responsibility to support the safety of our schools, our students, and our staff. It is the highest priority, you know.

As a father, I can tell you there nothing more important to me than the safety of my children and their peers and their teachers when they are in school. Our Administration is reviewing the report, the Federal Commission on School Safety Report issued by former Secretary DeVOS.

And as I said before, in the budget we do ask for funds that can assist. You mentioned Project Prevent, \$25 million there for projects to support community school strategies that help prevent community violence. There is also funding for mental health grants of \$55 million for school based mental health grants. You know, this is going to be something that is going to be ongoing.

And while the money is important, I think it is really important that the Department take a lead on providing technical assistance to the States—

Senator MANCHIN. Sorry to interrupt. Do you have any—are you all monitoring that to find out how many schools or school districts are participating in this actively?

Secretary CARDONA. Yes.

Senator MANCHIN. And because this started back in 2013 with the Sandy Hook shootings. We did a bill at that time, which is a background check, but we had school safety in that background, the Manchin-Toomey bill, and that school safety basically found out that we should harden all first floor schools, you know, with a windows and doors and bulletproof and lock down and single entry. I don't know how much of that was followed through and schools that took advantage of it or not.

Secretary CARDONA. I can definitely have more information provided to your office. Happy to follow up with you. Sure.

Senator MANCHIN. If you could. If we can monitor this a little bit. And also, you have the tool of holding some of your Federal funds

if they are not, and it is so important. They have got to do everything humanly possible.

It is awful to look back and say, we should have done this or should have done that, and I would hope you all would look at that seriously about using the one tool you have, which is the money that goes to them if they are going to use it to protect our children.

TEACHERS WITH A HISTORY OF ASSAULT OR ABUSE

Back in 1997, a young student from Fayette County, West Virginia, was killed by his teacher. That same teacher had previously taught at a school in Pennsylvania but was dismissed following the string of allegations involving sexual misconduct with student.

That teacher somehow received a positive recommendation just to get rid of that teacher from that school district and shoved him down to our school district, which has some horrific naming for this. And we don't want to go into that talking about teachers and all the things they have said.

But to allow this to happen, we have 130 teachers and teachers' aids that have reportedly been arrested for sexual related crimes. So, Secretary, Senator Toomey and I again introduced a bill that has been put into law. So why are States that are not complying with the law still receiving any funding?

Secretary CARDONA. You know, we take the safety, as I said earlier, the safety of students very seriously. We published a report that was developed in the last Administration, and we are setting up communication with districts—or with States.

We are going to award States and we are going to have a higher level of accountability and reporting on what is being done, and holding them accountable for complying with the report.

Senator MANCHIN. How does that teacher's record get transferred—so if Indiana, Senator Braun's school district is basically going to hire a person that was in West Virginia and didn't know that that person had been let go in West Virginia for violation to their student, sexual—you know, whatever it may have been. And they think they are hiring them with a good recommendation. How does that get into the system?

Secretary CARDONA. We are going to strengthen the system to make sure the States are complying with the recommendations of the report and the expectations of the report. And again, it just goes back to making sure we are holding States accountable for following the law.

UPWARD BOUND

Senator MANCHIN. And my final question, I know my time has run out. The Upward Bound program. The only thing I would say on that is that it has been such a wonderful program, helped so many kids in my State of West Virginia. But it didn't come out until the week before deadline and just didn't give us enough time to do the job. So, if you could, sir, anything you can do on the Upward Bound program. It is a tremendous program.

Secretary CARDONA. Thank you.

Senator MANCHIN. Thank you, Madam Chair.

Senator MURRAY. Senator Braun.

PARENTS' ROLE IN EDUCATION

Senator BRAUN. Thank you, Madam Chair. Last September, we had a conversation. And I was educated in a great public school system in my hometown in Jasper, Indiana. We have got issues in education, and I am a big believer that, and I think I told you, that parents should be the main stakeholder in their own kid's education, and I believe there should be choice along the way.

We had an election that transpired in Virginia where that was a key issue. And I asked you then if that was something you would be comfortable saying. Are the parents the most important part in a kid's education, their own kid's education, K through 12? Have you reconsidered kind of your stance on that?

Secretary CARDONA. Senator, for the last over two decades of serving as an educator, I have always felt teachers, teachers and parents have to work together. And parents are the most influential and most important teachers that our children have. So, yes, parents are the most important partner with educators, and they know their children most. So schools are more effective when parent voice is incorporated in every aspect of learning.

Senator BRAUN. Well, I am glad to see that maybe that has changed a bit.

Secretary CARDONA. Never changed, sir.

SCHOOL CHOICE AND DOLLARS FOLLOWING THE STUDENT

Senator BRAUN. I think it is a cornerstone of how things work. Coming to the idea of choice. We had a public school system to where that was almost a moot point that was so good. Not all places have that. Part of what works in Indiana is the money follows the child, not the building, not the district, so to speak.

Do you believe in that concept so that we are putting resources to the places that have the kids there? Or do you think it should be maybe the old paradigm that other places work off of, to where you are funding the school itself and not following the child?

Secretary CARDONA. I believe the latter. I believe we need to make sure all of our schools are well resourced, so we don't have a system of winners and losers. All schools, and this budget reflects an attempt to make sure that we are addressing inequities so that we don't have schools where students attend and maybe they are not taking advantage of different options that they have. We have to make sure our schools provide all students with high quality education.

Senator BRAUN. So, you do believe in the money following the child?

Secretary CARDONA. No. No, I believe that we need to fund public schools so that every student that attends a public school can have a high quality education.

Senator BRAUN. Regardless, though, of what the performance is at that given school that parents may not be happy about if they don't have other options?

Secretary CARDONA. Sir, I believe there has to be an equal part, support and accountability, right. So, you provide adequate resources, adequate professional learning opportunities, but then

there has to be an equivalent amount of oversight and accountability to make sure that those schools are producing.

And I understand that in some cases that is not happening. And that is why I am a big believer in making sure we are disaggregating data to make sure that some subgroups of students are not receiving a poorer education. But that is also why in this budget, sir, I request for Title I and IDEA to make sure that those students with additional needs get the support that they need.

CAREER AND TECHNICAL EDUCATION

Senator BRAUN. So, in traveling Indiana, pre-COVID, and especially exacerbated by COVID, workforce, workforce, workforce. Do you think there is enough emphasis being put on career and technical education for the high demand, high wage jobs that are mostly out there in Indiana? We have got great post-secondary institutions there, but we are starving for a better high school education that is going to give you at least life skills regardless of what you want to do.

Secretary CARDONA. Sir, I couldn't agree with you more. I don't think we are doing enough. We need to do better. We need to evolve our high schools to make sure that there are better career pathways. In the budget, we propose \$200 million for career connected pathways for that same reason, for students in Indiana to have options when they graduate.

They can go to a good, high paying, high skilled job because there are good connections with our workforce partners. They can go to 2-year school to level up on their skills, or they could go to a 4-year school. But then those skills that they get should be transferable into high paying jobs in the community that they live. I'm strongly in support of that.

Senator BRAUN. I am glad to see that that is your point of view because sadly, and when I looked into it, some guidance counselors were stigmatizing that pathway as not being one worthwhile pursuing. Brings me to my final question, the high cost of post-secondary education. \$1.7 trillion in debt is the manifestation of what that is about.

COST OF POSTSECONDARY EDUCATION

We have only got one university President across the country that I think is paying any attention to it, Mitch Daniels at Purdue, has held tuition flat, I think, for around 9 years. What are we going to do to address how expensive post-secondary education has gotten, and what do we do to disrupt the system to make it more within reach for those who choose to go that direction?

Secretary CARDONA. Thank you, Senator. I couldn't agree with you more. We have to fix that system. We increased the college scorecard requirements. We are meeting with institutions of higher education and saying this has to change. We have an office of enforcement at FSA. We recognize that college needs to be a good return on investment, and we are working really hard to fix a system that has led to like a runaway train of costs.

Senator BRAUN. Well, that is good, because to solve the problem, you got to lower the cost. And that begs the question of how we accumulate so much debt in the process, so thank you.

Secretary CARDONA. Thank you.
 Senator MURRAY. Senator Schatz.

ARMING TEACHERS

Senator SCHATZ. Thank you, Chair. Thank you, Secretary, for being here. Let me just start with an easy one. I think it is an easy one. Would arming teachers makes schools safer?

Secretary CARDONA. No.

Senator SCHATZ. Can you elaborate a bit?

Secretary CARDONA. Look, our educators over the last few years have bent over backwards for our students to think that arming our teachers and now having them be responsible for discharging a firearm in our schools, is just ludicrous to think about. I think it is a further reflection of the lack of respect that this profession has, and I would stand against that. That is not the way to move forward.

ONLINE AND BLENDED LEARNING

Senator SCHATZ. Thank you for that. What is your view of online learning? We are in a new phase of this pandemic. I will just give you my prejudices here. I just think it didn't work. I think it was understandable. I think we knew less about the virus. And this—a lot of those choices were made before the availability of the vaccine and our deeper understanding of how the virus impacts children. I think online learning was a total disaster. And I would just be interested to hear your views on this.

Secretary CARDONA. Sure. You know, having to develop a reopening plan in Connecticut when we know very little about the pandemic, there were no vaccines, testing took 5 days to get a response, and we didn't know transmissibility. We were working with OSHA (Occupational Safety and Health Administration), with epidemiologists.

I think the decision to close schools and provide safe alternatives was the best and the right decision. Moving quickly to reopening schools was a priority across the country. With that said, blended learning or hybrid learning is no substitute for in-person learning. I can agree with that.

I do think blended learning has a role as we move forward in education, but I don't think that the transition to fully online learning worked for most students, although for others—for some students, a small number of students in my visits have reported that they felt more comfortable that way. The majority of students wanted to return back to in-person learning.

SECOND CHANCE PELL

Senator SCHATZ. Amen. Let me ask you about Pell restoration and second chance Pell Grants. As the Department transitions from the second chance Pell pilot to the full Pell restoration, does the Department plan to integrate existing pilot sites into the new prison education program to prevent a gap in education programming?

Secretary CARDONA. Yes, we are proud of the increase in the Second Chance Pell experiment. We added, as you know, 73 additional

sites and now we are at 200. And we do look at this as an opportunity to help provide skills that could then translate into productive lives and jobs for those who are getting a second chance. And we do want to see that continue and continue to expand to close those gaps that were established.

MENTAL HEALTH

Senator SCHATZ. I want to talk to you about mental health support for students. In a recent School Pulse panel, 70 percent of public schools reported an increase in the percentage of students seeking mental health services.

And by the way, I think it is 100 percent of the schools having an increase in mental health challenges, 70 percent reporting. And only 56 percent of public schools reported that their schools are able to effectively provide mental health services. We are not going to have enough money for the Federal Department of Education to address this.

I am wondering how we can lift up what is working and scale it and provide it to Departments of education and schools, because I don't think we can necessarily pile on. There should be mental health resources spent, but some of this is going to be about lifting up what is already working. And I am wondering if you can comment on that.

Secretary CARDONA. Sure. And I can tell you, as an educator, we have never had enough mental health support available to our students. We haven't. You pile on pandemic, you pile on fears now of safety. You know, the ratio in some—I was in Michigan recently. The ratio between the school counselor and a student was like 700, over 700 in a particular community. That is unacceptable.

So, I recently was on a call with Governors from different—a bipartisan group of Governors talking about the importance at the State level, also that mental health supports get elevated. It can't just be the American Rescue Plan dollars. That is insufficient. Our budget does provide funding requests for long term help, but it is all hands on deck States and local communities also.

NATIVE HAWAIIAN EDUCATION PROGRAM

Senator SCHATZ. Final question, do I have your commitment to continue supporting the funding for the Native Hawaiian Education program?

Secretary CARDONA. Absolutely.

Senator SCHATZ. Thank you.

Senator MURRAY. Senator Shaheen.

UPWARD BOUND

Senator SHAHEEN. Thank you, Madam Chair. Secretary Cardona, thank you for being here this morning and for your testimony. Senator Manchin talked about the Upward Bound program. I have had direct experience in New Hampshire with the Upward Bound program when I worked at the University of New Hampshire.

It is one of two Upward Bound programs we have, and it has actually been in existence since 1966. Keene State College is the other in existence since 1974. These programs, like all others, have

to recompete every 5 years to continue to operate Upward Bound. But I am concerned because given that this is a predictable funding cycle for a longstanding Federal program, I don't understand why the Department is not able to award these grants on time.

I recognize that there are challenges—when there are budget challenges with certainty around your budget, that that creates a concern. But explain to me why you can't award these programs, because the delays put programs through crises. Their instructors and applicants are notified that they may not be able to get their funding. It has an impact on their ability to continue in higher education. And I just don't understand why this continues to be such a problem.

Secretary CARDONA. Thank you, Senator, for highlighting the importance of TRIO programs. I couldn't agree with you more. My wife is a graduate of a TRIO program, went on to get her degree in communications and she went back to teach at the TRIO program. So certainly I could see the benefits of that.

And, you know, as Senator Manchin mentioned and yourself, you know, there was no risk for delay with Upward Bound grants. There were—grantees were notified 2 weeks prior to the expiration. But what I am hearing from you is, could that process be improved so that it is not so late?

So what I will do, Senator, is convene with my team to discuss this, and then I will have someone from my team reach out to you about the process to see if there is anything we can do.

Senator SHAHEEN. That would be very helpful. I know that all of those who participate in those programs would appreciate it as well.

Secretary CARDONA. Thank you.

STUDENT LOAN REPAYMENT MORATORIUM

Senator SHAHEEN. I want to go back now to the issue of student loan payments. And you probably don't remember, but last year I asked you about the moratorium end date. And what you told me is that the Department would try and provide some certainty on when those student loan payments would be expected to resume.

Unfortunately, over that last year, the Administration has made three last minute extensions of the current payment moratorium. I am sure that all of those recipients appreciate that, but it doesn't provide the kind of certainty that they really need as they are planning their lives and trying to figure out what they need to do in order to ensure that they can start making those loan payments again.

So can you tell me what process is in place to try and determine when this moratorium will end and when those who need to repay their student loans are going to have to start those payments again?

Secretary CARDONA. Thank you. Yes. You know, the information from the Federal Reserve helps drive decisions on whether to extend or not. And we recognize that while the economy has improved, many Americans are still struggling to make ends meet and pay their bills and get their childcare bills back up, their mortgage. So, we felt that another extension was warranted.

We do, as I said last year, want to provide our borrowers a long onramp so that they understand when it is going to start, to better prepare them for this process. And we have resources at the Department of Education that are available now that weren't available before to help them.

Senator SHAHEEN. So, do you have any sense of when this current moratorium will end?

Secretary CARDONA. I don't have any information now to share with you about when it would end, or whether or not, you know, what the conversations are about, when it is going to be lifted.

I know we have a date, and it could be that it is extended, or it could be that it starts there. But what I will say is that our borrowers will have ample notice and we will communicate that with you as well.

MENTAL HEALTH PROFESSIONALS

Senator SHAHEEN. Thank you. You talked in your opening statement about the challenges that students are facing, the mental health challenges that we are seeing with students.

And one of the real issues we have, I know, across the country is not having enough professionals to address mental health challenges. Can you talk about what kind of plans the Department could put in place, what kind of legislation we might need to pass in order to help address that?

Secretary CARDONA. Yes. Thank you for that question. You know, we have an opportunity to really reimagine how we are looking at providing support for students. And there is a continuum, right. The social worker, the school social worker, the community social worker is obviously a major support, but additional funding and support for students having access to afterschool programs, to good summer programming, to a mentor.

Those are all good ways of doing it. Supporting programs that allow high school students that are thinking about a career in social work because it is just a shortage area to receive incentives to go into that field, and to create throughways between our K-12 systems and our 4 year institutions, to have these students get into the schools earlier, to do field work out there while they are getting college credits.

These are all creative ways that we are hearing about as they visit different States. But to incentivize that across the Nation, I think we are at that point now because there is a shortage there and in many other areas. Another area is incentivizing connections between schools and community based providers.

You know, in Connecticut, we benefited from the community health center tremendously. I have seen models where we have hospitals that are connected to school systems, and the level of care is great because there is a connection with the hospital and a 4 year university that helps train and educate these social workers.

So, I think there is room for growth there. I really want across the country for us to be a little bit more innovative and bold, saying that this has to be a foundational part of the educational experience.

Senator SHAHEEN. Well, thank you. I certainly agree with that. And anything that we can do on this committee, I am sure we stand ready. Thank you, Madam Chair.

Senator MURRAY. Senator Baldwin.

CAREER AND TECHNICAL EDUCATION

Senator BALDWIN. Thank you, Madam Chairman. Thank you for being here, Secretary Cardona. I wanted to start by discussing career and technical education. Despite the growing demand for CTE (career and technical education), Federal programs supporting career education and skills training have been persistently underfunded.

The President's budget proposes new innovative programs like the Career Connected High Schools Grant Program. However, the budget request does not have enough funding to launch these programs in every State, and the Administration did not request an increase for important existing programs that are helping to build a strong workforce in my home State of Wisconsin.

So, I want to ask you if you can ensure—well, if you will ensure that the Administration's new initiatives support, rather than supplant, the existing funding streams that are helping to connect students to skill and career focused services.

Secretary CARDONA. Thank you for the advocacy on behalf of that important and often pushed aside component of education. I believe it was Senator Braun who mentioned that in some cases it is not looked at as a viable option. And I can tell you, as a technical high school graduate myself, you know, leaving high school with options helps the students, the community.

So I am a big proponent of really just like with mental health, reimagining what career connected high schools and programing that are connected to our workforce partners, to the regional needs in the community, to our 2 year schools, 4 year schools, that has to be systematized across the country.

And while this \$200 million proposals for competitive awards, I recognize that the support—that those communities that are trying to do this has to increase as well, so I will continue to advocate and find ways to support those programs and find ways to make whatever new money is available eligible to those who are already doing some of this work.

STUDENT LOAN PREDATORY BEHAVIOR AND SCAMS

Senator BALDWIN. Thank you. You have had a number of discussions already on student debt. It is a burden for many students in Wisconsin. But part of it is made worse by predatory behavior of those who target students struggling to make ends meet.

That is why I was proud to introduce and witness the passage of the Stop Student Debt Relief Scams or Stop Act. That created criminal penalties for unauthorized access of student loan information.

And an important part of that bill was the creation of a third party data access system to ensure that there is a safe and secure way for legitimate actors like legal aid groups to easily and efficiently access the information that borrowers want them to have.

Secretary Cardona, what actions has the Department of Education taken to implement the Stop Act, and when can we expect to see the designated third party access system up and running?

Secretary CARDONA. Thank you for your hard work to protect students from scams out there on debt relief. We are faithfully implementing the Stop Act, and some of the ways we are doing that is we are implementing that third party access form as required by the Stop Act.

We are working with an investigator general to notify victims of fraud. We are updating the FSA website to allow borrowers to access their information more quickly. And these are just some ways that we are trying to improve services for those who have loans out there and make the information more open and transparent.

Senator BALDWIN. But do you know when that third party access system will be up and running?

Secretary CARDONA. We are currently implementing that.

SCHOOL DESEGREGATION AND EDUCATIONAL EQUITY

Senator BALDWIN. Okay. Multiple reports and investigations have found that nearly 70 years since Brown versus Board of Education decision, schools in Milwaukee and Waukesha remain some of the most segregated in the Nation. Despite prior intervention by the Department of Education, suspension and expulsion rates at Milwaukee Public Schools remain deeply unequal.

Every child in Wisconsin, regardless of their zip code, income, or background, deserves the opportunity to learn and thrive in a school that is safe and supportive. But sadly, these reports suggest that we have a lot of work left to do to realize that goal.

While the causes of educational inequality are complex, we cannot expect our State and local partners to carry this burden on their own. What is the Department of Education doing to address persistent inequities in education, and how are you working with State and local partners to secure better learning environments for all children in Wisconsin?

Secretary CARDONA. Thank you. You know, as an educator, I can tell you and the research proves that students learn better when they are in a diverse environment.

In our budget, we requested \$100 million to have new competitive grants to provide better programs that provide more racially and socially and economically diverse schools and classrooms, something that we pay very close attention to, and we want to make sure that all students in all schools achieve at high levels, which is why in our funding proposals, we also ask for additional funds to some of those schools where there may not be performing as well.

Title I schools that are disproportionately underperforming. So, you know, we are supporting it. We do have it in our proposal, and we continue to monitor if we feel that students are not being given opportunities or schools are used to segregate students. We also accept investigation requests in our Office for Civil Rights.

Senator BALDWIN. Thank you.

Senator MURRAY. Thank you, Mr. Secretary, our Nation's students have been through a lot in the past few years, as you well

know, and it has done a lot of harm to their learning, their mental health, their development.

LEARNING LOSS

And as you are aware, the American Rescue Plan provided \$122 billion under the Elementary and Secondary School Emergency Relief Fund to give our schools more resources to safely offer in-person instruction, address the academic, social, and emotional needs of students, and support evidence based strategies to tackle learning loss and help students get back on track, particularly those disproportionately impacted by the pandemic.

I know that over the past month your staff has worked really hard to review the State implementation plans and help local school districts meet those requirements. Can you tell us what evidence based practices you are seeing making the biggest difference in helping our students catch up?

Secretary CARDONA. I definitely can. And I can tell you from experience myself, Deputy Secretary Martin has been traveling the country too, seeing firsthand how the American Rescue Plan dollars are being used. The higher Ed level as well. Undersecretary Kvaal has seen many great examples. And I have to tell you, I am proud of our educators. I am proud of our students.

I am proud of our parents who have gone through such a disruption. And looking at our schools now, that sense of community that that they have lost, and students are thriving. Yes, they need help. It is not going to be a quick fix. But when I visit White Plains and I see that they focus on improved ventilations, which increased the confidence of the community to go back into the schools, I know that the money is being used well.

I remember going to Oregon and seeing a summer program that was three times the size it was the previous time they held it because of the American Rescue Plan dollars. I have seen high quality, high dosage tutoring implemented in communities where students missed out on school for a long time, and they are catching these students up.

You know, we talk a lot about mental health support, but without question, we must focus on the academic recovery of our students, the literacy, the numeracy, and school systems are providing extended school days, smaller class sizes, additional support teachers, and better parent liaison strategies.

I remember visiting a school, I think it was in Nevada, where they hired an additional group of parent liaisons that went out into the community, those communities where the students were chronically absent or not engaged as much because of the impacts of the pandemic.

And they got those families back into the school wraparound services. I am seeing such good use of the American Rescue Plan dollars. We wouldn't be at 99 percent of our schools open full time if it weren't for the American Rescue Plan. I would be talking to you now about colleges closing, about students that we can't find if it weren't for the American Rescue Plan dollars.

And I can tell you, you know, Future Ed reported \$30 billion going toward academic recovery and \$26 billion going toward additional staff, which help academic and mental health. \$3 billion a

month is being used to support our students, and I am thankful that we have those funds. Thank you for the support of them.

Senator MURRAY. Yes, I think that we are seeing a really diverse use of those needs across the country, and I think over the long term it would be very interesting to go back and see which ones really did help kids academically or mentally and what made a real difference in their lives and getting back on track.

Secretary CARDONA. Yes. Thank you.

MEETING THE BASIC NEEDS OF POSTSECONDARY STUDENTS

Senator MURRAY. Let me go to higher education again. And I am talking more than tuition fees and books, because if we want to really help our students, none of them should be worried about where they are going to get their next meal or how they are going to put a roof over their head, or how they are in or for childcare or get mental healthcare because those are barriers to them to be able to get a degree.

We know that three in five higher education students face housing or food insecurity, and two in five students drop out of college, do so because of financial pressures. And those are, of course, connected to mental health challenges as well.

So significantly, expanding Federal student aid, including doubling the Pell Grant, is a big part of a solution to that, but so are programs that are specifically targeted at addressing those students basic needs.

I wanted to ask you how the Department is using funds we provided that included both annually appropriated funding and COVID supplemental funding to meet student basic needs, connecting students to other Federal benefits like child tax credit or SNAP (Supplemental Nutrition Assistance Program).

Secretary CARDONA. Yes. Some of the best stories from my visits are those students who have benefited from those funds. I remember talking to a gentleman who was in a 2 year program at a community college, and he was sharing all his progress, and he went back to school a little bit later in life.

Later in the story he shared he was homeless, and that the college provided him with meals, with help so that he could have a place to stay so he is not sleeping in his car, and he can continue to get that degree. I was just floored by that. The \$198 million for basic needs as part of the American Rescue Plan, I have seen examples of that working.

CHILDCARE ACCESS MEANS PARENTS IN SCHOOL PROGRAM

I remember visiting Bergen Community College and announcing that and talking to a student who was able to continue her studies because there were childcare costs that were covered on campus, so her twins could be cared for while she continues to get her degree. So those funds are being used to help folks change the trajectory not only of their life, but of their children's lives.

And I have seen great examples of that. And any dollar that goes to that is used to help them stay in school, help them get better earning potential, help them take care of some of those basic needs that are critical.

Senator MURRAY. Great. Very good. Okay. Thank you. Senator Blunt.

Senator BLUNT. Thank you, Chair. On student loans again, though this would be collecting the student loans, not forgiving the student loans.

STUDENT LOAN COLLECTION AGREEMENTS

In the fiscal year 2021 appropriations bill, the first one you had as Secretary, we gave authority to extend the current loan collection agreements, which I believe you did. You extended them through December of next year.

What is your plan to go ahead and move forward on defining what those agreements will look like and issuing the agreements? And does your plan include the likelihood of a bid protest?

We can run through a timeline pretty quickly that gets beyond December 2023 if we are not thinking about this. So what is your plan for collecting the student loans that will be collected?

Secretary CARDONA. Thank you. So, what we are not going to do is go to a single servicer or system. We are pursuing long term servicing contracts to maintain that long term stability of the loan servicing environment, increase the accountability, make sure that we improve cybersecurity, and improve borrower experiences.

So that is a critical part of it, the borrower experience and outcomes. Obviously, we have partners in the process that we want to engage in this work, and we will be communicating with them so that they have information on what we are expecting in order for them to be a part of that process.

Senator BLUNT. So you would still anticipate having a significant number of different servicers?

Secretary CARDONA. We do plan on having different servicers, yes.

Senator BLUNT. And when do you think you will issue whatever sort of proposal you need to as to what those contracts would look like?

Secretary CARDONA. You know, what I will do is I will have my team, who has more specific information, reach back out to you about the timeline for that.

Senator BLUNT. All right. All right. I would like to see that. And Chair, I will probably have some other questions for the record, but I think that is all I have for today.

Senator MURRAY. Thank you very much. And that will end our hearing today. And I want to thank you, Secretary Cardona, for a very thoughtful discussion about how we can support our students and our educators and our schools. This is so important to me and families across my State and the country.

So, I am going to continue to keep pushing to make sure that every child in this country receives a safe, high quality public education and that our students and families can access affordable, high quality postsecondary education.

ADDITIONAL COMMITTEE QUESTIONS

With that, for any Senators who wish to ask additional questions, questions for the record will be due June 17, 5 p.m. The

hearing record will also remain open until then for members who do 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 SECRETARY MIGUEL CARDONA

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

Question. What are the Department's plans for evaluating and strengthening its monitoring and support for the use of funds provided by the Elementary and Secondary School Emergency Relief Fund (ESSER) in the American Rescue Plan Act (ARP) for evidence-based strategies to tackle learning loss and help students get back on track, particularly students disproportionately impacted by the pandemic? How will the Department monitor and support improvements to the targeting and effectiveness of the evidence-based interventions being implemented by State educational agencies and local educational agencies, particularly for students disproportionately impacted by the pandemic?

Answer. In fiscal year 2022, the Department implemented a process for regularly reviewing a high-priority issue (e.g., monitoring local educational agency (LEA) uses of funds, stakeholder engagement, State educational agency (SEA) reservations for evidence-based interventions) in all States. States are required to provide documentation in advance of the review and the goals of these reviews are to:

- Identify strong practices that can be shared across SEAs;
- Identify technical assistance needs; and
- Inform areas where more focused monitoring is needed.

These monitoring reviews will continue through the duration of the grant period and liquidation of funds.

The first review, conducted in May 2022, addressed (1) how States are supporting LEAs in use of the at least 20 percent set-aside to address the impact of lost instructional time ("learning loss") through evidence-based interventions, and (2) whether States have fully awarded at least 90 percent of their total ARP ESSER allocations to LEAs as required. The Department plans to share an executive summary with States that highlight successes and challenges that States have shared in supporting LEA required spending to address learning loss. The Department will uplift resources that States highlighted regarding their success. Additional resources will be shared from the Department and the Department's federally funded TA centers to address challenges identified. An internal report will be created that highlights State specific challenges and support each State is requesting. This information will be shared with program offices that can support with each request and technical assistance will be identified and provided.

In fiscal year 2023, the Department will continue to monitor the implementation of evidence-based strategies by SEAs and LEAs as a part of its monitoring strategy for all K-12 COVID relief programs, including ARP ESSER. States will be identified in September 2022 for monitoring using a risk assessment and notified of the intent of the Department to comprehensively monitor the implementation of COVID-19 programs. This review will include the implementation of evidence-based strategies intended to ensure that students disproportionately impacted by the pandemic get back on track academically. These monitoring activities are in addition to monthly check-ins with SEAs and the bi-annual reviews to occur in the fall of 2022 and spring of 2023 for fiscal year 2023.

Question. Please identify the specific steps and timeline for providing more information to state and local educational agencies about the late liquidation process outlined in the Department's May 13, 2022 letter to the AASA, The School Superintendents Association. That letter rightly noted the urgency of spending ARP ESSER funds to meet the immediate needs of students and address the long-term impact of the pandemic. How will you work with SEAs on quickly implementing an efficient and effective process for submission of late liquidation requests for LEAs under the process outlined in your May letter to AASA?

Answer. During the month of June, the Department engaged with various stakeholder groups about their priorities, needs, and general feedback regarding a liquidation extension request process. We continue to shape a process that prioritizes:

- Developing of a mechanism to provide sufficient oversight for the late liquidation of K-12 COVID relief funds
- Minimizing burden for SEAs to request approval on behalf of LEAs and ensuring support to SEAs in implementing approved requests

—Providing sufficient time to adjust state-level systems and control processes to support liquidation of CARES-funded obligations

Stakeholders included representative State educational agencies (SEAs), local educational agencies (LEAs), members of the Association for Latino Administrators and Superintendents (ALAS) and members of the National Association of State Auditors, Comptrollers, and Treasurers (NASACT), and the Council of Chief State School Officers.

These groups reported challenges with expending funds, including supply chain challenges, diminished access to labor (instructional and operational personnel), a shortage of available or willing contractors, and a consistent need for additional time, particularly in reference to the expenditure of American Rescue Plan (ARP) funding. High-level priorities for the request process include state-level responsibility for LEA requests, clear procedures and examples, and communication tools that can assist in supporting the requirements and the narrative of a liquidation extension.

Question. How will you ensure LEAs and SEAs have early knowledge that eligible liquidation requests are approvable as early as possible for the contracts they are signing today for authorized activities that cannot be completed without an extension of the liquidation requirement under 2 CFR § 200.344(b)?

Answer. The Department will provide technical assistance to all grantees on the requirements to submit requests for late liquidation of CARES ESSER and GEER funds as soon as the request package is finalized. In addition, the Department will review each State grantee's request in a timely manner provided all required documentation is submitted. The Department cannot, however, approve late liquidation requests in advance of receiving required documentation.

Question. The American Rescue Plan Act included a new fiscal equity requirement, maintenance of equity, that applied conditions to States and LEAs who receive ESSER money to prevent disproportionate education budget cuts to high-need LEAs or high-need schools, and no budget cuts for the highest-need schools.

Which States has the Department identified that are not in compliance (or on track to be in compliance) with the 2022 State-level maintenance of equity requirements?

Answer. In late July, the Department initiated technical assistance activities with States where preliminary State data indicated one or more high poverty LEAs may require additional State funding for the State to satisfy Maintenance of Equity requirements. As data are still preliminary, the Department has not yet identified instances of non-compliance.

Question. What is the Department's plan for bringing any such States into compliance, and what are anticipated consequences if a States does not comply with such requirements?

Answer. All States have been notified if their initial fiscal year 2022 data indicates the State is not maintaining equity in one or more high-need or highest-poverty LEAs. Following this notification, the Department is conducting calls with all non-compliant States and prioritizing those with the highest concentration of issues. The Department may take a range of enforcement actions to remedy such violations, since this requirement cannot be waived, which include applying a grant condition, designating a non-compliant SEA as a high-risk grantee, using SEA non-compliance as a factor in selecting grantees under discretionary grant competitions, and recovering funds.

Question. A recent report from the Association of School Business Officials International (<https://asbointl.org/Web/About/PR/2022/20220510.aspx>) found almost one in five LEA respondents indicated that "Conflicting Federal and State guidance and confusing rules about how funds can be used are slowing down spending for some districts".

What additional steps and outreach will the Department take to bring more clarity and consistency about ESSER's uses of funds for SEAs, LEAs, and oversight bodies that is needed to allow timely and effective uses of these funds?

Answer. The Department of Education has produced many publicly available resources in the form of Frequently Asked Questions (FAQs) documents, webinar recordings and transcripts, letters to grantees, and monitoring reports (see links below). We are currently in the process of updating the ESSER and GEER Use of Funds FAQs that will include both new FAQs addressing issues about which we have received inquiries from multiple States as well as incorporating several of the separate, related FAQs, such as the vaccination FAQs, the public safety FAQs, and the transportation FAQs, and the preventing, preparing for and responding to COVID-19 document so that grantees have use of funds information all in one document. When the revised ESSER and GEER FAQs are final, the Department will conduct another webinar for grantees. In addition to the ESSER and GEER Use of

Funds FAQs (issued May 2021), previous use of funds FAQs include the spring 2020 ESSER Use of Funds and the GEER Use of Funds.

The Department receives daily inquiries from States regarding allowable uses of ESSER or GEER funds, and works to provide timely responses. Weekly program meetings (ESSER, EANS, GEER/MOE/MOEQ) are convened to discuss inquiries received from grantees and other policy-related matters, and additional meetings are convened as needed. Every day, the Department of Education staff meets with staff from State educational agencies to answer questions, provide guidance, or address issues that have arisen. We also develop and widely disseminate communications to share with grantees that address emerging issues associated with program implementation. When local school districts come to us with questions about uses of funds, we ask them to connect with their SEAs as the SEA is ultimately accountable for approving or not district-level uses of funds.

Finally, the Department's ESSER website includes valuable information for grantees, including an awards resources page, a deadlines and announcement page, as well as links to related important documents, such as the Equitable Services FAQs. The website also contains links to webinars that the Department has conducted on such issues as using ESSER or GEER funds for HVAC improvements and the 2022 Compliance Supplement, as well as the Office Hours that were held to assist grantees in developing their ARP ESSER State Plans.

Question. In a 2020 Government Accountability Office (GAO) report, GAO estimated that 41 percent of LEAs needed to update or replace their heating, ventilation, and air conditioning (HVAC) systems in at least half of their schools. Such investments not only would help reduce the spread of COVID-19 and other infectious diseases, but also improve overall air quality for students and school staff, including millions of students with respiratory allergies that can cause a student to be absent from school.

What additional steps will the Administration take to support the use of Federal resources authorized to be used for investments that would improve air quality in our schools?

Answer. The Department has provided frequent guidance to SEAs, LEAs, and public stakeholders on the use of CARES Act, CRRSA Act, and ARP Act funds to improve air quality in schools. This guidance has taken place through live office hours presentations, webinars, published FAQs, and web pages, described below. In addition to this, the Department has responded to over twenty unique inquiries from SEAs regarding the allowable use of ESSER, GEER, or EANS funds on improving school air quality. We continue to respond to SEA and LEA-related questions on a daily basis and encourage grantees to reach out whenever they have a question.

The Department made several resources available to the public which describe allowable uses of Federal resources for improving air quality in schools. In particular, the Department hosts a web page on Improving Ventilation in Schools, Colleges, and Universities to Prevent COVID-19 which describes the allowable use of ESSER, GEER, and HEER funds towards improved ventilation. The Department published a set of ESSER and GEER FAQs that specifically allow funding to be spent on upgrading spaces to improve the indoor air quality in school facilities (ESSER/GEER FAQs, B-7). These FAQs direct interested parties to the CDC guidance on how to improve ventilation in schools and buildings. The Department also published a set of EANS FAQs that provide guidance on the allowability of a non-public school to apply to receive services for improving ventilation systems (EANS FAQs, D-1, D-16).

On June 17, 2021, the Department held an office hours presentation on the use of ESSER funds to support school construction, providing guidance on the use of funds to improve HVAC. The slides from the presentation are published on the Department website here.

On September 2, 2021, the Department hosted a webinar on "Using COVID Relief Funds for Facility Upgrades, Renovations, and Construction." In addition to Departmental guidance on the use of funds towards construction, this webinar included speakers and resources related to indoor air quality from the U.S. Environmental Protection Agency, the U.S. Department of Energy, the Maine Department of Education, and the Salt Lake City School District. The Department has made the slides from the presentation available on its website here.

On July 8, 2022, the Department held a webinar on "Improving Air Quality in Schools," where Secretary Cardona, White House COVID Response Coordinator Dr. Ashish Jha, and experts from the CDC and the EPA discussed the importance of improving air quality in schools and the use of ARP Act funds to upgrade ventilation in schools.

Question. What are the Department's plans for strengthening parent and family engagement in our schools and sharing and supporting implementation of evidence-based practices that create strong and effective relationships that serve the best interests of students?

Answer. Parents are our kids' first, and often most influential, teachers. From Day One, this Department has worked to not just listen to parent voices but uplift them and make sure they're heard in our school communities. The Department has held numerous engagements with parents and heard from more than 8,650 parents about their experiences, challenges, concerns, and ideas as we work to rebuild our schools better than they were before the pandemic.

This Administration believes it's essential for school districts to work closely with parents, and we provide resources to help ensure this can happen across the country. During my travels, I've held roundtables, listening sessions, and conversations with parents. In Texas, I learned about a school that was using American Rescue Plan funds to pay for a parent specialist who worked to keep parents connected and engaged in the school community. And I've worked to elevate that story for other states and schools because the feedback and perspective parents provide is invaluable.

In June, the Department launched the National Parents and Families Engagement Council (the Council) to facilitate strong and effective relationships between schools and parents, families and caregivers. Families' voices play a critical role in how the nation's children are recovering from the pandemic.

To ensure students are set up for success, the Department is working to answer the President's call to action and is calling on states and school districts to continue using American Rescue Plan funds to fully staff schools and provide high-quality tutoring, summer learning and enrichment, and afterschool programs to support, on average, an additional 4 months of learning gains in reading and math. The Department recently launched the National Partnership for Student Success and the Engage Every Student program to do just that.

Additionally, the Department of Education launched a campaign through the Best Practices Clearinghouse to highlight states and schools using ARP funds to support learning recovery and student mental health in evidence-based ways. The Department is calling on education leaders to nominate work for national recognition through the Clearinghouse.

I hope you will share the news about our Council and encourage your constituents to continue to be engaged with their local school communities.

Question. How will the National Parents and Families Engagement Council support the Department's engagement with parents and families at the local level, including families of students of color, students with disabilities, students from low-income backgrounds, English learners, migrant students, military connected students, students experiencing homelessness, and students in the foster care system?

Answer. The Council currently consists of parent, family, or caregiver representatives from national organizations that will work with the Department to help families engage at the local level.

The Council will be a channel for parents and families to constructively participate in their children's education.

I believe there's no one better equipped to work with schools and educators on what students need to recover than parents and families. The Council will serve as an important link between families and caregivers, education advocates and their school communities. The Council will help foster a collaborative environment where we can work together to serve the best interest of students.

The Department's commitment to all parents, and their crucial role in their children's education, is unwavering. I will continue to not just listen to parents but seek out their counsel and feedback because a school community works best when parents and educators are working together.

Question. How is the Department working with the Department of Health and Human Services to maximize the impact of Federal funding available for mental healthcare for children and youth, including by supporting increased use of the Medicaid in Schools program? When will the Department take the actions outlined in the March 24, 2022 letter issued jointly with the Secretary of Health and Human Services?

Answer. The Departments of Health and Human Services and Education continue to collaborate on strategies to increase access to mental health services elementary and secondary education students. The Bipartisan Safer Communities Act places HHS in the primary role with mandatory collaboration with Education, to develop guidance on how local educational agencies can partner with their state's Medicaid program to increase the availability of health services, including mental health services in schools. In addition, the law establishes a national technical assistance cen-

ter to assist with this process and provides \$50 million to states to address this work. We anticipate the ED and HHS collaboration's efforts, including the updates to the May 2003 Medicaid School-Based Administrative Claiming Guide, and the 1997 Medicaid and Schools Technical Assistance Guide, will be completed in accordance with the law's timeline.

Question. Please describe your monitoring and technical assistance plans in fiscal year 2023 and future years related to resource equity requirements of the Elementary and Secondary Education Act.

Answer. In spring and summer 2022, the Department has been conducting a targeted monitoring review of two resource equity provisions: (1) ESEA section 1111(d)(3)(A)(ii), which requires an SEA to periodically review resource allocation to support school improvement in each LEA in the State serving a significant number of schools identified for support and improvement; and (2) ESEA section 1111(d)(1)(B), which requires each comprehensive support and improvement and additional targeted support and improvement plan to identify the resource inequities to be addressed in the plan. After the conclusion of those reviews, the Department intends to share best practices, findings, and recommendations more broadly with all States and determine how to further conduct oversight of these important requirements in fiscal year 2023.

In addition to targeted monitoring, all resource equity provisions in Title I, Part A are included as part of the Department's consolidated monitoring, which is the Office of Elementary and Secondary Education's in-depth monitoring protocol that covers several formula grant programs and over-arching, cross-program fiscal requirements. The Department is currently finalizing its plans regarding the number of States that will participate in consolidated monitoring in fiscal year 2023.

Finally, for the past 3 years, the Department has conducted a review of each State's website to determine if States and districts were in compliance with report card requirements, looking at a subset of the requirements each year. This work begins in January to review the report cards for the prior school year. This year, the Department reviewed State websites to look for disaggregated performance and participation rate data on State assessments, per-pupil expenditures, and chronic absenteeism.

Question. The Comprehensive Literacy State Development Grants program provides resources to improve literacy instruction in high-need schools and early childhood education programs. Funds may be used by state educational agencies for coordination with institutions of higher education on strengthening and enhancing pre-service teacher training on explicit, systematic, and intensive instruction in evidence-based literacy methods for children from birth through 12th grade.

How many grantees have used funds for this purpose? How has the Department supported this work?

Answer. Currently, a few CLSD grantees use a small portion of the 5 percent set-aside in CLSD funds to coordinate with Institutions of Higher Education (IHEs). However, all grantees have expressed an interest in doing more in this area to complement the work that is already going on within their states through other initiatives. According to information we received, WY, MO and AZ are using a portion of CLSD monies for pre-service and in-service teachers as well as building capacity and knowledge about the Science of Reading. The Office of Well-Rounded Education (OWRE) is working to provide support through its the CLSD contractor for technical assistance to CLSD grantees.

Question. How would this budget further support this and other efforts to expand implementation of high-quality literacy instruction using the science of reading?

Answer. Funds can be used to conduct Communities of Practice (CoP) topical meetings, and other convenings to support and expand the implementation of high quality literacy instruction and the science of reading.

Question. Special education teachers and service provider shortages continue to be a significant challenge for more than 40 states and Puerto Rico. The budget includes \$250 million for the Personnel Preparation program that can help alleviate these challenges including for low-incidence disabilities like deaf-blindness.

Please describe the Department's plans to use requested resources to support additional grants for the training of interveners for services to deaf-blind students.

Answer. The Department's Interdisciplinary Preparation in Special Education, Early Intervention, and Related Services for Personnel Serving Children with Disabilities who have High-Intensity Needs (325K) program funds projects that prepare special education, early intervention, and related services personnel at the master's degree, educational specialist degree, or clinical doctoral degree levels for professional practice in a variety of education settings. While intervening services are not a part of IDEA's definition of related services, universities who apply to the 325K programs may include coursework focusing on the training of interveners as a com-

ponent of their training program. The Office of Special Education Programs (OSEP) has made significant investments in the preparation of interveners through our National and State Deaf-Blind projects. The OSEP-funded National Center on Deaf-Blindness has developed The Open Hands, Open Access: Deaf-Blind Intervener Learning Modules (OHOA modules) that were designed specifically for state deaf-blind projects and colleges/universities to use as part of intervener training programs. While, on their own, these intervener training modules do not constitute a complete training program, they are offered as part of a comprehensive training and coaching program provided by qualified individuals who work with our State Deaf-Blind projects. The Department acknowledges that despite widespread recognition by many of the OSEP-funded state deaf-blind project directors regarding the need to provide intervener services for students with deaf-blindness, most states have not mandated intervener services, and therefore, most school districts do not hire for intervener positions. If additional funds become available, OSEP will explore incentivizing states, through discretionary grants, to increase the supply of interveners and support their acceptance as providers of support for a free appropriate public education for deaf-blind children.

Question. In a 2021 qualitative study of the Department's national technical assistance center on deaf-blindness, (https://www.nationaldb.org/media/doc/2021InterviewsStateDeaf-BlindProjects_a.pdf) several of the state deaf-blind project directors reported "that their state has no mandate to provide intervener services, and therefore, the school districts cannot hire for intervener positions. Nearly all the interviewees considered interveners to be a valuable service provider that needs to be offered to students with deaf-blindness, and many expressed frustration with their state's department of education for not supporting the position". This is despite an August 2, 2018 letter from the Department indicating that "the members of the child's IEP [individualized education program] team . . . must make individual determinations of in light of each child's unique abilities and needs about whether the service, such as an intervener, is required to assist the child to benefit from special education."

What additional steps will the Department take to ensure that parents, school officials, and IEP teams are aware of a deaf-blind child's right to receive intervener services as determined appropriate by the IEP team?

Answer. All IDEA eligible children, including children with deaf-blindness, are entitled to receive effective instruction that will lead to positive educational and career outcomes. Each state's Parent Training and Information Center(s) (PTI) help guide parents through the process of ensuring that school districts develop individualized education programs (IEPs) that contain evidence of what a child needs to access the General Education Curriculum and free appropriate public education (FAPE). In addition, OSEP will continue to support the National Deaf-Blind Center and State Deaf-Blind projects, the Early Childhood TA Center, and the Progress Center (which stands for Promoting Rigorous Outcomes and Growth by Redesigning Educational Services for Students With Disabilities Center), all of which provide information, resources, tools, and technical assistance services to support local educators, leaders and parents in understanding rights of their children with disabilities and how to improve outcomes for students with disabilities, including students with deaf-blindness. Based on an increased appropriation in 2022, OSEP will be providing additional funds to each of the PTIs to better support parents. Finally, the Department is exploring options to provide further guidance that would emphasize, among other matters, the need for the IEP Team to ensure that the services of an intervener are provided without undue delay if the team determines that a student could benefit from such support.

Question. The 2020–21 program year saw a 17 percent decline in Part C enrollment from the previous academic year. However, a recent Infant & Toddler Coordinators Association survey response from Part C coordinators in 43 states shows in this program year, 60.5 percent are exceeding their 2020 child counts and 30.2 percent are exceeding their 2019 child counts. The Department requested \$932 million for Grants for Infants and Families. This is a substantial increase of \$436 million to help States implement statewide systems of early intervention services for children from birth through age 2. The request also proposes several changes through appropriations language to strengthen program implementation and improve equity by (1) allocating formula funds, in part, on the basis of poverty; (2) requiring States to develop and implement equity plans under Part C of the IDEA; (3) providing States with the flexibility to use program funds to support new parents of infants and toddlers with disabilities; (4) prohibiting out-of-pocket expenses for families participating in the program; (5) requiring States to provide adequate notice before instituting limits on eligibility under the program; (6) providing financial incentives to States to serve at risk infants and toddlers; and (7) increasing flexibility for

States to offer summer bridge services to children transitioning from the Part C program into their State's Part B program.

How does the President's fiscal year 2023 budget proposal support states to address increases in Part C enrollment and how would the proposed flexibilities and requirements better serve infants and toddlers with disabilities especially from underrepresented populations?

Answer. The Biden-Harris Administration is committed to ensuring that every child receives the services and supports they need to grow and thrive. To that end, the President's fiscal year 2023 Budget Request proposes historic increases and important reforms for the Grants for Infants and Families program that would support a significant expansion of early intervention services for infants and toddlers with disabilities and infants and toddlers at-risk of experiencing a substantial developmental delay, particularly for historically underserved children such as children of color, children from rural areas and children from low-income families. The COVID-19 pandemic resulted in a substantial decline in the number of children receiving services under the Part C program, likely due in significant part to difficulties in effectively identifying and evaluating children who were less likely to be regularly accessing services and supports that typically serve as vehicles for State child find systems (e.g., daycare centers, pediatricians).

As a result, the Administration believes States are likely to see a significant increase in the number of new children into the program over the coming years as pandemic-related barriers to identification and participation decrease and that these newly enrolled children are likely to have more intensive needs associated with the delay in identification, evaluation, and service provision. The requested funding increase for this program would provide critical support to increase States' capacity to serve more children such as by ensuring that they have enough high-quality and well-trained service providers to meet the increased demand.

Key activities supported by our request include more comprehensive State planning to engage and meet the needs of underserved groups, including proposed budgets for executing those plans; improving initial entry into the Part C system by expanding outreach to and engagement with individuals who are expected to become parents of an infant or toddler with a disability, which can result in earlier service provision which research has shown improves outcomes for children; eliminating fees and out-of-pocket expenses that can be a barrier to program participation; ensuring advance notice of eligibility changes that can disrupt or discourage program participation; and expanding services to children at-risk of developing delays and disabilities so that a child highly likely to develop a delay does not have to wait for the delay to clinically manifest before receiving services, which can both improve outcomes and increase access to the program for children of color, children from rural areas and children from low-income families who are disproportionately likely to qualify for services through risk factors for delays and disabilities.

In addition, the request also proposes to continue appropriations language initially provided in prior years which would allow States to subgrant funds they receive under this program and that would allow the Department to maximize the amount of funds distributed for State Incentive Grants and would allow States to offer summer bridge services through Part C to children prior to the beginning of the preschool year after their third birthday.

Question. In the 2020-2021 program year, 3.2 percent of infants and toddlers—or 365,715 infants and toddlers—were served under Part C. Coordination and seamless transition between services under IDEA Part C and Part B is critical for these thousands of children with disabilities to successfully begin K-12 learning. The President's fiscal year 2023 budget includes the authority for the Secretary to reserve up to \$5 million under section 611 of the Individuals with Disabilities Education Act to conduct a study to examine the "implications of establishing a comprehensive system of services and supports for children with disabilities from birth through age five."

Please describe the expected timeframe, scope and desired outcome of the study.

Answer. The proposed study would involve listening sessions and convenings of stakeholders to identify and discuss major issues and barriers to providing seamless services, such as issues of legal authorities, differing eligibility criteria, multiple service providers, and uncoordinated services. The products of these listening sessions and convenings would be analyzed by an expert panel to develop a report. This publication would include recommendations and best practices for addressing barriers and creating a more seamless early childhood system that could improve program administration and integration for States, school districts, and early intervention providers while improving outcomes and access for children with disabilities. This publication would likely be available within 2-3 years of appropriations becoming available for this purpose. The requested funding, up to \$5 million, would be

a one-time request—the Department does not anticipate additional funding would be needed in future years. A robust body of evidence shows that birth through 5 are critical years for a child’s development and providing States and school districts with evidence-based recommendations and best practices for serving these children and their families could produce benefits that far outweigh the modest investment requested.

Question. The budget requests \$3 million within the Program Administration account for the development of a P–12 equity data dashboard at the Department.

How would the requested funds be spent? Are they sufficient to develop and operate the system? If so, for how long? If not, how much additional funding would be required?

Answer. The budget request of \$3 million assumes 1 year of development, user testing, and iteration before posting a public website, covering costs for a prototype computing environment, operational computing environment, and contracted labor. It does not include additional Federal staff. The Department is in the process of determining the cost for the continued operations and maintenance of the system.

Question. How will the Department determine which existing information to include in the dashboard, including consideration of its significance as a factor in educational outcomes and opportunities? What steps would be considered to access or develop other information that research demonstrates or may demonstrate is an important factor in educational opportunities and outcomes?

Answer. The Department plans to incorporate data from existing sources into a dashboard that is accessible and easy to navigate, while also looking at a range of outcomes and factors that contribute to the educational experience and success. The data dashboard will be designed to highlight where opportunities gaps do and don’t exist, and where progress is being made, so that school communities can work on improving educational opportunities and outcomes. It is critically important that data used in the dashboard is reliable and comes from high-quality sources.

Question. What are the plans to engage stakeholders on the development of the system?

Answer. The Department plans to engage a wide range of stakeholders to ensure that the dashboard fulfills a need and will be useful for years to come. Once the Department has narrowed down a list of indicators, we will engage stakeholders on that list, and how best to present that data so that is accessible to all.

Question. The last two appropriations bills provided the Office for Civil Rights with a total increase of \$5.5 million, significantly less than the budget requests for OCR.

Please describe the impact of those unfortunate decisions on timely and thorough resolution of complaints filed with OCR and its ability to vigorously enforce civil rights laws under its jurisdiction.

Answer. The underfunding of the last few years has strained OCR’s ability efficiently to carry out its mission of safeguarding the civil rights of America’s students. OCR has seen a sharp increase in complaints over the last year: to a projected 10,843 in fiscal year 2022, a 22 percent increase over the total in fiscal year 2021 thus far in fiscal year 2022, OCR has received nearly 17,500 complaints, compared with 8,951 complaints received in all of fiscal year 2021. OCR anticipates further increases based on the return to in-person schooling, the lingering trauma of the pandemic, and the Biden-Harris administration’s efforts to ensure that students, families, and advocates are aware of the rights and responsibilities contemplated by the Federal civil rights laws that OCR enforces.

While the number of complaints has risen, staffing levels have not, with the small increases contained in the last two appropriations bills allowing for little more than covering rising personnel expenses. As of January, OCR had 330 investigative staff, roughly 100 fewer than were on board at the end of the Obama-Biden administration. Also as of that date, OCR’s investigators carried an average of 24 cases per staff—ranging from 16 cases per staff to over 50 cases per staff, depending on the regional office in question—an unreasonable and largely unmanageable caseload. OCR hopes to reach 15 cases per investigative staff, a caseload closer to manageable and one that would allow for the careful attention to each investigation that is necessary to resolve complaints effectively and efficiently.

Question. In *The Future of Education Research at IES*: Advancing an Equity-Oriented Science released earlier this year, the National Academies of Sciences, Engineering and Medicine made recommendations related to meeting the future educational needs of the nation through the work of the Institute of Education Science’s National Center for Education Research and National Center for Special Education Research, two of IES’s four centers.

Please describe plans and resource requirements for implementing each of the recommendations made in this report.

Please also describe how resources requested for all four IES centers would be used to advance IES's collective efforts to implement the recommendations in the National Academies' reports.

Answer. In response to these questions, IES notes that NASEM's recommendations were not available when the President's fiscal year 2023 Congressional Justification for IES was developed. Timing of NASEM's report publication coincided with the transmittal of the fiscal year 2023 President's Budget from the Department to Congress (on March 28th). Therefore, IES is now coordinating with the Department to respond without contradicting the President's fiscal year 2023 Budget and to determine what additional resources may be necessary to address the NASEM recommendations. We are unable to provide detailed resource requirements at this time and expect such details to be included in the President's fiscal year 2024 budget request.

Within the larger IES appropriations account, the Research, Development, and Dissemination (RD&D) line supports NCER research and research training grants programs along with other activities, such as support for the Small Business Innovation Research (SBIR) program, work by the National Center for Education Evaluation and Regional Assistance (NCEE), and the IES-wide dissemination and communication infrastructure. The Research in Special Education (RiSE) line supports NCSEER research and research training grant programs. Funds from both RDD and RiSE program appropriations are used to support application receipt, processing, and scientific peer review activities managed by the Office of Science.

Responding to NASEM's recommendations would require increases in both program and staffing appropriations, however (as described above) since the timing of these reports coincided with the transmission of the fiscal year 2023 PBR, we will include additional details on funding needed in the fiscal year 2024 request.

(1) The NASEM panel recommended that IES provide greater transparency about who is applying for and receiving funding, who is applying to and participating as trainees in our training programs, and who is serving as peer reviewers. The panel also recommended that IES collect and report more information about study participants in funded projects. In addition to this set of recommendations for descriptive information, the panel recommended that IES create a systematic, periodic, and transparent process for analyzing the state of the field.

IES has been working to improve the data we collect and report in these areas for many years, but has been constrained by limited staff, financial resources, and infrastructure. In order to implement NASEM's suite of recommendations pertaining to data transparency, IES will require significant additional resources to support a new central capacity to collect, analyze, and share data about our research investments (including data about applicants, grantees, trainees, and peer reviewers). Note that both NSF and NIH have multiple offices solely dedicated to collecting and reporting data about applicants, grantees, trainees, and peer reviewers.

IES also intends to support enhanced transparency on how our understanding of the state of the field relates to NCER and NCSEER focal topics through collaboration with the National Center for Education Evaluation (NCEE). To do so, IES proposes to expand the work of NCEE's What Works Clearinghouse (WWC) to gather systematic information about the state of rigorous research in broad areas of education practice and policy. Historically, the WWC has sought to review and synthesize research evidence in support of addressing specific educator and student needs, resulting in publications such as *Providing Reading Interventions for Students in Grades 4–9* and *Designing and Delivering Career Pathways at Community Colleges*. Going forward, the WWC intends to pilot a new approach whereby IES, in collaboration with leading experts, emerging scholars, and practitioners from a wide array of districts, would conduct broad field scans that yield more comprehensive understandings of the landscape of research in one or more topical areas.

The resulting product would help to inform decisions about where to invest our research funds, either in new topics within our primary field-initiated competitions, or in standing up new research networks designed to rapidly improve our evidence base in targeted areas. However, the breadth of topics able to be addressed is limited by funding available to expand the WWC's current work and staff to effectively oversee the new approach.

(2) The NASEM panel recommended that IES broaden our research investments and diversify participation in our training programs and on our peer review panels.

The NASEM panel recommended new competitions or topics within existing competitions in areas of national need, such as teacher education and education workforce development, education technology, data science and learning analytics, teaching practices, and school contexts associated with improved outcomes for students with disabilities. These recommendations align with areas of critical national need

that IES has already made limited investments in, but where we could likely play a transformative role with additional resources to devote to these topics.

New competitions would require individuals to serve as program officers, science office staff to manage peer review, and additional grants administration staff. Such competitions would also require new and different expertise, from non-academic and research settings.

In recent years, both NCER and NSCER have had to limit the number of competitions they run annually due to limitations on available funds. More specifically, due to funding constraints, neither center was able to fund all highly ranked applications in our primary research competitions in fiscal year 2021. In fiscal year 2022 NCER was unable to run any of its primary research competitions in special education due to funding limitations, and NCER faced a \$16.5M shortfall. Given budget limitations and the number of highly ranked applications unfunded in the previous competition, NCER made the painful decision to not hold its primary competition—the Education Research Grants program—in fiscal year 2023.

This decision (and NCER's decision for fiscal year 2022) are the equivalent of NIH telling the biomedical research community that they are unable to accept any applications for R01s. This not only puts many critical education research investments on hold for a year or more, it impedes our ability to help States and schools understand and respond quickly to improve outcomes for learners disproportionately impacted by the global pandemic. To meet the requirements of ESRA, NCER must also set aside at least \$8–10 million in fiscal year 2024 to compete 4 new R&D Centers or Networks with comparable continuation costs. Before initiating new competitions, or expanding existing ones, NCER and NSCER need sufficient funds to support our primary competitions aligned with our legislative mission and requirements.

Investing in Areas of High National Need

To stand up new competitions in areas of high national need, including areas recommended in the NASEM report, IES would require a substantial increase in program funds and staffing for NCER, NSCER, and the Office of Science. As noted above, IES is already engaging in work in many of the areas recommended by NASEM, including using extant digital data to ask and answer key questions more quickly and efficiently. NCER recently received responses to an RFI on large datasets that will inform our next investments in research opportunities using digital data, and we are investing in methods training in data science in fiscal year 23, so that we will have a cadre of scholars with appropriate expertise to tackle key questions in this area.

To carry out research that will improve outcomes for learners and schools, IES needs to expand our investments in methodological innovation and measurement. For example, we need to build methodological tools that will help us expand our use of learning analytics and machine learning techniques to transform instructional decisionmaking and personalized learning. We also need to create reliable and valid measures that use technological innovation to rapidly assess student needs and abilities, including academic knowledge, student mental health, and school climate. While the field has developed many high-quality measures in literacy and mathematics, we need to make sure that they are appropriate for the wide variation in learners, including those with disabilities and English Learners. In addition, there are disciplinary areas where high quality measures are rare. Science, computer science, engineering, civics, and history all lack measures that can be used to assess what learners across age and grade spans know. If classroom teachers are unable to assess what learners do and do not know, they cannot adjust their instruction to ensure that every learner in the classroom has an equal opportunity to learn.

Efforts to Diversify and Broaden Participation

IES has also started the process of acquiring contract support to expand our efforts to diversify and broaden participation in our research and research training investments. A similar effort has been undertaken to diversify participation in our peer review process. One critical task in our initial contract to support this work involves preparing a landscape analysis of what other Federal research funders are doing to diversify and broaden participation. For example, we are interested in identifying which programs focused on researchers from underrepresented groups have been successful at engaging early career researchers, and whether funding provided for mid-career researchers to join existing grants has led to increases in project team diversity. For IES to adopt strategies that emerge from this analysis, we will need additional programmatic funding and staffing resources to support the outreach and capacity building efforts. Such activities might include, for example, preparing branded outreach materials for distribution with communities of researchers

who have not historically applied for funding from IES, and developing a set of “how to apply” materials and video materials that may be used to reach and address these communities more effectively.

IES would welcome the opportunity to expand programs intended to broaden participation in the education sciences, particularly in research training. However, neither NCER nor NCSEER have program staff whose sole responsibility is research training. To fully implement a suite of activities focused on broadening participation in research training, NCER would need additional staff who can dedicate time and expertise to this work. With the benefit of such resources, NCER would expand the Pathways to the Education Sciences Research Training program by offering more grants. We would also offer it more frequently (currently it is competed every 4–5 years), and we would run a special Predoctoral Research Training competition limited to institutions that have not received an IES predoctoral training grant. As an example of the likely projected additional costs this might involve, to award 5 new Pathways programs and 10 new predoctoral training programs NCER would require \$12 million annually over a 5-year-period.

In addition, IES would like to offer supplements to existing projects to broaden participation in currently funded research projects. The supplemental award mechanism has been used by NIH for several years to broaden participation in health research. To do something similar within IES, both the RDD and RiSE budget lines would need additional program funding. Such increases would support wider participation in current projects through supplemental funding of a diverse group of fellows in NCER and NCSEER.

(3) The NASEM panel recommended that IES more directly support research on knowledge mobilization. IES has invested and continues to invest in developing a better understanding of strategies to increase the likelihood of educators and policymakers using research evidence to inform their work. Recent examples include investments by NCER in the National Center for Research in Policy and Practice (\$5 million; 2014–2019) and the Center for Research Use in Education (\$5 million; 2015–2020). Both projects highlighted the importance of IES’ largest knowledge mobilization effort—NCEE’s Regional Educational Laboratory (REL) Program—in promoting the use of rigorous evidence to address pressing problems of educational practice and policy.

Currently, REL research activities are focused on generating evidence that serves the needs of the state education agencies, local education officials, and institutions of higher education in 10 regions nationwide. With additional resources, NCEE could undertake a program of research that spans all 10 RELs, using the program as a “testbed” for new research on knowledge mobilization. For IES to (1) develop a knowledge mobilization learning agenda in collaboration with existing RELs, state and district partners, and experts in the use of research evidence; (2) design and deploy one or more studies across the program in service of answering priority learning questions; and (3) share actionable findings with key stakeholders inside and outside of the program, we estimates it would require additional staff and program resources each year for next 5 fiscal years, over the duration of the next cycle of REL contracts.

Question. In A Pragmatic Future for NAEP: Containing Costs and Updating Technologies released earlier this year, the National Academies of Sciences, Engineering and Medicine made recommendations related to innovations for meeting the cost-effectiveness of the National Assessment of Educational Progress while maintaining or improving its technical quality and the information it provides.

Please describe National Center for Education Statistics and National Assessment Governing Board plans and resource requirements for implementing each of the recommendations made in this report.

Answer. In response to these questions, IES notes that NASEM’s recommendations were not available when the President’s FY23 Congressional Justification for IES was developed. NASEM’s report publication coincided with the transmittal of the fiscal year 2023 President’s Budget from the Department to Congress (on March 28th). Therefore, IES is now coordinating with the Department to respond without contradicting the President’s fiscal year 2023 Budget and to determine what additional resources may be necessary to address the NASEM recommendations. We are unable to provide detailed resource requirements at this time and expect such details to be included in the President’s fiscal year 2024 budget request.

NCES and NAGB welcomed the National Academies’ recommendations, most of which endorse efforts the NAEP program is already undertaking to modernize the program, while others point to promising directions for the program. Below are NCES responses to key NASEM recommendations, including resource needs. NAGB’s responses are submitted under separate cover, reflecting NAGB’s independent status. However, you will see from the NCES and NAGB responses that

we are working together to build on the National Academies' recommendations to modernize and advance the program.

At the time the Department transmitted the fiscal year 2023 budget request for NAEP and NAGB to Congress (in March), the total requested amount for fiscal year 2023 was \$193 million, including \$185 million for NAEP and \$7.8M for NAGB. NCES is working with the Department to develop estimates of total program and staffing resources necessary to implement NASEM's recommendations. In these responses we are providing rough amounts that may change as we work with the Department and OMB to develop the President's fiscal year 2024 budget for NAEP.

We anticipate the need for approximately \$3 million in one-time programmatic costs to fund a review of the NAEP cost structures and to establish an independent panel for stress-testing and providing guidance on development of NAEP's digital assessment platform (eNAEP). We also anticipate an annual increase of \$9 million in program funds over the current enacted amount of \$180 million in fiscal year 2022 to implement an R&D program in response to the National Academies' recommendations and NCES's and NAGB's broader innovation goals. NAGB, in its response anticipates that it will require an increase of approximately \$1.7M in fiscal year 2023. Taking this into consideration, the total request for fiscal year 2023 for NAEP would be in the range of \$201.4M, which is \$16.4 over the fiscal year 2023 President's Budget submitted to Congress.

As stated above, IES and NCES are working with the Department to further refine these estimates, and we expect that the fiscal year 2024 President's Budget will reflect such changes. Everything in this response should be considered an estimate.

NCES has a detailed response to each of NASEM's recommendations, which we can share with Congressional staff as desired. Here we present just a few of our responses.

The NASEM report focused on cost controls and innovations to keep NAEP on the cutting edge of large-scale assessments.

First, we believe that NAEP requires a dedicated R&D funding stream that is separate from NAEP's Assessment program appropriation. Taking steps to ensure that there are protected funds to support routine modernization and enhancements over time is critical, and we see a dedicated R&D funding line as the best way to ensure that NAEP continues to invest sufficiently in keeping the assessment (along with the assessment administration infrastructure) modern and responsive to changing societal needs. We believe that this R&D fund should be 5 percent of the total NAEP/Assessment account budget, which would amount to approximately \$9 million in program funds annually at current levels of NAEP funding. This R&D funding set-aside would be dedicated solely to advancing NAEP's cost-efficiency, quality, and use.

Second, NASEM devoted considerable time analyzing the next generation of the NAEP on-line test administration platform (eNAEP). NCES agrees with the panel's recommendation that eNAEP components should be custom-built only if rigorous analysis shows that there are clearly large net benefits to this approach. However, NCES does not agree with the panel's position that current eNAEP does not have "contemporary data architecture." NCES is already deploying approaches that address these points with the new Next-Gen eNAEP development.

Wherever possible, mature, open-source and commercial components are already used and integrated as components into the eNAEP platform. In some cases, when no available technologies meet NAEP's technical or security requirements, custom-built software solutions are developed following open standards and best practices for reusability and cost-saving. The Next-Gen eNAEP platform was developed based on informed decisions on what to build versus buy considering development cost and efficiency as well as the total cost of ownership. NCES will commission a system review of the Next-Gen eNAEP and will establish an ongoing independent panel to support continued improvement of eNAEP. Similarly, we will empanel an independent set of experts to "stress test" eNAEP, as recommended by NASEM.

Finally, NASEM also recommends a clearer and more accessible description of NAEP's operating structure, costs, and cost drivers. We are committed to providing more transparency on these issues. NCES is developing a set of brief white papers and workshops for stakeholders designed to describe key aspects of NAEP's contracting and cost structure. These will be available to Congressional staff (and the public) as they are completed.

In response to NASEM's recommendation to improve visibility and coherence of research activities, NCES will produce a white paper describing our plans to modernize the program. NCES will post the white paper on its website in a new research and development hub disseminating information on NAEP research and development efforts. Please note that these research and development efforts include those recommended by the National Academies focusing on cost savings, as well as

the broader program of innovations for advancement of the program being developed with NAGB. See also the NAGB response to this recommendation.

The National Academies' NAEP report provided the National Assessment Governing Board (Governing Board) and the National Center for Education Statistics (NCES) with contributions that will lead to improvements—and potentially cost savings—in NAEP administration and operations. Because the responsibility for implementing the recommendations (and for NAEP more broadly) is shared between NCES and the Governing Board, both entities are submitting responses under separate cover. This document includes the Governing Board's response to the Senate's question for the record.

The Governing Board is encouraged by NCES' recent efforts to initiate structural changes in the program, including device-agnostic administration (meaning NAEP can be administered on different types of devices); automated scoring using artificial intelligence; and adaptive test design that adjusts in real-time based on students' responses. The fiscal year 2022 funding increase provided to NAEP contributed to making these modernization efforts possible.

Importantly, the Governing Board and NCES have identified additional opportunities for improvements in the program that NASEM did not address. As the joint stewards of NAEP, the Board and NCES are embarking upon an innovation agenda driven by relevance, utility, equity, efficiency, and adaptability. We have jointly determined the following innovation activities to be priorities in fiscal year 2023 and fiscal year 2024:

- Develop additional assessment items and testing methodologies to better describe the performance and needs of our nation's lowest performing students;
- Use geospatial data, linked with Census and IRS data, to provide more precise information about students socioeconomic status than can currently be reported by free and reduced priced lunch status;
- Develop remote testing capabilities, which means being able to test students wherever they are, e.g., virtual academies;
- Examine innovative ways to maintain trend, which currently relies on extensive and expensive bridge studies when changes are made to NAEP frameworks or elements of the test design;
- Capitalize on assessment process data as a critical source of information that is currently underdeveloped and underutilized in reporting; and
- Report more actionable information so that states and districts use NAEP as an essential source of information in their education systems (e.g., policy-relevant reporting, data visualization that helps communicate NAEP results to lay audiences, etc.).

Of these priorities for innovation, NCES will be responsible for implementing many of them. The Governing Board is responsible for innovation initiatives to strategically and proactively address stakeholder needs and to maintain assessment frameworks in ways that keep the NAEP assessments modern and relevant without threatening the valuable trend lines. To fulfill these objectives, the Governing Board requires its first budget increase in more than a decade. Our current funding level is \$7.745 million annually; we have requested a total of \$9.4 million in fiscal year 2023 and \$10 million in fiscal year 2024 as described in more detail below. We look forward to working collaboratively with NCES and in consultation with Congress to maintain NAEP as the gold standard while increasing relevance and utility.

In the table below, please find the Governing Board's responses to NASEM recommendations where the Board holds responsibility.

National Academies Recommendations for NAEP by Report Chapter	
Chapter 2	
RECOMMENDATION 2-1: NCES and NAGB should develop clear, consistent, and complete descriptions of current spending on the major components of NAEP and use them to ensure that their long-term budgetary impact is supportable.	
NAGB RESPONSE: NAGB has produced a summary of its budget and expenditures, including historical information on appropriations and spending, which is available upon request. The current NAGB budget has been level funded across many years. With an increasing workload (i.e., updates to four NAEP assessment frameworks in 2023 and 2024 and launching initiatives in strategic communications to promote greater use of NAEP data) the Governing Board requires additional staffing support.	
RESOURCE NEEDS: 1.0 FTE	
Chapter 3	
RECOMMENDATION 3-1: NCES should prepare a detailed plan and budget for the modernization of long-term trend NAEP. NAGB and NCES should then consider the value of a modernized and continued long-term trend NAEP in comparison with other program priorities.	
NAGB RESPONSE: In 2018, the Board previously examined the future value of LTT relative to other NAEP assessments. Congress provided appropriations to continue with LTT administration. The Board will need to set future direction for LTT in consultation with NCES and Congress. In the short-term, NCES plans to transition LTT from paper to digital administration.	

RESOURCE NEEDS: None at this time
RECOMMENDATION 3-2: NAGB and NCES should work both independently and collaboratively to implement smaller and more frequent framework updates.
NAGB RESPONSE: The Governing Board is exploring a new process for making smaller, more frequent changes (i.e., incremental updates) to assessment frameworks, which could result in a change to the Board's framework policy in 2023. This process began in May 2022 with discussion by the Board's Assessment Development Committee of potential options (see here). Board action on the new policy is possible in 2023. The Board's current budget and FY2023 request accounts for the ongoing research to inform potential changes to Board policy and processes for updating frameworks. NCES is costing out whether / how incremental updates will result in cost savings or increased costs, i.e., if new items are required with every incremental framework the costs may actually increase rather than decrease. Separately, the Governing Board has a pressing need to update several NAEP frameworks which have not been changed in 10-20 years or more. The Board awarded a contract (FY 2022) for updating the NAEP Science Framework. Our FY 2023 revised budget request and FY 2024 request to the Department include additional funding to account for needed updates to 3 other frameworks (Writing, U.S. History, and Civics). These necessary updates will position the Board to take on smaller, more frequent updates in the future, in accordance with potential changes to Board policy in 2023. RESOURCE NEEDS: The FY 2023 revised request and FY 2024 request includes additional funding to update new frameworks in each of these fiscal years: • \$2 million in FY 2023 • \$3 million in FY 2024 Potential costs to implement a new Board policy and process for updating frameworks more frequently is not yet known. Updated projections may be provided in a revised request for FY 2024 or a new request for FY 2025.
RECOMMENDATION 3-3: NAGB should give high priority to consideration of integrating non-mandated subjects that are currently assessed separately (such as science and technology and engineering literacy), as well as the possibility of integrated pairs of subjects that include a mandated subject, such as reading and writing.
NAGB RESPONSE: In 2018, the Board discussed assessing multiple subjects together and determined it was not advisable on technical grounds or for ease of interpretation/use of the data. The Board could potentially revisit these decisions when preparing for the updates of the Science, Writing, U.S. History, and Civics Frameworks in the next 3 years. The update of the NAEP Science Framework (to begin this year) will consider whether and how content from the Technology and Engineering Literacy (TEL) Framework might be integrated with science.

More generally, integrating multiple subjects is dependent on decisions about a two-subject design for the NAEP assessments.

RESOURCE NEEDS: None at this time

Chapter 4

RECOMMENDATION 4-2: NAGB and NCES should move towards using more structured processes for item development to both decrease costs and improve quality.

NAGB RESPONSE: NASEM included both NCES and NAGB in the recommendation, however, a review of costs under contracts held by NCES is for NCES to implement.

RESOURCE NEEDS: None at this time

RECOMMENDATION 4-3: NAGB should commission an analysis of the value and cost of different item types.

NAGB RESPONSE: Once NCES completes its analysis of the value of different item types and cost review of item development, the Board and NCES will determine how to proceed with decisions about the costs and benefits of different item types.

RESOURCE NEEDS: None at this time

Chapter 5

RECOMMENDATION 5-1: NCES should continue to develop its plan to administer NAEP using local school staff as proctors with online assessment delivery on local school computers, including tailored support for schools with more limited resources.

NAGB RESPONSE: The Board recognizes the potential cost savings of local administration and seeks to be strategic in the approach NAEP takes, as schools would assume more responsibility for NAEP administration in this model. NCES will continue to keep the Board apprised of operational plans for implementing a "local administration" model of NAEP so that the program can balance operational and policy priorities.

RESOURCE NEEDS: None at this time

RECOMMENDATION 5-3: NCES should review its estimates of the potential cost savings from local administration of the mandated assessments in reading and mathematics in grades 4 and 8. The estimated savings are unexpectedly small. NCES should also consider the use of the local administration model for reducing costs of all other assessments.

NAGB RESPONSE: NCES will continue to keep the Governing Board apprised of projected cost savings from local administration models for NAEP before final decisions are made.

RESOURCE NEEDS: None at this time

Chapter 6
RECOMMENDATION 6-1: NCES should continue to develop its plan to administer NAEP in longer sessions that allow for 90 minutes for the testing of cognitive items for each student. The decision to use longer tests should be based primarily on their potential to reduce overall testing burden and to understand dependencies in proficiency across subjects, rather than cost savings.
NAGB RESPONSE: The Board will continue to keep updated on progress and provide input on policy considerations for potential changes to the design, including the potential impact of increasing test length.
RESOURCE NEEDS: None at this time
RECOMMENDATION 6-3: NCES should pursue adaptive testing for NAEP not as a way of saving costs, but for its potential to improve the precision of statistical estimates and the test-taking experiences for low-performing students.
NAGB RESPONSE: 6-3: The Board will continue to keep updated on progress made by NCES in exploring such changes and will provide input on policy considerations, such as implications for what content can be assessed (e.g., frameworks) and for the setting of achievement levels.
RESOURCE NEEDS: None at this time
Chapter 7
RECOMMENDATION 7-1: NCES should continue its work to implement automated scoring.
NAGB RESPONSE: The Board will continue to keep updated by NCES on progress made in exploring automated scoring and provide input on policy considerations, including bias/fairness considerations.
RESOURCE NEEDS: None at this time
Chapter 8
RECOMMENDATION 8-1: NCES should devote a greater percentage of its budget for innovative analysis and reporting that will increase the use and understanding of NAEP's data.
NAGB RESPONSE: The Board is focused on using the release of upcoming 2022 data as an opportunity to advance understanding of what NAEP is, why it matters, and what the results mean. Beyond the recommendations from NASEM, the Board and NCES have discussed innovation priorities for NAEP that include improving our measure of socioeconomic status (currently tied to eligibility for Free and Reduced Price Lunch); improving our ability to measure and report assessment results for the nation's lower-performing students; and leveraging technology to communicate complex data from NAEP in clear, comprehensible ways.
Starting in fall 2022, the Governing Board will launch a strategic communications initiative targeted at increasing understanding and <u>use</u> of NAEP data by key stakeholders—particularly state and federal policymakers, district leaders, and the media. We also plan to make greater use of data visualization

techniques, taking complex NAEP data and translating them to easy-to-understand graphics that facilitate use of NAEP data. Two potential contracts will need to be funded for these initiatives.
RESOURCE NEEDS: Starting in FY 2023, an additional \$1 million annually is needed for strategic communications and data visualizations that will increase NAEP's relevance and utility.
Chapter 10
RECOMMENDATION 10-1: NAGB and NCES should commission an independent audit of the program management and decision-making processes and costs in the NAEP program, with a charge and sufficient access to review the program's costs in detail and propose ways to streamline these processes.
NAGB RESPONSE: The Board will award a contract in FY 2022 (or early FY 2023) for a financial audit of the Board's costs over the previous five years. We plan to conduct such an audit every five years thereafter.
RESOURCE NEEDS: FY 2022/FY 2023 contract award, estimated at \$75,000
RECOMMENDATION 10-2: NCES should increase the visibility and coherence of the NAEP's research activities. The NAEP research program should have an identifiable budget and program of activities.
NAGB RESPONSE: NAGB and NCES staff created an Innovation Strategy that was presented to Board Members at the March and May 2022 Board meetings. The Innovation Strategy will include a program of activities and joint NCES-NAGB deliberation of the program's innovation priorities, considering capacity, costs, and feasibility. The NAEP innovation agenda is based on five principles: adaptability, efficiency, equity, relevance, and utility. The principles aim to maintain the quality and technical integrity that is the hallmark of NAEP while advancing the program for the next decade and beyond. Innovations include improving our ability to measure what our nation's lowest performing students know and can do; improving NAEP's SES indicator through linking to other data sets and using geo-spatial data; creating more actionable information and using advanced analytics in reporting; and enhancing stakeholder engagement, among others.
RESOURCE NEEDS: The Board does not anticipate the need for additional resources of its own.

Question. In A Vision and Roadmap for Education Statistics released earlier this year, the National Academies of Sciences, Engineering and Medicine recommended changes to NCES's programs, operations, staffing, and use of contractors for the non-assessments work of the National Center for Education Statistics considering developments in collecting and using data and recent trends and future priorities.

Please describe plans and resource requirements for the National Center for Education Statistics to implement each of the recommendations made in this report.

Answer. In response to these questions, IES notes that NASEM's recommendations were not available when the President's FY23 Congressional Justification for IES was developed. Timing of NASEM's report publication coincided with the transmittal of the fiscal year 2023 President's Budget from the Department to Congress (on March 28th). Therefore, IES is now coordinating with the Department to respond without contradicting the President's fiscal year 2023 Budget, and to determine what additional resources may be necessary to address the NASEM recommendations. We are unable to provide detailed resource requirements at this time and expect such details to be included in the President's fiscal year 2024 budget request.

To support NCES efforts to implement NASEM's recommendations, the NASEM Panel provided a roadmap suggesting how the Panel's recommendations should be implemented over time. Consistent with that roadmap, NCES is now developing a formal Strategic Plan (Recommendation 2-1), which will serve as the foundation of our work to implement the remaining recommendations. We fully agree with NASEM's observation that our stakeholders need more modern, timely, actionable, and reliable information. To this end, the plan is focused on several areas:

—Prioritizing NCES's most important work

- Embedding diversity, equity, inclusion, and accessibility in all aspects of NCES' work
- Strengthening existing partnerships and developing new ones
- Improving internal processes, while adhering to all legal requirements

In coming months, NCES expects to have a plan that we will use to engage stakeholders, gather their input and ideas, and help us prioritize our work so that the statistics we produce are aligned with the nation's needs. Meanwhile, NCES is actively engaging with constituents here in the Department (including the Office of the Secretary, the IES director and other center leads, the Chief Data Officer, and the Evaluation Officer) on a number of critical issues raised in the report. These issues include how the Department and IES, as NCES's parent organization, can support NCES efforts to increase the relevance of the information we produce, improve efficiency and timeliness in publishing official statistics, and support the NCES Commissioner's role as the Statistical Official (Recommendations 2–2 and 2–3).

We are focusing our current plans and resources on near-term actions that will lay the foundation for future improvements. Many recommendations will require additional program and staffing resources beginning in fiscal year 2023. Successful implementation of first steps will determine how and when we implement other recommended changes.

The need for action is immediate. There are several recommendations in the report that direct NCES to begin action this year. NCES' ability to fully address most of these recommendations depends on additional program and staffing resources being made available in the coming year, sooner than the fiscal year 2024 President's Budget cycle. As noted, resources needed to address fiscal year 2023 work were not included in the President's budget request for IES/NCES in fiscal year 2023, because the report was released late in the budget cycle, just several days before the Budget was transmitted to Congress.

Developing an NCES Strategic Plan is an immediate priority. Items we expect to identify in this plan include continuing the School Pulse Survey (Recommendation 3–1), increasing coordination with and building the data capacity of our state partners (Recommendation 4–4), enhancing the Office of the Commissioner to meet the needs of the Evidence Act (Recommendation 3–2), incorporating equity in our data collections and products (Recommendation 2–4), and strengthening collaborations with other Federal statistical agencies (Recommendation 4–2). We believe that moving forward with these activities now will enhance NCES' capacity to produce and disseminate statistical products that meet the information needs of our stakeholders.

In fiscal year 2023, we intend to have both a Strategic Plan and an expanded Office of the Commissioner in place. This latter step is necessary to implement Titles II & III of the Foundations for Evidence-Based Policymaking Act (Evidence Act). After fiscal year 2023, NCES intends to continue following the roadmap within the NASEM report and focus on implementing the remaining recommendations, which include:

- exploring alternative data sources, more modern modes of accessing data, and in increased use of data science methods (all in conjunction with IES' new data science unit),
 - modernizing standard language on consent and planned uses to enable greater access to data,
 - deepening and broadening engagement with data users, including potential users, developing new feedback loops to ensure NCES data collections are serving constituents,
 - establishing and beginning work with an external consulting body to gather input for prioritizing our initiatives,
 - establishing a joint statistical research program matching internal staff with external experts, and
 - transforming our current programs, operations, and activities to build greater internal capacity.
- NCES and IES both look forward to continuing dialog with Congress as we work to realize the full potential of NCES as a statistical agency and its mission to provide meaningful, reliable, and timely Federal education data.

Question. The Department planned this year to expand its monitoring of States for homeless education programs, including the Title I, Part A LEA set-aside.

Please describe the Department's completed actions and plans for fiscal years 2023 and 2024.

Answer. This year, the Department's homeless education program team developed a new integrated monitoring plan for the Education for Homeless Children and Youth (EHCY) and American Rescue Plan—Homeless Children and Youth (ARP—

HCY) programs. Four States were monitored—Kansas, South Dakota, New Hampshire, and New Jersey between April and June 2022. Reports will be posted on the Department’s website as they are finalized. The EHCY and ARP–HCY monitoring plan is also located there at <https://oese.ed.gov/files/2022/01/SSA-EHCY-ARP-HCY-Monitoring-Plan-FY-22.docx>. <https://oese.ed.gov/files/2022/01/SSA-EHCY-ARP-HCY-Monitoring-Plan-FY-22.docx>.

The Department plans to monitor six States in fiscal year 2023 and between six and nine States in fiscal year 2024. This is an increase over the prior several years. It allows the Department to balance competing priorities to monitor and provide oversight while also providing technical assistance to States and districts and the Department’s other requirements for administering a Federal program (e.g., reviewing State and local data, coordinating with other agencies on programs addressing homelessness) with the current small number of staff for this program and in partnership with the National Center for Homeless Education.

Question. Please describe how what you are learning through these and other efforts will inform future monitoring and support of the effective use of Federal funds for students experiencing homelessness.

Answer. The Department is still finalizing the monitoring reports from the four States reviewed in fiscal year 2022. Our initial analysis indicates that more attention is needed on analyzing LEA-level homeless student enrollment and performance data to identify LEAs for subrecipient monitoring or to provide technical assistance to improve performance, for EHCY and ARP–HCY subgrantee LEAs and for all LEAs. In some cases, an LEA that has students experiencing homelessness has not set aside funds under the Title I, Part A program to provide services to those students, as required. In addition, the Department observed that the per-pupil amounts varied widely in most States.

The Department is planning to strengthen and update its technical assistance. Regarding the Title I set-aside, we will host, and post online, a webinar with knowledge checks and a certificate of completion through the National Center of Homeless Education. We will continue to provide support and assistance to State homeless coordinators to ensure they are providing guidance to all LEAs on the requirements to provide services to homeless students. Finally, we are adding questions related to the Title I set-aside to the Title I monitoring protocol.

In our monitoring, we also observed innovative and effective uses of funds at the local level. For example, a school in Kansas City, Kansas was being converted into a family transitional housing program with several supportive service providers colocated at the site and the targeted provision of supplies and other supports to high school students experiencing homelessness through graduation in Olathe, Kansas.

Question. What actions will the Department take in working across the Administration to address the impact housing instability and other challenges have on the education of children experiencing homelessness, from early childhood through higher education?

Answer. The Department works across the agency and with our colleagues across the Federal Government to provide supports for children and youth experiencing homelessness and those involved in the child welfare or juvenile justice systems. The Department will continue our role as a core agency of the U.S. Interagency Council on Homelessness especially in preventing and ending or reducing family, child and unaccompanied youth homelessness. The Department’s homeless education program team also coordinates with HUD on the Youth Homelessness Demonstration Program coordinated technical assistance and evaluation; the Family Youth Services Bureau of HHS on using the National Runaway Safeline; and the Office of Juvenile Justice and Delinquency Prevention at DOJ on preventing homelessness among reentering youth. The Department is also collaborating with the Department of Labor and National Youth Employment Coalition as well as the Department’s Office of Career and Technical Education regarding the Perkins program requirements for serving youth experiencing homelessness, the Workforce Investment Opportunities Act funding for disconnected youth, and the Performance Partnership Pilot programs for disconnected youth.

On early childhood education, the later this year, the Department will release the 2022 Early Childhood Homelessness State Profiles. For postsecondary education, the Department’s homeless education program team, along with our National Center for Homeless Education (NCHE), are coordinating with our Offices of Federal Student Aid and Postsecondary Education to provide technical assistance and guidance on FAFSA simplification.

Question. The calculation of current expenditures used under the ESEA excludes ESEA Title I–A funding. The amount of funding provided for COVID education relief, particularly through the Elementary and Secondary School Emergency Relief

Fund (ESSER), is significantly more funding than is provided annually through Title I-A.

If the COVID relief funds are not dropped from the current expenditures calculation, how could this potentially affect grant amounts under Federal elementary and secondary education programs that incorporate current expenditures into the formula grant calculation?

Answer. See response below under (b.)

Question. Would state shares of formula grants shift from previous years as a result of the inclusion of these funds?

Answer. (b.) By the end of September 2022, the Department expects to have received from States preliminary current expenditure data for fiscal year 2021 (July 1, 2020, to June 30, 2022) that will include COVID education relief expenditures as part of the current expenditures reported and the COVID education relief expenditures also reported separately. Once the Department has received these data, we will be in a position to analyze of the potential effects of these funds on allocations.

Question. If the funds remain in the calculation, would this distort measures of state and local effort to support public elementary and secondary education given the unprecedented Federal investment in these areas during the COVID19 pandemic?

Answer. With respect to the ESEA's local educational agency maintenance of effort (MOE) requirement, the Department's MOE regulations require that expenditures of Federal funds be excluded from the MOE calculation. Therefore, expenditures by a local educational agency of COVID relief funds will not have an effect on whether the LEA meets the ESEA's MOE requirements. With respect to the Title I Education Finance Incentive Grant formula's State MOE requirement that is based on current expenditure data, the Department will be in a position to analyze the potential effects once current expenditure data from fiscal year 2021 are available.

Question. In addition, does ED have a sense of the extent to which the Governor's Emergency Education Relief Fund and ESSER might be used for capital expenditures in some places and not others, which could create a situation in which some entities would have their COVID funds counted in their current expenditures calculation and others would not, depending on how the funds were used (as capital outlays are not included in current expenditures)?

Answer. "Current expenditures comprise expenditures for the day-to-day operation of schools and school districts for public elementary and secondary education, including expenditures for staff salaries and benefits, supplies, and purchased services. General administration expenditures and school administration expenditures are also included in current expenditures. Expenditures associated with repaying debts and capital outlays (e.g., purchases of land, school construction, and equipment) are excluded from current expenditures. Programs outside the scope of public prekindergarten through grade 12 education, such as community services and adult education are not included in current expenditures. Payments to private schools and payments to charter schools outside of the school district are also excluded from current expenditures." (Cornman, S.Q., Ampadu, O., Wheeler, S., Hanak, K. and Zhou, L. (2019), p. B-2).

According to this definition capital outlays (e.g., purchases of land, school construction, and equipment) are excluded from current expenditures. The vast majority of State Education Agencies (SEAs) and school districts across the country follow this definition of current expenditures and exclude capital outlays.

Furthermore, the U.S. Department of Education guidance on Every Student Succeed Act (ESSA) report cards provides in pertinent part that "If an SEA wants to ensure that data are uniform, understandable, and comparable across each LEA and school in a State, the SEA may establish uniform statewide procedures for calculation of per-pupil expenditures." (See <https://oese.ed.gov/files/2020/07/report-card-guidance-final.pdf>).

Commencing in October 2020, NCES has held quarterly meetings with State Fiscal Coordinators to facilitate the consistent collection and submission of accurate data. The technical workshops facilitate reporting accurate, consistent and timely information because the finance data item definitions and survey instructions are discussed in exhaustive detail. The primary purpose of the technical workshop is to make the reporting procedures on NPEFS, the F-33, and the School Level Finance Survey (SLFS) surveys as efficient and cost effective as possible. The foregoing definition of current expenditures is discussed in detail at each and every quarterly meeting held with State Fiscal Coordinators. The workshops include an interactive discussion on the reporting and editing processes associated with the surveys; detailed information about the items that comprise the surveys; and discussion of how

to coordinate submission of Common Core of Data (CCD) data with the respective state's data systems.

Current expenditures and capital expenditures paid from COVID—19 Federal Assistance Funds were collected as separate and distinct data items on the state level National Public Education Financial Survey (NPEFS) and the district level School District Financial Survey (F-33) for the fiscal year (FY) 2020 (school year 2019–20).

Current expenditures and capital expenditures paid from COVID—19 Federal Assistance Funds are currently being collected on the fiscal year 2021 (school year 2020–2021) NPEFS and F-33 surveys. Specifically, in fiscal year 2021, the NPEFS and F-33 surveys contained 10 data items which requested revenue amounts broken out by program and 8 data items which requested expenditure amounts from all COVID—19 Federal assistance funds for specific functions or objects.

Going forward for the fiscal year 2022 NPEFS and F-33 data collections, certain divisions within the U.S. Department of Education such as the Institute of Education Sciences (IES), the Office of Elementary and Secondary Education (OESE), the Office of Planning, Evaluation, and Policy Development (OPEPD), and the Budget Office recommended that the surveys be expanded to collect expenditures by specific sources of COVID—19 revenue.

State Fiscal Coordinators Workshops were held on October 21, 2021 and February 17, 2022. During these workshops, poll questions were conducted and the State Fiscal Coordinators provided feedback on their ability to report expenditures by source of revenue from COVID—19 Federal assistance funds. In December 2021, an expert panel comprised of State Fiscal Coordinators and district level school business officials also discussed the possibility of adding expenditures by source of revenue to the NPEFS and F-33. During these meetings, Federal staff collaborated with the state fiscal coordinators and district level personnel to make every effort to ensure that there is “match” between the data that the NCES is requesting and data that the SEAs can actually produce.

From October 2021 through April 2022, NCES carefully reviewed the recommendations on adding expenditures by source of COVID—19 Federal assistance fund on NPEFS and F-33 submitted by the respective divisions within the Department; select State Fiscal Coordinators and LEA-level personnel; and all State fiscal coordinators. On the basis of the comprehensive meetings set forth above and the ability of states to report the additional data, NCES recommended to the Office of Management and Budget (OMB) that NPEFS and F-33 be revised to expand the collection of expenditures to include current expenditures, instructional expenditures, and capital outlay by seven specific sources of funds.

These recommendations were presented to state fiscal coordinators at the quarterly meeting on April 28, 2022. The majority of states will be able to report on the new variables. However, some states are only able to collect data from LEAs on grants that are allocated and awarded through the state department of education. These states may not be able to report on grants that flow through to LEAs from other agencies, such as the State and Local Fiscal Recovery Funds. In these cases, states may report on only that data which is available and should provide appropriate explanations in their state notes. Some states also expressed concerns about the additional burden of the new survey codes. In some cases, states lack the resources required to make programming changes to their collection and reporting systems.

The 21 additional items to be added to the fiscal year 2022 (school year 2021–2022) NPEFS and F-33 surveys are set forth in blue font below.

- Current expenditures paid from ESSER I funds (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1A
- Current expenditures paid from ESSER II funds (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1B
- Current expenditures paid from ARP ESSER funds (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1C
- Current expenditures paid from GEER I funds (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1D
- Current expenditures paid from GEER II funds (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1E
- Current expenditures paid from the CRF (objects 100–600, 810, 820, 835, and 890 for functions 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1F

- Current expenditures paid from the SLFRF (objects 100–600, 810, 820, 835, and 890 for function 1000, 2000, 3100, and 3200; excluding objects 511, 561, 564, 567, and 591)—AE1G
- Instructional expenditures paid from ESSER I funds (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2A
- Instructional expenditures paid from ESSER II funds (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2B
- Instructional expenditures paid from ARP ESSER funds (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2C
- Instructional expenditures paid from GEER I funds (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2D
- Instructional expenditures paid from GEER II funds (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2E
- Instructional expenditures paid from the CRF (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2F
- Instructional expenditures paid from the SLFRF (objects 100–600, 810, and 890 for function 1000; excluding objects 561, 564, 567, and 591)—AE2G
- Capital outlay expenditures paid from ESSER I funds (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4A
- Capital outlay expenditures paid from ESSER II funds (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4B
- Capital outlay expenditures paid from ARP ESSER funds (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4C
- Capital outlay expenditures paid from GEER I funds (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4D
- Capital outlay expenditures paid from GEER II funds (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4E
- Capital outlay expenditures paid from the CRF (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4F
- Capital outlay expenditures paid from the SLFRF (objects 100–700, and 890 for function 4000; object 700 for ALL functions)—AE4G

The results of poll questions posed to State Fiscal Coordinators were very high with respect to reporting current expenditures, instruction expenditures, and capital outlays by specific source of COVID—19 revenues.

In summary, NCES recommended that the NPEFS and F–33 be revised to expand the collection of expenditures to include current expenditures, instructional expenditures, and capital outlay by 7 specific sources of COVID—19 Federal assistance funds.

The 60 day Federal register notice for fiscal year 2022 through fiscal year 2024 NPEFS survey came out on June 7, 2022. The comment period ends on August 8, 2022.

As a direct result of the quarterly meetings with State Fiscal Coordinators and the expert panel, it is submitted that the SEAs can report total current expenditures, instructional expenditures, and capital outlay expenditures broken out by source of revenue (21 new data items) on the NPEFS and F–33 surveys. The COVID—19 revenue streams include:

- ESSER I
- ESSER II
- ESSER III ARP Funds
- Coronavirus State and Local Fiscal Recovery Funds under ARP
- GEER I Funds
- GEER II Funds
- Coronavirus Relief Funds (CRF) under CARES Act

Question. Average daily attendance (ADA) is a factor that is included in several Federal elementary and secondary education program formulas.

Given what appears to be substantial shifts in ADA in some areas and potential problems counting students accurately and consistently, how is the Department considering using ADA data from the 2019–2020, 2020–2021, and 2021–2022 school years in grant calculations, and how would this affect grant allocations?

Answer. The Department published a letter to the Chief State School Officers on January 27th, 2022 addressing the collection of average daily attendance in school years 2019–2020 and 2020–2021 in light of the impacts of the COVID—19 pandemic. In the letter, the Department outlines flexibilities SEAs could utilize when collecting and reporting ADA in school year 2019–2020. In accordance with Section 8101(1) of the Elementary and Secondary Education Act of 1985, each SEA is still expected to report ADA based on either the Federal definition or its respective State definition. However, the letter addressed what SEAs should do during the periods of remote instruction. For example, in cases where the SEA was using the Federal defi-

dition but was unable to report during the periods of remote instruction, SEAs were advised to report the aggregate number of days of attendance of all students up until school facilities closed. The letter further notes that the expectation is that SEAs resume normal tracking of student attendance regardless of school building operational status.

The Department is in the process of collecting ADA data on school year 2020–2021 and will conduct an analysis of the impact of COVID–19 on the reporting of ADA as well as how shifts in the data impact grant allocations.

Response Specific to the REAP Program: To administer the Rural Education Achievement Program (REAP) in fiscal year 2022 the Department communicated with State Rural Coordinators during summer 2021 to assess if SEAs anticipated reporting issues due to average daily attendance (ADA) data quality concerns. Three SEAs reported data concerns in August 2021. These SEAs received technical assistance, helping to ensure compliance with the REAP eligibility requirement under section 5231(a) of the Elementary and Secondary Education Act of 1965 (ESEA), that requires a local educational agency (LEA) to conduct an annual census not earlier than the start of the school year and not later than December 1 of each year to determine the number of students in ADA in kindergarten through grade 12 at each school served by an LEA for the purposes of eligibility and allocations.

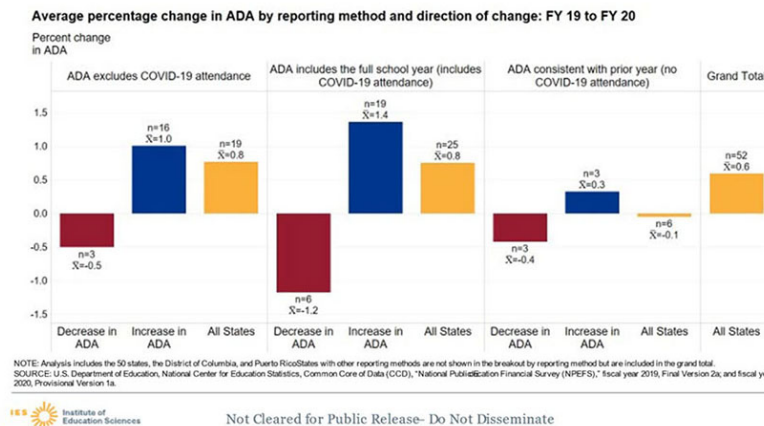
To incorporate additional SEA and LEA input on ADA data collection, the Department requested public comment on a proposed revision of a currently approved collection necessary to implement REAP in fiscal year 2023 (see here). In addition, because the ESEA does not clearly define how a census should be conducted and section 8101(1) of the ESEA includes a definition of ADA that differs from the process outlined in section 5231 of the ESEA, the Department included in the Unified Agenda report for Spring 2022 a plan to initiate rulemaking in May 2023 (RIN: 1810–AB65). The Department plans to clarify the process for calculating ADA for REAP, including the census determination process, under Section 5231(a) of the ESEA.

Question. The National Center for Education Statistics provided flexibility for collecting ADA data during the 2019–2020 school year. Did this flexibility result in reliable ADA counts or could an entity be advantaged or disadvantaged in the determination of formula grants based on the counting method that it used?

Answer. School finance experts from NCES and the Census Bureau performed an analysis of reporting on the 2019–2020 school year, which concluded that the flexibility provided by NCES: (a) resulted in reliable ADA data, and (b) the counting method an entity selected did not advantage or disadvantage them in the determination of formula grants. Results of this study were shared at the American Education Finance and Policy Associate conference this year.

This analysis also reviewed changes in ADA and state per pupil expenditures (SPPE) to determine if there were differences in reported ADA by the policy option, or counting method, that was selected by the state. We found there were no differences in the change in average ADA for those that included attendance for remote learning days compared to those that did not.

We note that since fiscal year 2020 contains several months of pandemic data, NCES will need to continue to monitor ADA and SPPE for impacts of COVID–19.



Question. Students of color and students with disabilities are disciplined at significantly higher rates than their white and nondisabled peers. These forms of discipline, ranging from suspensions and expulsions to restraint and corporal punishment, can have a disastrous impact not only on the academic stability of these students, but also on their physical, mental, and emotional health.

How would President Biden's fiscal year 2023 budget proposal for Education help to support and encourage the use of more positive alternatives to punitive and exclusionary discipline practices which disproportionately impact students of color and students with disabilities?

Answer. President Biden's fiscal year 2023 budget proposal describes several activities that the Department of Education would carry out under the Individuals with Disabilities Education Act (IDEA) Part B Grants to States. First, it references the existing requirements for States, on an annual basis, to determine whether there is significant disproportionality in race and ethnicity in the State or the LEAs of the State with respect to the identification (including identification of children with a particular disability), placement in particular education settings, and discipline of students with disabilities. While data from 2019–2020 revealed that 298 LEAs were identified with significant disproportionality on the basis of discipline, the Department has focused much of its attention on the effective collection and analysis of this data and has not yet been able to effectively respond to the identified disproportionality. Once an LEA is identified as having significant disproportionality, the LEA must conduct a root cause analysis and reserve 15 percent of its IDEA Part B allocation to provide comprehensive coordinated early intervening services (comprehensive CEIS) to students. Moving forward, the Department is committed to making this second phase of the significant disproportionality requirements a major focus in monitoring and technical assistance efforts. Additionally, the fiscal year 2023 Budget requests \$5 million to establish an Equity in IDEA Technical Assistance Center, which will support LEAs in conducting root cause analyses and identifying evidence-based strategies for effectively deploying funds reserved for comprehensive CEIS. With effective supports to identify the root causes of the disproportionality, as well as a better understanding of the most effective ways to provide comprehensive CEIS to students, LEAs can meaningfully address their disproportionality and set a path towards more equitable services of all students. Furthermore, the Center will disseminate research, data analyses and best practices related to equitably serving children with disabilities to provide all schools strategies to proactively prevent disproportionality.

Additionally, the fiscal year 2023 budget proposal indicates that the Department will issue updated guidance on the topics of restraint and seclusion—practices that disproportionately impact and harm students of color and students with disabilities—and will continue to leverage our investments under the IDEA Technical Assistance and Dissemination program to support efforts to limit the use of seclusion and physical restraint, reduce exclusionary discipline practices, and promote positive behavioral interventions and supports in schools. For example, the National Technical Assistance Center on Positive Social, Emotional, and Behavioral Outcomes for Students with Disabilities can reduce seclusion and restraint by improving State and local capacity to address the social, emotional, and behavioral development of young children with disabilities, while the National Technical Assistance Center on Positive Behavior Interventions and Supports provides schools with guidance on deploying school-wide strategies to improve school climates that can proactively reduce seclusion and restraint.

These efforts can help reduce the disproportionate use of punitive and exclusionary discipline of students with disabilities as well as students of color. In addition, the fiscal year 2023 Budget request for ED will enable OCR to add approximately 92 FTE over the 2021 enacted level. This funding will allow OCR to continue its enforcement and technical assistance efforts to ensure nondiscrimination in student discipline based on race, color, national origin, or disability. The President's fiscal year 2023 budget proposal will also enable OCR to continue to collect critical data regarding the discipline of students with disabilities and students of color, including corporal punishment, referral to law enforcement, school-based arrest, expulsion, transfer to alternative school, out-of-school suspensions, and in-school suspensions, as well as disaggregated data on school days lost due to out-of-school suspensions.

Question. Relatedly, what is the Department's timetable for releasing forthcoming school discipline guidance?

Answer. The now-rescinded guidance under Title VI of the Civil Rights Act of 1964, first issued in 2016, remains under review by the Departments of Justice and Education. On July 19, 2022, however, ED released two sets of guidance and resources on the topic of students with disabilities and discipline. OCR released Sup-

porting Students with Disabilities and Avoiding the Discriminatory Use of Student Discipline under Section 504 of the Rehabilitation Act of 1973, a guidance document explaining that Section 504 requires schools to provide behavioral supports and services to students with disabilities who need them in order to receive a FAPE.

OCR's guidance makes clear that providing the individualized services and supports required by Section 504 can help prevent or reduce disability-based behaviors that might otherwise lead to student discipline; outlines how Section 504's requirements to provide a free appropriate public education, or FAPE, apply to long-term disciplinary sanctions, such as out-of-school suspensions and expulsions; explains Section 504's general nondiscrimination requirements, in the context of discipline, which applies to school staff and to the conduct of everyone with whom the school has a contractual or other arrangement, such as security staff and school police; and makes clear that Section 504 requires schools to provide reasonable modifications to policies, practices, and procedures when necessary to avoid discrimination.

OSERS released three documents related to addressing the needs of children with disabilities and IDEA's discipline provisions. The guidance package included: (1) Dear Colleague Letter: Addressing the Needs of Children with Disabilities and IDEA's Discipline Provisions; (2) Questions and Answers: Addressing the Needs of Children with Disabilities and IDEA's Discipline Provisions; and (3) Stakeholders' Guide: Positive, Proactive Approaches to Supporting Children with Disabilities. This guidance describes the Department's concerns about the disparities in the use of aversive practices such as restraint and seclusion, and in student disciplinary practices such as suspensions and expulsions, in K–12 schools and early childhood settings for children with disabilities, particularly Black children with disabilities. It reminds SEAs and LEAs of their obligations under IDEA and urges them to examine existing policies, practices, and procedures to unpack the causes of discipline disparities. It also provides SEAs, LEAs, and educators resources to fulfill their obligations, to implement evidence-based, proactive practices to meet the needs of children with disabilities and prevent the need for exclusionary discipline.

Question. Additionally, has the Department considered collecting data on threat assessment practices to provide a better understanding of a practice that some research and advocates have indicated has a disproportionate impact on students of color and students with disabilities?

Answer. As discussed in Supporting Students with Disabilities and Avoiding the Discriminatory Use of Student Discipline under Section 504 of the Rehabilitation Act of 1973, under Section 504, “schools must avoid any disability discrimination in their use of threat or risk assessments, such as unnecessarily treating students with disabilities differently from other students, and must safeguard a student with a disability’s [rights to a free appropriate public education] throughout any threat or risk assessment process.” Similarly, the recently released guidance from OSERS describes how LEAs must continue to comply with IDEA and states that “the procedural safeguards and right to FAPE for a child with a disability must be protected throughout any threat or risk assessment process, including the provision of services during any removals beyond 10 cumulative school days in a school year.” Further, it clarifies that “States and LEAs should ensure that school personnel involved in screening for, and conducting, threat or risk assessments of children with disabilities are aware that the child has a disability and are sufficiently knowledgeable about the LEA’s obligation to ensure FAPE to the child, including IDEA’s discipline provisions. Where appropriate, the LEA can ensure that the school personnel conducting the threat or risk assessment have access to, and are coordinating with, the child’s IEP Team.”

With respect to the collection of data, OCR in December 2021 submitted to the Federal Register a proposed survey for the 2021–22 CRDC, and is reviewing comments submitted during the 60-day public comment period that ended February 11, 2022. In the coming months, OCR plans to announce the second, and final, 30-day public comment period and welcomes input on the collection of information related to threat-assessment practices.

Question. Research shows that funding matters. Increased school spending leads to increases in graduation rates, higher wages, and reduction in adult poverty, especially for students from low-income families. However, data shows that school districts serving the largest populations of Black, Latino, or Native students receive 13 percent less per student in state and local funding than those serving the fewest students of color. For a school district with 5,000 students, this gap equals a shortage of \$9 million per year.

How does the President’s fiscal year 2023 budget proposal encourage states to begin to address the inequitable state and local funding systems that perpetuate these gaps, and what else is the Department doing to remedy these inequities?

Answer. President Biden is keenly aware of the longstanding and unacceptable inequities in State and local education funding that led to significant gaps in academic, career, and life outcomes for students of color. This is why his fiscal year 2023 request for Title I Grants to Local Educational Agencies included a \$20 billion increase specifically intended to close gaps in funding that undermine the ability of our public education system to prepare all students to succeed, regardless of their zip code, family's income, race, ethnicity, or disability. In addition, our request would make available up to \$100 million to support comprehensive reviews of school finance systems by paying the costs of (1) voluntary State school funding equity commissions and (2) voluntary local educational agency equity reviews.

Voluntary State equity commissions could carry out activities such as identification of funding and educational opportunity gaps based on measures of equity and adequacy; development of action plans to address existing gaps, including new formulas and a plan to transition to a new formula; and public reporting on the State's progress in addressing school funding inequities. Local educational agency equity reviews would involve similar analyses of educational opportunity and funding gaps, as well as efforts to more equitably, adequately, and effectively target existing Federal, State, and local resources to meet student needs.

The 2023 request also would help address inequitable State and local funding through development of a P-12 equity data dashboard at the Department (see description of request in the Program Administration account). The dashboard would aggregate existing information about factors affecting P-12 educational opportunity and equity—including school-level data on resources (including per-pupil expenditures), school environmental factors, opportunities to engage in high-quality learning, access to well-rounded coursework, entry into college and career pathways, and access to most prepared and effective school staff—and make such data readily available to the public. The Administration believes that such transparency would increase meaningful engagement in education by diverse stakeholders, including parents, and promote informed State and local decisionmaking that can help eliminate inequities in our P-12 education systems.

Question. Research has demonstrated that Black and Latino students across the country experience inequitable access to advanced coursework opportunities, despite the fact that they are successful in these courses when given the opportunity. Not only are these students locked out of these opportunities at an early age by being denied access to gifted and talented programs, but they also face numerous systemic barriers, including funding inequities and educator bias, which prevent them from participating in advanced courses in secondary school, including Advanced Placement, International Baccalaureate, and dual enrollment courses. For example, a recent study found that despite roughly 2 in 5 Black and Latino students stating that they really enjoy STEM courses and aspire to go to college, less than 3 percent are enrolling in AP STEM courses. As a result, these students are missing out on critical opportunities that can set them up for success in college and future careers.

Please identify budget proposals that would support advanced coursework opportunities for students, particularly students of color and students from low-income backgrounds, and the actions the Department can take to help overcome the systemic barriers preventing these students from participating and succeeding in these courses.

Answer. The Administration strongly supports efforts to close persistent gaps in student preparation for, access to, and success in advanced coursework. To this end, the President's Budget dramatically increases funding under Title I Grants to LEAs that high-poverty schools can use to increase student participation in advanced courses and provide the supports needed to succeed, including foundational content and qualified educators. In addition, school districts can use funds for this purpose under Title IV-A Student Support and Academic Enrichment Grants. Finally, the Department stands ready to provide technical assistance to States and school districts that seek to examine the causes of inequitable access to rigorous coursework and develop plans to eliminate systemic barriers to student success.

Question. As students have returned to the classroom, however, it has become increasingly clear that more must be done by our schools to help address the significant mental and emotional toll the pandemic has had on our nation's students. Programs designed to address a student's social, emotional, and academic development can have a transformational impact in helping to address these challenges facing students. Furthermore, these programs can help to equip educators with the skills and resources necessary to better address the complex and evolving needs of their students. That is why Congress continued to robustly support social emotional learning initiatives and other whole child approaches in recent appropriations bills, including the Education Innovation and Research program, Supporting Effective Educator Development program, Full-Service Community Schools, and more.

Please describe how increased investments in social emotional learning initiatives and other related efforts can help to better equip educators with the skills and resources necessary to address student needs, and how might the Department help support these programs and other efforts to create a positive and healthy school climate and culture?

Answer. The Bipartisan Safer Communities Act provides the Department with an additional \$1.5 billion in funding to help schools put in place comprehensive strategies to create safe and healthy learning environments for all students and expand the number of qualified mental health service providers in schools.

Given the critical role that SEL and school safety play in students' overall well-being and academic experiences, the Department also administers the following programs designed to help support the mental health, social, emotional, and behavioral well-being of children and students:

- Project Prevent Grant Program (<https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/project-prevent-grant-program>), which provides grants to school districts to increase their capacity to help schools in communities with pervasive violence better address the needs of affected students and break the cycle of violence.
- Trauma Recovery Demonstration Grant Program (<https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/trauma-recovery-demonstration-grant-program>), which supports model programs that enable students from a low-income families who have experienced trauma that negatively affects the educational experience to access the trauma-specific mental-health services from the provider.
- The Mental Health Service Professional Demonstration Grant Program (<https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/mental-health-service-professional-demonstration-grant-program>), which provides competitive grants to support and demonstrate innovative partnerships to train school-based mental health service providers for employment in schools.
- The School-Based Mental Health Services Grants Program (<https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/school-based-mental-health-services-grant-program>), grant which provides competitive grants to SEAs to increase the number of qualified mental health service providers that provide school-based mental health services to students in local educational agencies; and
- School Emergency Response to Violence (Project SERV) (<https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/project-serv-school-emergency-response-to-violence>), which funds short-term education-related services for school districts and institutions of higher education to help them recover from violent or traumatic events.

In addition to these programs, the Department supports technical assistance centers that provide information, training, and other valuable resources to schools and communities address mental health and trauma, including:

- Center to Improve Social and Emotional Learning and School Safety (<https://selcenter.wested.org>), which provides technical assistance in the implementation of social and emotional learning evidence-based programs and practices;
- National Center on Safe and Supportive Learning Environments (<https://safesupportivelearning.ed.gov>), which supports efforts aimed at creating and nurturing safe and supportive learning environments;
- Center on Positive Behavioral Interventions and Supports (<https://www.pbis.org>), which helps States, districts, and schools to increase their capacity for implementing a multi-tiered approach to social, emotional and behavioral supports; and
- Readiness and Emergency Management for Schools (REMS) Technical Assistance (TA) Center (<https://rems.ed.gov>), which helps State and local educational agencies, with their community partners, manage safety, security, and emergency management programs;

In the Education Innovation and Research (EIR) discretionary grant program, social emotional learning (SEL) has been an explicit competition priority since fiscal year 2020. The fiscal year 2022 EIR competitions invited SEL projects in a wide variety of topics such as educator capacity to support SEL; multi-tiered systems of supports, including trauma-informed practices; and equitable access to social workers, psychologists, counselors, nurses, or mental health professionals; project-based learning to strengthen metacognitive, self-direction, self-efficacy, etc. fiscal year 2022 applications have closed and awards will be made by December 2022. In fiscal year 2021, EIR funded 14 SEL projects; in fiscal year 2020, EIR funded 10 SEL projects. The program office has various ongoing technical assistance efforts devoted

to support grantee implementation of SEL projects and disseminate key learnings to the field (including a white paper and webinar).

Question. Students in foster care face enormous obstacles to accessing and succeeding in school, including frequent home and school changes, missing credits, unreliable access to appropriate support services, confusion over education decision-making authority, and inconsistent access to special education services. These students have higher rates of absenteeism than their peers; lower test scores on standardized tests; and are three times more likely drop out of school. New requirements included in The Every Student Succeeds Act require state education agencies to ensure students in foster care remain in their school of origin unless it is not in their best interest and to collaborate with child welfare agencies on plans for providing cost-effective transportation for students to remain so enrolled, among other requirements.

How can existing Federal funds in the Department of Education and Department of Health and Human Services be used to strengthen partnerships between State and local education and child welfare agencies necessary to support educational stability and improve education outcomes of children in foster care?

Answer. Title I, Part A of the Elementary and Secondary Education Act of 1965 (ESEA), as amended by The Every Student Succeeds Act, includes requirements designed to enhance the educational stability of students in foster care. Collaboration between educational agencies and child welfare agencies is essential to the effective implementation of these requirements, and the ESEA requires such collaboration at the State level. Two staff members in the Office of Elementary and Secondary Education (OESE) support the implementation of these educational stability requirements. OESE staff members work closely with State educational agencies (SEAs), Federal staff from the U.S. Department of Health and Human Services' Administration on Children and Families, and non-Federal partners to encourage interagency collaboration through various technical assistance initiatives. Further, the Department has not received dedicated funds, such as national activity funds under Title I, specifically dedicated to the implementation of the educational stability provisions, staff have formed partnerships with a number of other Department offices to provide technical assistance.

For example, the Department's National Comprehensive Center has dedicated a small portion of its available resources to fund an online, collaborative space for SEA foster care points of contact, known as the Foster Care Exchange. Through the Foster Care Exchange, SEA foster care points of contact can collaborate asynchronously with one another by sharing resources, engaging in peer-to-peer learning, and creating a network of practitioners. The Foster Care Exchange is a password-protected space that is currently only available to SEA foster care points of contact; the Department intends to make a future iteration of the platform available to State child welfare agency points of contact.

Additionally, staff in OESE have partnered with the Department's Office of the Chief Data Officer (OCDO) to fund a study on interagency data-sharing agreements between SEAs and State child welfare agencies. This study, which will be completed in fall 2022, examines the prevalence and impact of State-level exchanges of data related to students in foster care. The Department will produce a series of State profiles demonstrating how States of different sizes and resources can establish their own data exchanges to improve educational outcomes for students in foster care. The Department will use these profiles as a key technical assistance tool to encourage States to establish (or improve) data exchanges between SEAs and State child welfare agencies.

Finally, OESE staff frequently present on webinars and at conferences about the importance of interagency collaboration to effectively support students in foster care. For example, the Department hosted a webinar in March 2022 that shared preliminary findings from its study on interagency data-sharing agreements (see above). The Department will also present three sessions, specifically focused on the needs of students in foster care, at the National Association for the Education of Homeless Children and Youth's (NAEHCY's) annual national conference in fall 2022. (These conference sessions will focus on an overview of the Title I, Part A educational stability provisions, interagency data-sharing agreements, and best interest determinations.) To model interagency collaboration, the Department has requested that its partners from the U.S. Department of Health and Human Services co-present the sessions at the NAEHCY conference. The Department will also present a session at the National Association of ESEA State Program Administrators' (NAESPA's) annual national conference in February 2023; this presentation will focus on the importance of interagency partnerships to improve outcomes students in foster care.

Question. How would additional funds further such partnerships?

Answer. While the Department has been able to provide technical assistance to grantees to support implementation of the Title I, Part A educational stability provisions, OESE's capacity to provide such technical assistance is limited. As mentioned, two staff members support the implementation of these requirements; however, both staff members split their time across other Federal programs and, thus, have limited bandwidth to focus on OESE's activities related to the foster care provisions. Further, while program staff have established important partnerships with internal and external stakeholders to provide technical assistance to grantees, the absence of a technical assistance center—dedicated solely to supporting the implementation of the Title I, Part A educational stability provisions and enhancing outcomes for students in foster care—limits the breadth and frequency of OESE's technical assistance offerings.

Additional funding that would establish a technical assistance center to support the implementation of the Title I, Part A educational stability provisions would allow OESE to more consistently and strategically provide technical assistance to grantees. The establishment of a technical assistance center would further stretch our internal capacity unless the Department also had additional funding to increase staff capacity for the foster care program. With these additional technical assistance resources and the extra staff capacity, OESE would be better positioned to continue and expand its collaborative efforts with its partners at the U.S. Department of Health and Human Services and other non-Federal partners.

Question. How will you and the Secretary of Health and Human Services collaborate on supporting implementation of requirements related to remaining in school of origin; making best interest determinations; and planning for transportation needed to remain in school of origin, among other requirements intended to improve education for children in foster care?

Answer. OESE staff regularly collaborate with partners at the U.S. Department of Health and Human Services to share information, to design and provide technical assistance to their respective grantees, and to coordinate messaging to practitioners and other stakeholders. For example, in July 2022 senior leaders from OESE and the Children's Bureau jointly authored a blog on the importance of interagency collaboration to support students in foster care, and the blog was posted simultaneously on the Department's Homeroom Blog and the Department of Health and Human Services' Family Room Blog. As mentioned previously, staff from both agencies will continue to co-facilitate presentations at national conferences to discuss the effective implementation of the ESEA provisions related to the educational stability of students in foster care. (OESE staff have also presented on webinars sponsored by the Children's Bureau about the implementation of the Fostering Connections to Success and Increasing Adoptions Act of 2008, and the Department will continue to support its partners at the Department of Health and Human Services in this way.)

Staff from both agencies meet regularly to share information and discuss opportunities for additional collaboration. For the next fiscal year, staff hope to undertake several joint projects, including an update to the jointly published non-regulatory guidance (published in June 2016) and the development of a technical assistance toolkit to support the creation and maintenance of interagency data-sharing agreements between State and local educational agencies and child welfare agencies.

Question. Please share the Department's plans in fiscal year 2023 and fiscal year 2024 for supporting, enhancing and monitoring resource allocation reviews by state and local education agencies and schools.

Answer. In spring and summer 2022, the Department is conducting a targeted monitoring review of two resource equity provisions: 1) ESEA section 1111(d)(3)(A)(ii), which requires an SEA to periodically review resource allocation to support school improvement in each LEA in the State serving a significant number of schools identified for support and improvement; and 2) ESEA section 1111(d)(1)(B), which requires each comprehensive support and improvement and additional targeted support and improvement plan to identify the resource inequities to be addressed in the plan. After the conclusion of those reviews, the Department intends to share best practices, findings, and recommendations more broadly with all States and determine how to further conduct oversight of these important requirements in fiscal year 2023.

In addition to targeted monitoring, all resource equity provisions in Title I, Part A are included as part of the Department's consolidated monitoring, which is the Office of Elementary and Secondary Education's in-depth monitoring protocol that covers several formula grant programs and over-arching, cross-program fiscal requirements. The Department is currently finalizing its plans regarding the number of States that will participate in consolidated monitoring in fiscal year 2023.

Question. Please describe the Department's plan for ensuring states and school districts comply with ESSA's policy requiring the reporting of actual personnel and

non-personnel 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 is taking several steps to ensure that SEAs and LEAs meet the report card requirements in ESEA section 1111(h). 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>).

To help ensure SEAs and LEAs comply with applicable requirements, 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, for the past 3 years, the Department has conducted a review of each State's website to determine if SEAs and LEAs were in compliance with report card requirements, looking at a subset of the requirements each year. This work begins in January to review the report cards for the prior school year. This year, the Department reviewed State websites to look for disaggregated performance and participation rate data on State assessments, per-pupil expenditures, chronic absenteeism, and (to the extent available) information on access to technology consistent with the assurance as part of the waiver of accountability and school identification for the 2020–2021 school year that most States received.

Based on our review this year, 50 States had posted per pupil expenditure data from at least one of the two prior fiscal years. As part of its annual review, the Department looked for actual personnel and non-personnel expenditures, as well as disaggregation by Federal and State and local funds. The Department followed up with any State that did not meet these requirements and intends to send letters to States that have not posted the required information this summer.

The Department is also providing on-going technical assistance to States to help them improve the collection, reporting, and use of these data. We have established communities of practice with States, districts, and other stakeholders to discuss these requirements. We ran a competition for interested individuals to partner with States to design interactive report card websites and to report per-pupil expenditure data. Through the Department's National Comprehensive Center, we have funded external experts to provide tools and resources for States and districts to support the reporting and use of expenditure data.

Question. How many competitive grant programs will include an evidence priority in fiscal years 2022 and 2023? Please describe the ways in which the Department is supporting or plans to support evidence building and use in ESEA formula grant programs.

Answer. Evidence Use in Fiscal Year 2022 Competitions.—The Department uses evidence in many of its grant competitions, either as “entry evidence,” which involves elements in the application to align projects with a particular threshold, or “exit evidence,” which is defined as elements to develop lessons learned from the review of the program interventions.

For fiscal year 2022, the Department is running 72 discretionary grant competitions. 47 competitions include entry evidence requirements or priorities, and 11 competitions involve exit evidence. For a more detailed breakdown of these requirements, please see the table, below:

	Entry	Exit
Total	47	11
Demonstrates a Rationale	36	-
Promising Evidence	6	5
Moderate Evidence	3	3
Strong Evidence	1	3
Logic Model	1	-

The Department continues to support grantees in building and using evidence through ESEA formula grant programs. For example, the Department prioritized the use of evidence-based interventions in Frequently Asked Questions released in February 2022 about implementing school accountability systems, given the impact of COVID–19. The Department also supports evidence building and use through the Comprehensive Center program, which operates 20 Comprehensive Centers, including 1 National Center and 19 Regional Centers. The Comprehensive Centers provide

high-quality universal and targeted capacity-building services, including in the area of implementing and scaling evidence-based practices, to State educational agencies (SEAs), regional educational agencies (REAs), local educational agencies (LEAs), and schools to improve educational outcomes for all students, close achievement gaps, and improve the quality of instruction. In addition, the Comprehensive Centers Network and other technical assistance providers identify evidence-based interventions that support states and school districts in using evidence in the work supported by their ESEA formula grants. In addition, the Institute of Education Sciences (IES) administers the Regional Educational Laboratories program, which supports ten Regional Educational Laboratories (RELs) that collaborate with school districts, state departments of education, and other education stakeholders to help these stakeholders translate and apply evidence, with the goal of improving learner outcomes.

Question. In the fiscal year 2023 congressional justification, the Department indicated “The Department also continues to advance its data strategy to realize the full potential of data to improve education outcomes and lead the nation in a new era of evidence-based policy insights and data-driven operations.”

Please describe the key activities the Department has taken and planned to advance this strategy. How will the Department work with other Federal agencies to advance the strategy?

Answer. The Department of Education’s Data Strategy—published December 2020 and found online here—documents the agency’s vision along with specific goals and objectives planned for calendar years 2021 and 2022. As of July 2022, the agency has already achieved 12 of its 19 objectives. These accomplishments include improving data maturity scores in 93 percent of principal offices; establishing a Data Coordinators Council and Data Professionals Community of Practice; creating Federal Government’s first data literacy program to improve basic data skills of all staff; launching the agency’s Data Science Training Program to upskill 41 existing data staff; conducting an internal three-day training conference attended by 400 agency staff to improve data visualization skills; and a data workforce plan to guide the agency’s human capital efforts as it relates to data-related positions.

In that time, the program management office overseeing the Data Strategy (the Office of the Chief Data Officer) also oversaw the development, launch, and maintenance of emergency and other major data solutions. This includes overseeing the Department’s emergency data collections associated with the Education Stabilization Fund (HEER, GEER, ESSER, and OA equivalents), the ESF Public Transparency Portal (Education Stabilization Fund), and the College Scorecard (College Scorecard | College Scorecard (ed.gov), among others.

By calendar year-end, the Department also plans to release a Data Quality Playbook to help grant managers reduce grantee burden and improve data quality; provide recommendations to agency leadership for a Data Investment Management process to improve the agency’s return on data investments; launch the agency’s first truly enterprise-wide data repository and analytics platform to bridge siloed data assets; publish an Open Data Plan informed by public input on how and what the agency will prioritize to make its data more accessible; and launch a process for external stakeholders to access non-public microdata for research purposes.

By December of 2022, the Department plans to publish a refreshed Data Strategy to guide its efforts in forthcoming years. Many of the planned initiatives—already in development with other agencies with similar customers—focus on enhancing collaboration, reducing cost, and improving products across Federal agencies. This will include streamlining the administrative processes for data sharing; developing solutions to share content and services related to internal workforce development programs already developed by ED such as its Data Science Training Program; and developing shared public-facing data products key life experiences that cut across Federal agencies, its programs, and its data.

Question. Please describe the state-identified challenges the Department seeks to address through the proposed 2 percent technical assistance and capacity building set-aside for English Acquisition State grants.

Answer. The Title III, Part A formula grant program continues to receive feedback from our state grantees that more technical assistance is needed to support the use of evidence-based practices and to build State and local capacity to implement their formula grant funds. In reviewing the Grantee Satisfaction Results for the Title III, Part A program, questions about satisfaction with ED’s technical assistance, products, and services have received marks that are below those of programs with established Technical Assistance centers.

There are many factors that make the Title III, Part A formula program particularly challenging for States to implement, including the crossover with Civil Rights requirements that must be implemented irrespective of the availability of these

funds and the prohibition on using Title III, Part A formula grant funds to supplant not only State and local funds, but also other Federal funds. Furthermore, the data reporting requirements for this program are among the most complex across the Office of Elementary and Secondary Education's (OESE's) formula grant data collections. Due to these challenges, States and districts may hesitate to explore more innovative and evidence-based uses of these funds to meet the needs of English learners, defaulting to a limited suite of activities that have not raised concerns in past monitoring reviews and outreach from ED.

Staff capacity in the Title III, Part A formula program has increased slightly in the past year but still falls well below what is necessary to provide proactive technical assistance to our grantees in order to clarify the requirements of the grant and highlight evidence-based practices that could potentially be allowable uses of funds. The National Clearinghouse for English Language Acquisition and Language Instruction Educational Program (NCELA) disseminates important information on practices for English learners to the field, but the statute limits its funding to \$2 million and its work to targeted areas, primarily dissemination of information. For these reasons and more, ED is looking to use this set-aside to provide more timely and tailored technical assistance for the Title III, Part A formula grant program as well as create opportunities for State grantees to collaborate with each other to learn about and share evidence-based practices.

Question. How would the proposal to focus \$320 million within the Education Innovation and Research program on improving educator recruitment and retention be designed to ensure projects address the disproportionate numbers of low-income students and students of color being taught by less experienced and effective teachers?

Answer. The Department recognizes that shortages of certified and experienced educators disproportionately affect low-income students and students of color. To address these disparities, which the pandemic has exacerbated, the Department could give priority for funds under the requested \$320 million to applicants that propose to develop and implement innovative educator recruitment and retention strategies in areas with concentrations of these students.

Question. A recent review of states' report cards showed that states largely failed to provide context for how schools are supporting students during recovery and, if data is not available, explain why. Public-facing report cards have been a requirement for states for 20 years since the passage of No Child Left Behind. When ESEA was reauthorized in 2015, the Every Student Succeeds Act required states to include additional student groups in their report cards. This year, 28 states disaggregated achievement data by all federally required student groups—an increase of three from 2019. However, while nine states added this information to their report cards, six states removed it. Of the 43 states that had already published 2021 report cards: 16 states did not include 2021 assessment data; 25 states did not include 2021 high school graduation rates; 26 states did not include 2020–21 chronic absenteeism data. Of the 25 states that included some form of translation, only 7 states had translations that were considered high quality.

Please describe the Department's work to monitor states' implementation of the annual public report card requirement under ESEA as well as the additional technical assistance and support the Department will provide to ensure every state is meeting all of the report card requirements specified in ESEA, including disaggregation requirements and also providing this information to the public in an accessible, understandable, and up-to-date format?

Answer. The Department is taking several steps to ensure that SEAs and LEAs meet the report card requirements in ESEA section 1111(h). 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>).

To help ensure SEAs and LEAs comply with applicable requirements, 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, for the past 3 years, the Department has conducted a review of each State's website to determine if States and districts were in compliance with report card requirements, looking at a subset of the requirements each year. This work begins in January to review the report cards for the prior school year. This year, the Department reviewed State websites to look for disaggregated performance and participation rate data on State assessments, per-pupil expenditures, chronic absentee-

ism, and (to the extent available) information on access to technology consistent with the assurance as part of the waiver of accountability and school identification for the 2020–2021 school year that most States received.

We believe the information provided in this question is based on a report from the Data Quality Campaign that is based on a review of data in February 2022. While accurate at the time, it is no longer accurate. All States have posted disaggregated achievement data, though in some cases, the data was posted significantly later than in prior years, likely due to fall administration of assessments from the 2020–2021 school year and challenges related to COVID–19. Of those, 41 States (of 50 required to post assessment data for that year) posted assessment data for all subgroups, including the new subgroups that are required under the ESEA, as amended by ESSA.

Regarding chronic absenteeism, this information is typically not required to be on State and local report cards, though it was a condition of the accountability waivers that were provided to most States for the 2020–2021 school year. Based on our review of State websites, 46 States posted disaggregated chronic absenteeism or attendance data and one State posted attendance data for all students but not disaggregated.

Following the Department’s initial review of selected requirements in January 2021, the Department has followed up with each State regarding the status of its report card and any missing requirements. The Department intends to send letters to each State that is still missing any required element from our 2020–2021 report card review this summer.

Question. The Biden Administration required states to resume the ESEA requirement to annually assess students in mathematics and English/language arts for the 2020–2021 school year and to maintain all state and local report card requirements, including the requirements to publish disaggregated data by student subgroup. However, according to recent analysis, only seventeen states published both disaggregated data and complete participation information for the 2020–21 school year assessments, meaning thirty-four states (including D.C.) did not provide the federally required data on student performance in each grade and participation information across student groups. Seven states only published overall proficiency data, and three states did not publicly release any performance data.

Please describe the steps the Department is taking to ensure states that remain in non-compliance do expeditiously comply with these requirements from the 2020–21 school year. In addition, please describe the steps you are taking to support states in meeting these requirements in a timely manner for the 2021–22 school year.

Answer. We believe the information provided in this question is based on a report from the Data Quality Campaign that is based on a review of data in February 2022. While accurate at the time, it is no longer accurate. Each year since the implementation of ESSA, the Department has conducted a review of State and local report cards. Beginning in January each year and continuing throughout the spring, the Department conducts reviews of select report card requirements. This year, the review focused on whether the State had reported disaggregated participation and performance data on State assessments, chronic absenteeism data, and per-pupil expenditure data. Following the Department’s initial review of selected requirements in January 2022, the Department contacted each State regarding the status of its report card and any missing requirements and has conducted follow up with each State. Every State has published disaggregated assessment data, though a small number have not published data for all required student subgroups. The Department has continued to follow up with each State. Most recently, we sent a letter in August to the 11 States that are still missing any required element from our 2020–2021 report card review. The State is required to respond demonstrating within 30 days that the issue has been resolved and, once the 2021–2022 report cards are published this fall or winter, to provide documentation that the State report card includes information currently missing on the 2020–2021 report cards. The Department will once again review State and local report cards in January 2022 for the 2021–2022 school year.

Question. When Congress reauthorized the Elementary and Secondary Education Act in 2015, Congress included multiple provisions to help alleviate the burden of standardized testing on states and school districts. For example, ESEA includes provisions that allow states to administer the statewide assessment in multiple statewide interim assessments during the course of a school year, so long as these interim assessments aggregate into a summative score. The law also permits states to use assessments that include portfolios and extended performance tasks. ESEA also allows for states to utilize computer adaptive assessments that meet certain Federal guardrails. ESEA also provided authority for states to conduct audits of

state and local assessment systems to reduce duplicative and unnecessary assessments. Congress also authorized the Innovative Assessment Demonstration Authority (IADA), with key civil rights and equity guardrails to provide states with the authority to innovate in the assessment space. Finally, Congress reauthorized funding for assessment design including competitive grants for states and districts to improve their assessment systems. To date, it does not appear many states have utilized many of these flexibilities and authorities, despite calls for even more flexibility in assessments. Please answer the following:

How many states are utilizing through course assessments in their statewide assessment systems?

Answer. The Department does not annually collect information from every State regarding this fine-grained detail on assessment designs. We know that some States have either begun to implement assessments that could be described as “through course” or “through year” assessments (e.g., Nebraska, Maine—though both currently administer the assessments at multiple points during the year but use only the final administration as the summative score for the student). We know Florida, and perhaps others, are planning to implement a through course design. Two States (Georgia, Louisiana) are piloting similar designs through the Innovative Assessment Demonstration Authority (IADA).

Question. How many states are using computer adaptive assessments in their statewide assessment systems?

Answer. As noted above, the Department currently does not annually collect information from every State regarding this fine-grained detail on assessment designs, so our information is incomplete. We know that at least 14 States are using a common assessment (Smarter Balanced) that is a computer adaptive test. There are several other States that have their own tests in reading/language arts and mathematics (e.g., Michigan, Kansas) that are based on an adaptive design.

We also know that at least 21 States are using a computer adaptive test for alternate assessments of alternate academic achievement standards (AA-AAAS) for students with the most significant cognitive disabilities (Dynamic Learning Maps). More than 40 States use the WIDA Access English language proficiency assessment for English Learners, which has adaptive components to it.

Question. How many states are utilizing portfolios and extended performance tasks in their statewide assessments as allowed under the law?

Answer. Again, the Department currently does not annually collect information from every State regarding this fine-grained detail on assessment designs, so our information is incomplete. The Department knows of two States (Massachusetts, Florida) using portfolios as part of their AA-AAAS. Massachusetts is piloting the development of extended performance tasks in science as part of its IADA plan, which was approved in 2020. New Hampshire was piloting a system of locally based extended performance tasks from 2015–19 under a series of waivers and then IADA, for which it was approved in 2018. New Hampshire withdrew from IADA in the 2021–22 school year (see <https://oese.ed.gov/files/2022/04/NHIADAWithdrawal3.9.2022.pdf>) citing, in part, the significant administrative burden on educators and school leaders that detracted from instructional time, the cost to implement, and because the pilot assessments fell short of expectations for assessment quality.

Question. How many states have conducted audits of the assessment systems and as a result of those audits, made changes to their state and local assessment systems?

Answer. States are not required to provide information to the Department regarding assessment system audits. The Department is unaware of any State that has recently conducted an assessment audit. Conducting assessment audits is a permitted activity under Section 1203 of the ESEA.

Question. Please provide an update on implementation of the IADA and any plans to make recommendations for changes to that program.

Answer. In 2018, two States (New Hampshire and Louisiana) were approved for IADA. In 2019, Georgia and North Carolina were approved. In 2020, Massachusetts received IADA. In 2021, no States applied to a Notice Inviting Applications (NIA) for IADA. During the Covid pandemic, the States were unable to administer their IADA proposals for the 2019–2020 and 2020–2021 school years. As noted above, this past year New Hampshire notified the Department that it would no longer be implementing its IADA proposal.

In addition to the States that have IADA, Hawaii was awarded a Competitive Grant for State Assessments (CGSA) in 2020 to support planning for a future IADA application. The Institute for Education Sciences is working to complete a report for Congress on the initial implementation of the IADA, which will inform future decisions regarding IADA.

Question. Please provide an update on how the Department is using the funding Congress provided for assessment development in last year's bill to encourage states to improve their statewide assessments to provide more timely and relevant data to educators and stakeholders.

Answer. On February 16, 2022, the Department released a Notice Inviting Applications (see <https://www.Federalregister.gov/documents/2022/02/16/2022-03290/applications-for-new-awards-competitive-grants-for-state-assessments-program>) to award grants to States for the purpose of improving Statewide assessments. The NIA included the two priorities established by Congress for the use of these funds: (1) the use of multiple measures, and (2) the development of comprehensive academic instruments based upon a competency based educational model. The NIA also included a competitive priority that incentivized projects to improve the reporting of timely and relevant data to educators and stakeholders. The Department combined the \$20.9 million appropriated by Congress for fiscal year 2022 with \$8.8 million set aside from fiscal year 2021 to fund worthy projects. In May 2022, 16 States submitted applications. The Department conducted a peer review of the applications and we anticipate announcing awards for these funds by September 2022.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

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. Last month, the Department provided widespread relief to Corinthian Colleges students through group borrower defense discharge. This relief totaled \$5.8 billion for 560,000 borrowers—regardless of whether they submitted a borrower defense application—and represents the largest single loan discharge in the history of the Department. I applaud the Department for taking steps to offer group borrower defense discharge to students, including former Corinthian Colleges and Marinello Schools of Beauty students. These students were misled by unscrupulous for-profit colleges, and they are not the only students who are crippled with student loan debt and a worthless degree. Since the closure of Corinthian, I have urged the Department to ensure that students are not left holding the bag, and I have supported group borrower defense discharge early on for students who have been defrauded by for-profit colleges. For example, I recently sent a follow up letter to the Department urging it to provide group discharge for former Illinois Westwood College students who were enrolled in the criminal justice program. Please provide, disaggregated for ITT Educational Services, Inc., Charlotte School of Law, Education Corporation of America, Vatterott Colleges, and Dream Center Education Holdings, respectively:

The number of borrower defense applications that have been received, approved, denied, ineligible, and closed;

Answer. The requested data is provided in the below chart.

School/Ownership Group	Approved	Denied (Ineligible)	Closed	Pending	Total Received
Charlotte School of Law	0	0	<50	1,300	1,300
ECA	0	2,100	100	6,800	9,000
Dream Center	0	2,000	100	7,200	9,300
ITT Technical Institute	22,700	6,600	1,000	16,300	46,600
Vatterott College	0	500	<50	1,000	1,600

Cases pulled using the fields School Owner or Primary School from the Customer Engagement Management System in July 2022 (except ECA, which was based on a list of OPE IDs).

Data has been rounded to the nearest 100 cases, and small cell sizes have been redacted. Due to rounding, totals may not sum as expected.

Data was retrieved from Customer Engagement Management System in July 2022.

Question. The total loan amount of such borrowers for whom the Department estimates are eligible for group borrower defense discharge;

Answer. None of these school ownership groups have been identified for group borrower defense discharge.

Question. The number of borrowers and the total loan amount that has been discharged through a borrower submitting a borrower defense application;

Answer. 15,500 ITT borrowers with an approved borrower defense application have received approximately \$371 million in loan discharges directly associated with an ITT loan. An additional 4,500 ITT borrowers have received approximately \$120 million in loan discharges associated with a consolidation loan.

Question. And the number of borrowers and the total loan amount that has been discharged through group borrower defense discharge.

Answer. None of these school ownership groups have been identified for group borrower defense discharge.

Question. Since June 2018, the Department has released borrower defense data on a quarterly basis:

Please provide the reason that no data has been released for 2022.

Answer. Borrower defense data through June 30, 2022 is currently available on FSA's Data Center at studentaid.gov/data-center/student/loan-forgiveness/borrower-defense-data.

Question. Please provide a breakdown of "total denied" borrower defense claims to date by institution.

Answer. An Excel file providing the requested data as of mid-May 2022 is enclosed.

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.

OPEID	School Name	Rounded Ineligible Case Count
020988	UNIVERSITY OF PHOENIX	20080
010727	DEVRY UNIVERSITY	7400
001499	ALTIERUS CAREER COLLEGE	4720
004586	PURDUE UNIVERSITY GLOBAL	4070
030106	VIRGINIA COLLEGE	2120
007234	HEALD COLLEGE	2070
007329	ITT TECHNICAL INSTITUTE	1910
001881	ASHFORD UNIVERSITY	1450
009157	WYOTEC	1430
021136	AMERICAN INTERCONTINENTAL UNIVERSITY	1420
001534	Everest University	1410
011858	EVEREST COLLEGE	1390
023001	ALTIERUS CAREER COLLEGE	1350
010148	COLORADO TECHNICAL UNIVERSITY	1330
009079	EVEREST COLLEGE	1310
009828	ALTIERUS CAREER EDUCATION	1260
021799	ARGOSY UNIVERSITY	1110
030314	SANFORD-BROWN COLLEGE	1000
008090	EVEREST COLLEGE	960
021160	SANFORD-BROWN COLLEGE	910
020754	Keller Graduate School of Management	900
007470	ART INSTITUTE OF PITTSBURGH (THE)	870
008532	Heald College	830
021004	EVEREST INSTITUTE	830
004646	MINNESOTA SCHOOL OF BUSINESS	760
004503	ALTIERUS CAREER COLLEGE	760
022613	ALTIERUS CAREER COLLEGE	740
026175	ALTIERUS CAREER COLLEGE	680
001123	BROOKS INSTITUTE	660
011109	EVEREST COLLEGE	650
008146	Everest University—Pompano Beach	620
025042	WALDEN UNIVERSITY	610
008093	Heald College	610
025693	LE CORDON BLEU COLLEGE OF CULINARY ARTS	600
007190	WYOTEC	590
022052	SANFORD-BROWN COLLEGE	580
001459	STRAYER UNIVERSITY	580
021875	Heald College	580
025933	Heald College	580
025932	Heald College	570

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
023621	FULL SAIL UNIVERSITY	560
022631	ANTHEM COLLEGE	560
032103	LE CORDON BLEU COLLEGE OF CULINARY ARTS	560
004811	EVEREST INSTITUTE	560
021519	KEISER UNIVERSITY	550
012873	WYOTEC	540
025998	Everest University	540
026167	LE CORDON BLEU COLLEGE OF CULINARY ARTS	530
009267	ALTIERUS CAREER COLLEGE	520
030226	LE CORDON BLEU COLLEGE OF CULINARY ARTS	510
026062	EVEREST COLLEGE	510
030723	EVEREST COLLEGE	510
021603	SANFORD-BROWN COLLEGE	500
010356	EVEREST INSTITUTE	500
004507	ALTIERUS CAREER COLLEGE	480
011123	EVEREST COLLEGE	480
004642	GLOBE UNIVERSITY	470
033953	ICDC COLLEGE	470
032673	CAPELLA UNIVERSITY	470
025931	Heald College	460
022932	ATI CAREER TRAINING CENTER	450
030032	Everest Institute	450
030764	BRYMAN SCHOOL OF ARIZONA (THE)	450
022375	LAS VEGAS COLLEGE	440
022950	EVEREST COLLEGE PHOENIX	440
021218	Everest Institute	430
007236	Art Institute of California—Los Angeles (The)	420
007477	Heald College	410
007531	ACADEMY OF ART UNIVERSITY	400
010195	ART INSTITUTE OF FORT LAUDERDALE (THE)	400
026164	SANFORD-BROWN COLLEGE	400
008350	ART INSTITUTE OF PHILADELPHIA (THE) -	390
025997	VATTEROTT COLLEGE	390
022506	EVEREST COLLEGE	390
030340	Heald College	380
023058	FLORIDA CAREER COLLEGE	360
008221	UNIVERSAL TECHNICAL INSTITUTE	350
005127	Brown Mackie College-Cincinnati	340
010490	REGENCY BEAUTY INSTITUTE	340
007327	ITT Technical Institute	340
009270	ART INSTITUTE OF ATLANTA (THE)	340
025911	CAREER POINT COLLEGE	340
020789	ART INSTITUTE OF COLORADO (THE)	330
011024	BRYMAN COLLEGE	330
012584	ILLINOIS INSTITUTE OF ART (THE)	320
021584	HARRISON COLLEGE	310
008329	ITT Technical Institute	310
030727	WESTWOOD COLLEGE—LOS ANGELES	310
011626	WESTWOOD COLLEGE—SOUTH BAY	300
011510	EVEREST INSTITUTE	300
026110	HERITAGE COLLEGE	290
030068	LE CORDON BLEU INSTITUTE OF CULINARY ARTS	290
022865	ITT Technical Institute	290
007362	MEDTECH COLLEGE	270
013039	SOUTH UNIVERSITY	270
030734	ITT Technical Institute	270
011107	EVEREST COLLEGE	270
009748	CARRINGTON COLLEGE	260
021749	Collins College	260
035493	ULTIMATE MEDICAL ACADEMY	260
038323	DADE MEDICAL COLLEGE	260

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
007548	WESTWOOD COLLEGE—DENVER NORTH	260
022985	EVEREST COLLEGE	260
010627	ITT Technical Institute	250
023598	ITT Technical Institute	250
040513	ART INSTITUTE OF LAS VEGAS (THE)	250
023522	LE CORDON BLEU COLLEGE OF CULINARY ARTS IN CHICAGO	240
033803	STAR CAREER ACADEMY	230
003807	MOUNTAIN STATE UNIVERSITY	220
007351	SANFORD—BROWN COLLEGE	220
007091	EVEREST INSTITUTE	220
002678	BRYANT & STRATTON COLLEGE	200
021005	UNIVERSAL TECHNICAL INSTITUTE	200
023276	Art Institute of California—San Diego	200
025593	UNITED EDUCATION INSTITUTE	200
026142	MILLER—MOTTE TECHNICAL COLLEGE	200
007557	ITT Technical Institute	200
007804	STAR CAREER ACADEMY	190
022913	ART INSTITUTE OF SEATTLE (THE)	190
026150	SANFORD—BROWN COLLEGE	190
004494	EVEREST COLLEGE	190
010248	ART INSTITUTES INTERNATIONAL MINNESOTA (THE)	180
020757	BRIARCLIFFE COLLEGE	180
022023	PITTSBURGH CAREER INSTITUTE	180
004898	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY	170
012461	LINCOLN TECHNICAL INSTITUTE	170
021171	ART INSTITUTE OF HOUSTON (THE)	170
022915	ITT Technical Institute	170
023218	ITT Technical Institute	170
030876	ITT Technical Institute	170
004583	Brown Mackie College-South Bend	160
031151	HERITAGE COLLEGE	160
023217	ITT Technical Institute	160
002667	DOWLING COLLEGE	150
004729	MOUNT WASHINGTON COLLEGE	150
007819	ART INSTITUTE OF PORTLAND (THE)	150
020652	ITT Technical Institute	150
022202	LE CORDON BLEU COLLEGE OF CULINARY ARTS	150
022392	ANTHEM COLLEGE	150
023462	WYOTECH	150
025971	HERITAGE INSTITUTE	150
023610	ITT Technical Institute	150
030875	ITT Technical Institute	150
008694	RASMUSSEN UNIVERSITY	140
009088	ITT Technical Institute	140
023286	ITT Technical Institute	140
025256	ART INSTITUTE OF NEW YORK CITY (THE)	140
030265	REMINGTON COLLEGE	140
030623	WESTECH COLLEGE	140
030704	ITT Technical Institute	140
030846	Art Institute of Las Vegas (The)	140
007486	NEW ENGLAND INSTITUTE OF ART (THE)	140
009837	ITT Technical Institute	140
004992	MILLER—MOTTE TECHNICAL COLLEGE	130
021207	SAN JOAQUIN VALLEY COLLEGE	130
023611	ITT Technical Institute	130
025396	Art Institute of Dallas (The)	130
035343	JONES INTERNATIONAL UNIVERSITY	130
022916	ITT Technical Institute	130
004673	BAKER COLLEGE	120
020655	BROOKS COLLEGE	120
021105	Art Institute of Charlotte (The)	120

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
022171	PIMA MEDICAL INSTITUTE	120
025321	BUSINESS CAREER TRAINING INSTITUTE	120
025889	MEDTECH COLLEGE	120
031623	FOUR-D COLLEGE	120
004553	ITT Technical Institute	120
031954	EVEREST COLLEGE	120
008878	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN	110
009420	SANFORD-BROWN COLLEGE	110
011574	BAUDER COLLEGE	110
011852	ITT Technical Institute	110
020530	LIBERTY UNIVERSITY	110
022159	ATI CAREER TRAINING CENTER	110
023620	UNIVERSAL TECHNICAL INSTITUTE	110
030718	ITT TECHNICAL INSTITUTE	110
001583	MORRIS BROWN COLLEGE	100
002704	COLLEGE OF NEW ROCHELLE (THE)	100
007586	Remington College—Tampa Campus	100
009777	KAPLAN COLLEGE	100
011647	SBI CAMPUS—AN AFFILIATE OF SANFORD-BROWN	100
023219	ITT Technical Institute	100
023329	DeVry Institute of Technology	100
023344	CENTURA COLLEGE	100
001509	NOVA SOUTHEASTERN UNIVERSITY-DAVIE	90
007303	LINCOLN TECHNICAL INSTITUTE	90
008441	ANTHEM INSTITUTE	90
009224	Devry Institute of Technology	90
021006	CARRINGTON COLLEGE	90
021209	ITT Technical Institute	90
022187	Florida Technical College	90
022188	BROOKLINE COLLEGE	90
025594	INTERCOAST COLLEGES	90
026055	Remington College—Mobile Campus	90
026162	Brown Mackie College-Findlay	90
030714	ITT Technical Institute	90
002937	KING'S COLLEGE	80
003076	Miami—Jacobs Career College	80
006755	BROWN MACKIE COLLEGE (THE -)	80
008443	ITT Technical Institute	80
008889	LEHIGH VALLEY COLLEGE	80
010217	International Academy of Design and Technology	80
034264	ANTHEM INSTITUTE	80
002249	DAVENPORT UNIVERSITY	70
002580	SOUTHERN NEW HAMPSHIRE UNIVERSITY	70
008322	DeVry Institute of Technology	70
009228	DeVry College of Technology	70
010913	MADISON MEDIA INSTITUTE	70
012877	SANFORD-BROWN COLLEGE	70
020552	HARRINGTON COLLEGE OF DESIGN	70
021123	RIDLEY—LOWELL BUSINESS & TECHNICAL INSTITUTE	70
021279	SOJOURNER-DOUGLASS COLLEGE	70
022788	SOUTHERN TECHNICAL COLLEGE	70
025769	CHARTER COLLEGE	70
026092	VATTEROTT COLLEGE	70
026149	SANFORD-BROWN INSTITUTE	70
030897	CAREER INSTITUTE OF HEALTH AND TECHNOLOGY	70
030955	ASA COLLEGE	70
032323	Lincoln Technical Institute	70
037563	ANAMARC COLLEGE	70
030874	ITT Technical Institute	70
001448	HOWARD UNIVERSITY	60
002455	Devry Institute of Technology	60

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
003642	TEXAS SOUTHERN UNIVERSITY	60
007481	SANFORD-BROWN COLLEGE	60
007506	Lincoln Technical Institute	60
009621	HERZING UNIVERSITY	60
009982	VICTORY UNIVERSITY	60
010057	AMERICAN COMMERCIAL COLLEGE	60
010779	PORTER AND CHESTER INSTITUTE	60
011112	FASHION INSTITUTE OF DESIGN & MERCHANDISING -	60
011121	BRYMAN COLLEGE	60
021032	BROWN MACKIE COLLEGE-MERRILLVILLE	60
021715	WESTERN INTERNATIONAL UNIVERSITY	60
022418	AMERICAN CAREER COLLEGE	60
022662	HELMS CAREER INSTITUTE	60
022838	BEAUTY SCHOOLS OF AMERICA	60
025720	VISTA COLLEGE	60
030777	DECKER COLLEGE	60
038094	MICROPOWER CAREER INSTITUTE	60
038193	AMERICAN PUBLIC UNIVERSITY SYSTEM	60
012061	BRYMAN COLLEGE	60
023186	EVEREST INSTITUTE	60
001081	ARIZONA STATE UNIVERSITY	50
001401	POST UNIVERSITY	50
001746	Robert Morris University Illinois	50
003099	Devry Institute of Technology	50
003191	CONCORDIA UNIVERSITY	50
007297	SPARTAN COLLEGE OF AERONAUTICS AND TECHNOLOGY	50
007405	WOOD TOBE-COBURN SCHOOL	50
007501	VATTEROTT COLLEGE	50
007678	SPARTAN COLLEGE OF AERONAUTICS AND TECHNOLOGY	50
010059	AMERICAN COMMERCIAL COLLEGE	50
010351	PSI INSTITUTE	50
021483	MANHATTAN BEAUTY SCHOOL	50
025829	KAPLAN CAREER INSTITUTE	50
030353	SOUTHERN CAREERS INSTITUTE	50
030911	ACT COLLEGE	50
031131	MARIC COLLEGE	50
031254	Art Institute of California-Hollywood (The)	50
032783	CHARTER COLLEGE	50
032943	BLUE CLIFF COLLEGE	50
033394	WESTERN GOVERNORS UNIVERSITY	50
033484	MATTIA COLLEGE	50
001328	UNIVERSITY OF SOUTHERN CALIFORNIA	40
001467	BETHUNE COOKMAN UNIVERSITY	40
001497	JONES COLLEGE	40
002193	MOUNT IDA COLLEGE	40
002410	JACKSON STATE UNIVERSITY	40
002521	WEBSTER UNIVERSITY	40
002629	RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY	40
002751	LONG ISLAND UNIVERSITY	40
003329	PENNSYLVANIA STATE UNIVERSITY (THE)	40
003404	JOHNSON & WALES UNIVERSITY	40
004730	MCINTOSH COLLEGE	40
004731	DANIEL WEBSTER COLLEGE	40
004799	MONROE COLLEGE	40
005203	Remington College—Lafayette Campus	40
007777	Remington College—Cleveland Campus	40
007814	BROOKSTONE COLLEGE OF BUSINESS	40
008537	CONCORDE CAREER COLLEGE	40
009635	FLORIDA INTERNATIONAL UNIVERSITY	40
010139	DeVry Institute of Technology	40
010198	ECPI UNIVERSITY	40

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
011005	KAPLAN COLLEGE	40
011460	NATIONAL UNIVERSITY—LA JOLLA	40
011644	UNIVERSITY OF MARYLAND GLOBAL CAMPUS	40
012891	ANTONELLI COLLEGE	40
021151	BUTLER BUSINESS SCHOOL	40
021368	AMERICAN COMMERCIAL COLLEGE	40
022008	AMERICAN COMMERCIAL COLLEGE	40
022949	INSTITUTE OF AUDIO RESEARCH	40
023287	ITT TECHNICAL INSTITUTE	40
025154	CITY COLLEGE	40
025412	STRATFORD UNIVERSITY	40
025654	KAPLAN COLLEGE	40
030306	CORTIVA INSTITUTE	40
030358	HERITAGE INSTITUTE	40
030425	CARRINGTON COLLEGE	40
030427	LAURUS TECHNICAL INSTITUTE	40
030445	KAPLAN COLLEGE	40
030675	INSTITUTE OF TECHNOLOGY	40
031133	UEI COLLEGE	40
031239	SOUTHEASTERN COLLEGE	40
031281	COLLEGE OF HEALTH CARE PROFESSIONS (THE)	40
033903	LINCOLN TECHNICAL INSTITUTE	40
033993	BRYAN COLLEGE	40
038133	NORTHCENTRAL UNIVERSITY	40
039035	SOUTHERN TECHNICAL COLLEGE	40
041215	COLUMBIA SOUTHERN UNIVERSITY	40
041900	RADIANS COLLEGE	40
007606	BRYMAN COLLEGE	40
030792	WESTWOOD COLLEGE—DUPAGE	40
001083	UNIVERSITY OF ARIZONA (THE)	30
001480	FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY	30
001665	COLUMBIA COLLEGE CHICAGO	30
002284	MARYGROVE COLLEGE	30
002329	WAYNE STATE UNIVERSITY	30
002456	COLUMBIA COLLEGE	30
002772	MERCY COLLEGE	30
002785	NEW YORK UNIVERSITY	30
003043	CHANCELLOR UNIVERSITY	30
003051	KENT STATE UNIVERSITY	30
003123	UNIVERSITY OF AKRON (THE)	30
004617	NATIONAL COLLEGE	30
004625	DELGADO COMMUNITY COLLEGE	30
004893	DUBOIS BUSINESS COLLEGE	30
007394	BERKELEY COLLEGE	30
007484	NEWBURY COLLEGE	30
007931	PACIFIC TRAVEL TRADE SCHOOL—MAIN CAMPUS	30
008417	STENOTYPE INSTITUTE OF JACKSONVILLE	30
008871	CONCORDE CAREER COLLEGE	30
009268	KELSEY -JENNEY COLLEGE	30
010405	PINNACLE CAREER INSTITUTE	30
012482	ATI TECHNICAL TRAINING CENTER	30
020712	KAPLAN COLLEGE	30
021066	AMERICAN INSTITUTE	30
021192	COURT REPORTING INSTITUTE OF ST LOUIS	30
021283	INSTITUTE FOR BUSINESS & TECHNOLOGY	30
021316	PENNCO TECH	30
021571	CONCORDE CAREER COLLEGE	30
021676	KAPLAN COLLEGE	30
021785	EAGLE GATE COLLEGE	30
022539	Berks Technical Institute	30
023013	PRISM CAREER INSTITUTE	30

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
024915	SOUTHWEST UNIVERSITY OF VISUAL ARTS	30
025389	INTERNATIONAL BUSINESS COLLEGE—	30
025476	FLORIDA NATIONAL UNIVERSITY	30
025762	MID-CONTINENT UNIVERSITY	30
025982	UNIVERSITY OF SOUTHERNMOST FLORIDA	30
026068	Career Technical College	30
030121	REMINGTON COLLEGE	30
031085	EVERGLADES UNIVERSITY	30
031100	ACADEMY OF HEALING ARTS	30
031264	Centura College	30
033683	MIDWEST TECHNICAL INSTITUTE	30
034254	CENTRAL FLORIDA INSTITUTE	30
034483	BUSINESS INDUSTRIAL RESOURCES	30
039696	UEI COLLEGE	30
041160	VIDEO SYMPHONY ENTERTRAINING	30
041223	GRANTHAM UNIVERSITY	30
041480	NEW LIFE BUSINESS INSTITUTE	30
001526	SAINT LEO UNIVERSITY	30
001528	ST. PETERSBURG COLLEGE	30
001671	DEPAUL UNIVERSITY	30
002782	NEW YORK INSTITUTE OF TECHNOLOGY	30
003420	BENEDICT COLLEGE	30
004866	STAUTZENBERGER COLLEGE	30
006750	VALENCIA COLLEGE	30
007844	Sanford-Brown Institute	30
009407	LINCOLN COLLEGE OF NEW ENGLAND	30
009451	Brown Mackie College	30
010142	TOURO UNIVERSITY	30
010633	HOUSTON COMMUNITY COLLEGE	30
012362	NORTHWESTERN COLLEGE	30
020555	DELTA SCHOOL OF BUSINESS AND TECHNOLOGY	30
020693	VATTEROTT COLLEGE	30
022151	HALLMARK INSTITUTE OF PHOTOGRAPHY	30
022195	MILDRED ELLEY	30
023378	COLLEGE OF OFFICE TECHNOLOGY	30
025578	ART INSTITUTE OF YORK (THE)—PENNSYLVANIA	30
025801	IVERSON INSTITUTE	30
025965	ATI- CAREER TRAINING CENTER	30
031081	SUMMIT COLLEGE	30
031287	MT. SIERRA COLLEGE	30
031724	CALIBER TRAINING INSTITUTE	30
033043	CENTURA COLLEGE	30
035954	ANGLEY COLLEGE	30
037893	UNITECH TRAINING ACADEMY	30
038663	GALIANO CAREER ACADEMY	30
041379	BRENSTEN EDUCATION	30
023139	WESTWOOD COLLEGE—O'HARE AIRPORT	30
001002	ALABAMA AGRICULTURAL & MECHANICAL UNIVERSITY	20
001005	ALABAMA STATE UNIVERSITY	20
001117	AZUSA PACIFIC UNIVERSITY	20
001139	CALIFORNIA STATE UNIVERSITY, LONG BEACH	20
001150	CALIFORNIA STATE UNIVERSITY—SACRAMENTO	20
001153	CALIFORNIA STATE UNIVERSITY, NORTHBRIDGE	20
001154	SAN FRANCISCO STATE UNIVERSITY	20
001155	SAN JOSE STATE UNIVERSITY	20
001315	UNIVERSITY OF CALIFORNIA, LOS ANGELES	20
001342	WHITTIER COLLEGE	20
001360	METROPOLITAN STATE UNIVERSITY OF DENVER	20
001363	REGIS UNIVERSITY	20
001444	GEORGE WASHINGTON UNIVERSITY	20
001456	SOUTHEASTERN UNIVERSITY	20

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
001469	FLORIDA INSTITUTE OF TECHNOLOGY	20
001481	FLORIDA ATLANTIC UNIVERSITY	20
001489	FLORIDA STATE UNIVERSITY	20
001500	BROWARD COLLEGE	20
001504	STATE COLLEGE OF FLORIDA, MANATEE—SARASOTA	20
001506	MIAMI DADE COLLEGE	20
001520	SEMINOLE STATE COLLEGE OF FLORIDA	20
001536	UNIVERSITY OF MIAMI	20
001544	ALBANY STATE UNIVERSITY	20
001559	CLARK ATLANTA UNIVERSITY	20
001574	GEORGIA STATE UNIVERSITY	20
001577	KENNESAW STATE UNIVERSITY	20
001694	CHICAGO STATE UNIVERSITY	20
001737	NORTHERN ILLINOIS UNIVERSITY	20
001758	SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE	20
001805	INDIANA INSTITUTE OF TECHNOLOGY	20
001813	INDIANA UNIVERSITY—PURDUE UNIVERSITY INDIANAPOLIS	20
001842	VALPARAISO UNIVERSITY	20
001983	ST. CATHARINE COLLEGE	20
002006	GRAMBLING STATE UNIVERSITY	20
002025	SOUTHERN UNIVERSITY AND AGRICULTURAL & MECHANICAL COLG AT BATON ROUGE	20
002083	MORGAN STATE UNIVERSITY	20
002130	BOSTON UNIVERSITY	20
002205	QUINCY COLLEGE	20
002211	SPRINGFIELD COLLEGE	20
002259	EASTERN MICHIGAN UNIVERSITY	20
002290	MICHIGAN STATE UNIVERSITY	20
002330	WESTERN MICHIGAN UNIVERSITY	20
002362	MINNEAPOLIS COMMUNITY AND TECHNICAL COLLEGE	20
002407	HINDS COMMUNITY COLLEGE	20
002441	UNIVERSITY OF SOUTHERN MISSISSIPPI	20
002569	UNIVERSITY OF NEVADA—LAS VEGAS	20
002617	MONTCLAIR STATE UNIVERSITY	20
002732	HOFSTRA UNIVERSITY	20
002791	PACE UNIVERSITY	20
002905	NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY	20
002909	BARBER—SCOTIA COLLEGE	20
002950	NORTH CAROLINA CENTRAL UNIVERSITY	20
002968	SAINT AUGUSTINE'S UNIVERSITY	20
003018	BOWLING GREEN STATE UNIVERSITY	20
003026	CENTRAL STATE UNIVERSITY	20
003090	OHIO STATE UNIVERSITY (THE)	20
003125	UNIVERSITY OF CINCINNATI	20
003131	UNIVERSITY OF TOLEDO	20
003196	LANE COMMUNITY COLLEGE	20
003199	MARYLHURST UNIVERSITY	20
003213	PORTLAND COMMUNITY COLLEGE	20
003249	COMMUNITY COLLEGE OF PHILADELPHIA	20
003256	DREXEL UNIVERSITY	20
003448	UNIVERSITY OF SOUTH CAROLINA—COLUMBIA	20
003509	UNIVERSITY OF MEMPHIS (THE)	20
003510	MIDDLE TENNESSEE STATE UNIVERSITY	20
003522	TENNESSEE STATE UNIVERSITY	20
003524	Tennessee Temple University	20
003594	UNIVERSITY OF NORTH TEXAS	20
003630	PRAIRIE VIEW AGRICULTURAL & MECHANICAL UNIVERSITY	20
003712	TIDEWATER COMMUNITY COLLEGE	20
003728	OLD DOMINION UNIVERSITY	20
003739	SAINT PAUL'S COLLEGE	20
003749	GEORGE MASON UNIVERSITY	20
003764	VIRGINIA STATE UNIVERSITY	20

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
003765	NORFOLK STATE UNIVERSITY	20
003827	WEST VIRGINIA UNIVERSITY	20
003866	MILWAUKEE AREA TECHNICAL COLLEGE	20
003896	UNIVERSITY OF WISCONSIN—MILWAUKEE	20
003954	UNIVERSITY OF CENTRAL FLORIDA—MAIN CAMPUS	20
003969	UNIVERSITY OF MINNESOTA—TWIN CITIES	20
003993	MIDLANDS TECHNICAL COLLEGE—AIRPORT CAMPUS	20
004072	NORTHWOOD UNIVERSITY	20
004220	Hamilton College	20
004453	DALLAS COLLEGE	20
004692	DORSEY COLLEGE	20
004920	TRIDENT TECHNICAL COLLEGE	20
004938	SOUTH COLLEGE	20
005208	COLLEGE OF WESTCHESTER (THE)	20
006731	CASA LOMA COLLEGE	20
006867	COLUMBUS STATE COMMUNITY COLLEGE- MAIN CAMPUS	20
007120	DES MOINES AREA COMMUNITY COLLEGE	20
007164	BRYAN UNIVERSITY	20
007229	WESTERN BEAUTY INSTITUTE	20
007401	MANDL SCHOOL	20
007439	FOUNTAINHEAD COLLEGE OF TECHNOLOGY	20
007440	Nashville Auto-Diesel College	20
007518	APEX TECHNICAL SCHOOL	20
007572	AMERICAN MUSICAL & DRAMATIC ACADEMY	20
007759	Lincoln Technical Institute	20
007845	NEW ENGLAND INSTITUTE OF TECHNOLOGY	20
007870	HILLSBOROUGH COMMUNITY COLLEGE	20
007946	Kaplan College	20
008071	CONCORDE CAREER COLLEGE	20
008217	PAUL MITCHELL THE SCHOOL GREEN BAY	20
008501	Rasmussen College	20
008887	CONCORDE CAREER COLLEGE	20
009022	ASSOCIATED TECHNICAL COLLEGE	20
009043	ELMIRA BUSINESS INSTITUTE	20
009432	ESS COLLEGE OF BUSINESS	20
009520	NATIONAL ACADEMY OF BEAUTY ARTS	20
009618	TULSA WELDING SCHOOL	20
009721	BRADFORD SCHOOL	20
010279	HICKEY COLLEGE	20
010362	COLLEGE OF SOUTHERN NEVADA	20
010503	WICHITA TECHNICAL INSTITUTE	20
010542	EMPIRE BEAUTY SCHOOL	20
010577	UNITED COLLEGE OF BUSINESS	20
010831	NEW COLLEGE OF CALIFORNIA	20
010881	STARK STATE COLLEGE	20
010930	SUBURBAN TECHNICAL SCHOOL	20
011031	TECHNICAL CAREER INSTITUTES	20
011145	LONE STAR COLLEGE SYSTEM	20
011166	BROADVIEW COLLEGE	20
011707	NORTH—WEST COLLEGE	20
011979	BLAKE BUSINESS SCHOOL	20
012027	GALEN COLLEGE OF CALIFORNIA	20
012262	USA TRAINING ACADEMY HOME STUDY	20
012346	Dover Business College	20
012872	NORTH—WEST COLLEGE	20
013005	OLYMPIAN ACADEMY OF COSMETOLOGY	20
020692	PACIFIC COAST COLLEGE	20
020741	CAPITOL CITY TRADE & TECHNICAL SCHOOL	20
020977	AMERICAN BUSINESS INSTITUTE	20
021107	CLEVELAND INSTITUTE OF DENTAL—MEDICAL ASSISTANTS	20
021280	SUPERIOR TRAINING SERVICES	20

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
021415	SAVANNAH COLLEGE OF ART AND DESIGN	20
021511	ATI COLLEGE OF HEALTH	20
021553	CHICAGO SCHOOL OF PROFESSIONAL PSYCHOLOGY	20
021618	MUSICIANS INSTITUTE	20
021642	FOREST INSTITUTE OF PROFESSIONAL PSYCHOLOGY	20
021732	EMPIRE BEAUTY SCHOOL	20
021775	RIO SALADO COMMUNITY COLLEGE	20
022025	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF CONN	20
022053	SAVANNAH RIVER COLLEGE	20
022180	CARRINGTON COLLEGE	20
022449	GOODWIN UNIVERSITY	20
022452	MTI COLLEGE OF BUSINESS AND TECHNOLOGY	20
022552	PENNSYLVANIA SCHOOL OF BUSINESS	20
022774	SOUTH COAST COLLEGE	20
022957	NATIONAL ACADEMY OF BEAUTY ARTS	20
022965	MASTERS INSTITUTE	20
022966	DeVry Institute of Technology	20
023040	MISSOURI TECHNICAL SCHOOL	20
023112	AMERICAN SCHOOL OF TECHNOLOGY	20
023301	PIONEER PACIFIC COLLEGE	20
023385	GLENDALE CAREER COLLEGE	20
023397	ROSS MEDICAL EDUCATION CENTER	20
023616	CONCORDE CAREER COLLEGE	20
024911	BECKFIELD COLLEGE	20
025399	STAR TECHNICAL INSTITUTE	20
025587	PRISM CAREER INSTITUTE	20
025590	UNIVERSITY OF ADVANCING COMPUTER TECHNOLOGY	20
025779	SANTA BARBARA BUSINESS COLLEGE	20
025862	Florida Career College	20
025964	SPARTAN COLLEGE OF AERONAUTICS & TECHNOLOGY	20
026089	PINNACLE COLLEGE	20
026220	SOUTHWEST ACUPUNCTURE COLLEGE	20
030125	NEW WAVE HAIR ACADEMY	20
030198	PCI HEALTH TRAINING CENTER	20
030235	CAMELOT COLLEGE	20
030258	DAWN CAREER INSTITUTE	20
030399	FREMONT UNIVERSITY	20
030627	PLATT COLLEGE	20
030669	INTELLITEC COLLEGE	20
030682	OHIO MEDIA SCHOOL	20
030706	SANFORD-BROWN COLLEGE	20
030716	CBT TECHNOLOGY INSTITUTE	20
030837	GALEN HEALTH INSTITUTES	20
030878	ITT TECHNICAL INSTITUTE	20
031043	CAREER TECHNICAL INSTITUTE	20
031087	ROYAL BEAUTY CAREERS	20
031090	SCHOOL OF COMMUNICATION ARTS OF NORTH CAROLINA	20
031103	SALON ACADEMY (THE)	20
031150	ARIZONA COLLEGE	20
031384	AMERICAN COLLEGE OF MEDICAL TECHNOLOGY	20
031963	Lincoln Technical Institute	20
031973	INSTITUTE FOR HEALTH EDUCATION (THE)	20
033163	LINCOLN TECHNICAL INSTITUTE—HARTFORD	20
033943	REMINGTON COLLEGE—SAN DIEGO CAMPUS	20
034003	QUEST COLLEGE	20
035423	CONCORDE CAREER COLLEGE	20
036253	PERFORMANCE TRAINING INSTITUTE	20
036274	JACKSONVILLE BEAUTY INSTITUTE	20
036984	CALIFORNIA COLLEGE OF VOCATIONAL CAREERS	20
037063	HOLLYWOOD INSTITUTE	20
038123	OMNITECH INSTITUTE	20

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
038753	MCI INSTITUTE OF TECHNOLOGY	20
039713	AMERICAN CAREER COLLEGE	20
039733	SAE EXPRESSION COLLEGE	20
040383	ATA COLLEGE	20
041157	REGINA'S COLLEGE OF BEAUTY	20
041279	TRIDENT UNIVERSITY INTERNATIONAL	20
041345	SAN DIEGO COLLEGE	20
041359	ORION COLLEGE	20
041414	LAURUS COLLEGE	20
041493	PARK WEST BARBER SCHOOL	20
041523	GEORGIA BEAUTY ACADEMY	20
041618	BRANDMAN UNIVERSITY	20
041625	HOLLYWOOD INSTITUTE OF BEAUTY CAREERS	20
041848	VANTAGE COLLEGE	20
001028	MILES COLLEGE	10
001044	STILLMAN COLLEGE	10
001047	TROY UNIVERSITY	10
001051	UNIVERSITY OF ALABAMA	10
001052	UNIVERSITY OF ALABAMA AT BIRMINGHAM	10
001057	UNIVERSITY OF SOUTH ALABAMA	10
001077	MESA COMMUNITY COLLEGE	10
001078	PHOENIX COLLEGE	10
001082	NORTHERN ARIZONA UNIVERSITY	10
001087	ARKANSAS BAPTIST COLLEGE	10
001090	ARKANSAS STATE UNIVERSITY	10
001092	UNIVERSITY OF CENTRAL ARKANSAS	10
001101	UNIVERSITY OF ARKANSAS AT LITTLE ROCK	10
001138	CALIFORNIA STATE UNIVERSITY, EAST BAY	10
001140	CALIFORNIA STATE UNIVERSITY, LOS ANGELES	10
001142	CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO	10
001147	CALIFORNIA STATE UNIVERSITY, FRESNO	10
001164	CHAPMAN UNIVERSITY	10
001325	UNIVERSITY OF SAN FRANCISCO	10
001378	CENTRAL CONNECTICUT STATE UNIVERSITY	10
001416	UNIVERSITY OF BRIDGEPORT	10
001428	DELAWARE STATE UNIVERSITY	10
001434	AMERICAN UNIVERSITY (THE)	10
001441	UNIVERSITY OF THE DISTRICT OF COLUMBIA	10
001475	DAYTONA STATE COLLEGE	10
001477	FLORIDA SOUTHWESTERN STATE COLLEGE	10
001484	FLORIDA STATE COLLEGE AT JACKSONVILLE	10
001486	FLORIDA MEMORIAL UNIVERSITY	10
001535	UNIVERSITY OF FLORIDA	10
001537	UNIVERSITY OF SOUTH FLORIDA	10
001562	Georgia Perimeter College	10
001572	GEORGIA SOUTHERN UNIVERSITY	10
001580	MERCER UNIVERSITY	10
001599	VALDOSTA STATE UNIVERSITY	10
001692	ILLINOIS STATE UNIVERSITY	10
001775	UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN	10
001776	UNIVERSITY OF ILLINOIS AT CHICAGO	10
001807	INDIANA STATE UNIVERSITY	10
001809	INDIANA UNIVERSITY—BLOOMINGTON	10
001822	INDIANA WESLEYAN UNIVERSITY	10
001825	PURDUE UNIVERSITY	10
001827	PURDUE UNIVERSITY NORTHWEST	10
001833	SAINT JOSEPH'S COLLEGE	10
001948	UNIVERSITY OF KANSAS	10
001962	UNIVERSITY OF THE CUMBERLANDS	10
001968	KENTUCKY STATE UNIVERSITY	10
001989	UNIVERSITY OF KENTUCKY	10

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
001999	UNIVERSITY OF LOUISVILLE	10
002002	WESTERN KENTUCKY UNIVERSITY	10
002015	UNIVERSITY OF NEW ORLEANS (THE)	10
002024	SOUTHEASTERN LOUISIANA UNIVERSITY	10
002103	UNIVERSITY OF MARYLAND, COLLEGE PARK	10
002155	HARVARD UNIVERSITY	10
002199	NORTHEASTERN UNIVERSITY	10
002218	SUFFOLK UNIVERSITY	10
002243	CENTRAL MICHIGAN UNIVERSITY	10
002270	HENRY FORD COLLEGE	10
002278	LANSING COMMUNITY COLLEGE	10
002323	UNIVERSITY OF DETROIT MERCY	10
002360	MINNESOTA STATE UNIVERSITY, MANKATO	10
002396	ALCORN STATE UNIVERSITY	10
002397	BELHAVEN UNIVERSITY	10
002424	MISSISSIPPI VALLEY STATE UNIVERSITY	10
002440	UNIVERSITY OF MISSISSIPPI	10
002480	LINDENWOOD UNIVERSITY	10
002503	MISSOURI STATE UNIVERSITY	10
002540	COLLEGE OF SAINT MARY	10
002568	UNIVERSITY OF NEVADA , RENO	10
002579	NEW ENGLAND COLLEGE	10
002607	FAIRLEIGH DICKINSON UNIVERSITY	10
002613	NEW JERSEY CITY UNIVERSITY	10
002622	KEAN UNIVERSITY	10
002632	SETON HALL UNIVERSITY	10
002657	NEW MEXICO STATE UNIVERSITY	10
002663	UNIVERSITY OF NEW MEXICO	10
002777	MEDAILLE COLLEGE	10
002790	NYACK COLLEGE	10
002806	ROCHESTER INSTITUTE OF TECHNOLOGY	10
002823	SAINT JOHN'S UNIVERSITY	10
002834	EXCELSIOR COLLEGE	10
002842	SUNY COLLEGE AT BUFFALO	10
002872	MONROE COMMUNITY COLLEGE	10
002873	NASSAU COMMUNITY COLLEGE	10
002923	EAST CAROLINA UNIVERSITY	10
002962	SHAW UNIVERSITY	10
003030	OHIO CHRISTIAN UNIVERSITY	10
003032	CLEVELAND STATE UNIVERSITY	10
003040	CUYAHOGA COMMUNITY COLLEGE	10
003046	FRANKLIN UNIVERSITY	10
003145	YOUNGSTOWN STATE UNIVERSITY	10
003157	LANGSTON UNIVERSITY	10
003216	PORTLAND STATE UNIVERSITY	10
003258	DUQUESNE UNIVERSITY OF THE HOLY SPIRIT	10
003273	HARRISBURG AREA COMMUNITY COLLEGE	10
003290	LINCOLN UNIVERSITY	10
003315	BLOOMSBURG UNIVERSITY OF PENNSYLVANIA	10
003317	CHEYNEY UNIVERSITY OF PENNSYLVANIA	10
003394	WILKES UNIVERSITY	10
003446	SOUTH CAROLINA STATE UNIVERSITY	10
003478	AUSTIN PEAY STATE UNIVERSITY	10
003480	BETHEL UNIVERSITY	10
003494	HIWASSEE COLLEGE	10
003497	KNOXVILLE COLLEGE	10
003501	LEMOYNE-OWEN COLLEGE	10
003530	UNIVERSITY OF TENNESSEE	10
003577	HUSTON—TILLOTSON UNIVERSITY	10
003585	LON MORRIS COLLEGE	10
003590	MCLENNAN COMMUNITY COLLEGE	10

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
003593	NAVARRO COLLEGE	10
003599	UNIVERSITY OF TEXAS RIO GRANDE VALLEY	10
003606	SAM HOUSTON STATE UNIVERSITY	10
003612	UNIVERSITY OF HOUSTON—DOWNTOWN	10
003615	TEXAS STATE UNIVERSITY	10
003626	TARRANT COUNTY COLLEGE DISTRICT	10
003634	TEXAS STATE TECHNICAL COLLEGE	10
003644	TEXAS TECH UNIVERSITY	10
003652	UNIVERSITY OF HOUSTON	10
003656	UNIVERSITY OF TEXAS AT ARLINGTON	10
003661	UNIVERSITY OF TEXAS AT EL PASO	10
003692	NORWICH UNIVERSITY	10
003727	NORTHERN VIRGINIA COMMUNITY COLLEGE	10
003735	VIRGINIA COMMONWEALTH UNIVERSITY	10
003752	VIRGINIA INTERMONT COLLEGE	10
003798	UNIVERSITY OF WASHINGTON	10
003800	WASHINGTON STATE UNIVERSITY	10
003842	CONCORDIA UNIVERSITY	10
003938	INTER AMERICAN UNIVERSITY OF PUERTO RICO—SAN GERMAN CAMPUS	10
003941	UNIVERSIDAD ANA G. MÉNDEZ—CAROLINA CAMPUS	10
003965	BAY STATE COLLEGE	10
003985	ORAL ROBERTS UNIVERSITY	10
003991	GREENVILLE TECHNICAL COLLEGE	10
004579	INTERNATIONAL BUSINESS COLLEGE	10
004844	WAKE TECHNICAL COMMUNITY COLLEGE	10
004852	CLARK STATE COLLEGE	10
004853	BRADFORD SCHOOL	10
004889	CAMBRIA—ROWE BUSINESS COLLEGE	10
004925	HORRY GEORGETOWN TECHNICAL COLLEGE	10
004947	WEST TENNESSEE BUSINESS COLLEGE	10
005541	MINNESOTA STATE COMMUNITY AND TECHNICAL COLLEGE	10
005753	OWENS COMMUNITY COLLEGE	10
006961	JEFFERSON COMMUNITY AND TECHNICAL COLLEGE	10
007372	AUSTIN'S SCHOOL OF SPA TECHNOLOGY	10
007430	ANTONELLI INSTITUTE	10
007437	PITTSBURGH TECHNICAL COLLEGE	10
007502	BERKELEY COLLEGE	10
007549	COYNE COLLEGE	10
007573	EMPIRE BEAUTY SCHOOL	10
007605	ACADEMY PACIFIC TRAVEL COLLEGE	10
007607	CONCORDE CAREER COLLEGE	10
007648	DENVER TECHNICAL COLLEGE	10
007686	SOUTHERN UNIVERSITY AT SHREVEPORT—BOSSIER CITY	10
007832	Lincoln Technical Institute	10
007930	CONCORDE CAREER COLLEGE	10
008178	EMPIRE BEAUTY SCHOOL	10
008310	AUBURN UNIVERSITY MONTGOMERY	10
008635	IBMC COLLEGE	10
009032	EMPIRE COLLEGE	10
009077	UTICA SCHOOL OF COMMERCE	10
009230	WAYNE COUNTY COMMUNITY COLLEGE DISTRICT	10
009447	WEBSTER CAREER COLLEGE	10
009449	PENNCO TECH	10
009482	MANSFIELD BUSINESS COLLEGE	10
009741	UNIVERSITY OF TEXAS AT DALLAS	10
009769	METROPOLITAN COLLEGE OF NEW YORK	10
009784	NATIONAL EDUCATION CENTER—BAUDER COLLEGE CAMPUS	10
009917	IVY TECH COMMUNITY COLLEGE OF INDIANA	10
010035	SOUTHERN COLLEGE	10
010061	BRYANT AND STRATTON COLLEGE -VIRGINIA BEACH CAMPUS	10
010115	UNIVERSITY OF TEXAS AT SAN ANTONIO	10

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
010286	SUNY EMPIRE STATE COLLEGE	10
010345	CINCINNATI STATE TECHNICAL & COMMUNITY COLLEGE	10
010372	ADELPHI BUSINESS COLLEGE	10
010463	NATIONAL TECHNICAL SCHOOLS	10
010509	HALLMARK UNIVERSITY	10
010554	CONCORDIA COLLEGE ALABAMA	10
010847	Arizona Automotive Institute	10
010877	AMERICAN BUSINESS INSTITUTE	10
010998	PENNSYLVANIA INSTITUTE OF TECHNOLOGY	10
011122	SAWYER COLLEGE	10
011219	COLUMBIA SCHOOL OF BROADCASTING, HOME STUDY	10
011719	UNIVERSIDAD ANA G. MENDEZ—GURABO CAMPUS	10
011745	OHIO TECHNICAL COLLEGE	10
011810	TAYLOR BUSINESS INSTITUTE	10
011911	BRICK COMPUTER SCIENCE INSTITUTE	10
012015	AUSTIN COMMUNITY COLLEGE	10
012425	STONE ACADEMY	10
012606	EMPIRE BEAUTY SCHOOL	10
012896	NORTH COAST COLLEGE, THE	10
012912	MTI COLLEGE	10
020543	TRUMBULL BUSINESS COLLEGE	10
020551	HAWAII BUSINESS COLLEGE	10
020609	BROWN COLLEGE OF COURT REPORTING	10
020662	NEW SCHOOL, THE	10
020753	UNIVERSITY OF ARKANSAS—PULASKI TECHNICAL COLLEGE	10
020794	EMPIRE BEAUTY SCHOOL	10
020924	RIDLEY—LOWELL SCHOOL OF BUSINESS	10
020926	PTC CAREER INSTITUTE	10
020997	ROSS MEDICAL EDUCATION CENTER	10
021206	SAYBROOK UNIVERSITY	10
021208	YORKTOWNE BUSINESS INSTITUTE	10
021324	BARCLAY COLLEGE	10
021474	CLEVELAND CHIROPRACTIC COLLEGE	10
021527	CENTER FOR THE MEDIA ARTS	10
021578	AMERICAN HI—TECH BUSINESS TECHNOLOGY	10
021604	WILFRED ACADEMY OF HAIR DESIGN & BEAUTY CULTURE	10
021654	TRAINCO BUS SCHOOL	10
021801	ROSS MEDICAL EDUCATION CENTER	10
021884	SIERRA VALLEY COLLEGE OF COURT REPORTING	10
022062	BEAUTY INSTITUTE (THE)	10
022168	CALIFORNIA INSTITUTE	10
022196	OMEGA INSTITUTE	10
022229	INTERNATIONAL AIR & HOSPITALITY ACADEMY	10
022288	Lincoln Technical Institute—East Windsor	10
022342	KEYSTONE TECHNICAL INSTITUTE	10
022702	INTERNATIONAL AVIATION AND TRAVEL ACADEMY	10
022708	JOYCE UNIVERSITY OF NURSING AND HEALTH SCIENCES	10
022843	INTERACTIVE COLLEGE OF TECHNOLOGY	10
022847	CHICAGO INSTITUTE OF TECHNOLOGY	10
022952	UNITED SCHOOLS	10
022959	AMERICAN CAREER TRAINING TRAVEL SCHOOL	10
023045	HERITAGE INSTITUTE	10
023124	LA COLLEGE INTERNATIONAL	10
023178	AMERICAN INSTITUTE OF TRUCKING	10
023268	MERIDIAN COLLEGE	10
023342	SOUTHEASTERN ACADEMY	10
023398	SOUTHERN INSTITUTE OF COSMETOLOGY	10
023405	ST. LOUIS COLLEGE OF HEALTH CAREERS	10
023543	GEORGIA SCHOOL OF BARTENDING	10
023608	PROVO COLLEGE	10
024905	HAIR FASHIONS BY KAYE BEAUTY COLLEGE	10

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Ineligible Case Count
025454	NORTH AMERICAN TRADE SCHOOLS	10
025464	MTI BUSINESS COLLEGE	10
025681	TEXAS BARBER COLLEGE	10
025728	VISTA COLLEGE	10
025812	CC'S COSMETOLOGY COLLEGE	10
025844	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF MASSACHUSETTS	10
026009	AVEDA ARTS & SCIENCES INSTITUTE COVINGTON	10
026095	CAREER TRAINING ACADEMY	10
026128	LOS ANGELES RECORDING SCHOOL	10
026154	STAR TECHNICAL INSTITUTE	10
026215	CAREER COLLEGE OF NORTHERN NEVADA	10
030097	Harrison College	10
030316	DPT BUSINESS SCHOOL	10
030644	REGENCY BEAUTY INSTITUTE	10
030780	MIAMI MEDIA SCHOOL	10
030913	REGENT UNIVERSITY	10
031226	EASTERN INTERNATIONAL COLLEGE	10
031733	ATLANTA'S JOHN MARSHALL LAW SCHOOL	10
032753	COSMETOLOGY CAREER INSTITUTE	10
033674	COMMUNITY CARE COLLEGE	10
034225	Blue Cliff College	10
034275	UNIVERSITY OF ANTELOPE VALLEY	10
034293	HARRIS SCHOOL OF BUSINESS	10
034455	FAYETTE BEAUTY ACADEMY	10
034685	MDT COLLEGE OF HEALTH SCIENCES	10
034793	PCI COLLEGE	10
035134	APEX SCHOOL OF THEOLOGY	10
035233	AVIATION INSTITUTE OF MAINTENANCE	10
035253	Blue Cliff College	10
036393	TRIAD EDUCATION	10
036764	HEALTHY HAIR ACADEMY	10
037503	PROSPECT COLLEGE	10
037863	ADVANCED COLLEGE	10
037974	CAREER CARE INSTITUTE	10
038385	NORTHWEST CAREER COLLEGE	10
038525	CIT COLLEGE OF INFOMEDICAL TECHNOLOGY	10
039104	NATIONAL POLYTECHNIC COLLEGE	10
039153	CAREER QUEST LEARNING CENTERS	10
039394	CENTURA INSTITUTE	10
040573	ASHER COLLEGE	10
041245	MYCOMPUTERCAREER AT COLUMBUS	10
041317	SOUTHWEST UNIVERSITY AT EL PASO	10
041341	JERSEY COLLEGE	10
041431	PROFESSIONAL HANDS INSTITUTE	10
041477	LAKE LANIER SCHOOL OF MASSAGE	10
041500	CENTRAL NURSING COLLEGE	10
041587	HOLLYWOOD BEAUTY COLLEGE	10
041772	REAL BARBERS COLLEGE (THE)	10
041893	ALLIED AMERICAN UNIVERSITY	10
	Schools with less than 10 denied applications	11510

Question. Please provide a breakdown of “total ineligible” borrower defense claims to date by institution.

Answer. Beginning in May 2021, the term “total ineligible” was no longer used in the borrower defense reports. This term was replaced by “total denied.” See response to 3b.

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 mid-May 2022 is enclosed.

Closed Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.

OPEID	School Name	Rounded Closed Case Count
007234	HEALD COLLEGE	1290
001499	ALTIERUS CAREER COLLEGE	1050
007329	ITT TECHNICAL INSTITUTE	670
012873	WYOTECH	260
020988	UNIVERSITY OF PHOENIX	240
009157	WYOTECH	240
011109	EVEREST COLLEGE	180
010727	DEVRY UNIVERSITY	170
001534	Everest University	170
008090	EVEREST COLLEGE	170
030723	EVEREST COLLEGE	170
009828	ALTIERUS CAREER EDUCATION	150
004494	EVEREST COLLEGE	140
023001	ALTIERUS CAREER COLLEGE	120
011123	EVEREST COLLEGE	120
007190	WYOTECH	110
004811	EVEREST INSTITUTE	110
010356	EVEREST INSTITUTE	110
011510	EVEREST INSTITUTE	110
026062	EVEREST COLLEGE	90
011858	EVEREST COLLEGE	80
022950	EVEREST COLLEGE PHOENIX	80
009079	EVEREST COLLEGE	70
021004	EVEREST INSTITUTE	70
022613	ALTIERUS CAREER COLLEGE	70
022506	EVEREST COLLEGE	70
004586	PURDUE UNIVERSITY GLOBAL	60
008532	Heald College	60
008146	Everest University—Pompano Beach	60
008093	Heald College	60
021875	Heald College	60
009267	ALTIERUS CAREER COLLEGE	60
011107	EVEREST COLLEGE	60
021799	ARGOSY UNIVERSITY	50
004503	ALTIERUS CAREER COLLEGE	50
026175	ALTIERUS CAREER COLLEGE	50
004507	ALTIERUS CAREER COLLEGE	50
011024	BRYMAN COLLEGE	50
030727	WESTWOOD COLLEGE—LOS ANGELES	50
007548	WESTWOOD COLLEGE—DENVER NORTH	50
022985	EVEREST COLLEGE	50
007091	EVEREST INSTITUTE	50
001881	ASHFORD UNIVERSITY	40
021136	AMERICAN INTERCONTINENTAL UNIVERSITY	40
025933	Heald College	40
025932	Heald College	40
021218	Everest Institute	40
037713	AMERICAN CAREER INSTITUTE	30
010148	COLORADO TECHNICAL UNIVERSITY	30
025998	Everest University	30
025931	Heald College	30
030032	Everest Institute	30
022375	LAS VEGAS COLLEGE	30
007477	Heald College	30
040513	ART INSTITUTE OF LAS VEGAS (THE)	30
007476	MARINELLO SCHOOL OF BEAUTY	20
025909	WRIGHT CAREER COLLEGE	20
030106	VIRGINIA COLLEGE	20
030314	SANFORD-BROWN COLLEGE	20
007470	ART INSTITUTE OF PITTSBURGH (THE)	20
004646	MINNESOTA SCHOOL OF BUSINESS	20
001123	BROOKS INSTITUTE	20

Closed Borrower Defense Applications by Institution as of May 2022
Note: Totals may not sum due to rounding.—Continued

OPEID	School Name	Rounded Closed Case Count
001459	STRAYER UNIVERSITY	20
022631	ANTHEM COLLEGE	20
032673	CAPELLA UNIVERSITY	20
030340	Heald College	20
007327	ITT Technical Institute	20
025911	CAREER POINT COLLEGE	20
008329	ITT Technical Institute	20
011626	WESTWOOD COLLEGE—SOUTH BAY	20
010627	ITT Technical Institute	20
030876	ITT Technical Institute	20
030875	ITT Technical Institute	20
004553	ITT Technical Institute	20
031954	EVEREST COLLEGE	20
030718	ITT TECHNICAL INSTITUTE	20
012061	BRYMAN COLLEGE	20
007606	BRYMAN COLLEGE	20
001074	GRAND CANYON UNIVERSITY	10
022239	DRAKE COLLEGE OF BUSINESS	10
021160	SANFORD—BROWN COLLEGE	10
020754	Keller Graduate School of Management	10
032103	LE CORDON BLEU COLLEGE OF CULINARY ARTS	10
021519	KEISER UNIVERSITY	10
026167	LE CORDON BLEU COLLEGE OF CULINARY ARTS	10
030226	LE CORDON BLEU COLLEGE OF CULINARY ARTS	10
021603	SANFORD—BROWN COLLEGE	10
030764	BRYMAN SCHOOL OF ARIZONA (THE)	10
026164	SANFORD—BROWN COLLEGE	10
025997	VATTEROTT COLLEGE	10
009270	ART INSTITUTE OF ATLANTA (THE)	10
012584	ILLINOIS INSTITUTE OF ART (THE)	10
022865	ITT Technical Institute	10
013039	SOUTH UNIVERSITY	10
030734	ITT Technical Institute	10
038323	DADE MEDICAL COLLEGE	10
023598	ITT Technical Institute	10
007351	SANFORD-BROWN COLLEGE	10
007557	ITT Technical Institute	10
023217	ITT Technical Institute	10
023610	ITT Technical Institute	10
007486	NEW ENGLAND INSTITUTE OF ART (THE)	10
009837	ITT Technical Institute	10
022916	ITT Technical Institute	10
030874	ITT Technical Institute	10
023139	WESTWOOD COLLEGE—O'HARE AIRPORT	10
030792	WESTWOOD COLLEGE—DUPAGE	10
023186	EVEREST INSTITUTE	10
	No school information listed	3110
	Schools with less than 10 closed applications	4180

Question. Please provide the top five reasons that borrower defense claims are placed in “total denied,” “total ineligible,” and “total closed.” Please also provide the number and corresponding percentage for borrower defense claims placed in each category.

Answer. Per our response to Durbin 3, “total ineligible” is no longer used as a category in borrower defense reporting.

As of mid-July 2022, the top five reasons applications have been deemed denied were as follows (numbers have been rounded to the nearest 5):

- Lack of Evidence (81,525 applications or 59 percent);
- No Claim Stated (36,875 applications or 27 percent);
- Failed Job Placement Rate-No Other Obligation (16,105 or 12 percent)

- Failure to State a Claim Actionable Under BD Regulations (1,465 applications or 1 percent)
- Reason Not Reported (1,005 applications or 1 percent).

As of mid-July 2022, the top five reasons applications have been closed were as follows (numbers have been rounded to the nearest 5):

- No Loans (e.g., no Federal loans; loans paid in full; no loans at the applicable school) (6785 applications or 51 percent);
- No Response from Customer (2565 applications or 19 percent);
- Borrower Received an Automatic Closed School Discharge (965 applications or 7 percent);
- Incomplete Application (775 applications or 6 percent);
- Borrower Requested Case Closure (545 applications or 4 percent).

Question. How many and which institutions is the Department currently investigating for purposes of making findings related to borrower defense? Please provide a list of those schools.

Answer. The Borrower Defense regulations require the Department to “resolve claims through a fact-finding process” conducted by the Department, 34 C.F.R. § 685.222. That process is defined as follows:

As part of the fact-finding process, the Department official notifies the school of the borrower defense application and considers any evidence or argument presented by the borrower and also any additional information, including—

- Department records;
- Any response or submissions from the school; and
- Any additional information or argument that may be obtained by the Department official. 34 C.F.R. § 685.222.

Although the Department does not comment on deliberative or preliminary work, including disclosing a number or list of institutions that may be subject to such work until the outcomes of any work has been made public, but the Department is committed to fulfilling its regulatory obligations and to providing relief to borrowers when appropriate.

Question. How many schools have submitted information to the Department based on the school’s right to respond to a pending borrower defense application? Please provide a list of those schools.

Answer. The 2016 and 2020 regulations require the Department to provide notice of borrower defense applications and an opportunity to respond to all open institutions prior to granting borrower defense and discharging Federal loans. The Department is committed to fulfilling its regulatory obligation and is in the process of providing notice to numerous schools.

Question. How many borrowers have received a direct notice via email or postal mail that they may be eligible for borrower defense cancellation under the Department’s new borrower defense findings?

Answer. Any time the Borrower Defense Group issues a new finding, FSA posts an announcement to the Borrower Defense Updates website (<https://studentaid.gov/announcements-events/borrower-defense-update>). The Borrower Defense Updates website includes executive summaries explaining the school’s misconduct that resulted in the finding(s) and when the misconduct occurred, statements of fact detailing the misconduct and who may be eligible for relief, and other borrower defense information, such as a link to the borrower defense application portal.

Question. The current borrower defense form is 25 pages and is difficult for student loan borrowers to navigate without an attorney. When does the Department anticipate publishing and using a new, easier to understand, and shorter borrower defense form?

Answer. The Department is committed to providing prospective applicants with a borrower-friendly application form. The Department is uncertain as to when this form will be updated due the lengthy regulatory review process and changes that may be required pursuant to the 2023 regulation.

Question. How many Department staff currently are assigned to determine whether to provide group discharges to borrowers?

Answer. The Department dedicates staff resources from Enforcement, the Office of General Counsel (OGC), and the Office of the Under Secretary (OUS) to working on group discharges issues. FSA’s Borrower Defense Group writes recommendations regarding group discharges, OGC reviews recommendations, and the Under Secretary ultimately determines whether to grant a group discharge. As of July 12, 2022, there are 2–3 attorneys in OGC and 2 individuals in OUS who spend time working on group discharges. There are 33 attorneys in the Borrower Defense Group, some of whom work on group discharge matters as well.

Question. How many Department staff currently are assigned to adjudicate individual borrower defense applications?

Answer. There are thirty-three attorneys in the Borrower Defense Group, all of whom play some role in the process for considering individual borrower defense applications.

Question. Please provide an organizational chart detailing who is tasked with making group discharge decisions, individual application adjudications, and drafting and finalizing communications with borrowers regarding borrower defense discharges.

Answer. The Department dedicates staffing resources from Enforcement, the Office of General Counsel (OGC), and the Office of the Under Secretary (OUS) to make group discharge decisions, adjudicate individual applications, and draft and finalize communication with borrowers. FSA's Borrower Defense Group makes recommendations regarding individual adjudication and group discharges. OGC reviews recommendations. The Under Secretary determines whether to grant a group discharge. Drafting and finalizing communications is a collaborative effort by FSA's office of Student Experience and Aid Delivery (SEAD), the Borrower Defense Group, OGC, and OUS. Communication with the borrower regarding discharges is handled by the post processing Borrower Defense Team in FSA.

The Department does not have a specific organizational chart of everyone involved in the group discharge or individual application adjudication process or communication process.

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 of total borrowers does this number represent?

Answer. FSA requires our vendors to remove the credit tradeline for any loans that are approved for 100 percent borrower defense relief.

Question. The Department previously notified me and other Members of Congress that former 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. The Department is committed to exercising the exceptional circumstances authority for closed school discharges when the Secretary determines it is warranted. We are continuing to review past closures to identify any instances where an exceptional circumstance did occur.

Question. In that same notification, the Department noted that former Secretary DeVos had not yet reached a decision on the request made by me and other Members of Congress 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. As noted above, we are committed to looking at instances where it would be warranted to use the exceptional circumstance authority.

Question. Please provide, disaggregated for 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 borrowers who 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, or assigned to private collection agencies).

Answer. Please find an Excel file with the requested data enclosed.

	Durbin 14.a-Estimated Eligible Borrowers for Closed School Discharge		Durbin 14.b-Borrowers Who Applied for a Non-automatic, Traditional Closed School Discharge		Durbin 14.c-Borrowers Who Received Closed School Discharge		Durbin 14d-Borrowers Who Received Automatic Closed School Discharge		Durbin 14.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	0	0
Dream Center Education Holdings	7,900	178	9,600	301	4,300	103	3,300	\$60	0	0
Education Corporation of America	11,900	81	11,700	120	6,500	39	4,200	31	0	0
ITT Educational Service	25,800	349	30,700	569	18,600	250	113,300	1,391	0	0
Vatterott Acquisition Co.	1,500	20	1,300	20	900	11	600	8	0	0

Notes:

Estimated eligibility for closed school discharge 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.

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.

14d includes the ITT borrowers received a discharge under the extended lookback window. <https://www.ed.gov/news/press-releases/extended-closed-school-discharge-will-provide-115k-borrowers-itt-technical-institute-more-11b-loan-forgiveness>.

Data for Durbin 14e is 0 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.

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 also are 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. 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 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 \$32.6 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 received recoupment funds from any for-profit college since 2014. This administration, however, is prioritizing accountability and taxpayer protection through recoupment of borrower defense discharges, including where discharges are granted with respect to schools that continue to operate. To that end, in August 2022 the Department initiated a recoupment proceeding against DeVry University.

Question. According to the most recently published borrower defense report (December 2021), the Department currently has nearly 109,953 pending borrower defense claims. Please provide:

The average length of time the 109,953 claims have been pending.

Answer. The average length of time that all applications have been pending as of mid-July 2022, is 517 days. This is not specific to the 109,953 claims referenced, but rather the total number of pending applications, as of mid-July 2022.

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.

A breakdown of the 109,953 pending claims by institution.

Answer. As of mid-May 2022, 83 percent of total pending applications were related to for-profit institutions; 8 percent were related to public institutions; and 9 percent were related to private not-for-profit institutions. A small number of applications (less than 1 percent) related to foreign institutions. Applications without a school listed were excluded from this calculation.

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. An Excel file providing the requested data as of mid-May 2022 is enclosed.

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.

OPEID	Primary School Name	Pending Applications
010727	DEVRY UNIVERSITY	26,600
020988	UNIVERSITY OF PHOENIX	15,200
004553	ITT Technical Institute	15,200
	No School Listed	9,800
007477	Heald College	4,600

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
030846	Art Institute of Las Vegas (The)	3,900
021799	ARGOSY UNIVERSITY	3,800
007491	BRIGHTWOOD COLLEGE	3,600
004586	PURDUE UNIVERSITY GLOBAL	3,300
007351	SANFORD-BROWN COLLEGE	3,100
001881	ASHFORD UNIVERSITY	2,900
001499	ALTIERUS CAREER COLLEGE	2,900
007470	ART INSTITUTE OF PITTSBURGH (THE)	2,600
020754	Keller Graduate School of Management	2,500
010148	COLORADO TECHNICAL UNIVERSITY	2,100
012651	Marinello School of Beauty	2,000
021136	AMERICAN INTERCONTINENTAL UNIVERSITY	1,900
025042	WALDEN UNIVERSITY	1,800
030106	VIRGINIA COLLEGE	1,600
022202	LE CORDON BLEU COLLEGE OF CULINARY ARTS	1,400
012584	ILLINOIS INSTITUTE OF ART (THE)	1,400
009079	EVEREST COLLEGE	1,300
007548	WESTWOOD COLLEGE—DENVER NORTH	1,300
001074	GRAND CANYON UNIVERSITY	1,200
009270	ART INSTITUTE OF ATLANTA (THE)	1,200
032673	CAPELLA UNIVERSITY	1,200
001534	Everest University	1,200
004646	MINNESOTA SCHOOL OF BUSINESS	1,100
041435	CHARLOTTE SCHOOL OF LAW	1,100
003674	INDEPENDENCE UNIVERSITY	1,000
001459	STRAYER UNIVERSITY	1,000
007547	Lincoln College of Technology	1,000
013039	SOUTH UNIVERSITY	900
030727	WESTWOOD COLLEGE—LOS ANGELES	900
023036	Fortis College	900
007236	Art Institute of California—Los Angeles (The)	900
021218	Everest Institute	900
007501	VATTEROTT COLLEGE	800
004910	BRIGHTWOOD CAREER INSTITUTE	800
023462	WYOTEC	800
025909	WRIGHT CAREER COLLEGE	700
025593	UNITED EDUCATION INSTITUTE	700
021519	KEISER UNIVERSITY	600
008350	ART INSTITUTE OF PHILADELPHIA (THE) -	600
010195	ART INSTITUTE OF FORT LAUDERDALE (THE)	600
023621	FULL SAIL UNIVERSITY	600
004642	GLOBE UNIVERSITY	600
004666	AMERICAN COLLEGE FOR MEDICAL CAREERS	600
007506	Lincoln Technical Institute	600
008878	MIAMI INTERNATIONAL UNIVERSITY OF ART & DESIGN	600
004934	Daymar College	600
022159	ATI CAREER TRAINING CENTER	500
022392	ANTHEM COLLEGE	500
022239	DRAKE COLLEGE OF BUSINESS	500
021171	ART INSTITUTE OF HOUSTON (THE)	500
005127	Brown Mackie College-Cincinnati	500
007486	NEW ENGLAND INSTITUTE OF ART (THE)	500
023276	Art Institute of California—San Diego	500
020789	ART INSTITUTE OF COLORADO (THE)	500
010851	BRANFORD HALL CAREER INSTITUTE	500
004057	NATIONAL AMERICAN UNIVERSITY	400
003726	AMERICAN NATIONAL UNIVERSITY	400
023139	WESTWOOD COLLEGE—O'HARE AIRPORT	400
002455	Devry Institute of Technology	400
022913	ART INSTITUTE OF SEATTLE (THE)	400
010248	ART INSTITUTES INTERNATIONAL MINNESOTA (THE)	400
030792	WESTWOOD COLLEGE—DUPAGE	400

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
023263	Fortis Institute	400
007804	STAR CAREER ACADEMY	400
009748	CARRINGTON COLLEGE	400
008146	Everest University—Pompano Beach	400
022950	EVEREST COLLEGE PHOENIX	400
025256	ART INSTITUTE OF NEW YORK CITY (THE)	300
008221	UNIVERSAL TECHNICAL INSTITUTE	300
009828	ALTIERUS CAREER EDUCATION	300
031254	Art Institute of California-Hollywood (The)	300
005009	Bryant & Stratton College	300
021105	Art Institute of Charlotte (The)	300
006755	BROWN MACKIE COLLEGE (THE -)	300
020530	LIBERTY UNIVERSITY	300
008694	RASMUSSEN UNIVERSITY	300
034274	CAREER COLLEGES OF AMERICA	300
011031	TECHNICAL CAREER INSTITUTES	300
025965	ATI-CAREER TRAINING CENTER	300
025862	Florida Career College	300
007434	COMPUTER SYSTEMS INSTITUTE	300
035493	ULTIMATE MEDICAL ACADEMY	300
004583	Brown Mackie College-South Bend	300
006385	CHAMBERLAIN UNIVERSITY	300
001123	BROOKS INSTITUTE	300
026162	Brown Mackie College-Findlay	300
010198	ECPI UNIVERSITY	300
012482	ATI TECHNICAL TRAINING CENTER	300
021521	Academy of Court Reporting and Technology	300
007819	ART INSTITUTE OF PORTLAND (THE)	300
002580	SOUTHERN NEW HAMPSHIRE UNIVERSITY	300
030764	BRYMAN SCHOOL OF ARIZONA (THE)	300
020757	BRIARCLIFFE COLLEGE	300
025911	CAREER POINT COLLEGE	300
007398	KATHARINE GIBBS SCHOOL	300
030097	Harrison College	200
025027	UEI (United Education Institute)	200
007531	ACADEMY OF ART UNIVERSITY	200
007607	CONCORDE CAREER COLLEGE	200
007362	MEDTECH COLLEGE	200
007946	Kaplan College	200
021040	HARRIS SCHOOL OF BUSINESS	200
004673	BAKER COLLEGE	200
033394	WESTERN GOVERNORS UNIVERSITY	200
031133	UEI COLLEGE	200
011626	WESTWOOD COLLEGE—SOUTH BAY	200
033953	ICDC COLLEGE	200
025991	REMINGTON COLLEGE	200
008865	Empire Beauty School	200
038193	AMERICAN PUBLIC UNIVERSITY SYSTEM	200
007421	Berkeley College	200
026142	MILLER—MOTTE TECHNICAL COLLEGE	200
023068	MILLER—MOTTE COLLEGE	200
033743	FLORIDA COASTAL SCHOOL OF LAW	200
007606	BRYMAN COLLEGE	200
030068	LE CORDON BLEU INSTITUTE OF CULINARY ARTS	200
041314	ARIZONA SUMMIT LAW SCHOOL	200
021207	SAN JOAQUIN VALLEY COLLEGE	200
022418	AMERICAN CAREER COLLEGE	200
026110	HERITAGE COLLEGE	200
003371	TEMPLE UNIVERSITY	200
025720	VISTA COLLEGE	200
010319	FORTIS INSTITUTE—TOWSON	200
021715	WESTERN INTERNATIONAL UNIVERSITY	200

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
004898	MCCANN SCHOOL OF BUSINESS & TECHNOLOGY	200
009917	IVY TECH COMMUNITY COLLEGE OF INDIANA	200
007488	KAPLAN CAREER INSTITUTE	200
010193	Herzing University	200
009795	MISSOURI COLLEGE	200
024973	MILAN INSTITUTE	200
025943	COLLEGEAMERICA DENVER	200
009602	Regency Beauty Institute	200
025294	AMERICAN CAREER INSTITUTE	100
011159	SAWYER SCHOOL (THE)	100
022838	BEAUTY SCHOOLS OF AMERICA	100
021511	ATI COLLEGE OF HEALTH	100
021192	COURT REPORTING INSTITUTE OF ST LOUIS	100
003807	MOUNTAIN STATE UNIVERSITY	100
007844	Sanford-Brown Institute	100
022171	PIMA MEDICAL INSTITUTE	100
025321	BUSINESS CAREER TRAINING INSTITUTE	100
004619	SULLIVAN UNIVERSITY	100
009451	Brown Mackie College	100
025578	ART INSTITUTE OF YORK (THE)—PENNSYLVANIA	100
038133	NORTHCENTRAL UNIVERSITY	100
030955	ASA COLLEGE	100
031264	Centura College	100
038323	DADE MEDICAL COLLEGE	100
030998	ILLINOIS SCHOOL OF HEALTH CAREERS	100
025830	GWINNETT COLLEGE	100
011246	BROOKS COLLEGE	100
022023	PITTSBURGH CAREER INSTITUTE	100
001401	POST UNIVERSITY	100
007341	INTERNATIONAL BEAUTY SCHOOL	100
035453	UNIVERSITY OF THE ROCKIES	100
004618	Spencerian College	100
001081	ARIZONA STATE UNIVERSITY	100
001509	NOVA SOUTHEASTERN UNIVERSITY—DAVIE	100
030675	INSTITUTE OF TECHNOLOGY	100
021867	HARRISON CAREER INSTITUTE	100
034933	ALL—STATE CAREER	100
001666	CONCORDIA UNIVERSITY	100
025769	CHARTER COLLEGE	100
011259	CONCORDE CAREER INSTITUTE	100
021749	Collins College	100
008424	LA' JAMES INTERNATIONAL COLLEGE	100
012891	ANTONELLI COLLEGE	100
004992	MILLER—MOTTE TECHNICAL COLLEGE	100
023522	LE CORDON BLEU COLLEGE OF CULINARY ARTS IN CHICAGO	100
023328	CENTER FOR EMPLOYMENT TRAINING	100
021210	SOUTHERN TECHNICAL COLLEGE	100
025396	Art Institute of Dallas (The)	100
007507	GIBBS COLLEGE	100
011647	SBI CAMPUS—AN AFFILIATE OF SANFORD—BROWN	100
007164	BRYAN UNIVERSITY	100
001746	Robert Morris University Illinois	100
030693	WESTERN CAREER COLLEGE	100
026055	Remington College—Mobile Campus	100
020997	ROSS MEDICAL EDUCATION CENTER	100
002667	DOWLING COLLEGE	100
011644	UNIVERSITY OF MARYLAND GLOBAL CAMPUS	100
023565	AMERICAN BEAUTY ACADEMY	100
022375	LAS VEGAS COLLEGE	100
011574	BAUDER COLLEGE	100
025154	CITY COLLEGE	100
004729	MOUNT WASHINGTON COLLEGE	100

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
011460	NATIONAL UNIVERSITY—LA JOLLA	100
025842	NEWBRIDGE COLLEGE	100
022188	BROOKLINE COLLEGE	100
040373	LOS ANGELES FILM SCHOOL (THE)	100
001583	MORRIS BROWN COLLEGE	100
003076	Miami—Jacobs Career College	100
031248	Platt College	100
021553	CHICAGO SCHOOL OF PROFESSIONAL PSYCHOLOGY	100
034095	CHESTER CAREER COLLEGE	100
035343	JONES INTERNATIONAL UNIVERSITY	100
010057	AMERICAN COMMERCIAL COLLEGE	100
002704	COLLEGE OF NEW ROCHELLE (THE)	100
040393	SULLIVAN AND COGLIANO TRAINING CENTERS	100
030012	MCNALLY SMITH COLLEGE OF MUSIC	100
010854	THOMAS JEFFERSON SCHOOL OF LAW	100
002383	CROWN COLLEGE	100
007296	COLEMAN UNIVERSITY	100
041215	COLUMBIA SOUTHERN UNIVERSITY	100
007297	SPARTAN COLLEGE OF AERONAUTICS AND TECHNOLOGY	100
022796	CORTIVA INSTITUTE	100
008441	ANTHEM INSTITUTE	100
001328	UNIVERSITY OF SOUTHERN CALIFORNIA	100
011112	FASHION INSTITUTE OF DESIGN & MERCHANDISING -	100
001526	SAINT LEO UNIVERSITY	100
007586	Remington College—Tampa Campus	100
030695	SAGE COLLEGE	100
031239	SOUTHEASTERN COLLEGE	100
021315	NORTHWESTERN COLLEGE	100
034225	Blue Cliff College	100
002751	LONG ISLAND UNIVERSITY	100
033583	ALLEN SCHOOL	100
022231	HERITAGE INSTITUTE	100
022460	ROSS UNIVERSITY, SCHOOL OF MEDICINE	100
030778	Brown Mackie College-North Canton	100
021082	Brown Mackie College-Louisville	100
010633	HOUSTON COMMUNITY COLLEGE	100
001466	BARRY UNIVERSITY	100
003404	JOHNSON & WALES UNIVERSITY	100
009635	FLORIDA INTERNATIONAL UNIVERSITY	100
003329	PENNSYLVANIA STATE UNIVERSITY (THE)	100
041319	FASTTRAIN OF MIAMI	100
002249	DAVENPORT UNIVERSITY	100
022195	MILDRED ELLEY	100
021032	BROWN MACKIE COLLEGE—MERRILLVILLE	100
010779	PORTER AND CHESTER INSTITUTE	100
022187	Florida Technical College	100
007437	PITTSBURGH TECHNICAL COLLEGE	100
001484	FLORIDA STATE COLLEGE AT JACKSONVILLE	100
036183	INSTITUTE OF TECHNICAL ARTS	100
008417	STENOTYPE INSTITUTE OF JACKSONVILLE	100
004731	DANIEL WEBSTER COLLEGE	100
002937	KING'S COLLEGE	100
023301	PIONEER PACIFIC COLLEGE	100
031281	COLLEGE OF HEALTH CARE PROFESSIONS (THE)	100
001480	FLORIDA AGRICULTURAL & MECHANICAL UNIVERSITY	100
002629	RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY	100
001574	GEORGIA STATE UNIVERSITY	100
030522	COURT REPORTING INSTITUTE, INC	100
002456	COLUMBIA COLLEGE	100
041223	GRANTHAM UNIVERSITY	100
004692	DORSEY COLLEGE	100
011145	LONE STAR COLLEGE SYSTEM	100

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
023071	COMPUTER LEARNING CENTER	100
030353	SOUTHERN CAREERS INSTITUTE	100
009743	BELLEVUE UNIVERSITY	100
002785	NEW YORK UNIVERSITY	100
001467	BETHUNE COOKMAN UNIVERSITY	100
025594	INTERCOAST COLLEGES	100
003121	TIFFIN UNIVERSITY	100
010217	International Academy of Design and Technology	100
003642	TEXAS SOUTHERN UNIVERSITY	100
033683	MIDWEST TECHNICAL INSTITUTE	100
021540	DIVERS ACADEMY OF THE EASTERN SEABOARD	100
002649	SANTA FE UNIVERSITY OF ART AND DESIGN	100
009228	DeVry College of Technology	100
001671	DEPAUL UNIVERSITY	100
010913	MADISON MEDIA INSTITUTE	100
004799	MONROE COLLEGE	100
021108	CALIFORNIA COLLEGE SAN DIEGO	100
003051	KENT STATE UNIVERSITY	100
035133	LACY COSMETOLOGY SCHOOL	100
011166	BROADVIEW COLLEGE	100
020552	HARRINGTON COLLEGE OF DESIGN	100
003954	UNIVERSITY OF CENTRAL FLORIDA—MAIN CAMPUS	100
005203	Remington College—Lafayette Campus	100
009591	COMPUTER LEARNING CENTERS, INC. LOS ANGELES	100
001537	UNIVERSITY OF SOUTH FLORIDA	<50
001047	TROY UNIVERSITY	<50
030623	WESTTECH COLLEGE	<50
001822	INDIANA WESLEYAN UNIVERSITY	<50
041320	FASTTRAIN OF FORT LAUDERDALE	<50
010405	PINNACLE CAREER INSTITUTE	<50
002834	EXCELSIOR COLLEGE	<50
002329	WAYNE STATE UNIVERSITY	<50
003522	TENNESSEE STATE UNIVERSITY	<50
031203	COLLEGEAMERICA—FLAGSTAFF	<50
022662	HELMS CAREER INSTITUTE	<50
002521	WEBSTER UNIVERSITY	<50
002772	MERCY COLLEGE	<50
010861	WEST VIRGINIA BUSINESS COLLEGE	<50
009572	COMPUTER LEARNING CENTER OF ALEXANDRIA	<50
003656	UNIVERSITY OF TEXAS AT ARLINGTON	<50
033993	BRYAN COLLEGE	<50
031623	FOUR-D COLLEGE	<50
001448	HOWARD UNIVERSITY	<50
002025	SOUTHERN UNIVERSITY AND AGRICULTURAL & MECHANICAL COLG AT BATON ROUGE	<50
036933	CARNEGIE CAREER COLLEGE	<50
005452	AVIATION INSTITUTE OF MAINTENANCE	<50
007777	Remington College—Cleveland Campus	<50
001153	CALIFORNIA STATE UNIVERSITY, NORTHRIDGE	<50
001481	FLORIDA ATLANTIC UNIVERSITY	<50
036983	WEST COAST UNIVERSITY	<50
025494	South Texas Vocational Technical Institute	<50
026068	Career Technical College	<50
001528	ST. PETERSBURG COLLEGE	<50
001694	CHICAGO STATE UNIVERSITY	<50
021279	SOJOURNER—DOUGLASS COLLEGE	<50
022449	GOODWIN UNIVERSITY	<50
009982	VICTORY UNIVERSITY	<50
020748	LIFE UNIVERSITY	<50
001805	INDIANA INSTITUTE OF TECHNOLOGY	<50
001665	COLUMBIA COLLEGE CHICAGO	<50
002290	MICHIGAN STATE UNIVERSITY	<50
024915	SOUTHWEST UNIVERSITY OF VISUAL ARTS	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
004853	BRADFORD SCHOOL	<50
003256	DREXEL UNIVERSITY	<50
006867	COLUMBUS STATE COMMUNITY COLLEGE- MAIN CAMPUS	<50
003125	UNIVERSITY OF CINCINNATI	<50
023378	COLLEGE OF OFFICE TECHNOLOGY	<50
022482	MILAN INSTITUTE OF COSMETOLOGY	<50
008889	LEHIGH VALLEY COLLEGE	<50
001559	CLARK ATLANTA UNIVERSITY	<50
006750	VALENCIA COLLEGE	<50
023089	MASTERS OF COSMETOLOGY COLLEGE	<50
011707	NORTH-WEST COLLEGE	<50
002193	MOUNT IDA COLLEGE	<50
001469	FLORIDA INSTITUTE OF TECHNOLOGY	<50
001489	FLORIDA STATE UNIVERSITY	<50
041322	FASTTRAIN OF JACKSONVILLE	<50
034414	NEWBRIDGE COLLEGE—SAN DIEGO EAST	<50
004531	PHILLIPS JUNIOR COLLEGE	<50
004938	SOUTH COLLEGE	<50
021415	SAVANNAH COLLEGE OF ART AND DESIGN	<50
004467	TUCSON COLLEGE	<50
004220	Hamilton College	<50
003509	UNIVERSITY OF MEMPHIS (THE)	<50
003131	UNIVERSITY OF TOLEDO	<50
003510	MIDDLE TENNESSEE STATE UNIVERSITY	<50
041321	FASTTRAIN OF TAMPA	<50
031287	MT. SIERRA COLLEGE	<50
022741	LA' JAMES INTERNATIONAL COLLEGE—DES MOINES	<50
021493	SCS BUSINESS AND TECHNICAL INSTITUTE	<50
003652	UNIVERSITY OF HOUSTON	<50
003273	HARRISBURG AREA COMMUNITY COLLEGE	<50
003184	UNIVERSITY OF OKLAHOMA	<50
039733	SAE EXPRESSION COLLEGE	<50
030911	ACT COLLEGE	<50
021785	EAGLE GATE COLLEGE	<50
023013	PRISM CAREER INSTITUTE	<50
008635	IBMC COLLEGE	<50
042279	MORTHLAND COLLEGE	<50
002732	HOFSTRA UNIVERSITY	<50
002123	BECKER COLLEGE	<50
009230	WAYNE COUNTY COMMUNITY COLLEGE DISTRICT	<50
003090	OHIO STATE UNIVERSITY (THE)	<50
001533	TALLAHASSEE COMMUNITY COLLEGE	<50
025412	STRATFORD UNIVERSITY	<50
022537	INTELLITEC COLLEGE	<50
003866	MILWAUKEE AREA TECHNICAL COLLEGE	<50
002569	UNIVERSITY OF NEVADA—LAS VEGAS	<50
001500	BROWARD COLLEGE	<50
001002	ALABAMA AGRICULTURAL & MECHANICAL UNIVERSITY	<50
001005	ALABAMA STATE UNIVERSITY	<50
034483	BUSINESS INDUSTRIAL RESOURCES	<50
041232	INSTITUTE OF ALLIED MEDICAL PROFESSIONS	<50
010142	TOURO UNIVERSITY	<50
002199	NORTHEASTERN UNIVERSITY	<50
001787	BETHEL UNIVERSITY	<50
001536	UNIVERSITY OF MIAMI	<50
005753	OWENS COMMUNITY COLLEGE	<50
004625	DELGADO COMMUNITY COLLEGE	<50
001577	KENNESAW STATE UNIVERSITY	<50
001758	SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE	<50
001813	INDIANA UNIVERSITY—PURDUE UNIVERSITY INDIANAPOLIS	<50
003594	UNIVERSITY OF NORTH TEXAS	<50
037404	ATI COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002823	SAINT JOHN'S UNIVERSITY	<50
030724	All-State Career School	<50
002259	EASTERN MICHIGAN UNIVERSITY	<50
001506	MIAMI DADE COLLEGE	<50
037633	MEDICAL PROFESSIONAL INSTITUTE	<50
040743	HONDROS COLLEGE OF NURSING	<50
001057	UNIVERSITY OF SOUTH ALABAMA	<50
001083	UNIVERSITY OF ARIZONA (THE)	<50
025476	FLORIDA NATIONAL UNIVERSITY	<50
004617	NATIONAL COLLEGE	<50
004866	STAUTZENBERGER COLLEGE	<50
012627	THOMAS M. COOLEY LAW SCHOOL	<50
022539	Berks Technical Institute	<50
002622	KEAN UNIVERSITY	<50
001737	NORTHERN ILLINOIS UNIVERSITY	<50
024911	BECKFIELD COLLEGE	<50
031131	MARIC COLLEGE	<50
021283	INSTITUTE FOR BUSINESS & TECHNOLOGY	<50
020798	HEALD COLLEGE, SCHOOL OF BUSINESS	<50
001703	Kendall College	<50
001733	NATIONAL LOUIS UNIVERSITY	<50
008976	CLAYTON STATE UNIVERSITY	<50
003630	PRAIRIE VIEW AGRICULTURAL & MECHANICAL UNIVERSITY	<50
003615	TEXAS STATE UNIVERSITY	<50
003040	CUYAHOGA COMMUNITY COLLEGE	<50
002617	MONTCLAIR STATE UNIVERSITY	<50
002441	UNIVERSITY OF SOUTHERN MISSISSIPPI	<50
002330	WESTERN MICHIGAN UNIVERSITY	<50
002410	JACKSON STATE UNIVERSITY	<50
035643	INTERNATIONAL SCHOOL OF HEALTH, BEAUTY & TECHNOLOGY	<50
041341	JERSEY COLLEGE	<50
021123	RIDLEY—LOWELL BUSINESS & TECHNICAL INSTITUTE	<50
002480	LINDENWOOD UNIVERSITY	<50
002791	PACE UNIVERSITY	<50
010881	STARK STATE COLLEGE	<50
003612	UNIVERSITY OF HOUSTON—DOWNTOWN	<50
003896	UNIVERSITY OF WISCONSIN—MILWAUKEE	<50
042087	COLORADO STATE UNIVERSITY—GLOBAL CAMPUS	<50
003735	VIRGINIA COMMONWEALTH UNIVERSITY	<50
003123	UNIVERSITY OF AKRON (THE)	<50
002518	UNIVERSITY OF MISSOURI—KANSAS CITY	<50
002002	WESTERN KENTUCKY UNIVERSITY	<50
002950	NORTH CAROLINA CENTRAL UNIVERSITY	<50
041160	VIDEO SYMPHONY ENTERTRAINING	<50
041279	TRIDENT UNIVERSITY INTERNATIONAL	<50
025779	SANTA BARBARA BUSINESS COLLEGE	<50
031150	ARIZONA COLLEGE	<50
031081	SUMMIT COLLEGE	<50
030837	GALEN HEALTH INSTITUTES	<50
011117	ALLIANT INTERNATIONAL UNIVERSITY	<50
009432	ESS COLLEGE OF BUSINESS	<50
002284	MARYGROVE COLLEGE	<50
001479	EMBRY—RIDDLE AERONAUTICAL UNIVERSITY	<50
001535	UNIVERSITY OF FLORIDA	<50
001520	SEMINOLE STATE COLLEGE OF FLORIDA	<50
001775	UNIVERSITY OF ILLINOIS URBANA—CHAMPAIGN	<50
001544	ALBANY STATE UNIVERSITY	<50
041359	ORION COLLEGE	<50
038425	CAMBRIDGE COLLEGE OF HEALTHCARE & TECHNOLOGY	<50
041323	INSTITUTE OF MEDICAL EDUCATION	<50
013005	OLYMPIAN ACADEMY OF COSMETOLOGY	<50
025762	MID—CONTINENT UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
004579	INTERNATIONAL BUSINESS COLLEGE	<50
003991	GREENVILLE TECHNICAL COLLEGE	<50
003800	WASHINGTON STATE UNIVERSITY	<50
003712	TIDEWATER COMMUNITY COLLEGE	<50
003626	TARRANT COUNTY COLLEGE DISTRICT	<50
003100	OHIO UNIVERSITY	<50
001154	SAN FRANCISCO STATE UNIVERSITY	<50
001082	NORTHERN ARIZONA UNIVERSITY	<50
001052	UNIVERSITY OF ALABAMA AT BIRMINGHAM	<50
033674	COMMUNITY CARE COLLEGE	<50
041618	BRANDMAN UNIVERSITY	<50
009449	PENNCO TECH	<50
023148	BALTIMORE INTERNATIONAL COLLEGE	<50
007518	APEX TECHNICAL SCHOOL	<50
007405	WOOD TOBE—COBURN SCHOOL	<50
003313	WIDENER UNIVERSITY	<50
020662	NEW SCHOOL, THE	<50
001562	Georgia Perimeter College	<50
010115	UNIVERSITY OF TEXAS AT SAN ANTONIO	<50
003644	TEXAS TECH UNIVERSITY	<50
002083	MORGAN STATE UNIVERSITY	<50
001561	COLUMBUS STATE UNIVERSITY	<50
002923	EAST CAROLINA UNIVERSITY	<50
002519	UNIVERSITY OF MISSOURI—SAINT LOUIS	<50
001776	UNIVERSITY OF ILLINOIS AT CHICAGO	<50
002006	GRAMBLING STATE UNIVERSITY	<50
002657	NEW MEXICO STATE UNIVERSITY	<50
002243	CENTRAL MICHIGAN UNIVERSITY	<50
002270	HENRY FORD COLLEGE	<50
041697	UNITEK COLLEGE	<50
037893	UNITECH TRAINING ACADEMY	<50
025215	LAMSON COLLEGE	<50
033484	MATTIA COLLEGE	<50
030897	CAREER INSTITUTE OF HEALTH AND TECHNOLOGY	<50
020555	DELTA SCHOOL OF BUSINESS AND TECHNOLOGY	<50
022949	INSTITUTE OF AUDIO RESEARCH	<50
008106	WESTERN TECHNICAL COLLEGE	<50
007948	WILMINGTON UNIVERSITY	<50
003420	BENEDICT COLLEGE	<50
011719	UNIVERSIDAD ANA G. MENDEZ—GURABO CAMPUS	<50
009401	COLORADO CHRISTIAN UNIVERSITY	<50
001497	JONES COLLEGE	<50
004846	Rasmussen College	<50
001003	FAULKNER UNIVERSITY	<50
001342	WHITTIER COLLEGE	<50
003728	OLD DOMINION UNIVERSITY	<50
007870	HILLSBOROUGH COMMUNITY COLLEGE	<50
010286	SUNY EMPIRE STATE COLLEGE	<50
010345	CINCINNATI STATE TECHNICAL & COMMUNITY COLLEGE	<50
021775	RIO SALADO COMMUNITY COLLEGE	<50
003152	UNIVERSITY OF CENTRAL OKLAHOMA	<50
002663	UNIVERSITY OF NEW MEXICO	<50
002613	NEW JERSEY CITY UNIVERSITY	<50
001150	CALIFORNIA STATE UNIVERSITY—SACRAMENTO	<50
036393	TRIAD EDUCATION	<50
001101	UNIVERSITY OF ARKANSAS AT LITTLE ROCK	<50
030316	DPT BUSINESS SCHOOL	<50
026009	AVEDA ARTS & SCIENCES INSTITUTE COVINGTON	<50
025868	HARRISON CAREER INSTITUTE—	<50
011505	TRICOCI UNIVERSITY OF BEAUTY CULTURE	<50
022965	MASTERS INSTITUTE	<50
004568	MIDSTATE COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
009769	METROPOLITAN COLLEGE OF NEW YORK	<50
010149	PEPPERDINE UNIVERSITY	<50
001486	FLORIDA MEMORIAL UNIVERSITY	<50
001444	GEORGE WASHINGTON UNIVERSITY	<50
003764	VIRGINIA STATE UNIVERSITY	<50
003634	TEXAS STATE TECHNICAL COLLEGE	<50
001360	METROPOLITAN STATE UNIVERSITY OF DENVER	<50
003446	SOUTH CAROLINA STATE UNIVERSITY	<50
003249	COMMUNITY COLLEGE OF PHILADELPHIA	<50
002010	LOUISIANA STATE UNIVERSITY & AGRICULTURAL & MECHANICAL COLLEGE	<50
039853	CDA TECHNICAL INSTITUTE	<50
001051	UNIVERSITY OF ALABAMA	<50
023405	ST. LOUIS COLLEGE OF HEALTH CAREERS	<50
023190	COMPUTER LEARNING CENTERS, INC. CHICAGO	<50
022606	NUC UNIVERSITY	<50
030375	HODGES UNIVERSITY	<50
003043	CHANCELLOR UNIVERSITY	<50
006975	LINCOLN UNIVERSITY	<50
001210	HEALD INSTITUTE OF TECHNOLOGY	<50
003765	NORFOLK STATE UNIVERSITY	<50
009145	GOVERNORS STATE UNIVERSITY	<50
001572	GEORGIA SOUTHERN UNIVERSITY	<50
001139	CALIFORNIA STATE UNIVERSITY, LONG BEACH	<50
001475	DAYTONA STATE COLLEGE	<50
001892	UNIVERSITY OF IOWA	<50
039153	CAREER QUEST LEARNING CENTERS	<50
025399	STAR TECHNICAL INSTITUTE	<50
030682	OHIO MEDIA SCHOOL	<50
023385	GLENDALE CAREER COLLEGE	<50
031043	CAREER TECHNICAL INSTITUTE	<50
030198	PCI HEALTH TRAINING CENTER	<50
021066	AMERICAN INSTITUTE	<50
012846	LAWTON SCHOOL FOR MEDICAL AND DENTAL ASSISTANTS	<50
004730	MCINTOSH COLLEGE	<50
009268	KELSEY -JENNEY COLLEGE	<50
002782	NEW YORK INSTITUTE OF TECHNOLOGY	<50
007572	AMERICAN MUSICAL & DRAMATIC ACADEMY	<50
004072	NORTHWOOD UNIVERSITY	<50
001767	BENEDICTINE UNIVERSITY	<50
001363	REGIS UNIVERSITY	<50
001416	UNIVERSITY OF BRIDGEPORT	<50
002130	BOSTON UNIVERSITY	<50
001456	SOUTHEASTERN UNIVERSITY	<50
001749	ROOSEVELT UNIVERSITY	<50
002975	UNIVERSITY OF NORTH CAROLINA—CHARLOTTE	<50
002842	SUNY COLLEGE AT BUFFALO	<50
001989	UNIVERSITY OF KENTUCKY	<50
003581	LAMAR UNIVERSITY	<50
002872	MONROE COMMUNITY COLLEGE	<50
002407	HINDS COMMUNITY COLLEGE	<50
001137	CALIFORNIA STATE UNIVERSITY, FULLERTON	<50
001599	VALDOSTA STATE UNIVERSITY	<50
001428	DELAWARE STATE UNIVERSITY	<50
001827	PURDUE UNIVERSITY NORTHWEST	<50
002303	OAKLAND COMMUNITY COLLEGE	<50
023220	COMPUTER LEARNING CENTERS, INC. SAN FRANCISCO	<50
034685	MDT COLLEGE OF HEALTH SCIENCES	<50
030642	COMPUTER LEARNING CENTER OF ANAHEIM	<50
025964	SPARTAN COLLEGE OF AERONAUTICS & TECHNOLOGY	<50
013016	OGLE SCHOOL HAIR SKIN NAILS	<50
035134	APEX SCHOOL OF THEOLOGY	<50
009618	TULSA WELDING SCHOOL	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
009043	ELMIRA BUSINESS INSTITUTE	<50
010831	NEW COLLEGE OF CALIFORNIA	<50
001710	LOYOLA UNIVERSITY CHICAGO	<50
003827	WEST VIRGINIA UNIVERSITY	<50
003648	TYLER JUNIOR COLLEGE	<50
009841	UNIVERSITY OF NORTH FLORIDA	<50
002837	STATE UNIVERSITY OF NEW YORK AT BUFFALO	<50
002362	MINNEAPOLIS COMMUNITY AND TECHNICAL COLLEGE	<50
003213	PORTLAND COMMUNITY COLLEGE	<50
002031	UNIVERSITY OF LOUISIANA AT LAFAYETTE	<50
003316	CALIFORNIA UNIVERSITY OF PENNSYLVANIA	<50
002609	ROWAN UNIVERSITY	<50
002396	ALCORN STATE UNIVERSITY	<50
001590	SAVANNAH STATE UNIVERSITY	<50
002307	OAKLAND UNIVERSITY	<50
041157	REGINA'S COLLEGE OF BEAUTY	<50
041848	VANTAGE COLLEGE	<50
037563	ANAMARC COLLEGE	<50
038663	GALIANO CAREER ACADEMY	<50
025982	UNIVERSITY OF SOUTHERNMOST FLORIDA	<50
012425	STONE ACADEMY	<50
021483	MANHATTAN BEAUTY SCHOOL	<50
009407	LINCOLN COLLEGE OF NEW ENGLAND	<50
031085	EVERGLADES UNIVERSITY	<50
002722	FORDHAM UNIVERSITY	<50
003938	INTER AMERICAN UNIVERSITY OF PUERTO RICO—SAN GERMAN CAMPUS	<50
002077	JOHNS HOPKINS UNIVERSITY	<50
022779	ROSS UNIVERSITY SCHOOL OF VETERINARY MEDICINE	<50
001325	UNIVERSITY OF SAN FRANCISCO	<50
007933	FRONT RANGE COMMUNITY COLLEGE	<50
003646	TEXAS WOMANS UNIVERSITY	<50
003955	UNIVERSITY OF WEST FLORIDA (THE)	<50
003448	UNIVERSITY OF SOUTH CAROLINA—COLUMBIA	<50
002835	STATE UNIVERSITY OF NEW YORK AT ALBANY	<50
003478	AUSTIN PEAY STATE UNIVERSITY	<50
001140	CALIFORNIA STATE UNIVERSITY, LOS ANGELES	<50
003032	CLEVELAND STATE UNIVERSITY	<50
001807	INDIANA STATE UNIVERSITY	<50
003451	COASTAL CAROLINA UNIVERSITY	<50
002268	GRAND VALLEY STATE UNIVERSITY	<50
002424	MISSISSIPPI VALLEY STATE UNIVERSITY	<50
002278	LANSING COMMUNITY COLLEGE	<50
040383	ATA COLLEGE	<50
040803	ASPEN UNIVERSITY	<50
036253	PERFORMANCE TRAINING INSTITUTE	<50
001090	ARKANSAS STATE UNIVERSITY	<50
025318	PAUL MITCHELL THE SCHOOL COSTA MESA	<50
021440	BEAUTY INSTITUTE (THE)	<50
008655	GENESIS CAREER COLLEGE	<50
007814	BROOKSTONE COLLEGE OF BUSINESS	<50
010351	PSI INSTITUTE	<50
003739	SAINT PAUL'S COLLEGE	<50
004484	JOHN F. KENNEDY UNIVERSITY	<50
012300	PALMER COLLEGE OF CHIROPRACTIC	<50
001842	VALPARAISO UNIVERSITY	<50
001580	MERCER UNIVERSITY	<50
002211	SPRINGFIELD COLLEGE	<50
001117	AZUSA PACIFIC UNIVERSITY	<50
002165	MCPHS UNIVERSITY	<50
001468	SAINT THOMAS UNIVERSITY	<50
004076	KIRKWOOD COMMUNITY COLLEGE	<50
004920	TRIDENT TECHNICAL COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003078	WRIGHT STATE UNIVERSITY	<50
002905	NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY	<50
002873	NASSAU COMMUNITY COLLEGE	<50
001809	INDIANA UNIVERSITY—BLOOMINGTON	<50
002928	FAYETTEVILLE STATE UNIVERSITY	<50
002260	FERRIS STATE UNIVERSITY	<50
003216	PORTLAND STATE UNIVERSITY	<50
001441	UNIVERSITY OF THE DISTRICT OF COLUMBIA	<50
002516	UNIVERSITY OF MISSOURI—COLUMBIA	<50
041826	HCI COLLEGE	<50
007648	DENVER TECHNICAL COLLEGE	<50
030913	REGENT UNIVERSITY	<50
007401	MANDL SCHOOL	<50
002632	SETON HALL UNIVERSITY	<50
003309	PEIRCE COLLEGE	<50
010509	HALLMARK UNIVERSITY	<50
001044	STILLMAN COLLEGE	<50
001216	UNIVERSITY OF LA VERNE	<50
001433	WESLEY COLLEGE	<50
001445	GEORGETOWN UNIVERSITY	<50
037303	BATON ROUGE COMMUNITY COLLEGE	<50
004508	UNIVERSITY OF COLORADO DENVER	<50
009763	TULSA COMMUNITY COLLEGE	<50
003632	TEXAS A&M UNIVERSITY	<50
004838	GUILFORD TECHNICAL COMMUNITY COLLEGE	<50
003749	GEORGE MASON UNIVERSITY	<50
021922	THOMAS EDISON STATE UNIVERSITY	<50
003969	UNIVERSITY OF MINNESOTA—TWIN CITIES	<50
003773	CLARK COLLEGE	<50
002976	UNIVERSITY OF NORTH CAROLINA -GREENSBORO	<50
001963	EASTERN KENTUCKY UNIVERSITY	<50
003145	YOUNGSTOWN STATE UNIVERSITY	<50
002325	UNIVERSITY OF MICHIGAN	<50
001999	UNIVERSITY OF LOUISVILLE	<50
002327	UNIVERSITY OF MICHIGAN—FLINT	<50
003119	SINCLAIR COMMUNITY COLLEGE	<50
001825	PURDUE UNIVERSITY	<50
001869	IOWA STATE UNIVERSITY OF SCIENCE & TECHNOLOGY	<50
001616	BOISE STATE UNIVERSITY	<50
001020	JACKSONVILLE STATE UNIVERSITY	<50
041194	AVEDA INSTITUTE—SOUTH FLORIDA	<50
041390	MIDWESTERN CAREER COLLEGE	<50
030716	CBT TECHNOLOGY INSTITUTE	<50
031258	PREMIERE CAREER COLLEGE	<50
031100	ACADEMY OF HEALING ARTS	<50
025801	IVERSON INSTITUTE	<50
034023	METROPOLITAN COMMUNITY COLLEGE	<50
025590	UNIVERSITY OF ADVANCING COMPUTER TECHNOLOGY	<50
031268	PACIFICA GRADUATE INSTITUTE	<50
021280	SUPERIOR TRAINING SERVICES	<50
022452	MTI COLLEGE OF BUSINESS AND TECHNOLOGY	<50
020912	ELEGANCE INTERNATIONAL	<50
021107	CLEVELAND INSTITUTE OF DENTAL—MEDICAL ASSISTANTS	<50
012912	MTI COLLEGE	<50
010279	HICKEY COLLEGE	<50
004297	WATTERSON COLLEGE	<50
003046	FRANKLIN UNIVERSITY	<50
003010	ANTIOCH UNIVERSITY	<50
003499	LANE COLLEGE	<50
003388	VILLANOVA UNIVERSITY	<50
002482	MARYVILLE UNIVERSITY OF SAINT LOUIS	<50
006942	MID-AMERICA CHRISTIAN UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003357	POINT PARK UNIVERSITY	<50
022444	AMERICAN UNIVERSITY OF THE CARIBBEAN	<50
002114	AMERICAN INTERNATIONAL COLLEGE	<50
001397	UNIVERSITY OF NEW HAVEN	<50
003798	UNIVERSITY OF WASHINGTON	<50
003727	NORTHERN VIRGINIA COMMUNITY COLLEGE	<50
002099	TOWSON UNIVERSITY	<50
002503	MISSOURI STATE UNIVERSITY	<50
001155	SAN JOSE STATE UNIVERSITY	<50
002222	UNIVERSITY OF MASSACHUSETTS AT BOSTON	<50
003277	INDIANA UNIVERSITY OF PENNSYLVANIA	<50
001786	BALL STATE UNIVERSITY	<50
003223	UNIVERSITY OF OREGON	<50
003018	BOWLING GREEN STATE UNIVERSITY	<50
001601	UNIVERSITY OF WEST GEORGIA	<50
002875	ONONDAGA COMMUNITY COLLEGE	<50
001151	SAN DIEGO STATE UNIVERSITY	<50
001024	UNIVERSITY OF WEST ALABAMA	<50
042065	MYCOMPUTERCAREER.COM	<50
001076	GLENDALE COMMUNITY COLLEGE	<50
001086	UNIVERSITY OF ARKANSAS AT PINE BLUFF	<50
041414	LAURUS COLLEGE	<50
033943	REMINGTON COLLEGE—SAN DIEGO CAMPUS	<50
023112	AMERICAN SCHOOL OF TECHNOLOGY	<50
030399	FREMONT UNIVERSITY	<50
022552	PENNSYLVANIA SCHOOL OF BUSINESS	<50
004825	TAYLOR BUSINESS INSTITUTE	<50
010061	BRYANT AND STRATTON COLLEGE -VIRGINIA BEACH CAMPUS	<50
007050	BELLUS ACADEMY	<50
010503	WICHITA TECHNICAL INSTITUTE	<50
009022	ASSOCIATED TECHNICAL COLLEGE	<50
021686	EAST-WEST UNIVERSITY	<50
006731	CASA LOMA COLLEGE	<50
007845	NEW ENGLAND INSTITUTE OF TECHNOLOGY	<50
002498	PARK UNIVERSITY	<50
008849	PALM BEACH ATLANTIC UNIVERSITY	<50
002342	ST. CATHERINE UNIVERSITY	<50
001371	UNIVERSITY OF DENVER	<50
003631	TARLETON STATE UNIVERSITY	<50
020753	UNIVERSITY OF ARKANSAS—PULASKI TECHNICAL COLLEGE	<50
010362	COLLEGE OF SOUTHERN NEVADA	<50
005622	GEORGIA PIEDMONT TECHNICAL COLLEGE	<50
006961	JEFFERSON COMMUNITY AND TECHNICAL COLLEGE	<50
009542	COMMUNITY COLLEGE OF DENVER	<50
007120	DES MOINES AREA COMMUNITY COLLEGE	<50
023614	COLLIN COUNTY COMMUNITY COLLEGE DISTRICT	<50
002423	MISSISSIPPI STATE UNIVERSITY	<50
001417	UNIVERSITY OF CONNECTICUT	<50
003565	TEXAS A&M UNIVERSITY—COMMERCE	<50
002625	WILLIAM PATERSON UNIVERSITY OF NEW JERSEY	<50
003593	NAVARRO COLLEGE	<50
003026	CENTRAL STATE UNIVERSITY	<50
001566	FORT VALLEY STATE UNIVERSITY	<50
002691	CUNY BOROUGH OF MANHATTAN COMMUNITY COLLEGE	<50
001815	INDIANA UNIVERSITY—NORTHWEST	<50
002026	SOUTHERN UNIVERSITY AT NEW ORLEANS	<50
002261	CHARLES STEWART MOTT COMMUNITY COLLEGE	<50
001315	UNIVERSITY OF CALIFORNIA, LOS ANGELES	<50
038123	OMNITECH INSTITUTE	<50
041317	SOUTHWEST UNIVERSITY AT EL PASO	<50
001077	MESA COMMUNITY COLLEGE	<50
025408	GLOBE INSTITUTE OF TECHNOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
025389	INTERNATIONAL BUSINESS COLLEGE—	<50
022708	JOYCE UNIVERSITY OF NURSING AND HEALTH SCIENCES	<50
020741	CAPITOL CITY TRADE & TECHNICAL SCHOOL	<50
022025	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF CONN	<50
021274	YTI CAREER INSTITUTE	<50
022342	KEYSTONE TECHNICAL INSTITUTE	<50
003965	BAY STATE COLLEGE	<50
009479	ST. PAUL'S SCHOOL OF NURSING	<50
005007	WEST VIRGINIA JUNIOR COLLEGE	<50
004645	MINNEAPOLIS BUSINESS COLLEGE	<50
007469	HUSSIAN COLLEGE	<50
021829	CAMBRIDGE COLLEGE	<50
002604	FAIRLEIGH DICKINSON UNIVERSITY	<50
003199	MARYLHURST UNIVERSITY	<50
003985	ORAL ROBERTS UNIVERSITY	<50
002962	SHAW UNIVERSITY	<50
001937	OTTAWA UNIVERSITY	<50
001243	MOUNT SAINT MARY'S UNIVERSITY	<50
005244	BLUEGRASS COMMUNITY & TECHNICAL COLLEGE	<50
004844	WAKE TECHNICAL COMMUNITY COLLEGE	<50
003815	MARSHALL UNIVERSITY	<50
007022	CUNY LEHMAN COLLEGE	<50
021163	PUEBLO COMMUNITY COLLEGE	<50
007191	NORTHAMPTON COUNTY AREA COMMUNITY COLLEGE	<50
003661	UNIVERSITY OF TEXAS AT EL PASO	<50
008145	NASHVILLE STATE COMMUNITY COLLEGE	<50
001512	PALM BEACH STATE COLLEGE	<50
002690	CUNY QUEENS COLLEGE	<50
002267	GRAND RAPIDS COMMUNITY COLLEGE	<50
002274	JACKSON COLLEGE	<50
002986	WINSTON-SALEM STATE UNIVERSITY	<50
001948	UNIVERSITY OF KANSAS	<50
001693	NORTHEASTERN ILLINOIS UNIVERSITY	<50
001350	COLORADO STATE UNIVERSITY	<50
002068	COPPIN STATE UNIVERSITY	<50
002015	UNIVERSITY OF NEW ORLEANS (THE)	<50
002360	MINNESOTA STATE UNIVERSITY, MANKATO	<50
037063	HOLLYWOOD INSTITUTE	<50
041245	MYCOMPUTERCAREER AT COLUMBUS	<50
037974	CAREER CARE INSTITUTE	<50
041327	HEALTHCARE CAREER COLLEGE	<50
025354	SKYLINE COLLEGE—RICHMOND	<50
025400	TENNESSEE ACADEMY OF COSMETOLOGY	<50
026095	CAREER TRAINING ACADEMY	<50
031724	CALIBER TRAINING INSTITUTE	<50
021618	MUSICIANS INSTITUTE	<50
020543	TRUMBULL BUSINESS COLLEGE	<50
030725	WORLD MEDICINE INSTITUTE	<50
009520	NATIONAL ACADEMY OF BEAUTY ARTS	<50
009892	DULUTH BUSINESS UNIVERSITY	<50
022425	BASTYR UNIVERSITY	<50
005208	COLLEGE OF WESTCHESTER (THE)	<50
002707	COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK	<50
003297	MERCYHURST UNIVERSITY	<50
003714	HAMPTON UNIVERSITY	<50
003367	SAINT JOSEPH'S UNIVERSITY	<50
003837	CARDINAL STRITCH UNIVERSITY	<50
001893	UPPER IOWA UNIVERSITY	<50
001821	MARIAN UNIVERSITY	<50
001125	CALIFORNIA BAPTIST UNIVERSITY	<50
001543	Darton State College	<50
001087	ARKANSAS BAPTIST COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001434	AMERICAN UNIVERSITY (THE)	<50
002029	TULANE UNIVERSITY	<50
008545	Rockford Career College	<50
022288	Lincoln Technical Institute—East Windsor	<50
007640	FAYETTEVILLE TECHNICAL COMMUNITY COLLEGE	<50
008037	GATEWAY COMMUNITY COLLEGE	<50
007993	CALIFORNIA STATE UNIVERSITY, BAKERSFIELD	<50
004852	CLARK STATE COLLEGE	<50
004736	BERGEN COMMUNITY COLLEGE	<50
008543	ATLANTA TECHNICAL COLLEGE	<50
030830	OZARKS TECHNICAL COMMUNITY COLLEGE	<50
001470	EASTERN FLORIDA STATE COLLEGE	<50
001828	PURDUE UNIVERSITY FORT WAYNE	<50
001313	UNIVERSITY OF CALIFORNIA, DAVIS	<50
001674	EASTERN ILLINOIS UNIVERSITY	<50
001610	UNIVERSITY OF HAWAII AT MANOA	<50
001692	ILLINOIS STATE UNIVERSITY	<50
001654	CITY COLLEGES OF CHICAGO—KENNEDY KING COLLEGE	<50
001780	WESTERN ILLINOIS UNIVERSITY	<50
002454	UNIVERSITY OF CENTRAL MISSOURI	<50
002314	SAGINAW VALLEY STATE UNIVERSITY	<50
001977	MURRAY STATE UNIVERSITY	<50
002326	UNIVERSITY OF MICHIGAN—DEARBORN	<50
002005	NICHOLLS STATE UNIVERSITY	<50
001370	UNIVERSITY OF COLORADO BOULDER	<50
002021	NORTHWESTERN STATE UNIVERSITY	<50
001316	UNIVERSITY OF CALIFORNIA, RIVERSIDE	<50
002102	UNIVERSITY OF BALTIMORE	<50
001519	SANTA FE COLLEGE	<50
002440	UNIVERSITY OF MISSISSIPPI	<50
002838	STATE UNIVERSITY OF NEW YORK AT STONY BROOK	<50
041698	GURNICK ACADEMY OF MEDICAL ARTS	<50
034275	UNIVERSITY OF ANTELOPE VALLEY	<50
031226	EASTERN INTERNATIONAL COLLEGE	<50
023491	HAIR FASHIONS BY KAYE BEAUTY COLLEGE	<50
033083	BRISTOL UNIVERSITY	<50
022053	SAVANNAH RIVER COLLEGE	<50
025875	UNIVERSIDAD ANA G. MÉNDEZ—CUPEY CAMPUS	<50
030673	METROPOLITAN COLLEGE	<50
007229	WESTERN BEAUTY INSTITUTE	<50
007791	WILFRED ACADEMY OF HAIR & BEAUTY CULTURE	<50
009989	CALIFORNIA AERONAUTICAL UNIVERSITY	<50
007439	FOUNTAINHEAD COLLEGE OF TECHNOLOGY	<50
003820	SALEM UNIVERSITY	<50
041633	COMPASS COLLEGE OF CINEMATIC ARTS	<50
008682	ACADEMY OF HAIR DESIGN	<50
012393	THOMAS JEFFERSON UNIVERSITY	<50
010923	UNION INSTITUTE & UNIVERSITY	<50
002949	UNIVERSITY OF MOUNT OLIVE	<50
002709	CONCORDIA COLLEGE	<50
010998	PENNSYLVANIA INSTITUTE OF TECHNOLOGY	<50
002397	BELHAVEN UNIVERSITY	<50
002936	JOHNSON C. SMITH UNIVERSITY	<50
002790	NYACK COLLEGE	<50
001983	ST. CATHARINE COLLEGE	<50
001050	TUSKEGEE UNIVERSITY	<50
001707	LEWIS UNIVERSITY	<50
001556	BRENAU UNIVERSITY	<50
002208	SIMMONS UNIVERSITY	<50
002218	SUFFOLK UNIVERSITY	<50
001028	MILES COLLEGE	<50
022769	COMMUNITY COLLEGE OF AURORA CENTRETECH CAMPUS	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
007273	CUNY BERNARD M. BARUCH COLLEGE	<50
003775	EASTERN WASHINGTON UNIVERSITY	<50
006804	LAKELAND COMMUNITY COLLEGE	<50
005533	SAINT PAUL COLLEGE—A COMMUNITY & TECHNICAL COLLEGE	<50
003992	PIEDMONT TECHNICAL COLLEGE	<50
004452	MONTGOMERY COUNTY COMMUNITY COLLEGE	<50
007266	PIMA COUNTY COMMUNITY COLLEGE	<50
009741	UNIVERSITY OF TEXAS AT DALLAS	<50
003624	STEPHEN F AUSTIN STATE UNIVERSITY	<50
005317	FORSYTH TECHNICAL COMMUNITY COLLEGE	<50
003523	TENNESSEE TECHNOLOGICAL UNIVERSITY	<50
001477	FLORIDA SOUTHWESTERN STATE COLLEGE	<50
003210	OREGON STATE UNIVERSITY	<50
002554	UNIVERSITY OF NEBRASKA AT OMAHA	<50
002106	UNIVERSITY OF MARYLAND—EASTERN SHORE	<50
001581	MIDDLE GEORGIA STATE UNIVERSITY	<50
002063	COMMUNITY COLLEGE OF BALTIMORE COUNTY	<50
002621	NEW JERSEY INSTITUTE OF TECHNOLOGY	<50
003231	COMMUNITY COLLEGE OF ALLEGHENY COUNTY	<50
002693	CUNY JOHN JAY COLLEGE OF CRIMINAL JUSTICE	<50
003379	UNIVERSITY OF PITTSBURGH	<50
001147	CALIFORNIA STATE UNIVERSITY, FRESNO	<50
003487	EAST TENNESSEE STATE UNIVERSITY	<50
002954	UNIVERSITY OF NORTH CAROLINA AT PEMBROKE	<50
003590	MCLENNAN COMMUNITY COLLEGE	<50
003077	MIAMI UNIVERSITY	<50
001092	UNIVERSITY OF CENTRAL ARKANSAS	<50
039394	CENTURA INSTITUTE	<50
001055	UNIVERSITY OF ALABAMA IN HUNTSVILLE	<50
041625	HOLLYWOOD INSTITUTE OF BEAUTY CAREERS	<50
001108	UNIVERSITY OF ARKANSAS	<50
032423	CAREER NETWORKS INSTITUTE	<50
023251	KEY COLLEGE	<50
030427	LAURUS TECHNICAL INSTITUTE	<50
023124	LA COLLEGE INTERNATIONAL	<50
025812	CC'S COSMETOLOGY COLLEGE	<50
025910	WRIGHT BUSINESS SCHOOL	<50
030277	PACIFIC COLLEGE OF HEALTH AND SCIENCE	<50
012561	FIVE TOWNS COLLEGE	<50
020924	RIDLEY—LOWELL SCHOOL OF BUSINESS	<50
021585	OHIO BUSINESS COLLEGE	<50
022417	PJ'S COLLEGE OF COSMETOLOGY	<50
020651	REMINGTON COLLEGE—NEW ORLEANS CAMPUS	<50
004894	ERIE BUSINESS CENTER	<50
025929	HEALD COLLEGE—SCHOOL OF TECHNOLOGY	<50
009246	PACIFIC COAST COLLEGE	<50
008575	SALON PROFESSIONAL ACADEMY (THE)	<50
003029	CINCINNATI CHRISTIAN UNIVERSITY	<50
002666	ADELPHI UNIVERSITY	<50
003645	TEXAS WESLEYAN UNIVERSITY	<50
003545	BAYLOR UNIVERSITY	<50
002506	SAINT LOUIS UNIVERSITY	<50
003578	UNIVERSITY OF THE INCARNATE WORD	<50
002628	RIDER UNIVERSITY	<50
003584	LETOURNEAU UNIVERSITY	<50
003693	SOUTHERN VERMONT COLLEGE	<50
003354	Philadelphia University	<50
002032	XAVIER UNIVERSITY OF LOUISIANA	<50
010040	Ivy Tech Community College of Indiana—Region 1	<50
003675	UNIVERSITY OF UTAH	<50
011161	TEXAS A&M UNIVERSITY—CORPUS CHRISTI	<50
003793	SPOKANE COMMUNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
041429	GEORGIA GWINNETT COLLEGE	<50
003771	CENTRAL WASHINGTON UNIVERSITY	<50
003812	FAIRMONT STATE UNIVERSITY	<50
003658	UNIVERSITY OF TEXAS—AUSTIN	<50
009345	STOCKTON UNIVERSITY	<50
004509	UNIVERSITY OF COLORADO COLORADO SPRINGS	<50
005752	CLOVER PARK TECHNICAL COLLEGE	<50
011462	UNIVERSITY OF ALASKA ANCHORAGE	<50
003998	CHATTANOOGA STATE COMMUNITY COLLEGE	<50
020554	BOSSIER PARISH COMMUNITY COLLEGE	<50
004007	MADISON AREA TECHNICAL COLLEGE	<50
022884	GWINNETT TECHNICAL COLLEGE	<50
004027	UTAH VALLEY UNIVERSITY	<50
010388	READING AREA COMMUNITY COLLEGE	<50
001504	STATE COLLEGE OF FLORIDA, MANATEE—SARASOTA	<50
003530	UNIVERSITY OF TENNESSEE	<50
002471	SAINT LOUIS COMMUNITY COLLEGE	<50
001493	INDIAN RIVER STATE COLLEGE	<50
002103	UNIVERSITY OF MARYLAND, COLLEGE PARK	<50
001232	AMERICAN RIVER COLLEGE	<50
001431	UNIVERSITY OF DELAWARE	<50
003196	LANE COMMUNITY COLLEGE	<50
003328	WEST CHESTER UNIVERSITY OF PENNSYLVANIA	<50
003599	UNIVERSITY OF TEXAS RIO GRANDE VALLEY	<50
001138	CALIFORNIA STATE UNIVERSITY, EAST BAY	<50
001571	GEORGIA MILITARY COLLEGE	<50
001575	GORDON STATE COLLEGE	<50
001406	SOUTHERN CONNECTICUT STATE UNIVERSITY	<50
001620	IDAHO STATE UNIVERSITY	<50
001378	CENTRAL CONNECTICUT STATE UNIVERSITY	<50
001759	SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE	<50
001141	CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS	<50
038753	MCI INSTITUTE OF TECHNOLOGY	<50
001078	PHOENIX COLLEGE	<50
041900	RADIANS COLLEGE	<50
026215	CAREER COLLEGE OF NORTHERN NEVADA	<50
026089	PINNACLE COLLEGE	<50
030235	CAMELOT COLLEGE	<50
031444	AMERICAN COLLEGE OF HEALTHCARE AND TECHNOLOGY	<50
030780	MIAMI MEDIA SCHOOL	<50
025383	DELTA COLLEGE OF ARTS & TECHNOLOGY	<50
023214	TONI & GUY HAIRDRESSING ACADEMY	<50
031713	UNIVERSITY OF ST. AUGUSTINE FOR HEALTH SCIENCES	<50
033163	LINCOLN TECHNICAL INSTITUTE—HARTFORD	<50
031090	SCHOOL OF COMMUNICATION ARTS OF NORTH CAROLINA	<50
030777	DECKER COLLEGE	<50
011118	SAWYER COLLEGE OF BUSINESS	<50
022896	CONSOLIDATED SCHOOL OF BUSINESS	<50
021884	SIERRA VALLEY COLLEGE OF COURT REPORTING	<50
020609	BROWN COLLEGE OF COURT REPORTING	<50
021691	DAVIS COLLEGE	<50
004890	CENTRAL PENN COLLEGE	<50
004947	WEST TENNESSEE BUSINESS COLLEGE	<50
009078	CAPRI INSTITUTE OF HAIR DESIGN	<50
004893	DUBOIS BUSINESS COLLEGE	<50
003296	MARYWOOD UNIVERSITY	<50
010813	AMERICAN ACADEMY MCALLISTER INSTITUTE	<50
002942	LIVINGSTONE COLLEGE	<50
003537	ABILENE CHRISTIAN UNIVERSITY	<50
007279	HAWAII PACIFIC UNIVERSITY	<50
003501	LEMOYNE—OWEN COLLEGE	<50
002883	UTICA UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003613	SOUTHERN METHODIST UNIVERSITY	<50
002968	SAINT AUGUSTINE'S UNIVERSITY	<50
003030	OHIO CHRISTIAN UNIVERSITY	<50
003560	DALLAS BAPTIST UNIVERSITY	<50
002415	MISSISSIPPI COLLEGE	<50
002155	HARVARD UNIVERSITY	<50
001179	NOTRE DAME DE NAMUR UNIVERSITY	<50
001211	HEALD BUSINESS COLLEGE	<50
010847	Arizona Automotive Institute	<50
002143	CURRY COLLEGE	<50
001229	SOUTHERN CALIFORNIA UNIVERSITY OF HEALTH SCIENCES	<50
001205	GOLDEN GATE UNIVERSITY	<50
022333	ST. GEORGE'S UNIVERSITY, SCHOOL OF MEDICINE	<50
002347	CONCORDIA UNIVERSITY—SAINT PAUL	<50
001164	CHAPMAN UNIVERSITY	<50
003133	Urbana University	<50
001804	UNIVERSITY OF INDIANAPOLIS	<50
011711	UNIVERSITY OF HOUSTON—CLEAR LAKE	<50
003754	VIRGINIA POLYTECHNIC INSTITUTE & STATE UNIVERSITY	<50
030633	NORTHWEST ARKANSAS COMMUNITY COLLEGE	<50
007686	SOUTHERN UNIVERSITY AT SHREVEPORT—BOSSIER CITY	<50
003627	TEMPLE COLLEGE	<50
005220	SALT LAKE COMMUNITY COLLEGE	<50
007109	SUNY COLLEGE AT OLD WESTBURY	<50
002405	EAST MISSISSIPPI COMMUNITY COLLEGE	<50
002089	PRINCE GEORGE'S COMMUNITY COLLEGE	<50
002210	UNIVERSITY OF MASSACHUSETTS—DARTMOUTH	<50
001317	UNIVERSITY OF CALIFORNIA, SAN DIEGO	<50
001619	COLLEGE OF SOUTHERN IDAHO	<50
001314	UNIVERSITY OF CALIFORNIA, IRVINE	<50
001157	CALIFORNIA STATE UNIVERSITY, STANISLAUS	<50
003318	CLARION UNIVERSITY OF PENNSYLVANIA	<50
001144	CALIFORNIA STATE POLYTECHNIC UNIVERSITY, POMONA	<50
003320	EAST STROUDSBURG UNIVERSITY OF PENNSYLVANIA	<50
002984	UNIVERSITY OF NORTH CAROLINA AT WILMINGTON (THE)	<50
003321	EDINBORO UNIVERSITY OF PENNSYLVANIA	<50
002183	BRIDGEWATER STATE UNIVERSITY	<50
002062	BOWIE STATE UNIVERSITY	<50
002417	MISSISSIPPI GULF COAST COMMUNITY COLLEGE	<50
002871	MOHAWK VALLEY COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
038094	MICROPOWER CAREER INSTITUTE	<50
041379	BRENSTEN EDUCATION	<50
041274	DIGITAL MEDIA ARTS COLLEGE	<50
041893	ALLIED AMERICAN UNIVERSITY	<50
041203	HEALTH AND STYLE INSTITUTE	<50
038893	STANBRIDGE UNIVERSITY	<50
037634	BOLD BEAUTY ACADEMY	<50
039653	NEW ENGLAND COLLEGE OF BUSINESS AND FINANCE	<50
041378	AVEDA INSTITUTE COLUMBUS	<50
037503	PROSPECT COLLEGE	<50
034003	QUEST COLLEGE	<50
023265	INTERFACE COLLEGE	<50
030258	DAWN CAREER INSTITUTE	<50
030951	GRETN A CAREER COLLEGE	<50
024980	NEW WAVE HAIR ACADEMY	<50
023608	PROVO COLLEGE	<50
034254	CENTRAL FLORIDA INSTITUTE	<50
021208	YORKTOWNE BUSINESS INSTITUTE	<50
022612	G SKIN & BEAUTY INSTITUTE	<50
022843	INTERACTIVE COLLEGE OF TECHNOLOGY	<50
021802	METRO BUSINESS COLLEGE	<50
021049	SUMNER COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
021122	GREAT LAKES INSTITUTE OF TECHNOLOGY	<50
012670	BEL—REA INSTITUTE OF ANIMAL TECHNOLOGY	<50
021662	ITI TECHNICAL COLLEGE	<50
004889	CAMBRIA—ROWE BUSINESS COLLEGE	<50
004932	DRAUGHONS COLLEGE	<50
007203	SALON SUCCESS ACADEMY	<50
007549	COYNE COLLEGE	<50
007649	ROCKY MOUNTAIN COLLEGE OF ART + DESIGN	<50
007931	PACIFIC TRAVEL TRADE SCHOOL—MAIN CAMPUS	<50
006136	NATIONAL AVIATION ACADEMY—NEW ENGLAND	<50
002929	GARDNER—WEBB UNIVERSITY	<50
002579	NEW ENGLAND COLLEGE	<50
003663	WAYLAND BAPTIST UNIVERSITY—PLAINVIEW CAMPUS	<50
003436	LIMESTONE UNIVERSITY	<50
003127	UNIVERSITY OF DAYTON	<50
002825	ST. JOSEPH'S UNIVERSITY NEW YORK	<50
002616	MONMOUTH UNIVERSITY	<50
007304	CULINARY INSTITUTE OF AMERICA	<50
003259	EASTERN UNIVERSITY	<50
003636	TEXAS CHRISTIAN UNIVERSITY	<50
003455	VOORHEES UNIVERSITY	<50
011649	LOYOLA MARYMOUNT UNIVERSITY	<50
003963	AMERICAN INSTITUTE OF BUSINESS	<50
003258	DUQUESNE UNIVERSITY OF THE HOLY SPIRIT	<50
002798	PRATT INSTITUTE	<50
002206	REGIS COLLEGE	<50
001218	LOMA LINDA UNIVERSITY	<50
001582	MOREHOUSE COLLEGE	<50
001591	SHORTER UNIVERSITY	<50
002160	LESLEY UNIVERSITY	<50
001546	Armstrong State University	<50
002345	UNIVERSITY OF SAINT THOMAS	<50
008906	MACOMB COMMUNITY COLLEGE	<50
010391	OKLAHOMA CITY COMMUNITY COLLEGE	<50
007118	PARKLAND COLLEGE	<50
003826	WEST VIRGINIA STATE UNIVERSITY	<50
007871	GEORGE C. WALLACE STATE COMMUNITY COLLEGE—MAIN CAMPUS	<50
006871	THOMAS NELSON COMMUNITY COLLEGE	<50
010652	PASCO—HERNANDO STATE COLLEGE	<50
006911	MONTGOMERY COLLEGE	<50
005273	GATEWAY COMMUNITY AND TECHNICAL COLLEGE	<50
004453	DALLAS COLLEGE	<50
010491	HENNEPIN TECHNICAL COLLEGE -	<50
013231	UNIVERSITY OF HOUSTON—VICTORIA	<50
025083	SOUTHEAST COMMUNITY COLLEGE	<50
003993	MIDLANDS TECHNICAL COLLEGE—AIRPORT CAMPUS	<50
030646	TEXAS SOUTHMOST COLLEGE	<50
003895	UNIVERSITY OF WISCONSIN—MADISON	<50
032553	FLORIDA GULF COAST UNIVERSITY	<50
003606	SAM HOUSTON STATE UNIVERSITY	<50
003721	JAMES MADISON UNIVERSITY	<50
003926	UNIVERSITY OF WISCONSIN—WHITewater	<50
006760	UNIVERSITY OF MAINE—AUGUSTA	<50
002488	MISSOURI SOUTHERN STATE UNIVERSITY	<50
003209	WESTERN OREGON UNIVERSITY	<50
001471	COLLEGE OF CENTRAL FLORIDA	<50
001346	ARAPAHOE COMMUNITY COLLEGE	<50
003407	RHODE ISLAND COLLEGE	<50
001928	KANSAS STATE UNIVERSITY	<50
001321	UNIVERSITY OF CALIFORNIA, SANTA CRUZ	<50
002974	UNIVERSITY OF NORTH CAROLINA—CHAPEL HILL	<50
003549	BLINN COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002221	UNIVERSITY OF MASSACHUSETTS—AMHERST	<50
002868	HUDSON VALLEY COMMUNITY COLLEGE	<50
001514	POLK STATE COLLEGE	<50
002328	WASHTENAW COMMUNITY COLLEGE	<50
001949	WASHBURN UNIVERSITY—TOPEKA	<50
002104	UNIVERSITY OF MARYLAND, BALTIMORE	<50
003317	CHEYNEY UNIVERSITY OF PENNSYLVANIA	<50
001650	CITY COLLEGES OF CHICAGO—MALCOLM X COLLEGE	<50
002565	UNIVERSITY OF NEBRASKA	<50
003170	OKLAHOMA STATE UNIVERSITY	<50
002589	UNIVERSITY OF NEW HAMPSHIRE	<50
001349	UNIVERSITY OF NORTHERN COLORADO	<50
002024	SOUTHEASTERN LOUISIANA UNIVERSITY	<50
002624	OCEAN COUNTY COLLEGE	<50
002866	FASHION INSTITUTE OF TECHNOLOGY	<50
001380	WESTERN CONNECTICUT STATE UNIVERSITY	<50
041004	TAFT UNIVERSITY SYSTEM (THE)	<50
041188	NEW YORK FILM ACADEMY	<50
038333	AMERICAN ACADEMY OF TRADITIONAL CHINESE MEDICINE	<50
036764	HEALTHY HAIR ACADEMY	<50
001009	AUBURN UNIVERSITY	<50
040573	ASHER COLLEGE	<50
030927	SKYLINE COLLEGE	<50
030891	GEORGIA INSTITUTE OF COSMETOLOGY	<50
030308	AMERICAN BROADCASTING SCHOOL	<50
030658	OHIO INSTITUTE OF HEALTH CAREERS	<50
030054	GEORGIA CAREER INSTITUTE	<50
023209	TIDEWATER TECH	<50
022863	CAROLINA BEAUTY COLLEGE	<50
022774	SOUTH COAST COLLEGE	<50
022378	SPECS HOWARD SCHOOL OF MEDIA ARTS	<50
011131	SAWYER SCHOOL—SAWYER SCHOOL	<50
021789	JOLIE HEALTH AND BEAUTY ACADEMY	<50
012879	PAT GOINS BENTON ROAD BEAUTY SCHOOL	<50
021211	MIDWEST INSTITUTE	<50
022060	HUNTER BUSINESS SCHOOL	<50
022586	AVALON SCHOOL OF COSMETOLOGY	<50
011745	OHIO TECHNICAL COLLEGE	<50
010859	BARCLAY CAREER SCHOOL	<50
012047	MTA SCHOOL, RESIDENT SCHOOL	<50
020683	DOUGLAS EDUCATION CENTER	<50
021088	WARDS CORNER BEAUTY ACADEMY	<50
012462	EASTWICK COLLEGE—HACKENSACK CAMPUS.	<50
022229	INTERNATIONAL AIR & HOSPITALITY ACADEMY	<50
010877	AMERICAN BUSINESS INSTITUTE	<50
020603	MIAT COLLEGE OF TECHNOLOGY	<50
022472	MEDSPA CAREERS INSTITUTE	<50
023053	PARKER UNIVERSITY	<50
009418	CENTURY COLLEGE	<50
008601	SAWYER COLLEGE	<50
004463	DRAUGHONS JUNIOR COLLEGE	<50
010035	SOUTHERN COLLEGE	<50
032503	CBD COLLEGE	<50
003147	BACONE COLLEGE	<50
002705	COLLEGE OF SAINT ROSE	<50
002449	AVILA UNIVERSITY	<50
007294	HEALD COLLEGE—SCHOOL OF BUSINESS	<50
003424	CLAFLIN UNIVERSITY	<50
003777	HERITAGE UNIVERSITY	<50
003527	TUSCULUM UNIVERSITY	<50
007484	NEWBURY COLLEGE	<50
003585	LON MORRIS COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002882	SYRACUSE UNIVERSITY	<50
002775	MOLLOY COLLEGE	<50
007893	FLAGLER COLLEGE	<50
002913	CAMPBELL UNIVERSITY	<50
001722	MCKENDREE UNIVERSITY	<50
008147	UNIVERSIDAD AUTONOMA DE GUADALAJARA	<50
042401	AMERICAN UNIVERSITY OF ANTIGUA COLLEGE OF MEDICINE	<50
001478	EDWARD WATERS UNIVERSITY	<50
001212	HUMPHREYS UNIVERSITY	<50
001403	SACRED HEART UNIVERSITY	<50
001826	Purdue University—North Central	<50
001833	SAINT JOSEPH'S COLLEGE	<50
001329	UNIVERSITY OF THE PACIFIC	<50
011075	LE CORDON BLEU	<50
034165	Dallas Nursing Institute	<50
002004	DILLARD UNIVERSITY	<50
002226	WESTERN NEW ENGLAND UNIVERSITY	<50
012346	Dover Business College	<50
001538	UNIVERSITY OF TAMPA (THE)	<50
006865	CAMDEN COUNTY COLLEGE	<50
005763	CENTRAL GEORGIA TECHNICAL COLLEGE	<50
003809	BLUEFIELD STATE COLLEGE	<50
003780	GREEN RIVER COLLEGE	<50
010997	EAST GEORGIA STATE COLLEGE	<50
004925	HORRY GEORGETOWN TECHNICAL COLLEGE	<50
003732	RADFORD UNIVERSITY	<50
008896	PIKES PEAK COMMUNITY COLLEGE	<50
010374	METROPOLITAN STATE UNIVERSITY	<50
009163	SAN ANTONIO COLLEGE	<50
006656	COLLEGE OF DUPAGE	<50
009226	FRANCIS MARION UNIVERSITY	<50
006810	LEHIGH CARBON COMMUNITY COLLEGE	<50
009275	NORTHERN KENTUCKY UNIVERSITY	<50
003639	TEXAS A&M UNIVERSITY—KINGSVILLE	<50
004595	HAWKEYE COMMUNITY COLLEGE	<50
010176	WESTMORELAND COUNTY COMMUNITY COLLEGE	<50
007110	DELAWARE COUNTY COMMUNITY COLLEGE	<50
002403	DELTA STATE UNIVERSITY	<50
003414	UNIVERSITY OF RHODE ISLAND	<50
003239	BUCKS COUNTY COMMUNITY COLLEGE	<50
002643	UNION COUNTY COLLEGE	<50
002530	MONTANA STATE UNIVERSITY—BILLINGS	<50
002205	QUINCY COLLEGE	<50
003218	CHEMEKETA COMMUNITY COLLEGE	<50
002697	QUEENSBOROUGH COMMUNITY COLLEGE—CUNY	<50
003325	MILLERSVILLE UNIVERSITY OF PENNSYLVANIA	<50
001728	MORTON COLLEGE	<50
002496	NORTHWEST MISSOURI STATE UNIVERSITY	<50
002860	ADIRONDACK COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
001558	COLLEGE OF COASTAL GEORGIA	<50
001113	ANTELOPE VALLEY COLLEGE	<50
001811	INDIANA UNIVERSITY—EAST	<50
002878	SUFFOLK COUNTY COMMUNITY COLLEGE	<50
003219	SOUTHERN OREGON UNIVERSITY	<50
002981	WESTERN CAROLINA UNIVERSITY	<50
002058	ANNE ARUNDEL COMMUNITY COLLEGE	<50
002013	LOUISIANA STATE UNIVERSITY IN SHREVEPORT	<50
003395	PENNSYLVANIA COLLEGE OF TECHNOLOGY	<50
001906	BUTLER COUNTY COMMUNITY COLLEGE	<50
003428	COLLEGE OF CHARLESTON	<50
002017	MCNEESE STATE UNIVERSITY	<50
001843	VINCENNES UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002020	UNIVERSITY OF LOUISIANA AT MONROE	<50
003529	UNIVERSITY OF TENNESSEE—CHATTANOOGA	<50
003150	CAMERON UNIVERSITY	<50
003172	OKLAHOMA STATE UNIVERSITY INSTITUTE OF TECHNOLOGY—OKMULGEE	<50
002590	KEENE STATE COLLEGE	<50
041400	GLOBAL HEALTH COLLEGE	<50
001008	ATHENS STATE UNIVERSITY	<50
038525	CIT COLLEGE OF INFOMEDICAL TECHNOLOGY	<50
035954	ANGLEY COLLEGE	<50
038743	CAMBRIDGE JUNIOR COLLEGE	<50
042281	HIGH DESERT MEDICAL COLLEGE	<50
042178	BOCA BEAUTY ACADEMY	<50
041628	PAUL MITCHELL THE SCHOOL MODESTO	<50
036506	PC AGE	<50
042293	MEDQUEST COLLEGE	<50
001060	COASTAL ALABAMA COMMUNITY COLLEGE	<50
037773	PAUL MITCHELL THE SCHOOL GASTONIA	<50
041660	MANHATTAN INSTITUTE (THE)	<50
037813	PITC INSTITUTE	<50
038303	SAE INSTITUTE OF TECHNOLOGY	<50
041345	SAN DIEGO COLLEGE	<50
041574	NATIONAL PARALEGAL COLLEGE	<50
030654	PROFESSIONAL CAREERS INSTITUTE	<50
023577	PAUL MITCHELL THE SCHOOL HOUSTON	<50
025423	NATIONAL HOLISTIC INSTITUTE	<50
031136	SOUTHERN CALIFORNIA INSTITUTE OF TECHNOLOGY	<50
023268	MERIDIAN COLLEGE	<50
025561	ETI SCHOOL OF SKILLED TRADES	<50
023178	AMERICAN INSTITUTE OF TRUCKING	<50
025212	ARLINGTON CAREER INSTITUTE	<50
022602	DIESEL DRIVING ACADEMY	<50
022895	PACE INSTITUTE	<50
010858	AVALON INSTITUTE	<50
022042	CHATTANOOGA COLLEGE—MEDICAL, DENTAL AND TECHNICAL CAREERS	<50
022151	HALLMARK INSTITUTE OF PHOTOGRAPHY	<50
021526	MTI BUSINESS COLLEGE	<50
022960	PRINCE INSTITUTE—SOUTHEAST	<50
012358	PLAZA COLLEGE	<50
020775	MOUNTAIN STATES TECHNICAL INSTITUTE	<50
021151	BUTLER BUSINESS SCHOOL	<50
012262	USA TRAINING ACADEMY HOME STUDY	<50
022540	NEW ENGLAND CULINARY INSTITUTE	<50
020537	EASTWICK COLLEGE	<50
021253	NASHVILLE COLLEGE OF MEDICAL CAREERS	<50
021206	SAYBROOK UNIVERSITY	<50
030908	LAKE ERIE COLLEGE OF OSTEOPATHIC MEDICINE	<50
009077	UTICA SCHOOL OF COMMERCE	<50
008263	AWARD BEAUTY SCHOOL	<50
008270	WILFRED ACADEMY	<50
007372	AUSTIN'S SCHOOL OF SPA TECHNOLOGY	<50
003528	UNION UNIVERSITY	<50
002665	VAUGHN COLLEGE OF AERONAUTICS AND TECHNOLOGY	<50
003854	LAKELAND UNIVERSITY	<50
003863	MARQUETTE UNIVERSITY	<50
003014	BALDWIN WALLACE UNIVERSITY	<50
003245	CHESTNUT HILL COLLEGE	<50
002737	IONA COLLEGE	<50
002916	CHOWAN UNIVERSITY	<50
002777	MEDAILLE COLLEGE	<50
003724	MARYMOUNT UNIVERSITY	<50
002638	SAINT PETER'S UNIVERSITY	<50
002464	FONTBONNE UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022
Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002820	SAINT FRANCIS COLLEGE	<50
002941	LENOIR-RHYNE UNIVERSITY	<50
003024	CASE WESTERN RESERVE UNIVERSITY	<50
002477	A. T. STILL UNIVERSITY OF HEALTH SCIENCES	<50
013022	CITY UNIVERSITY OF SEATTLE	<50
003359	ROBERT MORRIS UNIVERSITY	<50
007012	SAMUEL MERRITT UNIVERSITY	<50
003033	MOUNT ST. JOSEPH UNIVERSITY	<50
004703	LOGAN UNIVERSITY	<50
003141	WILBERFORCE UNIVERSITY	<50
004861	UNIVERSITY OF NORTHWESTERN OHIO	<50
003353	UNIVERSITY OF THE SCIENCES IN PHILADELPHIA	<50
001768	SAINT XAVIER UNIVERSITY	<50
001495	JACKSONVILLE UNIVERSITY	<50
023518	UNIVERSIDAD IBEROAMERICANA (UNIBE)	<50
009924	Ivy Tech Community College of Indiana—Region 6	<50
010832	Western State University College of Law	<50
001785	ANDERSON UNIVERSITY	<50
001698	John Marshall Law School (The)	<50
001505	LYNN UNIVERSITY	<50
008423	Ivy Tech Community College of Indiana—Region 2	<50
009926	Ivy Tech Community College of Indiana- Region 3	<50
001709	LINCOLN COLLEGE	<50
001664	UNIVERSITY OF ST. FRANCIS	<50
003524	Tennessee Temple University	<50
001422	UNIVERSITY OF HARTFORD	<50
001753	SCHOOL OF THE ART INSTITUTE OF CHICAGO	<50
010977	UNIVERSIDAD CENTRAL DEL ESTE	<50
006951	UNIVERSITY OF SOUTH CAROLINA UPSTATE	<50
005320	CAPE FEAR COMMUNITY COLLEGE	<50
004003	CENTRAL TEXAS COLLEGE	<50
005601	ALBANY TECHNICAL COLLEGE	<50
005389	GATEWAY TECHNICAL COLLEGE	<50
004742	CENTRAL NEW MEXICO COMMUNITY COLLEGE	<50
008310	AUBURN UNIVERSITY MONTGOMERY	<50
007532	FINGER LAKES COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
003665	WEST TEXAS A&M UNIVERSITY	<50
009185	ROSE STATE COLLEGE	<50
012165	ATLANTA METROPOLITAN STATE COLLEGE	<50
007954	NORMANDALE COMMUNITY COLLEGE	<50
004075	EASTERN IOWA COMMUNITY COLLEGE DISTRICT	<50
003920	UNIVERSITY OF WISCONSIN—OSHKOSH	<50
030113	CALIFORNIA STATE UNIVERSITY, SAN MARCOS	<50
005301	NORTHEAST WISCONSIN TECHNICAL COLLEGE	<50
042118	COLLEGE OF WESTERN IDAHO	<50
037894	RIVER PARISHES COMMUNITY COLLEGE	<50
010097	CUNY MEDGAR EVERS COLLEGE	<50
009767	OLIVE—HARVEY COLLEGE	<50
002926	ELIZABETH CITY STATE UNIVERSITY	<50
001773	TRITON COLLEGE	<50
002687	CUNY BROOKLYN COLLEGE	<50
002997	NORTH DAKOTA STATE UNIVERSITY—FARGO	<50
001156	SONOMA STATE UNIVERSITY	<50
003580	KILGORE COLLEGE	<50
002188	SALEM STATE UNIVERSITY	<50
002174	NORTHERN ESSEX COMMUNITY COLLEGE	<50
001950	WICHITA STATE UNIVERSITY	<50
002335	RIVERLAND COMMUNITY COLLEGE	<50
001968	KENTUCKY STATE UNIVERSITY	<50
002161	UNIVERSITY OF MASSACHUSETTS—LOWELL	<50
002501	SOUTHEAST MISSOURI STATE UNIVERSITY	<50
002698	COLLEGE OF STATEN ISLAND/CUNY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001865	IOWA CENTRAL COMMUNITY COLLEGE	<50
001425	EASTERN CONNECTICUT STATE UNIVERSITY	<50
002858	STATE UNIVERSITY OF NEW YORK AT FARMINGDALE	<50
002836	BINGHAMTON UNIVERSITY	<50
002054	UNIVERSITY OF SOUTHERN MAINE	<50
003157	LANGSTON UNIVERSITY	<50
001817	INDIANA UNIVERSITY SOUTHEAST	<50
001149	CALIFORNIA STATE POLYTECHNIC UNIVERSITY, HUMBOLDT	<50
001142	CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO	<50
001640	PRAIRIE STATE COLLEGE	<50
001976	MOREHEAD STATE UNIVERSITY	<50
003204	MT. HOOD COMMUNITY COLLEGE	<50
002688	CITY COLLEGE OF NEW YORK—CUNY	<50
002841	SUNY COLLEGE AT BROCKPORT	<50
002184	FITCHBURG STATE UNIVERSITY	<50
001146	CALIFORNIA STATE UNIVERSITY, CHICO	<50
002276	KELLOGG COMMUNITY COLLEGE	<50
001312	UNIVERSITY OF CALIFORNIA, BERKELEY	<50
001219	LONG BEACH CITY COLLEGE	<50
001541	ABRAHAM BALDWIN AGRICULTURAL COLLEGE	<50
002849	STATE UNIVERSITY OF NEW YORK COLLEGE AT PLATTSBURGH	<50
001623	NORTH IDAHO COLLEGE	<50
001808	UNIVERSITY OF SOUTHERN INDIANA	<50
041874	JOHN AMICO SCHOOL OF HAIR DESIGN	<50
041676	FINGER LAKES SCHOOL OF MASSAGE (THE)	<50
038383	NIGHTINGALE COLLEGE	<50
040563	CAREER COLLEGE OF CALIFORNIA	<50
041723	ETERNITY COSMETOLOGY SCHOOL, CORP.	<50
041145	VALLEY COLLEGE OF MEDICAL CAREERS	<50
001013	CALHOUN COMMUNITY COLLEGE	<50
041348	AVEDA INSTITUTE—TALLAHASSEE	<50
001085	UNIVERSITY OF ARKANSAS AT MONTICELLO	<50
041493	PARK WEST BARBER SCHOOL	<50
041528	PAUL MITCHELL THE SCHOOL SACRAMENTO	<50
032753	COSMETOLOGY CAREER INSTITUTE	<50
031087	ROYAL BEAUTY CAREERS	<50
023041	WILSHIRE COMPUTER COLLEGE	<50
025228	FOX COLLEGE	<50
031249	PAUL MITCHELL THE SCHOOL—LITTLE ROCK	<50
030790	ETI TECHNICAL COLLEGE OF NILES	<50
025283	TDDS TECHNICAL INSTITUTE	<50
026094	VALLEY COLLEGE	<50
031733	ATLANTA'S JOHN MARSHALL LAW SCHOOL	<50
021634	NEW YORK CAREER INSTITUTE	<50
022859	UCAS UNIVERSITY OF COSMETOLOGY ARTS & SCIENCES	<50
012496	EVERGREEN BEAUTY AND BARBER COLLEGE	<50
020923	EASTWICK COLLEGE—NUTLEY CAMPUS	<50
022724	EASTERN COLLEGE OF HEALTH VOCATIONS	<50
012850	INTERNATIONAL SALON AND SPA ACADEMY	<50
008217	PAUL MITCHELL THE SCHOOL GREEN BAY	<50
009104	TONI&GUY HAIRDRESSING ACADEMY	<50
009032	EMPIRE COLLEGE	<50
035904	NTMA TRAINING CENTERS OF SOUTHERN CALIFORNIA	<50
031155	ADVENTHEALTH UNIVERSITY	<50
001177	UNIVERSITY OF SILICON VALLEY	<50
031070	SONORAN UNIVERSITY OF HEALTH SCIENCES	<50
001895	WALDORF UNIVERSITY	<50
009034	CATHERINE COLLEGE	<50
021474	CLEVELAND CHIROPRACTIC COLLEGE	<50
009284	BRITTANY BEAUTY SCHOOL	<50
007305	PORTER AND CHESTER INSTITUTE OF HAMDEN	<50
009784	NATIONAL EDUCATION CENTER—BAUDER COLLEGE CAMPUS	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
007466	LIM COLLEGE	<50
007468	SCHOOL OF VISUAL ARTS	<50
003638	TEXAS COLLEGE	<50
012183	BURLINGTON COLLEGE	<50
002951	NORTH CAROLINA WESLEYAN COLLEGE	<50
003244	CHATHAM UNIVERSITY	<50
003502	LINCOLN MEMORIAL UNIVERSITY	<50
002575	FRANKLIN PIERCE UNIVERSITY	<50
003752	VIRGINIA INTERMONT COLLEGE	<50
003270	GWYNEDD MERCY UNIVERSITY	<50
002712	D'YOUVILLE UNIVERSITY	<50
003272	HARCUM COLLEGE	<50
003494	HIWASSEE COLLEGE	<50
003276	IMMACULATA UNIVERSITY	<50
002806	ROCHESTER INSTITUTE OF TECHNOLOGY	<50
002765	MARIST COLLEGE	<50
002909	BARBER-SCOTIA COLLEGE	<50
002769	MARYMOUNT MANHATTAN COLLEGE	<50
003988	NEUMANN UNIVERSITY	<50
002597	BLOOMFIELD COLLEGE	<50
002439	TOUGALOO COLLEGE	<50
003410	ROGER WILLIAMS UNIVERSITY	<50
010395	UNIVERSITY OF SAN DIEGO	<50
003417	ALLEN UNIVERSITY	<50
003479	BELMONT UNIVERSITY	<50
003557	CONCORDIA UNIVERSITY TEXAS	<50
010039	Ivy Tech Community College of Indiana—Region 4	<50
002318	SPRING ARBOR UNIVERSITY	<50
001940	SOUTHWESTERN COLLEGE	<50
039003	MEDICAL UNIVERSITY OF THE AMERICAS	<50
001046	TALLADEGA COLLEGE	<50
002050	UNIVERSITY OF NEW ENGLAND	<50
001531	STETSON UNIVERSITY	<50
001295	SOUTHWESTERN LAW SCHOOL	<50
007440	Nashville Auto-Diesel College	<50
002107	STEVENSON UNIVERSITY	<50
011074	Bainbridge State College	<50
001033	OAKWOOD UNIVERSITY	<50
001258	PACIFIC UNION COLLEGE	<50
001169	CLAREMONT GRADUATE UNIVERSITY	<50
001262	POINT LOMA NAZARENE UNIVERSITY	<50
001374	ALBERTUS MAGNUS COLLEGE	<50
026214	Asher School of Business	<50
001253	FRESNO PACIFIC UNIVERSITY	<50
001972	LINDSEY WILSON COLLEGE	<50
002146	EMERSON COLLEGE	<50
001293	VANGUARD UNIVERSITY OF SOUTHERN CALIFORNIA	<50
002150	FISHER COLLEGE	<50
037405	Art Institute of Tucson (The)	<50
007728	Macon State College	<50
001460	TRINITY WASHINGTON UNIVERSITY	<50
001657	MIDWESTERN UNIVERSITY	<50
007764	SOUTHEAST TECHNICAL COLLEGE	<50
008404	BROOKDALE COMMUNITY COLLEGE	<50
009647	OKLAHOMA STATE UNIVERSITY—OKLAHOMA CITY	<50
010684	ERIE COMMUNITY COLLEGE	<50
009344	RAMAPO COLLEGE OF NEW JERSEY	<50
003915	UNIVERSITY OF WISCONSIN—STOUT	<50
003796	TACOMA COMMUNITY COLLEGE	<50
009744	FOX VALLEY TECHNICAL COLLEGE	<50
009256	MORaine PARK TECHNICAL COLLEGE	<50
008304	SCOTTSDALE COMMUNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
006949	KALAMAZOO VALLEY COMMUNITY COLLEGE	<50
011163	UNIVERSITY OF TEXAS AT TYLER	<50
003677	UTAH STATE UNIVERSITY	<50
007350	ANOKA TECHNICAL COLLEGE	<50
005757	LAKE SUPERIOR COLLEGE	<50
039563	SOUTH LOUISIANA COMMUNITY COLLEGE	<50
003776	EVERETT COMMUNITY COLLEGE	<50
012015	AUSTIN COMMUNITY COLLEGE	<50
003996	YORK TECHNICAL COLLEGE	<50
003990	FLORENCE—DARLINGTON TECHNICAL COLLEGE	<50
007283	CENTRAL ARIZONA COLLEGE	<50
004598	IOWA WESTERN COMMUNITY COLLEGE—COUNCIL BLUFFS	<50
003471	SOUTH DAKOTA STATE UNIVERSITY	<50
003408	COMMUNITY COLLEGE OF RHODE ISLAND	<50
003540	AMARILLO COLLEGE	<50
001621	LEWIS—CLARK STATE COLLEGE	<50
003435	LANDER UNIVERSITY	<50
002315	SCHOOLCRAFT COLLEGE	<50
002532	MONTANA STATE UNIVERSITY BOZEMAN	<50
002848	SUNY COLLEGE AT OSWEGO	<50
001699	JOLIET JUNIOR COLLEGE	<50
003222	UMPUQUA COMMUNITY COLLEGE	<50
003425	CLEMSON UNIVERSITY	<50
002408	HOLMES COMMUNITY COLLEGE	<50
002377	ST. CLOUD STATE UNIVERSITY	<50
002411	JONES COUNTY JUNIOR COLLEGE	<50
002862	SUNY BROOME COMMUNITY COLLEGE	<50
002694	KINGSBOROUGH COMMUNITY COLLEGE/CUNY	<50
002551	UNIVERSITY OF NEBRASKA—KEARNEY	<50
001358	COLORADO MESA UNIVERSITY	<50
002302	NORTHWESTERN MICHIGAN COLLEGE	<50
001626	UNIVERSITY OF IDAHO	<50
002651	EASTERN NEW MEXICO UNIVERSITY	<50
003315	BLOOMSBURG UNIVERSITY OF PENNSYLVANIA	<50
001569	GEORGIA INSTITUTE OF TECHNOLOGY	<50
002011	LOUISIANA STATE UNIVERSITY AT ALEXANDRIA	<50
002919	DAVIDSON—DAVIE COMMUNITY COLLEGE	<50
002427	NORTHWEST MISSISSIPPI COMMUNITY COLLEGE	<50
001915	FORT HAYS STATE UNIVERSITY	<50
003068	LORAIN COUNTY COMMUNITY COLLEGE	<50
001602	GEORGIA COLLEGE & STATE UNIVERSITY	<50
001320	UNIVERSITY OF CALIFORNIA, SANTA BARBARA	<50
003474	UNIVERSITY OF SOUTH DAKOTA	<50
002468	JEFFERSON COLLEGE	<50
002385	NORTHLAND COMMUNITY AND TECHNICAL COLLEGE	<50
003322	KUTZTOWN UNIVERSITY OF PENNSYLVANIA	<50
002175	QUINSIGAMOND COMMUNITY COLLEGE	<50
003323	LOCK HAVEN UNIVERSITY OF PENNSYLVANIA	<50
003531	UNIVERSITY OF TENNESSEE—MARTIN	<50
002850	STATE UNIVERSITY OF NEW YORK COLLEGE AT POTSDAM	<50
001991	ELIZABETHTOWN COMMUNITY AND TECHNICAL COLLEGE	<50
001290	SIERRA COLLEGE	<50
001280	SAN JOAQUIN DELTA COLLEGE	<50
002072	FROSTBURG STATE UNIVERSITY	<50
003592	MIDWESTERN STATE UNIVERSITY	<50
002859	SUNY COLLEGE OF AGRICULTURE & TECHNOLOGY AT MORRISVILLE	<50
002490	MISSOURI WESTERN STATE UNIVERSITY	<50
002370	NORTH HENNEPIN COMMUNITY COLLEGE	<50
039104	NATIONAL POLYTECHNIC COLLEGE	<50
037276	AUGUSTE ESCOFFIER SCHOOL OF CULINARY ARTS	<50
042546	MEDICAL PREP INSTITUTE OF TAMPA BAY	<50
039523	NATIONAL MASSAGE THERAPY INSTITUTE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
041632	TENAJ SALON INSTITUTE	<50
041470	PAUL MITCHELL THE SCHOOL ATLANTA	<50
041752	PAUL MITCHELL THE SCHOOL EAST BAY	<50
041480	NEW LIFE BUSINESS INSTITUTE	<50
039393	WOLFORD COLLEGE	<50
040033	BLAKE AUSTIN COLLEGE	<50
001110	UNIVERSITY OF ARKANSAS AT FORT SMITH	<50
036813	CALIFORNIA HEALING ARTS COLLEGE	<50
030185	BENE'S CAREER ACADEMY	<50
025838	SCS BUSINESS & TECHNICAL INSTITUTE	<50
026047	CENTER FOR ADVANCED LEGAL STUDIES	<50
033243	CENTRAL CAREER SCHOOL	<50
026220	SOUTHWEST ACUPUNCTURE COLLEGE	<50
033326	DELTA COLLEGE	<50
023314	NORTHWEST HAIR ACADEMY	<50
030653	PAUL MITCHELL THE SCHOOL TINLEY PARK	<50
030359	NATIONAL AVIATION ACADEMY	<50
025844	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL OF MASSACHUSETTS	<50
031018	ILLINOIS MEDIA SCHOOL	<50
024987	DEMARGE COLLEGE	<50
032054	JOLIE HAIR AND BEAUTY ACADEMY	<50
023330	HAIR ACADEMY	<50
023342	SOUTHEASTERN ACADEMY	<50
023043	PLATT COLLEGE, SAN DIEGO	<50
025782	NOSSI COLLEGE OF ART	<50
023141	SCHILLER INTERNATIONAL UNIVERSITY	<50
022049	AMERICAN ACADEMY OF HAIR DESIGN	<50
021578	AMERICAN HI-TECH BUSINESS TECHNOLOGY	<50
010934	GRIFFIN COLLEGE	<50
012350	PHAGANS' SCHOOL OF HAIR DESIGN	<50
010836	PIVOT POINT ACADEMY	<50
021286	ART INSTITUTE OF CINCINNATI (THE)	<50
022948	CAPITOL CITY CAREERS	<50
021886	AUSTIN BUSINESS COLLEGE	<50
022343	FASHION CAREERS OF CALIFORNIA COLLEGE	<50
012090	ROBERT FIANCE BEAUTY SCHOOLS	<50
021975	BATON ROUGE SCHOOL OF COMPUTERS	<50
022697	AVEDA INSTITUTE MARYLAND	<50
021700	SWEDISH INSTITUTE	<50
023040	MISSOURI TECHNICAL SCHOOL	<50
021408	MARTIN UNIVERSITY	<50
026037	OREGON COLLEGE OF ORIENTAL MEDICINE	<50
021175	NAROPA UNIVERSITY	<50
023584	COMMONWEALTH INTERNATIONAL UNIVERSITY	<50
040653	ROSEMAN UNIVERSITY OF HEALTH SCIENCES	<50
007522	CONTINENTAL SCHOOL OF BEAUTY CULTURE	<50
041425	TOURO UNIVERSITY WORLDWIDE	<50
022372	PHILLIPS GRADUATE UNIVERSITY	<50
009047	HUNTINGTON JUNIOR COLLEGE OF BUSINESS	<50
033463	ACADEMY FOR NURSING AND HEALTH OCCUPATIONS	<50
007187	NORTH ADRIAN'S COLLEGE OF BEAUTY	<50
007839	TRIANGLE TECH	<50
009511	INTERNATIONAL ACADEMY	<50
040883	WESTMED COLLEGE	<50
010076	COMPUTER PROCESSING INST	<50
003169	OKLAHOMA JUNIOR COLLEGE OF BUSINESS & TECHNOLOGY	<50
010551	NEW YORK SCHOOL FOR MEDICAL & DENTAL ASSISTANTS	<50
010724	ALBIZU UNIVERSITY	<50
002599	CENTENARY UNIVERSITY	<50
003936	PONTIFICAL CATHOLIC UNIVERSITY OF PUERTO RICO (THE)	<50
003500	LEE UNIVERSITY	<50
007540	MISSOURI BAPTIST UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002805	ROBERTS WESLEYAN COLLEGE	<50
003496	KING UNIVERSITY	<50
002778	MOUNT SAINT MARY COLLEGE	<50
003294	MANOR COLLEGE	<50
003526	TREVECCA NAZARENE UNIVERSITY	<50
002703	COLLEGE OF MOUNT SAINT VINCENT	<50
003225	WARNER PACIFIC UNIVERSITY	<50
003241	CABRINI UNIVERSITY	<50
002739	ITHACA COLLEGE	<50
003089	OHIO NORTHERN UNIVERSITY	<50
003598	OUR LADY OF THE LAKE UNIVERSITY	<50
002447	WILLIAM CAREY UNIVERSITY	<50
003616	SOUTHWESTERN ASSEMBLIES OF GOD UNIVERSITY	<50
003948	SAN FRANCISCO ART INSTITUTE	<50
003165	OKLAHOMA CHRISTIAN UNIVERSITY	<50
006324	LABOURE COLLEGE OF HEALTHCARE	<50
003378	UNIVERSITY OF PENNSYLVANIA	<50
002957	QUEENS UNIVERSITY OF CHARLOTTE	<50
003687	GREEN MOUNTAIN COLLEGE	<50
003467	PRESENTATION COLLEGE	<50
003702	AVERETT UNIVERSITY	<50
008848	WARNER UNIVERSITY	<50
003183	SAINT GREGORY'S UNIVERSITY	<50
003212	PACIFIC UNIVERSITY	<50
003392	WESTMINSTER COLLEGE	<50
003085	NOTRE DAME COLLEGE OF OHIO	<50
003283	LACKAWANNA COLLEGE	<50
002735	HILBERT COLLEGE	<50
003766	VIRGINIA UNION UNIVERSITY	<50
012277	NORTHEAST COLLEGE OF HEALTH SCIENCES	<50
003838	CARROLL UNIVERSITY	<50
002650	UNIVERSITY OF THE SOUTHWEST	<50
003623	ST. MARY'S UNIVERSITY	<50
012088	Sullivan College of Technology and Design	<50
001343	WOODBURY UNIVERSITY	<50
001029	UNIVERSITY OF MOBILE	<50
001641	BRADLEY UNIVERSITY	<50
001429	GOLDEY-BEACOM COLLEGE	<50
002126	BERKLEE COLLEGE OF MUSIC	<50
002016	LOYOLA UNIVERSITY NEW ORLEANS	<50
008504	Richland College	<50
001588	PIEDMONT UNIVERSITY	<50
001402	QUINNIPIAC UNIVERSITY	<50
001605	CHAMINADE UNIVERSITY OF HONOLULU	<50
001255	PACIFIC OAKS COLLEGE	<50
010041	Ivy Tech Community College of Indiana—Region 5	<50
001547	POINT UNIVERSITY	<50
002007	LOUISIANA COLLEGE	<50
010109	Ivy Tech Community College of Indiana—Region 13	<50
002246	CLEARY UNIVERSITY	<50
001302	SAINT MARY'S COLLEGE OF CALIFORNIA	<50
001587	PAINÉ COLLEGE	<50
001900	WILLIAM PENN UNIVERSITY	<50
002323	UNIVERSITY OF DETROIT MERCY	<50
009292	Andover College	<50
001594	SPELMAN COLLEGE	<50
001578	LAGRANGE COLLEGE	<50
002201	PINE MANOR COLLEGE	<50
001238	MILLS COLLEGE	<50
008611	HOSTOS COMMUNITY COLLEGE OF THE CITY UNIVERSITY OF NEW YORK	<50
003994	SPARTANBURG COMMUNITY COLLEGE	<50
005621	SOUTHERN CRESCENT TECHNICAL COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003688	NORTHERN VERMONT UNIVERSITY	<50
030722	CHANDLER—GILBERT COMMUNITY COLLEGE	<50
003671	DIXIE STATE UNIVERSITY	<50
021466	SOUTH MOUNTAIN COMMUNITY COLLEGE	<50
003784	OLYMPIC COLLEGE	<50
003769	BELLEVUE COLLEGE	<50
007598	HOCKING TECHNICAL COLLEGE	<50
010387	EL PASO COUNTY COMMUNITY COLLEGE DISTRICT	<50
008244	JOHNSON COUNTY COMMUNITY COLLEGE	<50
003897	UNIVERSITY OF WISCONSIN COLLEGES	<50
003759	J SARGEANT REYNOLDS COMMUNITY COLLEGE	<50
005015	UNIVERSITY OF WISCONSIN—PARKSIDE	<50
009914	ROANE STATE COMMUNITY COLLEGE	<50
004926	TRI—COUNTY TECHNICAL COLLEGE	<50
006835	DYERSBURG STATE COMMUNITY COLLEGE	<50
006960	MAYSVILLE COMMUNITY AND TECHNICAL COLLEGE	<50
005541	MINNESOTA STATE COMMUNITY AND TECHNICAL COLLEGE	<50
008596	WEST LOS ANGELES COLLEGE	<50
040385	PIERPONT COMMUNITY & TECHNICAL COLLEGE	<50
005294	WAUKESHA COUNTY TECHNICAL COLLEGE	<50
003921	UNIVERSITY OF WISCONSIN—PLATTEVILLE	<50
003680	WEBER STATE UNIVERSITY	<50
012693	PELLISSIPPI STATE COMMUNITY COLLEGE	<50
003995	CENTRAL CAROLINA TECHNICAL COLLEGE	<50
007730	ROWAN COLLEGE AT BURLINGTON COUNTY	<50
009507	GEORGIA HIGHLANDS COLLEGE	<50
003816	EASTERN WEST VIRGINIA COMMUNITY & TECHNICAL COLLEGE	<50
003932	UNIVERSITY OF WYOMING	<50
007316	WESTERN IOWA TECH COMMUNITY COLLEGE	<50
006931	WAUBONSEE COMMUNITY COLLEGE	<50
009942	SHAWNEE STATE UNIVERSITY	<50
010027	JAMES A. RHODES STATE COLLEGE	<50
006785	SCHENECTADY COUNTY COMMUNITY COLLEGE	<50
003423	CITADEL, THE MILITARY COLLEGE OF SOUTH CAROLINA	<50
002173	NORTH SHORE COMMUNITY COLLEGE	<50
003456	WINTHROP UNIVERSITY	<50
001994	HOPKINSVILLE COMMUNITY COLLEGE	<50
001598	UNIVERSITY OF GEORGIA	<50
002906	APPALACHIAN STATE UNIVERSITY	<50
003449	UNIVERSITY OF SOUTH CAROLINA—AIKEN	<50
002185	FRAMINGHAM STATE UNIVERSITY	<50
002393	MINNESOTA STATE COLLEGE SOUTHEAST	<50
001848	SOUTHEASTERN COMMUNITY COLLEGE	<50
002870	JEFFERSON COMMUNITY COLLEGE	<50
002988	BISMARCK STATE COLLEGE	<50
003327	SLIPPERY ROCK UNIVERSITY	<50
002994	MINOT STATE UNIVERSITY	<50
002847	SUNY COLLEGE AT ONEONTA	<50
001226	LOS ANGELES PIERCE COLLEGE	<50
002388	UNIVERSITY OF MINNESOTA DULUTH	<50
003161	NORTHEASTERN STATE UNIVERSITY	<50
002855	SUNY COLLEGE OF TECHNOLOGY AT CANTON	<50
003168	ROGERS STATE UNIVERSITY	<50
002861	CAYUGA COMMUNITY COLLEGE	<50
002591	PLYMOUTH STATE UNIVERSITY OF THE UNIVERSITY SYSTEM OF NEW HAMPSHIRE	<50
003553	CISCO COLLEGE	<50
001925	KANSAS CITY KANSAS COMMUNITY COLLEGE	<50
002664	WESTERN NEW MEXICO UNIVERSITY	<50
002301	NORTHERN MICHIGAN UNIVERSITY	<50
001022	JEFFERSON STATE COMMUNITY COLLEGE	<50
042440	CALIFORNIA INTERCONTINENTAL UNIVERSITY	<50
042063	FVI SCHOOL OF NURSING AND TECHNOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
037834	ABDILL CAREER COLLEGE	<50
041529	STUDIO ACADEMY OF BEAUTY (THE)	<50
041298	MEDIATECH INSTITUTE	<50
041280	MILLENNIUM TRAINING INSTITUTE	<50
041687	PELTON COLLEGE	<50
042289	MCDUGGLE TECHNICAL INSTITUTE	<50
041330	BIOHEALTH COLLEGE	<50
001089	ARKANSAS TECH UNIVERSITY	<50
041302	INSTITUTE OF PRODUCTION AND RECORDING (THE)	<50
001016	UNIVERSITY OF NORTH ALABAMA	<50
041812	SOUTHERN CALIFORNIA HEALTH INSTITUTE (SOCHI)	<50
041365	PCCENTER	<50
038033	HEALTHCARE TRAINING INSTITUTE	<50
035933	SOUTHWEST INSTITUTE OF HEALING ARTS	<50
040583	HEALTH OPPORTUNITY TECHNICAL CENTER	<50
001109	UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES	<50
034557	CORTIVA INSTITUTE—CHICAGO	<50
031152	MOTORING TECHNICAL TRAINING INSTITUTE	<50
033563	MEDICAL TRAINING COLLEGE	<50
023257	LABARON HAIRDRESSING ACADEMY	<50
026059	TESST COLLEGE OF TECHNOLOGY	<50
033923	CHASE COLLEGE	<50
034903	PAUL MITCHELL THE SCHOOL CHICAGO	<50
030670	ANTONELLI MEDICAL & PROFESSIONAL INSTITUTE	<50
030104	CRESCENT CITY SCHOOL OF GAMING & BARTENDING	<50
023182	KD CONSERVATORY COLLEGE OF FILM AND DRAMATIC ARTS	<50
034297	EAST WEST COLLEGE OF NATURAL MEDICINE	<50
025681	TEXAS BARBER COLLEGE	<50
030947	KRS COMPUTER AND BUSINESS SCHOOL	<50
031275	ADVANCED TECHNOLOGY INSTITUTE	<50
025548	VANGUARD COLLEGE OF COSMETOLOGY A PAUL MITCHELL PARTNER SCHOOLMETAIRIE	<50
023322	HAIR PROFESSIONALS CAREER COLLEGE	<50
023382	BAY STATE SCHOOL OF TECHNOLOGY	<50
032993	PACIFIC COLLEGE	<50
026107	SHIRLEY BAKER CAREER INSTITUTE	<50
023424	ACADEMY OF RADIO & TV BROADCASTING	<50
026128	LOS ANGELES RECORDING SCHOOL	<50
026010	AMERICAN SCHOOL OF BUSINESS	<50
021506	COSMETOLOGY AND SPA ACADEMY	<50
021928	WALNUT HILL COLLEGE	<50
021641	MTI BUSINESS SCHOOLS (CLOSED)	<50
013087	CAPRI BEAUTY COLLEGE	<50
022702	INTERNATIONAL AVIATION AND TRAVEL ACADEMY	<50
020618	ROMAN ACADEMY OF BEAUTY CULTURE	<50
011911	BRICK COMPUTER SCIENCE INSTITUTE	<50
020932	WATTERSON COLLEGE PACIFIC	<50
021650	ELDORADO COLLEGE	<50
021010	NORTHWEST COLLEGE SCHOOL OF BEAUTY	<50
022676	SOFIA UNIVERSITY	<50
011631	D'JAY'S INSTITUTE OF COSMETOLOGY AND ESTHIOLOGY	<50
011129	NATIONAL EDUCATION CENTER BRYMAN CAMPUS	<50
010930	SUBURBAN TECHNICAL SCHOOL	<50
021604	WILFRED ACADEMY OF HAIR DESIGN & BEAUTY CULTURE	<50
004902	PENN COMMERCIAL BUSINESS/TECHNICAL SCHOOL	<50
008544	CAREER COLLEGES OF CHICAGO	<50
005008	MOUNTAIN STATE COLLEGE	<50
023269	SUNSTATE ACADEMY	<50
009283	MIDWAY PARIS BEAUTY SCHOOL	<50
021830	ORLEANS TECHNICAL COLLEGE	<50
021642	FOREST INSTITUTE OF PROFESSIONAL PSYCHOLOGY	<50
010424	SUMMIT SALON ACADEMY	<50
008328	ALVAREITA'S COLLEGE OF COSMETOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
010631	ALBERT MERRILL SCHOOL	<50
004847	INTERSTATE BUSINESS COLLEGE	<50
038744	COMMUNITY CHRISTIAN COLLEGE	<50
021636	WILLIAM JAMES COLLEGE	<50
030763	BEULAH HEIGHTS UNIVERSITY	<50
009739	GLEN DOW ACADEMY OF HAIR DESIGN & SALONS	<50
024827	WESTERN UNIVERSITY OF HEALTH SCIENCES	<50
010098	NEUMONT COLLEGE OF COMPUTER SCIENCE	<50
007926	TRAVEL & TRADE CAREER INSTITUTE	<50
025034	AMRIDGE UNIVERSITY	<50
003083	UNIVERSITY OF MOUNT UNION	<50
002369	NORTH CENTRAL UNIVERSITY	<50
003737	SHENANDOAH UNIVERSITY	<50
003399	YORK COLLEGE OF PENNSYLVANIA	<50
002779	NAZARETH COLLEGE OF ROCHESTER	<50
003790	SEATTLE UNIVERSITY	<50
003235	ARCADIA UNIVERSITY	<50
003797	UNIVERSITY OF PUGET SOUND	<50
012500	RANKEN TECHNICAL COLLEGE	<50
003818	UNIVERSITY OF CHARLESTON	<50
003287	LA SALLE UNIVERSITY	<50
003819	OHIO VALLEY UNIVERSITY	<50
003045	UNIVERSITY OF FINDLAY (THE)	<50
003832	ALVERNO COLLEGE	<50
003684	CHAMPLAIN COLLEGE	<50
002639	STEVENS INSTITUTE OF TECHNOLOGY	<50
012050	ROSDALE TECHNICAL COLLEGE	<50
003243	CEDAR CREST COLLEGE	<50
003282	KINGS COLLEGE	<50
002473	KANSAS CITY ART INSTITUTE	<50
002985	WINGATE UNIVERSITY	<50
002927	ELON UNIVERSITY	<50
007465	AMERICAN ACADEMY OF DRAMATIC ARTS	<50
002788	NIAGARA UNIVERSITY	<50
002527	UNIVERSITY OF PROVIDENCE	<50
003940	INTER AMERICAN UNIVERSITY OF PUERTO RICO—METROPOLITAN CAMPUS	<50
013103	CALIFORNIA WESTERN SCHOOL OF LAW	<50
003422	SOUTHERN WESLEYAN UNIVERSITY	<50
002542	CREIGHTON UNIVERSITY	<50
003979	TEACHERS COLLEGE, COLUMBIA UNIVERSITY	<50
003490	FISK UNIVERSITY	<50
003577	HUSTON—TILLOTSON UNIVERSITY	<50
003360	ROSEMONT COLLEGE	<50
002463	EVANGEL UNIVERSITY	<50
003497	KNOXVILLE COLLEGE	<50
002821	SAINT JOHN FISHER COLLEGE	<50
003720	UNIVERSITY OF LYNCHBURG	<50
003591	MCMURRY UNIVERSITY	<50
003144	XAVIER UNIVERSITY	<50
002953	WILLIAM PEACE UNIVERSITY	<50
012399	LEWIS COLLEGE OF BUSINESS	<50
002586	RIVIER UNIVERSITY	<50
003303	CARLOW UNIVERSITY	<50
003602	PAUL QUINN COLLEGE	<50
003166	OKLAHOMA CITY UNIVERSITY	<50
003635	TEXAS CHIROPRACTIC COLLEGE	<50
002903	YESHIVA UNIVERSITY	<50
002122	BAY PATH UNIVERSITY	<50
001784	ANCILLA DOMINI COLLEGE	<50
001724	MILLIKIN UNIVERSITY	<50
008510	Eastfield College	<50
001946	TABOR COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001097	HARDING UNIVERSITY	<50
002354	HAMLIN UNIVERSITY	<50
001103	PHILANDER SMITH COLLEGE	<50
001739	NORTHWESTERN UNIVERSITY	<50
001183	HOLY NAMES UNIVERSITY	<50
001929	KANSAS WESLEYAN UNIVERSITY	<50
001215	LA SIERRA UNIVERSITY	<50
001962	UNIVERSITY OF THE CUMBERLANDS	<50
008276	Bryant & Stratton Business Institute—Syracuse	<50
002334	AUGSBURG UNIVERSITY	<50
001252	HOPE INTERNATIONAL UNIVERSITY	<50
031005	Virginia College at Pensacola	<50
001322	UNIVERSITY OF REDLANDS	<50
001734	NORTH CENTRAL COLLEGE	<50
039063	ATA Career Education	<50
001741	OLIVET NAZARENE UNIVERSITY	<50
011708	Hair Design School, The	<50
001847	BUENA VISTA UNIVERSITY	<50
042066	SAE Institute of Technology—Atlanta	<50
020695	Akron Institute of Herzog University	<50
010264	South College-Asheville	<50
001959	CAMPBELLSVILLE UNIVERSITY	<50
001563	EMMANUEL COLLEGE	<50
002067	WASHINGTON ADVENTIST UNIVERSITY	<50
001624	NORTHWEST NAZARENE UNIVERSITY	<50
002282	MADONNA UNIVERSITY	<50
001634	AURORA UNIVERSITY	<50
008547	Ivy Tech Community College of Indiana—Region 7	<50
001717	MACMURRAY COLLEGE	<50
010182	ROGUE COMMUNITY COLLEGE	<50
008133	ZANE STATE COLLEGE	<50
005006	WALLA WALLA COMMUNITY COLLEGE	<50
006787	CLINTON COMMUNITY COLLEGE	<50
003899	UNIVERSITY OF WISCONSIN—GREEN BAY	<50
007582	AIMS COMMUNITY COLLEGE	<50
031153	GENESEE—LIVINGSTON—STEBEN—WYOMING BOCES	<50
006791	SUNY COLLEGE AT PURCHASE	<50
041143	NEVADA STATE COLLEGE	<50
009314	GREAT FALLS COLLEGE MONTANA STATE UNIVERSITY	<50
009930	UNIVERSITY OF TEXAS OF THE PERMIAN BASIN	<50
011046	CENTRAL OHIO TECHNICAL COLLEGE	<50
004878	CLACKAMAS COMMUNITY COLLEGE	<50
009333	UNIVERSITY OF ILLINOIS AT SPRINGFIELD	<50
003823	WEST LIBERTY UNIVERSITY	<50
003813	GLENVILLE STATE UNIVERSITY	<50
004502	CITY COLLEGE OF SAN FRANCISCO	<50
005277	EASTERN MAINE COMMUNITY COLLEGE	<50
003925	UNIVERSITY OF WISCONSIN—SUPERIOR	<50
006811	LUZERNE COUNTY COMMUNITY COLLEGE	<50
003611	SOUTH PLAINS COLLEGE	<50
003747	UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE (THE)	<50
004788	HERKIMER COUNTY COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
011678	STATE UNIVERSITY OF NEW YORK POLYTECHNIC INSTITUTE	<50
004062	PITT COMMUNITY COLLEGE	<50
009544	SPOKANE FALLS COMMUNITY COLLEGE	<50
003816	SOUTHERN WEST VIRGINIA COMMUNITY AND TECHNICAL COLLEGE	<50
003961	HARPER COLLEGE	<50
005697	NORTHWEST—SHOALS COMMUNITY COLLEGE	<50
004024	GEORGIA NORTHWESTERN TECHNICAL COLLEGE	<50
030686	SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY	<50
003791	SHORELINE COMMUNITY COLLEGE	<50
003802	WESTERN WASHINGTON UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
006901	ROWAN COLLEGE OF SOUTH JERSEY	<50
005754	ROWAN-CABARRUS COMMUNITY COLLEGE	<50
004759	CUNY YORK COLLEGE	<50
005001	EDMONDS COLLEGE	<50
005525	SOUTHERN MAINE COMMUNITY COLLEGE	<50
039573	BLUE RIDGE COMMUNITY AND TECHNICAL COLLEGE	<50
020995	CENTRAL COMMUNITY COLLEGE	<50
040414	MOUNTWEST COMMUNITY AND TECHNICAL COLLEGE	<50
008038	MIDDLESEX COMMUNITY COLLEGE	<50
010487	WEST GEORGIA TECHNICAL COLLEGE	<50
009912	VOLUNTEER STATE COMMUNITY COLLEGE	<50
003782	LOWER COLUMBIA COLLEGE	<50
021661	ELAINE P. NUNEZ COMMUNITY COLLEGE	<50
003600	PANOLA COLLEGE	<50
003005	UNIVERSITY OF NORTH DAKOTA	<50
002008	LOUISIANA TECH UNIVERSITY	<50
002696	NEW YORK CITY COLLEGE OF TECHNOLOGY OF THE CITY UNIVERSITY OF NEW YORK	<50
001890	UNIVERSITY OF NORTHERN IOWA	<50
001348	COLORADO SCHOOL OF MINES	<50
002531	MONTANA TECHNOLOGICAL UNIVERSITY	<50
002689	CUNY HUNTER COLLEGE	<50
001292	SOLANO COMMUNITY COLLEGE	<50
002972	NORTH CAROLINA STATE UNIVERSITY	<50
002877	ROCKLAND COMMUNITY COLLEGE	<50
001816	INDIANA UNIVERSITY—SOUTH BEND	<50
001902	COWLEY COUNTY COMMUNITY COLLEGE & AREA VOCATIONAL TECHNICAL SCHOOL	<50
002856	SUNY COLLEGE OF AGRICULTURE & TECHNOLOGY AT COBLESKILL	<50
001233	SACRAMENTO CITY COLLEGE	<50
001193	CYPRESS COLLEGE	<50
002581	NHTI—CONCORD'S COMMUNITY COLLEGE	<50
002091	SALISBURY UNIVERSITY	<50
002277	LAKE MICHIGAN COLLEGE	<50
001266	LANEY COLLEGE	<50
002053	UNIVERSITY OF MAINE	<50
001246	MT. SAN JACINTO COLLEGE	<50
002876	ORANGE COUNTY COMMUNITY COLLEGE	<50
002845	SUNY COLLEGE AT GENESEO	<50
003179	SOUTHEASTERN OKLAHOMA STATE UNIVERSITY	<50
003450	UNIVERSITY OF SOUTH CAROLINA BEAUFORT	<50
003181	SOUTHWESTERN OKLAHOMA STATE UNIVERSITY	<50
001285	SANTA BARBARA CITY COLLEGE	<50
002176	BRISTOL COMMUNITY COLLEGE	<50
002881	SUNY WESTCHESTER COMMUNITY COLLEGE	<50
002189	WESTFIELD STATE UNIVERSITY	<50
003558	NORTH CENTRAL TEXAS COLLEGE	<50
002317	SOUTHWESTERN MICHIGAN COLLEGE	<50
001585	UNIVERSITY OF NORTH GEORGIA	<50
001345	ADAMS STATE UNIVERSITY	<50
041174	MILWAUKEE CAREER COLLEGE	<50
042058	SAE INSTITUTE OF TECHNOLOGY, LOS ANGELES	<50
041791	VERVE COLLEGE	<50
037485	DURHAM BEAUTY ACADEMY	<50
042211	NEW HORIZONS MEDICAL INSTITUTE	<50
040143	P&A SCHOLARS BEAUTY SCHOOL	<50
001072	COCHISE COLLEGE	<50
037593	STELLAR CAREER COLLEGE	<50
041093	ACADEMY OF BARBERING ARTS (THE)	<50
036114	FLORIDA BARBER ACADEMY	<50
038063	LAKE COLLEGE	<50
040165	AMERICAN INSTITUTE OF BEAUTY	<50
037013	MEMPHIS INSTITUTE OF BARBERING	<50
041387	PAUL MITCHELL THE SCHOOL—PASADENA	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
038163	ARTISTIC NAILS & BEAUTY ACADEMY	<50
040213	AUGUSTA SCHOOL OF MASSAGE	<50
037233	CULINARY INSTITUTE LENOTRE	<50
041477	LAKE LANIER SCHOOL OF MASSAGE	<50
041800	CINTA AVEDA INSTITUTE	<50
039396	DAYTONA COLLEGE	<50
042047	PAUL MITCHELL THE SCHOOL RALEIGH	<50
001107	SOUTHERN ARKANSAS UNIVERSITY	<50
041156	MAYFIELD COLLEGE	<50
041587	HOLLYWOOD BEAUTY COLLEGE	<50
042106	ADVANCED COMPUTING INSTITUTE	<50
037833	BLUE CLIFF CAREER COLLEGE	<50
042245	TRENZ BEAUTY ACADEMY	<50
040823	PROFESSIONAL CAREER TRAINING INSTITUTE	<50
042476	NEW BEGINNINGS BEAUTY ACADEMY	<50
040894	CCI TRAINING CENTER	<50
042779	HOUSTON SCHOOL OF CARPENTRY	<50
041670	PAUL MITCHELL THE SCHOOL TEMECULA	<50
041211	ELEVATE SALON INSTITUTE	<50
040963	CHARLESTON SCHOOL OF LAW	<50
038385	NORTHWEST CAREER COLLEGE	<50
036984	CALIFORNIA COLLEGE OF VOCATIONAL CAREERS	<50
041784	VOGUE COLLEGE OF COSMETOLOGY	<50
041732	TAYLOR ANDREWS ACADEMY OF HAIR DESIGN	<50
034453	HDS TRUCK DRIVING INSTITUTE	<50
033273	HAIR ACADEMY II	<50
024925	DELAWARE VALLEY ACADEMY OF MEDICAL & DENTAL ASSISTANTS	<50
025410	ALASKA CAREER COLLEGE	<50
033963	OKLAHOMA HEALTH ACADEMY	<50
023110	PAUL MITCHELL THE SCHOOL PORTLAND	<50
030819	YTI CAREER INSTITUTE—ALTOONA	<50
025536	DIVERSIFIED VOCATIONAL COLLEGE	<50
031973	INSTITUTE FOR HEALTH EDUCATION (THE)	<50
025619	BRILLARE HAIRDRESSING ACADEMY	<50
033615	WILLSEY INSTITUTE	<50
023067	FORT WORTH BEAUTY SCHOOL	<50
025200	INTERNATIONAL SCHOOL OF SKIN AND NAILCARE	<50
025827	CORTIVA INSTITUTE—TUCSON	<50
023529	AMERICAN BUSINESS INSTITUTE (CLOSED)	<50
026031	CRAVE BEAUTY ACADEMY.LLC	<50
023183	AMERICAN CAREER ACADEMY	<50
023398	SOUTHERN INSTITUTE OF COSMETOLOGY	<50
031513	SUCCESS INSTITUTE OF BUSINESS	<50
026158	COLLEGE OF COURT REPORTING	<50
032183	UNIVERSITY OF THE POTOMAC	<50
026161	JEAN MADELINE AVEDA INSTITUTE	<50
033413	SOUTHWESTERN PROFESSIONAL INSTITUTE	<50
023411	KENNETH SHULER SCHOOL OF COSMETOLOGY & NAILS	<50
023198	BEAUTY INSTITUTE SCHWARZKOPF PROFESSIONAL (THE)	<50
030079	GALLIPOLIS CAREER COLLEGE	<50
034183	GWINNETT COLLEGE—SANDY SPRINGS	<50
023438	MONTGOMERY BEAUTY SCHOOL	<50
030327	COOPER CAREER INSTITUTE	<50
030634	MODERN TECHNOLOGY SCHOOL	<50
021654	TRAINCO BUS SCHOOL	<50
022546	CONCHO CAREER INSTITUTE	<50
022183	SOUTHWEST SCHOOL OF BUSINESS & TECHNICAL CAREERS	<50
020925	LAUREL TECHNICAL INSTITUTE	<50
022959	AMERICAN CAREER TRAINING TRAVEL SCHOOL	<50
012932	TINT SCHOOL OF MAKEUP & COSMETOLOGY	<50
020860	VIDEO TECHNICAL INSTITUTE	<50
011519	JOSEPH'S COLLEGE COSMETOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022385	CENTRAL OKLAHOMA COLLEGE	<50
021026	ROYAL BUSINESS SCHOOL (CLOSED)	<50
022880	PROFESSIONAL BUSINESS SCHOOL	<50
011617	CENTER FOR ALLIED HEALTH EDUCATION	<50
023014	EAST OHIO COLLEGE	<50
021178	AVEDA ARTS & SCIENCES INSTITUTE LAFAYETTE	<50
012027	GALEN COLLEGE OF CALIFORNIA	<50
011744	NATIONAL BEAUTY COLLEGE	<50
022021	CULINARY SCHOOL OF WASHINGTON	<50
021232	AVEDA ARTS & SCIENCES INSTITUTE MINNEAPOLIS	<50
022340	CAMERON COLLEGE	<50
021499	PAUL MITCHELL THE SCHOOL JACKSONVILLE	<50
022475	ARIZONA INSTITUTE OF ELECTROLYSIS DIV UNIF SCHOOL OF AM	<50
020551	HAWAII BUSINESS COLLEGE	<50
022776	INTERNATIONAL BARBER & STYLE COLLEGE	<50
011844	INTERNATIONAL TECHNICAL INSTITUTE	<50
022952	UNITED SCHOOLS	<50
021544	BEAU MONDE ACADEMY OF BARBERING AND COSMETOLOGY	<50
012896	NORTH COAST COLLEGE, THE	<50
023015	CAMBRIDGE TECHL INST	<50
012982	BORDER INSTITUTE OF TECHNOLOGY	<50
021877	CROWN BUSINESS INSTITUTE MIAMI	<50
025994	NEW YORK COLLEGE OF HEALTH PROFESSIONS	<50
042183	MIDWIVES COLLEGE OF UTAH	<50
040943	ROBERT B. MILLER COLLEGE (THE)	<50
042788	LOS ANGELES PACIFIC UNIVERSITY	<50
021102	COLUMBIA COLLEGE HOLLYWOOD	<50
008123	ADVANCED CAREER TRAINING	<50
009435	PHILLIPS JUNIOR COLLEGE AT BIRMINGHAM	<50
020882	JORDAN COLLEGE	<50
009890	VALLEY COMMERCIAL COLLEGE	<50
042213	PHILADELPHIA TECHNICIAN TRAINING INSTITUTE	<50
010372	ADELPHI BUSINESS COLLEGE	<50
008486	NATIONAL EDUCATION CENTER NATIONAL INSTITUTE OF TECHNOLOGY CAMPUS	<50
007253	FEDERICO BEAUTY INSTITUTE	<50
036124	VALLEY GRANDE INSTITUTE FOR ACADEMIC STUDIES	<50
002134	BURDETT COLLEGE — MAIN CAMPUS	<50
008568	VET TECH INSTITUTE	<50
030888	WATKINS COLLEGE OF ART, DESIGN & FILM	<50
031062	FRANCISCAN MISSIONARIES OF OUR LADY UNIVERSITY	<50
007389	MIDLAND CAREER INSTITUTE	<50
036914	AVE MARIA SCHOOL OF LAW	<50
034403	BAPTIST MEMORIAL COLLEGE OF HEALTH SCIENCES	<50
025340	NATIONAL UNIVERSITY OF NATURAL MEDICINE	<50
021446	KILIAN COMMUNITY COLLEGE	<50
004630	DRAUGHON TRAINING INSTITUTE	<50
007853	NATIONAL EDUCATION CENTER KEE BUSINESS COLLEGE CAMPUS	<50
036523	METROPOLITAN LEARNING INSTITUTE	<50
007387	LONG ISLAND BEAUTY SCHOOL	<50
007430	ANTONELLI INSTITUTE	<50
003376	THIEL COLLEGE	<50
002598	CALDWELL UNIVERSITY	<50
003035	OHIO DOMINICAN UNIVERSITY	<50
003302	MOUNT ALOYSIUS COLLEGE	<50
012580	SAINT LOUIS CHRISTIAN COLLEGE	<50
002899	WAGNER COLLEGE	<50
003012	ASHLAND UNIVERSITY	<50
002603	DREW UNIVERSITY	<50
002783	NEW YORK LAW SCHOOL	<50
003723	MARY BALDWIN UNIVERSITY	<50
002760	MANHATTANVILLE COLLEGE	<50
003439	MORRIS COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003298	MESSIAH UNIVERSITY	<50
002795	PAUL SMITH'S COLLEGE OF ARTS & SCIENCES	<50
003571	HARDIN-SIMMONS UNIVERSITY	<50
003742	SWEET BRIAR COLLEGE	<50
002610	FELICIAN UNIVERSITY	<50
003767	VIRGINIA WESLEYAN UNIVERSITY	<50
003066	LAKE ERIE COLLEGE	<50
002910	BELMONT ABBEY COLLEGE	<50
002744	KEUKA COLLEGE	<50
003481	CARSON—NEWMAN UNIVERSITY	<50
012031	SAN DIEGO CHRISTIAN COLLEGE	<50
003486	LIPSCOMB UNIVERSITY	<50
002461	DRURY UNIVERSITY	<50
002911	BENNETT COLLEGE	<50
002817	ST. BONAVENTURE UNIVERSITY	<50
003831	WHEELING UNIVERSITY	<50
002699	CLARKSON UNIVERSITY	<50
003498	LAMBUTH UNIVERSITY	<50
002608	GEORGIAN COURT UNIVERSITY	<50
003280	KEYSTONE COLLEGE	<50
003575	HOWARD PAYNE UNIVERSITY	<50
002502	SOUTHWEST BAPTIST UNIVERSITY	<50
003384	UNIVERSITY OF SCRANTON	<50
003941	UNIVERSIDAD ANA G. MENDEZ—CAROLINA CAMPUS	<50
002713	DOMINICAN UNIVERSITY NEW YORK	<50
002931	GUILFORD COLLEGE	<50
003586	LUBBOCK CHRISTIAN UNIVERSITY	<50
003507	MEMPHIS COLLEGE OF ART	<50
003069	LOURDES UNIVERSITY	<50
002935	JOHN WESLEY UNIVERSITY	<50
010554	CONCORDIA COLLEGE ALABAMA	<50
003987	LA ROCHE UNIVERSITY	<50
010771	GUPTON—JONES COLLEGE OF FUNERAL SERVICE	<50
003247	MISERICORDIA UNIVERSITY	<50
003110	OTTERBEIN UNIVERSITY	<50
002520	WASHINGTON UNIVERSITY IN ST. LOUIS	<50
003411	SALVE REGINA UNIVERSITY	<50
002681	CANISIUS COLLEGE	<50
012328	NORTHWESTERN HEALTH SCIENCES UNIVERSITY	<50
002944	MARS HILL UNIVERSITY	<50
003651	UNIVERSITY OF DALLAS	<50
003369	SUSQUEHANNA UNIVERSITY	<50
003149	SOUTHERN NAZARENE UNIVERSITY	<50
006873	MARIAN COURT COLLEGE	<50
007032	MIDAMERICA NAZARENE UNIVERSITY	<50
021449	Delaware Technical Community College	<50
001824	OAKLAND CITY UNIVERSITY	<50
002225	WENTWORTH INSTITUTE OF TECHNOLOGY	<50
008491	Nebraska College of Business	<50
001867	GRAND VIEW UNIVERSITY	<50
021849	Palmer College of Chiropractic West	<50
001158	UNITED STATES INTERNATIONAL UNIV	<50
001379	CONNECTICUT COLLEGE	<50
002266	CORNERSTONE UNIVERSITY	<50
021887	Prince Institute—Rocky Mountains	<50
001850	CENTRAL COLLEGE	<50
003561	Cedar Valley College	<50
001887	SIMPSON COLLEGE	<50
001023	JUDSON COLLEGE	<50
001918	FRIENDS UNIVERSITY	<50
001488	FLORIDA SOUTHERN COLLEGE	<50
001196	DOMINICAN UNIVERSITY OF CALIFORNIA	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022087	San Diego Golf Academy	<50
002239	AQUINAS COLLEGE	<50
001540	WEBBER INTERNATIONAL UNIVERSITY	<50
002322	FINLANDIA UNIVERSITY	<50
001545	ANDREW COLLEGE	<50
001839	TRINE UNIVERSITY	<50
001557	BREWTON PARKER COLLEGE	<50
001866	GRACELAND UNIVERSITY	<50
001564	EMORY UNIVERSITY	<50
001871	IOWA WESLEYAN UNIVERSITY	<50
001625	BRIGHAM YOUNG UNIVERSITY—IDAHO	<50
001891	UNIVERSITY OF DUBUQUE	<50
012470	Bryant & Stratton Business Institute—Rochester	<50
001903	BAKER UNIVERSITY	<50
001691	ILLINOIS INSTITUTE OF TECHNOLOGY	<50
001132	CALIFORNIA INSTITUTE OF THE ARTS	<50
001716	GENERATIONS COLLEGE	<50
004721	Lincoln School of Commerce	<50
001725	MONMOUTH COLLEGE	<50
002144	DEAN COLLEGE	<50
010037	Ivy Tech Community College of Indiana—Region 9	<50
002236	ALMA COLLEGE	<50
001116	ART CENTER COLLEGE OF DESIGN	<50
002265	GRACE CHRISTIAN UNIVERSITY	<50
001750	DOMINICAN UNIVERSITY	<50
002279	LAWRENCE TECHNOLOGICAL UNIVERSITY	<50
#N/A	(blank)	<50
001121	BETHANY UNIVERSITY OF THE ASSEMBLIES OF GOD	<50
001774	UNIVERSITY OF CHICAGO (THE)	<50
011210	BUNKER HILL COMMUNITY COLLEGE—	<50
033723	NORTHWEST VISTA COLLEGE	<50
026236	PARADISE VALLEY COMMUNITY COLLEGE	<50
003625	SUL ROSS STATE UNIVERSITY	<50
004069	UNIVERSITY OF MINNESOTA—CROOKSTON	<50
004480	DE ANZA COMMUNITY COLLEGE	<50
003999	CLEVELAND STATE COMMUNITY COLLEGE	<50
003917	UNIVERSITY OF WISCONSIN—EAU CLAIRE	<50
031013	GRANITE STATE COLLEGE	<50
007536	COSUMNES RIVER COLLEGE	<50
006789	COLUMBIA—GREENE COMMUNITY COLLEGE—SUNY OFFICE OF CMNTY COLLEGES	<50
007644	LAKE LAND COLLEGE	<50
005537	SOUTH CENTRAL COLLEGE	<50
007692	MORaine VALLEY COMMUNITY COLLEGE	<50
012652	ONONDAGA CORTLAND MADISON BOCES	<50
003928	CASPER COLLEGE	<50
022781	SANTA FE COMMUNITY COLLEGE	<50
008073	BUTTE COLLEGE	<50
030665	SOUTHEASTERN TECHNICAL COLLEGE	<50
008129	ADULT & COMMUNITY EDUCATION, COLUMBUS CITY SCHOOLS	<50
032343	CHARTER OAK STATE COLLEGE	<50
004999	BELLINGHAM TECHNICAL COLLEGE	<50
006788	TOMPKINS CORTLAND COMMUNITY COLLEGE	<50
005000	PIERCE COLLEGE	<50
042421	UNIVERSITY OF NORTH TEXAS AT DALLAS	<50
008403	INDIAN HILLS COMMUNITY COLLEGE	<50
005535	PINE TECHNICAL AND COMMUNITY COLLEGE	<50
008558	BEAUFORT COUNTY COMMUNITY COLLEGE	<50
011167	COMMUNITY COLLEGE OF VERMONT	<50
008659	LAUREL RIDGE COMMUNITY COLLEGE	<50
012105	NATIONAL PARK COLLEGE	<50
005252	RIDGEWATER COLLEGE	<50
003745	UNIVERSITY OF VIRGINIA	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
005258	HAWAII COMMUNITY COLLEGE	<50
021921	BUTLER TECHNOLOGY AND CAREER DEVELOPMENT SCHOOLS	<50
005304	CHIPPEWA VALLEY TECHNICAL COLLEGE	<50
023413	PALO ALTO COLLEGE	<50
005318	CATAWBA VALLEY COMMUNITY COLLEGE	<50
003608	SAINT PHILIP'S COLLEGE	<50
010060	VERNON COLLEGE	<50
030838	HEARTLAND COMMUNITY COLLEGE	<50
042485	TEXAS A&M UNIVERSITY—SAN ANTONIO	<50
031563	ESTRELLA MOUNTAIN COMMUNITY COLLEGE	<50
005390	BLACKHAWK TECHNICAL COLLEGE	<50
032603	CALIFORNIA STATE UNIVERSITY, MONTEREY BAY	<50
010364	WHATCOM COMMUNITY COLLEGE	<50
034283	KLAMATH COMMUNITY COLLEGE	<50
010453	WASHINGTON STATE COMMUNITY COLLEGE	<50
040386	BRIDGEVALLEY COMMUNITY AND TECHNICAL COLLEGE	<50
010641	SOUTHERN WESTCHESTER BOCES	<50
006807	COMMUNITY COLLEGE OF BEAVER COUNTY	<50
003981	UNIVERSITY OF NORTH CAROLINA SCHOOL OF THE ARTS	<50
010674	TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER	<50
003662	VICTORIA COLLEGE	<50
002568	UNIVERSITY OF NEVADA , RENO	<50
001143	CALIFORNIA POLYTECHNIC STATE UNIVERSITY	<50
001365	COLORADO STATE UNIVERSITY—PUEBLO	<50
003220	SOUTHWESTERN OREGON COMMUNITY COLLEGE	<50
001910	COFFEYVILLE COMMUNITY COLLEGE	<50
003221	TREASURE VALLEY COMMUNITY COLLEGE	<50
002292	MICHIGAN TECHNOLOGICAL UNIV	<50
001705	ILLINOIS VALLEY COMMUNITY COLLEGE	<50
002171	MASSACHUSETTS BAY COMMUNITY COLLEGE	<50
001926	PITTSBURG STATE UNIVERSITY	<50
001206	GOLDEN WEST COLLEGE	<50
003153	CONNORS STATE COLLEGE	<50
001573	GEORGIA SOUTHWESTERN STATE UNIVERSITY	<50
003154	EAST CENTRAL UNIVERSITY	<50
003186	BLUE MOUNTAIN COMMUNITY COLLEGE	<50
002536	UNIVERSITY OF MONTANA (THE)	<50
002295	MONTCALM COMMUNITY COLLEGE	<50
003160	NORTHEASTERN OKLAHOMA A & M COLLEGE	<50
002170	HOLYOKE COMMUNITY COLLEGE	<50
001197	EL CAMINO COLLEGE	<50
003541	ANGELO STATE UNIVERSITY	<50
001652	HAROLD WASHINGTON COLLEGE	<50
003554	CLARENDON COLLEGE	<50
002692	CUNY BRONX COMMUNITY COLLEGE	<50
003573	HILL COLLEGE	<50
002915	CENTRAL PIEDMONT COMMUNITY COLLEGE	<50
002846	STATE UNIVERSITY OF NEW YORK AT NEW PALTZ	<50
001187	COLLEGE OF THE SISKIYOU	<50
002105	UNIVERSITY OF MARYLAND—BALTIMORE COUNTY	<50
003163	NORTHWESTERN OKLAHOMA STATE UNIVERSITY	<50
002879	SULLIVAN COUNTY COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
001615	UNIVERSITY OF HAWAII MAUI COLLEGE	<50
002596	ATLANTIC CAPE COMMUNITY COLLEGE	<50
002336	BEMIDJI STATE UNIVERSITY	<50
001877	NORTH IOWA AREA COMMUNITY COLLEGE	<50
002430	PEARL RIVER COMMUNITY COLLEGE	<50
002857	SUNY COLLEGE OF TECHNOLOGY AT DELHI	<50
001579	AUGUSTA UNIVERSITY	<50
001979	WEST KENTUCKY COMMUNITY AND TECHNICAL COLLEGE	<50
001523	SAINT JOHNS RIVER STATE COLLEGE	<50
001997	SOMERSET COMMUNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001223	LOS ANGELES CITY COLLEGE	<50
002517	MISSOURI UNIVERSITY OF SCIENCE AND TECHNOLOGY	<50
001814	INDIANA UNIVERSITY—KOKOMO	<50
003546	COASTAL BEND COLLEGE	<50
002367	MINNESOTA STATE UNIVERSITY MOORHEAD	<50
001227	LOS ANGELES TRADE-TECHNICAL COLLEGE	<50
001294	SOUTHWESTERN COMMUNITY COLLEGE DISTRICT	<50
002874	NIAGARA COUNTY COMMUNITY COLLEGE	<50
002373	ROCHESTER COMMUNITY AND TECHNICAL COLLEGE	<50
003572	TRINITY VALLEY COMMUNITY COLLEGE	<50
002843	SUNY COLLEGE AT CORTLAND	<50
001923	HUTCHINSON COMMUNITY COLLEGE	<50
003174	OKLAHOMA PANHANDLE STATE UNIVERSITY	<50
002422	MISSISSIPPI UNIVERSITY FOR WOMEN	<50
001490	GULF COAST STATE COLLEGE	<50
002177	MASSASOIT COMMUNITY COLLEGE	<50
002057	ALLEGANY COLLEGE OF MARYLAND	<50
002394	WINONA STATE UNIVERSITY	<50
041523	GEORGIA BEAUTY ACADEMY	<50
041204	PAUL MITCHELL THE SCHOOL MIAMI	<50
041582	PAUL MITCHELL THE SCHOOL SHERMAN OAKS	<50
040053	UNITED STATES UNIVERSITY	<50
039655	HAIR EXPRESSIONS—PAUL MITCHELL PARTNER SCHOOL	<50
036703	TIGI HAIRDRESSING ACADEMY LEGACY	<50
041173	DAYTON SCHOOL OF MEDICAL MASSAGE	<50
041671	AVEDA INSTITUTE DENVER	<50
038143	TURNING POINT BEAUTY COLLEGE	<50
041423	AVEDA ARTS & SCIENCES INSTITUTE CORPUS CHRISTI	<50
038393	AVEDA ARTS & SCIENCES INSTITUTE NEW YORK	<50
041431	PROFESSIONAL HANDS INSTITUTE	<50
042151	CALIFORNIA CAREER INSTITUTE	<50
037863	ADVANCED COLLEGE	<50
038105	MID CITY COLLEGE	<50
041710	ADVANCED TRAINING INSTITUTE	<50
039013	PACIFIC COAST TRADE SCHOOL	<50
041013	CAROLINA SCHOOL OF BROADCASTING	<50
036274	JACKSONVILLE BEAUTY INSTITUTE	<50
041265	COAST CAREER INSTITUTE	<50
041192	EAGLE ROCK COLLEGE	<50
041043	ACADEMY DI CAPELLI	<50
041601	TRINITY SCHOOL OF HEALTH AND ALLIED SCIENCES	<50
041753	PENROSE ACADEMY	<50
036454	RUDY & KELLY ACADEMY, A PAUL MITCHELL PARTNER SCHOOL	<50
041454	OXFORD ACADEMY OF HAIR DESIGN	<50
039073	PAUL MITCHELL THE SCHOOL GREAT LAKES	<50
041455	SKIN SCIENCE INSTITUTE OF LASER & ESTHETICS	<50
041505	PREFERRED COLLEGE OF NURSING, LOS ANGELES	<50
041796	ENTOURAGE INSTITUTE OF BEAUTY AND ESTHETICS	<50
040384	AVI CAREER TRAINING	<50
041468	SOUTH TEXAS TRAINING CENTER	<50
042349	AMG COLLEGE	<50
041063	PALM BEACH ACADEMY OF HEALTH & BEAUTY	<50
042449	SONORAN DESERT INSTITUTE	<50
037534	MICHAEL'S SCHOOL OF BEAUTY	<50
039554	MIDWEST INSTITUTE OF MASSAGE THERAPY	<50
041869	INTERNATIONAL COLLEGE OF BEAUTY, ARTS & SCIENCES	<50
001004	UNIVERSITY OF MONTEVALLO	<50
039633	INSTITUTE OF HEALTH AND TECHNOLOGY	<50
001007	CENTRAL ALABAMA COMMUNITY COLLEGE	<50
041878	CYBERTEX INSTITUTE OF TECHNOLOGY	<50
041584	L'ESPRIT ACADEMY	<50
041944	AMERICAN COLLEGE OF HEALTHCARE SCIENCES	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
037143	TREND BARBER COLLEGE	<50
041948	VELVET TOUCH ACADEMY OF COSMETOLOGY	<50
035844	COLORADO SCHOOL OF HEALING ARTS	<50
042045	ELAINE STERLING INSTITUTE(THE)	<50
041624	PAUL MITCHELL THE SCHOOL ALBUQUERQUE	<50
041326	DAVINES PROFESSIONAL ACADEMY OF BEAUTY AND BUSINESS	<50
035773	COBA ACADEMY	<50
036803	JAY'S TECHNICAL INSTITUTE	<50
040144	PALLADIUM TECHNICAL ACADEMY	<50
041284	MIAMI REGIONAL UNIVERSITY	<50
001098	HENDERSON STATE UNIVERSITY	<50
041494	GARY MANUEL AVEDA INSTITUTE	<50
041340	JOHN PAOLO'S XTREME BEAUTY INSTITUTE, GOLDWELL PRODUCTS ARTISTRY	<50
041503	RWM FIBER OPTICS	<50
041580	METRO BEAUTY ACADEMY	<50
033073	CSC INSTITUTE	<50
031384	AMERICAN COLLEGE OF MEDICAL TECHNOLOGY	<50
026196	COLLEGE FOR EARLY CHILDHOOD EDUCATORS	<50
030161	SOUTHWESTERN COLLEGE OF BUSINESS	<50
025454	NORTH AMERICAN TRADE SCHOOLS	<50
023243	CAREERCOM COLLEGE OF BUSINESS	<50
025044	VOCATIONAL INSTITUTE	<50
030288	AMERICAN NATIONAL COLLEGE	<50
030020	HAIRMASTERS INSTITUTE OF COSMETOLOGY	<50
025420	SIERRA ACADEMY OF AERONAUTICS—AIRLINE TRAINING CENTER	<50
024984	NATIONAL CAREER INSTITUTE	<50
030344	CONSERVATORY OF RECORDING ARTS & SCIENCES	<50
032383	FLORIDA COLLEGE OF INTEGRATIVE MEDICINE	<50
030541	ROYALE COLLEGE OF BEAUTY AND BARBERING	<50
025647	ELAINE STEVEN BEAUTY COLLEGE	<50
025863	FLORIDA INSTITUTE OF TRADITIONAL CHINESE MEDICINE	<50
033673	PROFESSIONAL GOLFERS CAREER COLLEGE	<50
023208	MAGNOLIA COLLEGE OF COSMETOLOGY	<50
025184	NATIONAL HISPANIC UNIVERSITY (THE)	<50
023044	YTI CAREER INSTITUTE—CAPITAL REGION	<50
034404	MARIAN HEALTH CAREERS CENTER	<50
023545	SOUTHEASTERN BEAUTY SCHOOLS	<50
026063	PAUL MITCHELL THE SCHOOL WICHITA	<50
026021	NORTHWEST COLLEGE OF ART & DESIGN	<50
026071	PAUL MITCHELL THE SCHOOL BOISE	<50
030906	COBB BEAUTY COLLEGE	<50
032243	NEW PROFESSIONS TECHNICAL INSTITUTE	<50
023601	PROFESSIONAL CAREER COLLEGE	<50
032533	PAUL MITCHELL THE SCHOOL MEMPHIS	<50
023602	STENOTYPE INSTITUTE OF SPRINGFIELD	<50
026146	SUMMIT INSTITUTE	<50
030977	CENTRAL CALIFORNIA SCHOOL OF CONTINUING EDUCATION	<50
033553	GHENT BEAUTY ACADEMY	<50
030978	CARSTEN INSTITUTE OF COSMETOLOGY	<50
025696	SEARCY BEAUTY COLLEGE	<50
030990	CORTIVA INSTITUTE—SEATTLE	<50
025135	MARJON SCHOOL OF BEAUTY	<50
025574	STAR COLLEGE OF COSMETOLOGY	<50
025706	CAREERCOM JUNIOR COLLEGE OF BUSINESS	<50
031111	NEW YORK PARALEGAL SCHOOL	<50
034145	ACUPUNCTURE AND MASSAGE COLLEGE	<50
023377	PROFESSIONAL SKILLS INSTITUTE	<50
025754	INTERNATIONAL CULINARY CENTER	<50
031161	VOGUE BEAUTY AND BARBER SCHOOL	<50
030144	SOUTHERN CALIFORNIA INTERNATIONAL COLLEGE	<50
024947	BALTIMORE STUDIO OF HAIR DESIGN	<50
030650	PAUL MITCHELL THE SCHOOL RICHLAND	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
030439	NEWSCHOOL OF ARCHITECTURE AND DESIGN	<50
022675	GLENWOOD BEAUTY ACADEMY	<50
020503	ACADEMY COLLEGE	<50
022847	CHICAGO INSTITUTE OF TECHNOLOGY	<50
011690	PHILLIPS COLLEGE OF ATLANTA	<50
022515	TREND SETTERS' ACADEMY OF BEAUTY CULTURE	<50
011193	STRATFORD SCHOOL	<50
011481	DIVERS INSTITUTE OF TECHNOLOGY	<50
011256	UNITED ELECTRONICS INST	<50
020523	UNIVERSITY OF WEST LOS ANGELES	<50
020937	LONG ISLAND BUSINESS INSTITUTE	<50
022430	SOUTHWEST COLLEGE	<50
021664	NATIONAL UNIVERSITY COLLEGE—IBC INSTITUTE	<50
011816	GREAT LAKES TECHL INST	<50
012901	DOMINION COLLEGE	<50
022694	EASTERN HILLS ACADEMY OF HAIR DESIGN	<50
021059	BRITTANY BEAUTY ACADEMY	<50
022732	INSTITUTE OF COMPUTER SCIENCE	<50
021858	MOLER BARBER COLLEGE	<50
022879	RAPHAEL'S SCHOOL OF BEAUTY CULTURE	<50
021250	CAREER ACADEMY OF BEAUTY	<50
022980	DESIGN INSTITUTE OF SAN DIEGO	<50
011000	BAILIE SCHOOL OF BROADCAST	<50
020564	CAPRI COSMETOLOGY LEARNING CENTER	<50
010903	RIZZIERI AVEDA SCHOOL FOR BEAUTY AND WELLNESS	<50
021448	VET TECH INSTITUTE OF HOUSTON	<50
021256	MICHIGAN COLLEGE OF BEAUTY—TROY	<50
012483	PAUL MITCHELL THE SCHOOL DALLAS	<50
012064	ORION TECHNICAL COLLEGE	<50
022584	AVEDA ARTS & SCIENCES INSTITUTE BATON ROUGE	<50
022041	NEW ENGLAND TRACTOR TRAILER TRAINING SCHOOL	<50
020772	ROSS TECHNICAL INSTITUTE	<50
022050	COLLEGE OF WILMINGTON	<50
022695	WESTERN HILLS SCHOOL OF BEAUTY & HAIR DESIGN	<50
012092	KENNETH SHULER SCHOOL OF COSMETOLOGY	<50
020837	VOCATIONAL TRAINING CENTER	<50
022127	LANCASTER SCHOOL OF COSMETOLOGY & THERAPEUTIC BODYWORK	<50
020936	SOUTHWEST INSTITUTE OF TECHNOLOGY	<50
022173	NORTH AMERICAN COLLEGE	<50
022855	CREATIVE CIRCUS	<50
021284	CERTIFIED WELDING & TRADE SCHOOL	<50
021139	KATHERINE GIBBS SCHOOL	<50
022197	CORTEZ W PETERS BUSINESS COLLEGE OF CHICAGO	<50
011866	LU ROSS ACADEMY	<50
021318	JEFFERSON BUSINESS COLLEGE (CLOSED)	<50
022999	A BUSINESS CAREER INSTITUTE	<50
022346	SHORE BEAUTY SCHOOL	<50
011896	ACADEMY OF BEAUTY CULTURE	<50
022362	MAY TECHNICAL COLLEGE	<50
021436	RETS ELECTRONIC INSTITUTE	<50
021782	CHARLESTON SCHOOL OF BEAUTY CULTURE	<50
041432	HULT INTERNATIONAL BUSINESS SCHOOL	<50
021706	UNITED STATES SPORTS ACADEMY	<50
007779	LANSDALE SCHOOL OF BUSINESS	<50
004490	PATTEN UNIVERSITY	<50
010063	DELTA CAREER COLLEGE	<50
008552	STEVENS—THE INSTITUTE OF BUSINESS & ARTS	<50
007391	BEAUTY SCHOOL OF MIDDLETOWN	<50
004924	FORREST COLLEGE	<50
009708	ELITE ACADEMY OF COSMETOLOGY	<50
025703	LOS ANGELES ORT TECHNICAL INSTITUTE	<50
032353	MASSACHUSETTS SCHOOL OF LAW AT ANDOVER	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022220	AMERICAN FILM INSTITUTE CONSERVATORY	<50
040673	SELMA UNIVERSITY	<50
008958	STENOGRAPH INSTITUTE OF TEXAS	<50
010447	PLAZA BEAUTY SCHOOL	<50
007515	ROBERT FIANCE HAIR DESIGN INST	<50
008494	HOHOKUS SCHOOL OF TRADE AND TECHNICAL SCIENCES	<50
004991	COMMONWEALTH COLLEGE, NORFOLK	<50
009523	LA'JAMES INTERNATIONAL COLLEGE	<50
004621	AYERS CAREER COLLEGE	<50
030088	BRILLARE BEAUTY INSTITUTE	<50
005204	BEAL UNIVERSITY	<50
020961	FIELDING GRADUATE UNIVERSITY	<50
009223	MBTI BUSINESS TRAINING INSTITUTE	<50
041565	GEORGIA CHRISTIAN UNIVERSITY	<50
007595	WILFRED ACADEMY OF HAIR AND BEAUTY CULTURE	<50
041933	SHEPHERD UNIVERSITY	<50
025240	JONES TECHNICAL INSTITUTE	<50
010161	LORAINES ACADEMY & SPA	<50
009363	EMPIRE TECHNICAL SCHOOL	<50
041497	HOMESTEAD SCHOOLS	<50
007617	CARNEGIE INSTITUTE	<50
010463	NATIONAL TECHNICAL SCHOOLS	<50
006606	BAPTIST HEALTH SYSTEM SCHOOL OF HEALTH PROFESSIONS	<50
010577	UNITED COLLEGE OF BUSINESS	<50
009447	WEBSTER CAREER COLLEGE	<50
009482	MANSFIELD BUSINESS COLLEGE	<50
007397	CENTER FOR THE MEDIA ARTS	<50
002955	PFEIFFER UNIVERSITY	<50
003142	WILMINGTON COLLEGE	<50
004071	WALSH COLLEGE OF ACCOUNTANCY & BUSINESS ADMINISTRATION	<50
003848	EDGEWOOD COLLEGE	<50
002808	DAEMEN UNIVERSITY	<50
002894	UNIVERSITY OF ROCHESTER	<50
010618	MID-AMERICA COLLEGE OF FUNERAL SERVICE	<50
003850	HOLY FAMILY COLLEGE	<50
002763	MARIA COLLEGE	<50
003198	LINFIELD UNIVERSITY	<50
003637	JARVIS CHRISTIAN UNIVERSITY	<50
002908	BARTON COLLEGE	<50
002816	SIENA COLLEGE	<50
003869	MOUNT MARY UNIVERSITY	<50
003084	MUSKINGUM UNIVERSITY	<50
002992	UNIVERSITY OF MARY	<50
003518	SOUTHERN ADVENTIST UNIVERSITY	<50
003911	VITERBO UNIVERSITY	<50
010880	CHATFIELD COLLEGE	<50
002748	LE MOYNE COLLEGE	<50
003134	URSULINE COLLEGE	<50
003937	UNIVERSIDAD DEL SAGRADO CORAZON	<50
003762	VIRGINIA UNIVERSITY OF LYNCHBURG	<50
003576	HOUSTON BAPTIST UNIVERSITY	<50
002685	CAZENOVIA COLLEGE	<50
002749	NEW YORK COLLEGE OF PODIATRIC MEDICINE	<50
012574	RINGLING COLLEGE OF ART AND DESIGN	<50
002534	ROCKY MOUNTAIN COLLEGE	<50
013029	BORICUA COLLEGE	<50
003025	CEDARVILLE UNIVERSITY	<50
003288	LEBANON VALLEY COLLEGE	<50
002540	COLLEGE OF SAINT MARY	<50
003986	DESALES UNIVERSITY	<50
003431	CONVERSE UNIVERSITY	<50
003811	DAVIS & ELKINS COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003366	SAINT FRANCIS UNIVERSITY	<50
003402	BRYANT UNIVERSITY	<50
008880	MORRISON INSTITUTE OF TECHNOLOGY	<50
003229	ALBRIGHT COLLEGE	<50
003783	NORTHWEST UNIVERSITY	<50
002544	DOANE UNIVERSITY	<50
009109	RIVERSIDE SCHOOL OF AERONUTICS	<50
011113	MAHARISHI INTERNATIONAL UNIVERSITY	<50
009117	MILWAUKEE COLLEGE OF BUSINESS	<50
002555	NEBRASKA WESLEYAN UNIVERSITY	<50
003504	MARTIN METHODIST COLLEGE	<50
002474	KANSAS CITY UNIVERSITY	<50
002412	MARY HOLMES COLLEGE	<50
002489	MISSOURI VALLEY COLLEGE	<50
003685	COLLEGE OF SAINT JOSEPH	<50
003352	PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE	<50
003048	HEIDELBERG UNIVERSITY	<50
003275	HOLY FAMILY UNIVERSITY	<50
009800	RUSH UNIVERSITY	<50
002886	ALBANY LAW SCHOOL OF UNION UNIVERSITY	<50
003966	BOSTON ARCHITECTURAL COLLEGE	<50
003242	CARNEGIE MELLON UNIVERSITY	<50
003266	GANNON UNIVERSITY	<50
003669	WILEY COLLEGE	<50
003306	UNIVERSITY OF VALLEY FORGE	<50
003670	BRIGHAM YOUNG UNIVERSITY	<50
010266	RANDALL UNIVERSITY	<50
010365	CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE	<50
007085	MOUNT VERNON NAZARENE UNIVERSITY	<50
003351	CAIRN UNIVERSITY	<50
002241	CALVIN UNIVERSITY	<50
001975	MIDWAY UNIVERSITY	<50
039883	SAE Institute of Technology, New York	<50
001326	SANTA CLARA UNIVERSITY	<50
002132	BRADFORD COLLEGE	<50
001036	SAMFORD UNIVERSITY	<50
001889	SAINT AMBROSE UNIVERSITY	<50
031823	New Hampshire Institute of Art	<50
030501	STUDIO ARTS COLLEGE INTERNATIONAL	<50
001568	INTERDENOMINATIONAL THEOLOGICAL CENTER	<50
001291	SIMPSON UNIVERSITY	<50
012184	International Academy of Hair Design	<50
012766	NATIONAL UNIVERSITY OF IRELAND, GALWAY	<50
001589	REINHARDT UNIVERSITY	<50
008981	Marinello Schools of Beauty	<50
041956	Tribeca Flashpoint College	<50
001917	BARCLAY COLLEGE	<50
001041	SPRING HILL COLLEGE	<50
006191	Saint Vincent's College	<50
003689	Northern Vermont University Lyndon	<50
001965	KENTUCKY CHRISTIAN UNIVERSITY	<50
006740	University of Colorado at Denver	<50
002001	THOMAS MORE UNIVERSITY	<50
001676	ELMHURST UNIVERSITY	<50
002109	MCDANIEL COLLEGE	<50
001251	OTIS COLLEGE OF ART AND DESIGN	<50
009423	ROYAL COLLEGE OF ART	<50
001070	THUNDERBIRD SCHOOL OF GLOBAL MANAGEMENT	<50
002238	ANDREWS UNIVERSITY	<50
001093	CENTRAL BAPTIST COLLEGE	<50
001555	THOMAS UNIVERSITY	<50
001094	UNIVERSITY OF THE OZARKS	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001281	WILLIAM JESSUP UNIVERSITY	<50
001732	NATIONAL UNIVERSITY OF HEALTH SCIENCES (THE)	<50
001904	BETHANY COLLEGE	<50
001409	UNIVERSITY OF SAINT JOSEPH	<50
001133	CALIFORNIA LUTHERAN UNIVERSITY	<50
001745	QUINCY UNIVERSITY	<50
001954	BELLARMINE UNIVERSITY	<50
010038	Ivy Tech Community College of Indiana—Region 10	<50
001960	SPALDING UNIVERSITY	<50
001426	YALE UNIVERSITY	<50
001964	GEORGETOWN COLLEGE	<50
009923	Ivy Tech Community College of Indiana—Region 11	<50
001969	KENTUCKY WESLEYAN COLLEGE	<50
001772	TRINITY INTERNATIONAL UNIVERSITY	<50
001988	UNION COLLEGE	<50
001236	MENLO COLLEGE	<50
002043	HUSSON UNIVERSITY	<50
001793	EARLHAM COLLEGE	<50
002080	MARYLAND INSTITUTE COLLEGE OF ART	<50
009925	Ivy Tech Community College of Indiana—Region 12	<50
002118	ASSUMPTION UNIVERSITY	<50
001437	CATHOLIC UNIVERSITY OF AMERICA (THE)	<50
002148	ENDICOTT COLLEGE	<50
001838	TAYLOR UNIVERSITY	<50
002219	TUFTS UNIVERSITY	<50
004648	Rasmussen College—Eagan	<50
002234	ADRIAN COLLEGE	<50
011686	Rasmussen College—Eden Prairie	<50
033343	UNIVERSIDAD CATOLICA NORDESTANA	<50
001854	COE COLLEGE	<50
033353	MEDICAL UNIVERSITY OF SILESIA (THE)	<50
025033	Rasmussen College—Mankato	<50
008503	Mountain View College	<50
008080	STATE FAIR COMMUNITY COLLEGE	<50
041522	CARTHAGE R-9 SCHOOL DISTRICT/CARTHAGE TECHNICAL CENTER	<50
031004	COCONINO COUNTY COMMUNITY COLLEGE	<50
009010	MADISONVILLE COMMUNITY COLLEGE	<50
003805	YAKIMA VALLEY COLLEGE	<50
009054	WEST VIRGINIA NORTHERN COMMUNITY COLLEGE—WHEELING CAMPUS	<50
006725	UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER	<50
004711	STATE TECHNICAL COLLEGE OF MISSOURI	<50
006782	GENESEE COMMUNITY COLLEGE	<50
004713	THREE RIVERS COLLEGE	<50
012954	HUDSON COUNTY COMMUNITY COLLEGE	<50
009194	LAKESHORE TECHNICAL COLLEGE	<50
022260	EAST LOS ANGELES COLLEGE	<50
005271	SOUTHCENTRAL KENTUCKY COMMUNITY AND TECHNICAL COLLEGE	<50
023502	INDIANA COUNTY TECHNOLOGY CENTER	<50
007275	EASTERN GATEWAY COMMUNITY COLLEGE	<50
006753	ILLINOIS CENTRAL COLLEGE	<50
005313	NORTH CENTRAL STATE COLLEGE	<50
008308	CECIL COLLEGE	<50
003787	SEATTLE CENTRAL COLLEGE	<50
007170	LINCOLN LAND COMMUNITY COLLEGE	<50
003760	VIRGINIA WESTERN COMMUNITY COLLEGE	<50
008727	CHICAGO CITY-WIDE COLLEGE	<50
009651	TEXAS A&M INTERNATIONAL UNIVERSITY	<50
020635	COASTLINE COMMUNITY COLLEGE	<50
009740	INVER HILLS COMMUNITY COLLEGE	<50
021702	ALBANY SCHOHARIE SCHENECTADY SARATOGA BOCES PRACTICAL NURSING PROGRAM	<50
003956	DALTON STATE COLLEGE	<50
022637	MIAMI VALLEY CAREER TECHNOLOGY CENTER	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
009764	TUNXIS COMMUNITY COLLEGE	<50
023120	BERGEN COUNTY TECHNICAL SCHOOLS	<50
005363	DENMARK TECHNICAL COLLEGE	<50
025395	IRVINE VALLEY COLLEGE	<50
005378	NORTHEAST STATE COMMUNITY COLLEGE	<50
030345	OWENSBORO COMMUNITY & TECHNICAL COLLEGE	<50
009941	BELMONT COLLEGE	<50
006768	MID MICHIGAN COLLEGE	<50
009994	PASSAIC COUNTY COMMUNITY COLLEGE	<50
008284	MITCHELL TECHNICAL COLLEGE	<50
010014	GARRETT COLLEGE	<50
007111	NORTH COUNTRY COMMUNITY COLLEGE	<50
004740	MERCER COUNTY COMMUNITY COLLEGE	<50
003609	SAN JACINTO COMMUNITY COLLEGE DISTRICT	<50
005387	NORTHCENTRAL TECHNICAL COLLEGE	<50
041301	LOUISIANA DELTA COMMUNITY COLLEGE	<50
003919	UNIVERSITY OF WISCONSIN—LACROSSE	<50
007171	KIRTLAND COMMUNITY COLLEGE	<50
003779	GRAYS HARBOR COLLEGE	<50
012870	SOUTHERN STATE COMMUNITY COLLEGE	<50
010338	EASTERN VIRGINIA MEDICAL SCHOOL	<50
005624	COLUMBUS TECHNICAL COLLEGE	<50
005448	DURHAM TECHNICAL COMMUNITY COLLEGE	<50
021077	TRUCKEE MEADOWS COMMUNITY COLLEGE	<50
006815	ORANGEBURG—CALHOUN TECHNICAL COLLEGE	<50
003696	UNIVERSITY OF VERMONT AND STATE AGRICULTURAL COLLEGE	<50
005489	CENTRAL LOUISIANA TECHNICAL COMMUNITY COLLEGE	<50
008078	SPRINGFIELD TECHNICAL COMMUNITY COLLEGE	<50
005498	WICHITA STATE UNIVERSITY CAMPUS OF APPLIED SCIENCES AND TECHNOLOGY	<50
022456	WARREN COUNTY CAREER CENTER	<50
010402	DAKOTA COUNTY TECHNICAL COLLEGE	<50
005761	L. E. FLETCHER TECHNICAL COMMUNITY COLLEGE	<50
007555	LAKES REGION COMMUNITY COLLEGE	<50
023108	LANCASTER COUNTY CAREER AND TECHNOLOGY CENTER	<50
003792	SKAGIT VALLEY COLLEGE	<50
006962	HAZARD COMMUNITY AND TECHNICAL COLLEGE	<50
006938	LINN—BENTON COMMUNITY COLLEGE	<50
023528	POLARIS CAREER CENTER—ADULT EDUCATION DEPARTMENT	<50
007684	KISHWAUKEE COLLEGE	<50
008132	TOLEDO PUBLIC SCHOOLS ADULT AND CONTINUING EDUCATION	<50
004513	HOUSATONIC COMMUNITY COLLEGE	<50
030300	OGEECHEE TECHNICAL COLLEGE	<50
007729	COUNTY COLLEGE OF MORRIS	<50
004952	UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON	<50
010710	CAPITAL AREA CAREER CENTER	<50
004972	GALVESTON COLLEGE	<50
003923	UNIVERSITY OF WISCONSIN—RIVER FALLS	<50
008155	EVERGREEN STATE COLLEGE (THE)	<50
003924	UNIVERSITY OF WISCONSIN—STEVENS POINT	<50
008278	TERRA STATE COMMUNITY COLLEGE	<50
003781	HIGHLINE COLLEGE	<50
007108	UNIVERSITY OF PUERTO RICO—RIO PIEDRAS CAMPUS	<50
003719	LONGWOOD UNIVERSITY	<50
003774	COLUMBIA BASIN COLLEGE	<50
011824	NORTHWOOD TECHNICAL COLLEGE	<50
036273	LAMAR INSTITUTE OF TECHNOLOGY	<50
011864	MOHAVE COMMUNITY COLLEGE	<50
038713	FOLSOM LAKE COLLEGE	<50
004549	LEEWARD COMMUNITY COLLEGE	<50
003601	PARIS JUNIOR COLLEGE	<50
003668	WHARTON COUNTY JUNIOR COLLEGE	<50
003935	UNIVERSITY OF GUAM	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
012182	CHATTAHOOCHEE VALLEY COMMUNITY COLLEGE	<50
006799	CRAVEN COMMUNITY COLLEGE	<50
012293	VEEB NASSAU COUNTY SCHOOL OF PRACTICAL NURSING	<50
003678	SOUTHERN UTAH UNIVERSITY	<50
003930	NORTHERN WYOMING COMMUNITY COLLEGE DISTRICT	<50
042295	TEXAS A&M UNIVERSITY—CENTRAL TEXAS	<50
004951	UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON	<50
008903	COLLEGE OF THE CANYONS	<50
012750	EDISON STATE COMMUNITY COLLEGE	<50
005534	ST. CLOUD TECHNICAL AND COMMUNITY COLLEGE	<50
001636	SOUTHWESTERN ILLINOIS COLLEGE	<50
001592	SOUTH GEORGIA STATE COLLEGE	<50
002566	WAYNE STATE COLLEGE	<50
001124	CABRILLO COLLEGE	<50
001502	LAKE SUMTER STATE COLLEGE	<50
001510	NORTHWEST FLORIDA STATE COLLEGE	<50
001649	RICHARD J DALEY COLLEGE—CITY COLLEGES OF CHICAGO	<50
001217	LASSEN COLLEGE	<50
003463	DAKOTA STATE UNIVERSITY	<50
002459	CROWDER COLLEGE	<50
003156	REDLANDS COMMUNITY COLLEGE	<50
002466	HARRIS—STOWE STATE UNIVERSITY	<50
001201	FULLERTON COLLEGE	<50
001275	SAN DIEGO MESA COLLEGE	<50
003193	EASTERN OREGON UNIVERSITY	<50
001190	CONTRA COSTA COLLEGE	<50
002559	PERU STATE COLLEGE	<50
002332	ANOKA—RAMSEY COMMUNITY COLLEGE	<50
003146	WESTERN OKLAHOMA STATE COLLEGE	<50
001611	UNIVERSITY OF HAWAII AT HILO	<50
001287	SANTA ROSA JUNIOR COLLEGE	<50
002491	MOBERLY AREA COMMUNITY COLLEGE	<50
003155	EASTERN OKLAHOMA STATE COLLEGE	<50
001242	MONTEREY PENINSULA COLLEGE	<50
003158	MURRAY STATE COLLEGE	<50
001185	COLLEGE OF THE REDWOODS	<50
002180	MASSACHUSETTS COLLEGE OF ART AND DESIGN	<50
002980	WAYNE COMMUNITY COLLEGE	<50
001202	GAVILAN COLLEGE	<50
001675	ELGIN COMMUNITY COLLEGE	<50
003189	CLATSOP COMMUNITY COLLEGE	<50
002983	WILKES COMMUNITY COLLEGE	<50
002642	COLLEGE OF NEW JERSEY (THE)	<50
001681	HIGHLAND COMMUNITY COLLEGE	<50
003438	MEDICAL UNIVERSITY OF SOUTH CAROLINA	<50
002514	NORTH CENTRAL MISSOURI COLLEGE	<50
001307	FRESNO CITY COLLEGE	<50
001513	PENSACOLA STATE COLLEGE	<50
002293	LAKE SUPERIOR STATE UNIVERSITY	<50
002993	MAYVILLE STATE UNIVERSITY	<50
001199	FOOTHILL COLLEGE	<50
002012	LOUISIANA STATE UNIVERSITY AT EUNICE	<50
003466	NORTHERN STATE UNIVERSITY	<50
002995	DAKOTA COLLEGE AT BOTTINEAU	<50
001747	ROCK VALLEY COLLEGE	<50
003326	SHIPPENSBURG UNIVERSITY OF PENNSYLVANIA	<50
003483	COLUMBIA STATE COMMUNITY COLLEGE	<50
002996	NORTH DAKOTA STATE COLLEGE OF SCIENCE	<50
001250	ORANGE COAST COLLEGE	<50
001353	FORT LEWIS COLLEGE	<50
002409	ITAWAMBA COMMUNITY COLLEGE	<50
001245	MOUNT SAN ANTONIO COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002867	SUNY FULTON–MONTGOMERY COMMUNITY COLLEGE	<50
002014	LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER	<50
002413	MERIDIAN COMMUNITY COLLEGE	<50
002375	SOUTHWEST MINNESOTA STATE UNIVERSITY	<50
002615	MIDDLESEX COLLEGE	<50
001118	BAKERSFIELD COLLEGE	<50
001864	IOWA LAKES COMMUNITY COLLEGE	<50
001286	SANTA MONICA COLLEGE	<50
003563	DEL MAR COLLEGE	<50
002533	MONTANA STATE UNIVERSITY—NORTHERN	<50
001273	SAN DIEGO CITY COLLEGE	<50
001938	PRATT COMMUNITY COLLEGE	<50
003574	HOWARD COUNTY JUNIOR COLLEGE DISTRICT	<50
002537	UNIVERSITY OF MONTANA WESTERN (THE)	<50
002426	NORTHEAST MISSISSIPPI COMMUNITY COLLEGE	<50
002539	CHADRON STATE COLLEGE	<50
001875	MARSHALLTOWN COMMUNITY COLLEGE	<50
002172	MOUNT WACHUSETT COMMUNITY COLLEGE	<50
002653	NEW MEXICO HIGHLANDS UNIVERSITY	<50
001261	PASADENA CITY COLLEGE	<50
002355	HIBBING COMMUNITY COLLEGE	<50
035883	IRENE'S MYOMASSOLOGY INSTITUTE	<50
042335	MED–LIFE INSTITUTE	<50
041731	LAB PAUL MITCHELL PARTNER SCHOOL (THE)	<50
041254	PAUL MITCHELL THE SCHOOL AUSTIN	<50
042504	FOSBRE ACADEMY OF HAIR DESIGN	<50
041257	CUT BEAUTY SCHOOL (THE)	<50
041707	PAUL MITCHELL THE SCHOOL ST LOUIS	<50
041264	CHAMPION INSTITUTE OF COSMETOLOGY	<50
042283	PAUL MITCHELL THE SCHOOL SCHENECTADY	<50
041822	HAWAII MEDICAL COLLEGE	<50
040983	TECHSKILLS—CHARLOTTE	<50
041845	CHRISTINE VALMY INTERNATIONAL SCHOOL OF ESTHETICS & COSMETOLOGY	<50
042697	UR BEAUTY & BARBER ACADEMY	<50
041476	AVEDA INSTITUTE LAS VEGAS	<50
041364	AMERICAN INSTITUTE OF MEDICAL SCIENCES & EDUCATION	<50
041855	BEVERLY HILLS DESIGN INSTITUTE	<50
041714	AVEDA INSTITUTE PORTLAND	<50
041863	PAUL MITCHELL THE SCHOOL LAS VEGAS	<50
041758	JRENEE COLLEGE	<50
039143	CALC, INSTITUTE OF TECHNOLOGY	<50
040014	MOJAVE BARBER COLLEGE	<50
041872	NEW BEGINNING COLLEGE OF COSMETOLOGY	<50
035983	PAUL MITCHELL THE SCHOOL SANTA BARBARA	<50
039704	WELLSPRING SCHOOL OF ALLIED HEALTH	<50
042460	MICHAEL K. GALVIN BEAUTY & BUSINESS ACADEMY	<50
041483	DENVER COLLEGE OF NURSING	<50
041337	NEW YORK MEDICAL CAREER TRAINING CENTER	<50
041879	JOE BLASCO MAKEUP ARTIST TRAINING CENTER	<50
042777	CALIFORNIA COLLEGE OF BARBERING AND COSMETOLOGY	<50
041883	FLORIDA ACADEMY	<50
041349	ORANGE PARK INTERNATIONAL SCHOOL OF BEAUTY	<50
038043	BELLEFONTE ACADEMY OF BEAUTY	<50
041703	BEAUTY ACADEMY OF SOUTH FLORIDA	<50
041896	STATE CAREER SCHOOL	<50
041385	HOUSTON INTERNATIONAL COLLEGE CARDIOTECH ULTRASOUND SCHOOL	<50
041919	PAUL MITCHELL THE SCHOOL SPOKANE	<50
036543	EASTERN VIRGINIA CAREER COLLEGE	<50
041927	BARBER SCHOOL (THE) BY TIM HITE	<50
040434	ALPINE COLLEGE	<50
041485	MEDICAL INSTITUTE OF PALM BEACH	<50
041443	INSTITUTE OF CULINARY EDUCATION	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
041945	AVEDA INSTITUTE TUCSON	<50
035573	NORTH FLORIDA COSMETOLOGY INSTITUTE	<50
041491	PAUL MITCHELL THE SCHOOL CINCINNATI	<50
042304	PAUL MITCHELL THE SCHOOL LANSING	<50
041976	FLORIDA INSTITUTE OF RECORDING, SOUND AND TECHNOLOGY	<50
042342	CENTER FOR ULTRASOUND RESEARCH & EDUCATION	<50
042031	PAUL MITCHELL THE SCHOOL RENO	<50
042369	K&G 5 STAR BARBER COLLEGE	<50
036614	SOUTH FLORIDA INSTITUTE OF TECHNOLOGY	<50
037573	ADVANCE SCIENCE INTERNATIONAL COLLEGE	<50
041288	BRANFORD ACADEMY OF HAIR & COSMETOLOGY	<50
041187	AMERICAN BUSINESS & TECHNOLOGY UNIVERSITY	<50
041153	COACHELLA VALLEY BEAUTY COLLEGE	<50
042537	SACRAMENTO ULTRASOUND INSTITUTE	<50
039203	INSTITUTE OF HAIR DESIGN	<50
042646	HOGAN INSTITUTE OF COSMETOLOGY AND ESTHETICS	<50
041518	TEMPLE (THE): A PAUL MITCHELL PARTNER SCHOOL	<50
042700	URBAN BARBER COLLEGE	<50
041304	SHEAR EXCELLENCE HAIR ACADEMY	<50
041003	DENMARK COLLEGE	<50
042135	SHARP EDGEZ BARBER INSTITUTE	<50
039333	MUELLER COLLEGE	<50
037003	REGENCY BEAUTY INSTITUTE—CLEVELAND	<50
039353	CALIFORNIA NURSES EDUCATIONAL INSTITUTE	<50
042160	UNIVERSAL TRAINING INSTITUTE	<50
041210	MYCOMPUTERCAREER AT INDIANAPOLIS	<50
042166	AZURE COLLEGE	<50
036276	FLORIDA EDUCATION INSTITUTE	<50
042182	PAUL MITCHELL THE SCHOOL—JERSEY SHORE	<50
001040	SOUTHERN UNION STATE COMMUNITY COLLEGE	<50
042189	ROCKY VISTA UNIVERSITY	<50
001063	UNIVERSITY OF ALASKA FAIRBANKS	<50
042192	ACE COSMETOLOGY AND BARBER TRAINING CENTER	<50
041023	NEW AGE TRAINING	<50
040924	MAKE-UP DESIGNORY	<50
001079	YAVAPAI COLLEGE	<50
042212	BLY'S SCHOOL OF COSMETOLOGY	<50
041407	AVEDA INSTITUTE CHAPEL HILL	<50
042219	CALIFORNIA TECHNICAL ACADEMY	<50
041241	ELITE COLLEGE OF COSMETOLOGY	<50
042226	HEALTHCARE INSTITUTE (THE)	<50
041782	VOGUE COLLEGE—SAN ANTONIO	<50
042237	BAY AREA MEDICAL ACADEMY	<50
041053	NIGHTINGALE MEDICAL INSTITUTE	<50
041533	PAUL MITCHELL THE SCHOOL COLUMBUS	<50
041708	UNITY COSMETOLOGY COLLEGE	<50
026211	PTC CAREER INSTITUTE OF WASHINGTON	<50
025530	MODERN COLLEGE OF DESIGN (THE)	<50
023326	METROPOLITAN TECHNICAL INSTITUTE & BUSINESS COLLEGE	<50
025882	DOUGLAS J AVEDA INSTITUTE	<50
026181	BUSINESS AND BANKING INSTITUTE	<50
025891	AMERICAN COLLEGE OF BUSINESS	<50
030050	SAFFORD COLLEGE OF BEAUTY CULTURE	<50
023472	BRANELL INSTITUTE	<50
034793	PCI COLLEGE	<50
025258	LEES SCHOOL OF COSMETOLOGY	<50
031784	CORAL RIDGE TRAINING SCHOOL	<50
035373	NEW YORK AUTOMOTIVE & DIESEL INSTITUTE	<50
025738	L'ACADEMIE DE CUISINE	<50
025906	UNIVERSITY OF SARASOTA—	<50
026238	CORTIVA INSTITUTE—SCOTTSDALE	<50
030614	ASCENSION COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
025183	LASALLE TECH	<50
025908	AMERICAN TELLER SCHOOLS OF ARIZONA	<50
030261	POLYTECHNIC INSTITUTE	<50
025586	MR RICH'S BEAUTY COLLEGE	<50
031313	FIVE BRANCHES UNIVERSITY	<50
023517	PAUL MITCHELL THE SCHOOL—LOUISVILLE	<50
031643	CREATIVE CENTER (THE)	<50
030667	AILANO SCHOOL OF COSMETOLOGY	<50
026166	SHEAR EGO INTERNATIONAL SCHOOL OF HAIR DESIGN	<50
025950	HAIR ACADEMY THE	<50
032364	L T INTERNATIONAL BEAUTY SCHOOL	<50
023537	FEDERAL TRUCK DRIVING SCHOOL	<50
032623	DAVID DEMUTH INSTITUTE OF COSMETOLOGY	<50
026002	OCEAN CORPORATION (THE)	<50
025018	DELTA COLLEGE OF BUSINESS & TECHNOLOGY	<50
023555	NATIONAL CAREER COLLEGE	<50
023266	ALASKA COMPUTER INSTITUTE	<50
023566	CHARLESTON COSMETOLOGY INSTITUTE	<50
023423	CAREER INSTITUTE (THE)	<50
025599	BNS TECHNICAL INSTITUTE	<50
025185	HAIR DYNAMICS EDUCATION CENTER	<50
030882	CARSON CITY BEAUTY ACADEMY	<50
025849	FIRST INSTITUTE	<50
030885	NEW YORK INTERNATIONAL BEAUTY SCHOOL	<50
034543	TENNESSEE CAREER COLLEGE	<50
030894	SCHOOL OF HAIR DESIGN	<50
035344	AMERICAN INSTITUTE OF ALTERNATIVE MEDICINE	<50
030902	APOLLO COLLEGE	<50
023237	PAT WILSON'S BEAUTY COLLEGE	<50
026023	CENTRAL COAST COLLEGE	<50
031564	AOMA GRADUATE SCHOOL OF INTEGRATIVE MEDICINE	<50
025438	PARIS II EDUCATIONAL CENTER	<50
025729	BUSINESS INFORMATICS CENTER	<50
025633	KANKAKEE ACADEMY OF HAIR DESIGN	<50
031795	TEXAS HEALTH AND SCIENCE UNIVERSITY	<50
025329	BUSINESS SKILLS INSTITUTE	<50
026171	BATON ROUGE COLLEGE	<50
025656	CABOT COLLEGE	<50
032253	AMERICAN UNIVERSITY OF HEALTH SCIENCES	<50
026085	DELTA CAREER INSTITUTE	<50
032374	FARIS TECHNICAL INSTITUTE	<50
031082	FRANCOIS D. COLLEGE OF HAIR SKIN & NAILS	<50
026204	UNIFIED SCHOOLS OF AMERICA—COMPTON CAMPUS	<50
026108	COURT REPORTING INSTITUTE	<50
024997	CAREER DEVELOPMENT INSTITUTE	<50
023635	ARTHUR'S BEAUTY COLLEGE	<50
025013	TREBAS INSTITUTE OF REC ARTS	<50
031096	NATIONAL INSTITUTE OF TECHNOLOGY	<50
025372	PALOMAR INSTITUTE OF COSMETOLOGY	<50
031109	ACADEMY OF BEAUTY PROFESSIONALS	<50
023417	CAREER ACADEMY OF HAIR DESIGN	<50
025685	GRABBER SCHOOL OF HAIR DESIGN	<50
030047	MUNDUS INSTITUTE	<50
023185	CENTURY SCHOOLS	<50
030051	ARKANSAS BEAUTY SCHOOL- LITTLE ROCK	<50
031147	PRAXIS INSTITUTE	<50
025568	PAUL MITCHELL THE SCHOOL SALT LAKE CITY	<50
026127	SALON PROFESSIONAL ACADEMY—MELBOURNE, THE	<50
023429	ELSA COOPER INSTITUTE OF COURT REPORTING	<50
026136	OKLAHOMA JUNIOR COLLEGE	<50
034096	BENNETT CAREER INSTITUTE	<50
024944	COMPUTER DYNAMICS INSTITUTE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
023337	AMERICAN BARTENDERS SCHOOL	<50
031240	NORTHWESTERN TECHNOLOGICAL INSTITUTE	<50
030255	MECH TECH COLLEGE	<50
031244	VALDOSTA ACADEMY OF BEAUTY CULTURE	<50
025205	NATIONAL CAREER ACADEMY	<50
026139	COMPUTER BUSINESS COLLEGE	<50
030285	LAWTON CAREER INSTITUTE	<50
031256	MIAMI AD SCHOOL	<50
035193	MISSOURI COLLEGE OF COSMETOLOGY NORTH	<50
024948	CR'U INSTITUTE OF COSMETOLOGY AND BARBERING	<50
023104	NEVADA CAREER SCHOOL	<50
024971	MEDICAL CAREERS INSTITUTE	<50
023474	MOORE CAREER COLLEGE	<50
022858	CAREER TECHL INST	<50
010716	TOBE-COBURN SCHOOL FOR FASHION CAREERS	<50
020639	ROYALE BEAUTY COLLEGE	<50
020926	PTC CAREER INSTITUTE	<50
011126	GARGES COMMERCIAL COLLEGE	<50
013024	RILEY COLLEGE	<50
021904	SCHILLING—DOUGLAS SCHOOL OF HAIR DESIGN	<50
021044	SPA TECH INSTITUTE	<50
022039	ERIE INSTITUTE OF TECHNOLOGY	<50
021094	ROBERT FIANCE INSTITUTE OF FLORIDA	<50
010808	BRANELL INST	<50
011621	AUTOMOTIVE TRAINING CENTER	<50
022755	PAUL MITCHELL THE SCHOOL KNOXVILLE	<50
013088	CAPRI OAK FOREST BEAUTY COLLEGE	<50
022939	VOLUNTEER BEAUTY ACADEMY	<50
013132	INTERNATIONAL COLLEGE OF BROADCASTING	<50
020620	ABC TECHNICAL & TRADE SCHOOLS	<50
011689	REFRIGERATION SCHOOL (THE)	<50
022032	CAREER POINT BUSINESS SCHOOL	<50
013165	CLIMATE CONTROL INSTITUTE	<50
022092	DORSEY SCHOOL OF BEAUTY	<50
011709	CINCINNATI METROPOLITAN COLLEGE	<50
011034	LONG BEACH COLLEGE OF BUSINESS	<50
021267	BAY AREA LEGAL ACADEMY	<50
022551	INST OF SECURITY & TECHLGY	<50
021268	DIESEL INSTITUTE OF AMERICA	<50
022627	DELAWARE COUNTY INSTITUTE OF TRAINING	<50
011751	PHOENIX INSTITUTE OF TECHNOLOGY	<50
022824	NATIONAL TECHNICAL COLLEGE	<50
021282	BRIDGES BEAUTY COLLEGE	<50
013008	SUMMIT SALON ACADEMY—PORTLAND	<50
020508	AMERICAN BUSINESS COLLEGE	<50
022978	PAUL MITCHELL THE SCHOOL RAPID CITY	<50
021390	CRAFT INSTITUTE (THE)	<50
021924	MR. JOHN'S SCHOOL OF COSMETOLOGY, ESTHETICS & NAILS	<50
021451	SCOTT COLLEGE OF COSMETOLOGY	<50
010909	CONCORDE CAREER INST	<50
020528	COUNTY SCHOOLS HOME STUDY	<50
022022	STYLEMASTERS COLLEGE OF HAIR DESIGN	<50
021492	TEXCEL CAREER CENTER	<50
022033	GENE JUAREZ BEAUTY SCHOOLS	<50
021514	COASTAL TRAINING INSTITUTE	<50
012072	PHILLIPS HAIRSTYLING INSTITUTE	<50
011865	CALIFORNIA HAIR DESIGN ACADEMY	<50
022149	COMPUTER PROCESSING INSTITUTE	<50
021535	OAKBRIDGE ACADEMY OF ARTS	<50
022196	OMEGA INSTITUTE	<50
021586	MR. BELA'S SCHOOL OF COSMETOLOGY	<50
022381	MINNESOTA SCHOOL OF COSMETOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
021635	NEW ENGLAND SCHOOL OF PHOTOGRAPHY	<50
020765	OREGON POLYTECHNIC INSTITUTE	<50
020565	MITCHELL'S ACADEMY	<50
010821	AMERICAN COLLEGE	<50
021658	NATIONAL TRAINING SYSTEMS—CORRESPONDENCE SCHOOL	<50
012562	CALIFORNIA PARAMEDICAL AND TECHNICAL COLLEGE	<50
021668	JOHN AMICO'S SCHOOL OF HAIR DESIGN	<50
010827	DAVID PRESSLEY PROFESSIONAL SCHOOL OF COSMETOLOGY	<50
021718	SABINA'S BEAUTY ACADEMY	<50
020797	COLLEGE OF HAIR DESIGN	<50
021760	CHERYL FELL'S SCHOOL OF BUSINESS	<50
020801	UNITED COLLEGE	<50
021763	SPENCER BUSINESS & TECHNICAL INSTITUTE	<50
022878	NATIONAL TRACTOR TRAILER SCHOOL	<50
021780	HARGEST VOCATIONAL TECHNICAL COLLEGE	<50
022902	GENERAL COMMUNICATIONS	<50
011979	BLAKE BUSINESS SCHOOL	<50
012848	MOLER HOLLYWOOD BEAUTY ACADEMY	<50
011221	NATIONAL EDUCATION CENTER, BRYMAN CAMPUS	<50
021814	MSTA BUSINESS COLLEGE (CLOSED)	<50
021964	CUTTING EDGE HAIRSTYLING ACADEMY	<50
004567	METROPOLITAN BUSINESS COLLEGE	<50
031091	ASPIRA CITY COLLEGE	<50
002034	MID STATE COLLEGE	<50
004857	HAMMEL COLLEGE	<50
022704	SOUTHEASTERN BIBLE COLLEGE	<50
021064	O'MORE COLLEGE OF DESIGN	<50
010347	STAGE ONE, THE HAIR SCHOOL	<50
004872	DRAUGHON COLLEGE	<50
008873	PAUL MITCHELL THE SCHOOL DANBURY	<50
004879	TREND COLLEGE	<50
031105	CITY COLLEGE OF COLORADO SPRINGS	<50
004901	NEWPORT BUSINESS INSTITUTE	<50
036663	PILLAR COLLEGE	<50
036894	FAITH INTERNATIONAL UNIVERSITY	<50
034743	AVE MARIA COLLEGE	<50
004935	EDMONDSON JUNIOR COLLEGE	<50
033813	CONNECTICUT TRAINING CENTER	<50
005186	LAMSON JUNIOR COLLEGE	<50
038853	EMPLOYMENT SOLUTIONS	<50
005202	FRANKLIN COLLEGE	<50
008939	CANNELLA SCHOOL OF HAIR DESIGN	<50
033274	ACUPUNCTURE AND INTEGRATIVE MEDICINE COLLEGE, BERKELEY	<50
009035	PHILLIPS COLLEGE OF CHICAGO	<50
006666	LUTHERAN SCHOOL OF NURSING	<50
009221	PHILLIPS COLLEGES	<50
007142	LYLE'S COLLEGE OF BEAUTY	<50
035163	KING'S UNIVERSITY (THE)	<50
041806	APPALACHIAN COLLEGE OF PHARMACY	<50
009607	HOUSE OF HEAVILIN BEAUTY COLLEGE	<50
007318	CDI CAREER DEVELOPMENT INST	<50
036673	FAITH THEOLOGICAL SEMINARY	<50
036964	SABER COLLEGE	<50
010246	FLEET BUSINESS SCHOOL	<50
021943	NORTHEAST INSTITUTE OF EDUCATION	<50
010421	NATIONAL EDUCATION CENTER—SAWYER CAMPUS	<50
010634	NATIONAL EDUCATION CENTER—ARKANSAS COLLEGE OF TECHNOLOGY CAMPUS	<50
004839	PHILLIPS JUNIOR COLLEGE HARDBARGER CAMPUS	<50
007375	ISLAND DRAFTING & TECHNICAL INSTITUTE	<50
036353	CARVER BIBLE COLLEGE	<50
037093	EDWARD VIA VIRGINIA COLLEGE OF OSTEOPATHIC MEDICINE	<50
031052	BAPTIST HEALTH COLLEGE LITTLE ROCK	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022027	OZARK CHRISTIAN COLLEGE	<50
021068	BRAMSON ORT COLLEGE MAIN CAMPUS-01	<50
022141	OAK POINT UNIVERSITY	<50
003421	BOB JONES UNIVERSITY	<50
022285	LIFE CHIROPRACTIC COLLEGE WEST	<50
025308	POLYTECHNICAL INSTITUTE OF FLORIDA	<50
007508	PLAZA SCHOOL OF TECHNOLOGY	<50
025326	LANDMARK COLLEGE	<50
022310	WOMEN'S TECHL INSTITUTE	<50
039483	HARRISBURG UNIVERSITY OF SCIENCE AND TECHNOLOGY	<50
007546	CDI CAREER DEVELOPMENT INSTITUTE	<50
004462	GADSDEN BUSINESS COLLEGE	<50
022316	MGH INSTITUTE OF HEALTH PROFESSIONS	<50
009279	EDUTEK PROFESSIONAL COLLEGES	<50
007588	CAPRI COLLEGE	<50
009409	CENTRAL CITY BUSINESS INSTITUTE	<50
007752	JON LOUIS SCHOOL OF BEAUTY	<50
004504	BARNES BUSINESS COLLEGE	<50
007798	WILFRED ACADEMY OF HAIR & BEAUTY CULTURE	<50
009687	PHILLIPS JUNIOR COLLEGE CONDIE CAMPUS	<50
038533	KECK GRADUATE INSTITUTE OF APPLIED LIFE SCIENCES	<50
025784	MARYLAND UNIVERSITY OF INTEGRATIVE HEALTH	<50
030970	MERCY COLLEGE OF OHIO	<50
025799	NORTH CENTRAL OPPORTUNITIES INDUSTRIALIZATION CENTER	<50
021000	UNIVERSIDAD POLITECNICA DE PUERTO RICO	<50
010211	KINYON-CAMPBELL BUSINESS SCHOOL	<50
031009	LUTHER RICE COLLEGE & SEMINARY	<50
010251	NATIONAL EDUCATION CENTER—CAPITOL HILL CAMPUS	<50
021404	ST. JOSEPH SCHOOL OF NURSING	<50
041184	CHICAGO ORT TECHNICAL INSTITUTE	<50
001628	AMERICAN ACADEMY OF ART COLLEGE	<50
023315	GRAND ISLAND COLLEGE	<50
025000	SAN JOAQUIN COLLEGE OF LAW	<50
038724	DIVINE MERCY UNIVERSITY	<50
003289	LEHIGH UNIVERSITY	<50
020653	PRESCOTT COLLEGE	<50
003535	VANDERBILT UNIVERSITY	<50
003362	SETON HILL UNIVERSITY	<50
003799	WALLA WALLA UNIVERSITY	<50
003185	UNIVERSITY OF TULSA (THE)	<50
011917	DRAKE SCHOOL OF MANHATTAN	<50
003194	GEORGE FOX UNIVERSITY	<50
002504	UNIVERSITY OF HEALTH SCIENCES AND PHARMACY IN ST. LOUIS	<50
004712	NORTHWEST MISSOURI COMMUNITY COLLEGE	<50
003072	MALONE UNIVERSITY	<50
003604	WILLIAM MARSH RICE UNIVERSITY	<50
002948	MONTREAT COLLEGE	<50
006305	MAINE COLLEGE OF HEALTH PROFESSIONS	<50
002567	YORK COLLEGE	<50
003610	SCHREINER UNIVERSITY	<50
003300	MOORE COLLEGE OF ART AND DESIGN	<50
006445	BILL AND SANDRA POMEROY COLLEGE OF NURSING AT CROUSE HOSPITAL	<50
002525	WILLIAM WOODS UNIVERSITY	<50
006467	SAINT JOSEPH'S COLLEGE OF NURSING AT ST JOSEPH'S HOSPITAL HEALTH CENTE	<50
003164	OKLAHOMA BAPTIST UNIVERSITY	<50
006487	AULTMAN COLLEGE OF NURSING AND HEALTH SCIENCES	<50
002677	BROOKLYN LAW SCHOOL	<50
003197	LEWIS & CLARK COLLEGE	<50
002553	MIDLAND UNIVERSITY	<50
006771	COLLEGE FOR CREATIVE STUDIES	<50
002946	METHODIST UNIVERSITY	<50
006858	UNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003112	PENN OHIO COLLEGE	<50
002914	CATAWBA COLLEGE	<50
002741	AMERICAN JEWISH UNIVERSITY	<50
003621	ST. EDWARD'S UNIVERSITY	<50
011673	MAINE COLLEGE OF ART	<50
003023	CAPITAL UNIVERSITY	<50
011934	VERMONT LAW SCHOOL	<50
002512	STEPHENS COLLEGE	<50
012154	CALIFORNIA INSTITUTE OF INTEGRAL STUDIES	<50
003385	URSINUS COLLEGE	<50
012309	UNIVERSITY OF WESTERN STATES	<50
002920	DUKE UNIVERSITY	<50
002526	CARROLL COLLEGE	<50
007113	ARIZONA CHRISTIAN UNIVERSITY	<50
003982	CLEVELAND INSTITUTE OF ART (THE)	<50
003391	WAYNESBURG UNIVERSITY	<50
002759	MANHATTAN SCHOOL OF MUSIC	<50
003641	TEXAS LUTHERAN UNIVERSITY	<50
020681	ADLER UNIVERSITY	<50
003227	WILLAMETTE UNIVERSITY	<50
003482	CHRISTIAN BROTHERS UNIVERSITY	<50
003394	WILKES UNIVERSITY	<50
003788	SEATTLE PACIFIC UNIVERSITY	<50
002513	TARKIO COLLEGE	<50
002945	MEREDITH COLLEGE	<50
007462	COLLEGE OF VISUAL ARTS	<50
010624	LIGHTHOUSE CAREER INSTITUTE	<50
003401	BROWN UNIVERSITY	<50
010761	DALLAS INSTITUTE OF FUNERAL SERVICE	<50
003233	ALVERNIA UNIVERSITY	<50
002371	UNIVERSITY OF NORTHWESTERN- ST PAUL	<50
002499	ROCKHURST UNIVERSITY	<50
003116	UNIVERSITY OF RIO GRANDE	<50
002718	ELMIRA COLLEGE	<50
003293	LYCOMING COLLEGE	<50
002933	HIGH POINT UNIVERSITY	<50
003506	MEHARRY MEDICAL COLLEGE	<50
003036	FRANCISCAN UNIVERSITY OF STEUBENVILLE	<50
002896	VILLA MARIA COLLEGE OF BUFFALO	<50
003691	MIDDLEBURY COLLEGE	<50
003525	TENNESSEE WESLEYAN UNIVERSITY	<50
008174	ART INSTITUTE OF BOSTON	<50
011918	DRAKE SCHOOL OF THE BRONX	<50
003692	NORWICH UNIVERSITY	<50
003135	WALSH UNIVERSITY	<50
003039	COLUMBUS COLLEGE OF ART & DESIGN	<50
012059	TRINITY BIBLE COLLEGE AND GRADUATE SCHOOL	<50
002600	SAINT ELIZABETH UNIVERSITY	<50
003301	MORAVIAN UNIVERSITY	<50
002547	GRACE UNIVERSITY	<50
002956	CAROLINA UNIVERSITY	<50
009089	HANNIBAL—LAGRANGE UNIVERSITY	<50
012315	CORNISH COLLEGE OF THE ARTS	<50
003427	COKER UNIVERSITY	<50
003143	WITTENBERG UNIVERSITY	<50
003252	DELAWARE VALLEY UNIVERSITY	<50
003311	SALUS UNIVERSITY	<50
002939	LEES-MCRAE COLLEGE	<50
002758	MANHATTAN COLLEGE	<50
003049	HIRAM COLLEGE	<50
013007	NAZARENE BIBLE COLLEGE	<50
003441	NORTH GREENVILLE UNIVERSITY	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002803	RENSSELAER POLYTECHNIC INSTITUTE	<50
003050	JOHN CARROLL UNIVERSITY	<50
003175	PHILLIPS UNIVERSITY	<50
003465	MOUNT MARTY UNIVERSITY	<50
002433	RUST COLLEGE	<50
003262	ELIZABETHTOWN COLLEGE	<50
003588	UNIVERSITY OF MARY HARDIN—BAYLOR	<50
002734	HOUGHTON COLLEGE	<50
003419	CHARLESTON SOUTHERN UNIVERSITY	<50
031277	Southern New England School of Law	<50
002197	NICHOLS COLLEGE	<50
002119	ATLANTIC UNION COLLEGE	<50
001635	BARAT COLLEGE	<50
004922	Columbia Junior College	<50
003825	West Virginia University Institute of Technology	<50
001803	HUNTINGTON UNIVERSITY	<50
001570	Southern Polytechnic State University	<50
021002	Brookhaven College	<50
004948	Texas A&M University System Health Science Center	<50
037803	SABA UNIVERSITY SCHOOL OF MEDICINE	<50
001735	NORTH PARK UNIVERSITY	<50
010228	UNIVERSITY OF STIRLING	<50
040473	Bridgemont Community and Technical College	<50
002311	KUYPER COLLEGE	<50
040533	Clemens College	<50
002117	ANNA MARIA COLLEGE	<50
001288	CLAREMONT SCHOOL OF THEOLOGY	<50
002124	BENTLEY UNIVERSITY	<50
001105	SHORTER COLLEGE	<50
001832	UNIVERSITY OF SAINT FRANCIS	<50
001414	TRINITY COLLEGE	<50
035183	EUROPEAN GRADUATE SCHOOL (EGS)	<50
006622	Jefferson College of Health Sciences	<50
001846	BRIAR CLIFF UNIVERSITY	<50
042079	SAE Institute of Technology—Miami	<50
009786	Illinois Eastern Community Colleges—Lincoln Trail College	<50
001659	ROSALIND FRANKLIN UNIVERSITY OF MEDICINE AND SCIENCE	<50
001542	AGNES SCOTT COLLEGE	<50
005034	AMERICAN UNIVERSITY IN CAIRO (THE)	<50
002288	ROCHESTER UNIVERSITY	<50
001943	UNIVERSITY OF SAINT MARY	<50
001019	HUNTINGDON COLLEGE	<50
001748	ROCKFORD UNIVERSITY	<50
001708	LINCOLN CHRISTIAN UNIVERSITY	<50
001952	ASBURY UNIVERSITY	<50
035213	Ivy Tech Community College of Indiana—Region 14	<50
010394	University of Medicine & Dentistry of New Jersey	<50
004779	Long Island University—Brooklyn	<50
001958	BRESCIA UNIVERSITY	<50
001552	Augusta State University	<50
005889	University of Oklahoma Health Sciences Center	<50
002145	EASTERN NAZARENE COLLEGE	<50
025086	Middle Georgia Technical College	<50
002158	LASELL UNIVERSITY	<50
001606	BRIGHAM YOUNG UNIVERSITY—HAWAII	<50
009085	KING'S COLLEGE LONDON	<50
001678	EUREKA COLLEGE	<50
001339	CORBAN UNIVERSITY	<50
001617	COLLEGE OF IDAHO (THE)	<50
002233	WORCESTER POLYTECHNIC INSTITUTE	<50
001436	CAPITOL TECHNOLOGY UNIVERSITY	<50
002235	ALBION COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
023563	UNIVERSIDAD FEDERICO HENRIQUEZ Y CARDAJAL	<50
001127	CALIFORNIA COLLEGE OF THE ARTS	<50
001980	UNIVERSITY OF PIKEVILLE	<50
020533	CENTRO DE ESTUDIOS UNIVERSITARIOS XOCHICALCO	<50
001788	BUTLER UNIVERSITY	<50
002262	KETTERING UNIVERSITY	<50
001586	OGLETHORPE UNIVERSITY	<50
001860	DRAKE UNIVERSITY	<50
001795	UNIVERSITY OF EVANSVILLE	<50
030917	POZNAN UNIVERSITY OF MEDICAL SCIENCES	<50
002052	THOMAS COLLEGE	<50
002308	OLIVET COLLEGE	<50
002065	NOTRE DAME OF MARYLAND UNIVERSITY	<50
002316	SIENA HEIGHTS UNIVERSITY	<50
001800	GRACE COLLEGE AND THEOLOGICAL SEMINARY	<50
002078	LOYOLA UNIVERSITY MARYLAND	<50
002353	GUSTAVUS ADOLPHUS COLLEGE	<50
022527	Hair Design School (The)	<50
001880	MOUNT MERCY UNIVERSITY	<50
001696	ILLINOIS WESLEYAN UNIVERSITY	<50
005330	FAYETTE COUNTY CAREER & TECHNICAL INSTITUTE	<50
004004	JOHN TYLER COMMUNITY COLLEGE	<50
021963	COLLINS CAREER TECHNICAL CENTER	<50
009928	PIEDMONT VIRGINIA COMMUNITY COLLEGE	<50
009509	CHARLES A. JONES CAREER AND EDUCATION CENTER	<50
007986	HALIFAX COMMUNITY COLLEGE	<50
042544	ARKANSAS STATE UNIVERSITY—MOUNTAIN HOME	<50
003929	EASTERN WYOMING COLLEGE	<50
005267	NORTHWEST KANSAS TECHNICAL COLLEGE	<50
005380	MID-STATE TECHNICAL COLLEGE	<50
030192	SI TANKA UNIVERSITY	<50
003707	RICHARD BLAND COLLEGE	<50
031555	OCONEE FALL LINE TECHNICAL COLLEGE	<50
010006	GREATER JOHNSTOWN AREA VOCATIONAL TECHNICAL SCHOOL -	<50
041949	TILLAMOOK BAY COMMUNITY COLLEGE	<50
006819	BLUE RIDGE COMMUNITY COLLEGE	<50
021728	DUTCHESS BOCES SCHOOL OF PRACTICAL NURSING	<50
010019	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER (THE)	<50
022825	LENAPE TECHNICAL SCHOOL	<50
010020	LEWIS AND CLARK COMMUNITY COLLEGE	<50
009236	NASHUA COMMUNITY COLLEGE	<50
010051	CUNY LAGUARDIA COMMUNITY COLLEGE	<50
009259	LARAMIE COUNTY COMMUNITY COLLEGE	<50
010056	AIKEN TECHNICAL COLLEGE	<50
003786	PENINSULA COLLEGE	<50
003761	WYTHEVILLE COMMUNITY COLLEGE	<50
031229	YORK COUNTY COMMUNITY COLLEGE	<50
003828	WEST VIRGINIA UNIVERSITY—PARKERSBURG	<50
004608	BARTON COUNTY COMMUNITY COLLEGE	<50
006973	CANADA COLLEGE	<50
004033	ASHEVILLE BUNCOMBE TECHNICAL COMMUNITY COLLEGE	<50
010147	WESTERN SUFFOLK BOCES	<50
009910	TECHNICAL COLLEGE OF THE LOWCOUNTRY—BEAUFORT CAMPUS	<50
005424	SOUTH CENTRAL CAREER CENTER	<50
021582	WASHINGTON SARATOGA WARREN HAMILTON ESSEX BOCES	<50
005429	ROLLA TECHNICAL INSTITUTE CENTER	<50
021794	EASTERN SUFFOLK BOCES	<50
010323	HANNAH E. MULLINS SCHOOL OF PRACTICAL NURSING	<50
042817	COMPTON COLLEGE	<50
010340	LOS MEDANOS COLLEGE	<50
023047	TRI-RIVERS CAREER CENTER	<50
010363	WESTERN NEVADA COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
004600	NORTHWEST IOWA COMMUNITY COLLEGE	<50
005467	SOWELA TECHNICAL COMMUNITY COLLEGE	<50
003944	UNIVERSITY OF PUERTO RICO—MAYAGUEZ	<50
007107	ESSEX COUNTY COLLEGE	<50
024978	GREENE COUNTY CAREER CENTER	<50
008175	HOWARD COMMUNITY COLLEGE	<50
026038	LORAIN COUNTY JVS ADULT CAREER CENTER	<50
005500	MANHATTAN AREA TECHNICAL COLLEGE	<50
009336	JOHNSTON COMMUNITY COLLEGE	<50
005532	CAPE GIRARDEAU CAREER AND TECHNOLOGY CENTER	<50
005306	BATES TECHNICAL COLLEGE	<50
007570	HELENA COLLEGE UNIVERSITY OF MONTANA	<50
007742	FT LAUDERDALE SCHOOL OF ALLIED HEALTH CAREERS	<50
004765	CUNY GRADUATE SCHOOL & UNIVERSITY CENTER	<50
031284	DELAWARE COUNTY TECHNICAL SCHOOL	<50
010736	MARION TECHNICAL COLLEGE	<50
006777	FLATHEAD VALLEY COMMUNITY COLLEGE	<50
010879	RICHLAND COMMUNITY COLLEGE	<50
007916	FRANKLIN COUNTY CAREER AND TECHNOLOGY CENTER	<50
007635	CAPITAL COMMUNITY COLLEGE	<50
039603	NEW RIVER COMMUNITY AND TECHNICAL COLLEGE	<50
003664	WEATHERFORD COLLEGE	<50
009826	KENNEBEC VALLEY COMMUNITY COLLEGE	<50
005544	ALEXANDRIA TECHNICAL AND COMMUNITY COLLEGE	<50
009895	ALBERT EINSTEIN COLLEGE OF MEDICINE	<50
005599	AUGUSTA TECHNICAL COLLEGE	<50
021515	CENTRAL SUSQUEHANNA LPN CAREER CENTER	<50
011245	WEST VIRGINIA SCHOOL OF OSTEOPATHIC MEDICINE	<50
021562	TECHNICAL COLLEGE OF THE ROCKIES	<50
003628	TEXARKANA COLLEGE	<50
003942	UNIVERSITY OF PUERTO RICO—CENTRAL ADMINISTRATION	<50
011667	NORTHEAST COMMUNITY COLLEGE	<50
005759	NORTHWEST TECHNICAL COLLEGE—BEMIDJI	<50
005618	SAVANNAH TECHNICAL COLLEGE	<50
007690	KANKAKEE COMMUNITY COLLEGE	<50
011727	DELAWARE TECHNICAL COMMUNITY COLLEGE	<50
003705	COLLEGE OF WILLIAM & MARY	<50
008557	NASH COMMUNITY COLLEGE	<50
005263	MINNESOTA WEST COMMUNITY AND TECHNICAL COLLEGE	<50
005620	CHATTAHOOCHIE TECHNICAL COLLEGE	<50
003810	CONCORD UNIVERSITY	<50
003933	WESTERN WYOMING COMMUNITY COLLEGE	<50
023062	VENANGO COUNTY AREA VOCATIONAL TECHNICAL SCHOOL	<50
012123	UNIVERSITY OF PUERTO RICO—AGUADILLA	<50
023154	NORTHEAST TEXAS COMMUNITY COLLEGE	<50
007669	SOUTHWEST WISCONSIN TECHNICAL COLLEGE	<50
023485	LAMAR STATE COLLEGE—PORT ARTHUR	<50
003683	CASTLETON UNIVERSITY	<50
023515	NORTHERN CAREER INSTITUTE	<50
012407	SCHUYLER STEUBEN CHEMUNG TIOGA ALLEGANY BOCES	<50
023582	LAMAR STATE COLLEGE—ORANGE	<50
012550	LOS ANGELES MISSION COLLEGE	<50
024544	NORTHEAST OHIO MEDICAL UNIVERSITY	<50
012589	ERIE 1 BOARD OF COOPERATIVE EDUCATIONAL SERVICES	<50
025039	WARREN COUNTY COMMUNITY COLLEGE	<50
008660	GERMANNA COMMUNITY COLLEGE	<50
025864	TRUMBULL CAREER AND TECHNICAL CENTER—ADULT TRAINING CENTER	<50
008677	NORTHWEST STATE COMMUNITY COLLEGE	<50
005276	CENTRAL MAINE COMMUNITY COLLEGE	<50
004835	CALDWELL COMMUNITY COLLEGE & TECHNICAL INSTITUTE	<50
003947	UNIVERSITY OF CALIFORNIA, HASTINGS COLLEGE OF THE LAW	<50
012813	JOHN WOOD COMMUNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
030514	AUBURN CAREER CENTER	<50
012860	ARKANSAS NORTHEASTERN COLLEGE	<50
007731	RARITAN VALLEY COMMUNITY COLLEGE	<50
008862	EAST CENTRAL COLLEGE	<50
006756	NORTHSHORE TECHNICAL COMMUNITY COLLEGE	<50
008863	WALTERS STATE COMMUNITY COLLEGE	<50
009543	RED ROCKS COMMUNITY COLLEGE	<50
020522	BLACK RIVER TECHNICAL COLLEGE	<50
031060	MISSOURI STATE UNIVERSITY—WEST PLAINS	<50
020735	UNIVERSITY OF ARKANSAS COMMUNITY COLLEGE AT BATESVILLE	<50
031279	OSCEOLA TECHNICAL COLLEGE	<50
020746	SOUTH ARKANSAS COMMUNITY COLLEGE	<50
031291	FOND DU LAC TRIBAL & COMMUNITY COLLEGE	<50
005707	SOUTHEAST ARKANSAS COLLEGE	<50
009549	WESTERN TEXAS COLLEGE	<50
020839	NORTHERN NEW MEXICO COLLEGE	<50
004845	WILSON COMMUNITY COLLEGE	<50
020870	OZARKA COLLEGE	<50
035353	HUNTINGDON COUNTY CAREER AND TECHNOLOGY CENTER	<50
003746	UNIVERSITY OF MARY WASHINGTON	<50
003603	RANGER COLLEGE	<50
021078	UNIVERSITY OF HAWAII—WEST OAHU	<50
038763	CULPEPER COSMETOLOGY TRAINING CENTER	<50
021099	JAMES MARTIN ADULT HEALTH OCCUPATIONS	<50
007950	WEST SHORE COMMUNITY COLLEGE	<50
021113	CUYAMACA COLLEGE	<50
041271	UNIVERSITY OF CALIFORNIA, MERCED	<50
021169	UPPER VALLEY CAREER CENTER	<50
003679	SNOW COLLEGE	<50
021263	MADISON ONEIDA BOCES PRACTICAL NURSING PROGRAM	<50
042034	ARKANSAS STATE UNIVERSITY—NEWPORT	<50
021407	CANTON CITY SCHOOL DISTRICT ADULT CAREER & TECHNICAL EDUCATION	<50
009903	VANCE—GRANVILLE COMMUNITY COLLEGE	<50
021460	WAYNE—FINGER LAKES BOCES	<50
005372	SOUTH PUGET SOUND COMMUNITY COLLEGE	<50
003614	SOUTHWEST TEXAS JUNIOR COLLEGE	<50
005373	LAKE WASHINGTON INSTITUTE OF TECHNOLOGY	<50
003464	HURON UNIVERSITY	<50
001993	HENDERSON COMMUNITY COLLEGE	<50
003570	GRAYSON COLLEGE	<50
001909	CLOUD COUNTY COMMUNITY COLLEGE	<50
001162	CHABOT COLLEGE	<50
001267	MERRITT COLLEGE	<50
002982	WESTERN PIEDMONT COMMUNITY COLLEGE	<50
001228	LOS ANGELES VALLEY COLLEGE	<50
002190	WORCESTER STATE UNIVERSITY	<50
002339	CENTRAL LAKES COLLEGE	<50
001181	COLLEGE OF SAN MATEO	<50
003596	ODESSA COLLEGE	<50
003454	UNIVERSITY OF SOUTH CAROLINA—SALKEHATCHIE	<50
001911	COLBY COMMUNITY COLLEGE	<50
001335	VICTOR VALLEY COMMUNITY COLLEGE	<50
002654	NEW MEXICO INSTITUTE OF MINING & TECHNOLOGY	<50
001166	CITRUS COLLEGE	<50
001208	GROSSMONT COLLEGE	<50
001308	REEDLEY COLLEGE	<50
002074	HAGERSTOWN COMMUNITY COLLEGE	<50
002486	MINERAL AREA COLLEGE	<50
002075	HARFORD COMMUNITY COLLEGE	<50
001996	BIG SANDY COMMUNITY AND TECHNICAL COLLEGE	<50
001176	WEST HILLS COMMUNITY COLLEGE	<50
002880	ULSTER COUNTY COMMUNITY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
001913	DODGE CITY COMMUNITY COLLEGE	<50
001284	SANTA ANA COLLEGE	<50
001289	SHASTA COLLEGE	<50
003459	BLACK HILLS STATE UNIVERSITY	<50
002095	SAINT MARY'S COLLEGE OF MARYLAND	<50
001372	WESTERN COLORADO UNIVERSITY	<50
001916	FORT SCOTT COMMUNITY COLLEGE	<50
001851	IOWA WESTERN COMMUNITY COLLEGE	<50
003162	NORTHERN OKLAHOMA COLLEGE	<50
002991	LAKE REGION STATE COLLEGE	<50
001919	GARDEN CITY COMMUNITY COLLEGE	<50
001338	WEST VALLEY COLLEGE	<50
003167	UNIVERSITY OF SCIENCE & ARTS OF OKLAHOMA	<50
003008	VALLEY CITY STATE UNIVERSITY	<50
001924	INDEPENDENCE COMMUNITY COLLEGE	<50
001901	ALLEN COUNTY COMMUNITY COLLEGE	<50
001742	ILLINOIS EASTERN COMMUNITY COLLEGES	<50
002869	JAMESTOWN COMMUNITY COLLEGE	<50
003176	CARL ALBERT STATE COLLEGE	<50
001282	SAN JOSE CITY COLLEGE	<50
003178	SEMINOLE STATE COLLEGE	<50
001161	CERRITOS COMMUNITY COLLEGE	<50
002402	COPIAH-LINCOLN COMMUNITY COLLEGE	<50
002240	BAY DE NOC COMMUNITY COLLEGE	<50
001239	MIRACOSTA COLLEGE	<50
001368	TRINIDAD STATE COLLEGE	<50
003188	CENTRAL OREGON COMMUNITY COLLEGE	<50
001998	SOUTHEAST KENTUCKY COMMUNITY AND TECHNICAL COLLEGE	<50
002404	EAST CENTRAL COMMUNITY COLLEGE	<50
002907	UNIVERSITY OF NORTH CAROLINA ASHEVILLE	<50
001752	SAUK VALLEY COMMUNITY COLLEGE	<50
003453	UNIVERSITY OF SOUTH CAROLINA—LANCASTER	<50
001930	LABETTE COMMUNITY COLLEGE	<50
001643	SPOON RIVER COLLEGE	<50
002844	SUNY AT FREDONIA	<50
001648	CITY COLLEGES OF CHICAGO HARRY S TRUMAN COLLEGE	<50
003211	OREGON INSTITUTE OF TECHNOLOGY	<50
002947	MITCHELL COMMUNITY COLLEGE	<50
001612	HONOLULU COMMUNITY COLLEGE	<50
001186	COLLEGE OF THE SEQUOIAS	<50
001613	KAPIOLANI COMMUNITY COLLEGE	<50
001260	PALOMAR COLLEGE	<50
002853	SUNY MARITIME COLLEGE	<50
001857	SOUTHWESTERN COMMUNITY COLLEGE	<50
002854	SUNY COLLEGE OF TECHNOLOGY AT ALFRED	<50
001655	WILBUR WRIGHT COLLEGE	<50
001269	RIO HONDO COMMUNITY COLLEGE	<50
002582	MANCHESTER COMMUNITY COLLEGE	<50
001319	UNIVERSITY OF CALIFORNIA, SAN FRANCISCO	<50
002310	ST. CLAIR COUNTY COMMUNITY COLLEGE	<50
002181	MASSACHUSETTS MARITIME ACADEMY	<50
003568	FRANK PHILLIPS COLLEGE	<50
002187	MASSACHUSETTS COLLEGE OF LIBERAL ARTS	<50
001413	THAMES VALLEY STATE TECHNICAL COLLEGE	<50
002863	CORNING COMMUNITY COLLEGE—SUNY OFFICE OF COMMUNITY COLLEGES	<50
002040	UNIVERSITY OF MAINE—FARMINGTON	<50
002864	DUTCHESS COMMUNITY COLLEGE	<50
003583	LEE COLLEGE	<50
001485	COLLEGE OF THE FLORIDA KEYS (THE)	<50
001270	RIVERSIDE CITY COLLEGE	<50
003324	MANSFIELD UNIVERSITY OF PENNSYLVANIA	<50
001990	ASHLAND COMMUNITY AND TECHNICAL COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
042417	SAINT JOSEPH'S SCHOOL OF NURSING	<50
001071	ARIZONA WESTERN COLLEGE	<50
042759	ANOTHER LEVEL BARBERING AND COSMETOLOGY SCHOOL	<50
041742	ALL BEAUTY COLLEGE	<50
041179	CHAMPION BEAUTY COLLEGE	<50
041748	AMERICAN TRADE SCHOOL	<50
042531	ALLIED HEALTH CAREERS INSTITUTE	<50
041749	ESTELLE INTERNATIONAL	<50
041659	PAUL MITCHELL THE SCHOOL FRESNO	<50
041751	PAUL MITCHELL THE SCHOOL HONOLULU	<50
041736	NOTTER SCHOOL OF PASTRY ARTS	<50
037764	ORION INSTITUTE	<50
041589	FLAIR BEAUTY COLLEGE	<50
041402	MISSISSIPPI INSTITUTE OF AESTHETICS, NAILS, & COSMETOLOGY	<50
041622	AMERICAN ACADEMY OF HEALTH AND BEAUTY	<50
041754	ELITE COSMETOLOGY SCHOOL	<50
042654	ANN WEBB SKIN INSTITUTE	<50
041756	PARK AVENUE SCHOOL OF COSMETOLOGY	<50
042853	HOLLYWOOD CULTURAL COLLEGE	<50
038913	SOMA INSTITUTE—THE NATIONAL SCHOOL OF CLINICAL MASSAGE THERAPY	<50
001038	SNEAD STATE COMMUNITY COLLEGE	<50
041772	REAL BARBERS COLLEGE (THE)	<50
041721	CCIC BEAUTY COLLEGE	<50
041779	BUCKNER BARBER SCHOOL	<50
037513	ESCUELA HOTELERA DE SAN JUAN	<50
041781	CAROLINA COLLEGE OF HAIR DESIGN	<50
042328	JOHN PATRICK UNIVERSITY OF HEALTH AND APPLIED SCIENCES	<50
041409	INTERNATIONAL COSMETOLOGY ACADEMY	<50
042367	BLUSH SCHOOL OF MAKEUP	<50
041410	DOUGLAS J AVEDA INSTITUTE—CHICAGO	<50
041602	ATLANTA BEAUTY & BARBER ACADEMY	<50
041789	ASHDOWN COLLEGE OF HEALTH SCIENCES	<50
039873	TEXAS HEALTH SCHOOL	<50
041411	FRENCH ACADEMY OF COSMETOLOGY	<50
042556	INTERNATIONAL DIVING INSTITUTE	<50
041413	SAN FRANCISCO INSTITUTE OF ESTHETICS & COSMETOLOGY	<50
042733	VICTORY CAREER COLLEGE	<50
036143	DAVID'S ACADEMY OF BEAUTY	<50
042778	PRO BEAUTY ACADEMY (THE)	<50
041417	HEALING HANDS SCHOOL OF HOLISTIC HEALTH	<50
038113	EASTERN SCHOOL OF ACUPUNCTURE AND TRADITIONAL MEDICINE	<50
041816	INTEGRITY COLLEGE OF HEALTH	<50
036103	MJ'S BEAUTY ACADEMY	<50
038923	HARLEY'S BEAUTY & BARBER CAREER INSTITUTE	<50
038324	COSMETOLOGY SCHOOL OF ARTS & SCIENCES	<50
035744	CORTIVA INSTITUTE—SOMERSET SCHOOL OF MASSAGE THERAPY	<50
037243	DIGIPEN INSTITUTE OF TECHNOLOGY	<50
041831	WASHINGTON BARBER COLLEGE	<50
041239	LEXINGTON HEALING ARTS ACADEMY	<50
041833	ABCOTT INSTITUTE	<50
042266	CAROLINA CAREER COLLEGE	<50
041836	SALON PROFESSIONAL ACADEMY OF KENOSHA (THE)	<50
036955	ARIZONA SCHOOL OF ACUPUNCTURE AND ORIENTAL MEDICINE	<50
041840	PAUL MITCHELL THE SCHOOL INDIANAPOLIS	<50
042319	ALAMO CITY BARBER COLLEGE	<50
041842	TAYLOR ANDREWS ACADEMY—ST. GEORGE	<50
041588	THEATRE OF ARTS	<50
039163	ECLIPS SCHOOL OF COSMETOLOGY AND BARBERING	<50
042359	BELLA COSMETOLOGY AND BARBER COLLEGE	<50
041847	PROTEGE ACADEMY	<50
042385	TRAINING DOMAIN (THE)	<50
037783	HEALTH WORKS INSTITUTE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
042425	ASSOCIATED BARBER COLLEGE OF SAN DIEGO	<50
041851	NORTHEAST TECHNICAL INSTITUTE	<50
041606	PAUL MITCHELL THE SCHOOL NORMAL	<50
040253	LAST MINUTE CUTS SCHOOL OF BARBERING AND COSMETOLOGY	<50
042494	CENTER FOR NEUROSOMATIC STUDIES	<50
041856	MEDICAL ALLIED CAREER CENTER	<50
042524	WORLDCLASS ACADEMY OF BEAUTY CAREERS	<50
041859	ELITE SCHOOL OF COSMETOLOGY	<50
041627	ERIC FISHER ACADEMY	<50
041444	ACADEMY OF HAIR DESIGN (THE)	<50
042604	CUTTING EDGE ACADEMY	<50
041448	INTERNATIONAL ACADEMY OF STYLE	<50
041338	SOUTHEAST CULINARY & HOSPITALITY COLLEGE	<50
041260	PAUL MITCHELL THE SCHOOL CLEVELAND	<50
042742	INSTALLER INSTITUTE	<50
040363	SOUTHEAST TEXAS CAREER INSTITUTE	<50
042763	AMERICAN MASSAGE & BODYWORK INSTITUTE	<50
041877	CREVIER'S SCHOOL OF COSMETOLOGY	<50
042806	GOODFELLAS BARBER COLLEGE	<50
041459	CELEBRITY SCHOOL OF BEAUTY	<50
042911	COMMERCIAL DIVERS INTERNATIONAL	<50
039683	LAKEWOOD SCHOOL OF THERAPEUTIC MASSAGE	<50
041653	PAUL MITCHELL THE SCHOOL MILWAUKEE	<50
041269	ACADEMY OF CAREER TRAINING	<50
041669	COSMETIC ARTS INSTITUTE	<50
041275	CDE CAREER INSTITUTE	<50
001030	BISHOP STATE COMMUNITY COLLEGE	<50
041277	AMERICAN SENTINEL UNIVERSITY	<50
038223	PAUL MITCHELL THE SCHOOL—MADISON	<50
041898	ACADEMY FOR SALON PROFESSIONALS	<50
039414	ELITE ACADEMY OF BEAUTY ARTS	<50
041903	AMERICAN INSTITUTE OF MEDICAL SONOGRAPHY	<50
041216	FILA ACADEMY (THE)	<50
041905	NEW YORK SCHOOL OF ESTHETICS & DAY SPA	<50
041369	UNIVERSITY OF AESTHETICS & COSMETOLOGY	<50
041914	SCHOOL OF COURT REPORTING (THE)	<50
038684	LOS ANGELES COLLEGE OF MUSIC	<50
039703	HANDS ON THERAPY	<50
041240	DOMINION SCHOOL OF HAIR DESIGN	<50
041921	AMERICAN MEDICAL ACADEMY	<50
042264	MT TRAINING CENTER	<50
041926	PALMETTO BEAUTY SCHOOL	<50
036263	BROWN AVEDA INSTITUTE	<50
041123	LOUISIANA CULINARY INSTITUTE	<50
040723	AVEDA INSTITUTE PROVO	<50
041930	RIO GRANDE VALLEY COLLEGE	<50
042302	PAUL MITCHELL THE SCHOOL FARMINGTON HILLS	<50
038783	PROFESSIONAL MASSAGE TRAINING CENTER	<50
042305	PAUL MITCHELL THE SCHOOL GRAND RAPIDS	<50
040433	ACE INSTITUTE OF TECHNOLOGY	<50
042324	VANTAGE COLLEGE—SAN ANTONIO	<50
041299	FLORIDA SCHOOL OF MASSAGE	<50
042329	PREPARING PEOPLE BARBER STYLING COLLEGE	<50
039034	AMERICAN BEAUTY SCHOOL	<50
042337	CHRISTINE VALMY INTERNATIONAL SCHOOL FORESTHETICS, SKIN CARE & MAKE-UP	<50
042028	PANACHE ACADEMY OF BEAUTY	<50
041597	AMERICAN MEDICAL SCIENCES CENTER	<50
041495	A & W HEALTHCARE EDUCATORS	<50
042364	SANDRA ACADEMY OF SALON SERVICES	<50
042032	BOISE BARBER COLLEGE A D.MARTIN ACADEMY	<50
035873	GENESIS VOCATIONAL TRAINING	<50
042035	AUSTIN KADE ACADEMY	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
042386	GOULD'S ACADEMY	<50
042038	WOODRUFF MEDICAL AND WELLNESS TRAINING	<50
042423	DALTON INSTITUTE OF ESTHETICS AND COSMETOLOGY	<50
042040	ASPEN BEAUTY ACADEMY—LAUREL	<50
042436	INTERNATIONAL HAIR AND BARBER ACADEMY	<50
041500	CENTRAL NURSING COLLEGE	<50
041604	ANGELES COLLEGE	<50
042046	BEAUTY AND HEALTH INSTITUTE	<50
042467	LEARNING BRIDGE CAREER INSTITUTE	<50
039745	CALIFORNIA CAREER COLLEGE	<50
042490	MEDICAL CAREER AND TECHNICAL COLLEGE	<50
042052	WADE GORDON HAIRDRESSING ACADEMY	<50
042498	DOLCE THE ACADEMY	<50
042053	MITSU SATO HAIR ACADEMY	<50
042523	PREMIER BARBER INSTITUTE	<50
041312	TOTAL IMAGE BEAUTY ACADEMY	<50
042529	INTERNATIONAL BEAUTY EDUCATION CENTER	<50
042062	DIGITAL FILM ACADEMY	<50
035683	LEON STUDIO ONE SCHOOL OF BEAUTY KNOWLEDGE	<50
041511	SUMMIT BEAUTY SCHOOL	<50
042555	ALABAMA SCHOOL OF NAIL TECHNOLOGY & COSMETOLOGY	<50
041515	AMERICAN ACADEMY OF COSMETOLOGY	<50
042562	KENNY'S ACADEMY OF BARBERING	<50
042073	SCHOOL FOR ALLIED HEALTH PROFESSIONALS	<50
039953	UNIVERSITY OF EAST—WEST MEDICINE	<50
042075	MEDICAL CAREER INSTITUTE	<50
041631	SUMMIT SALON ACADEMY—GAINESVILLE	<50
042088	GLORIA FRANCIS SCHOOL OF MAKE—UP ARTISTRY	<50
042716	AVENUE ACADEMY, A COSMETOLOGY INSTITUTE (THE)	<50
042096	INSTITUTE OF HEALTH SCIENCES	<50
042735	WINONAH'S INTERNATIONAL SCHOOL OF COSMETOLOGY	<50
042098	HINTON BARBER AND BEAUTY COLLEGE	<50
042751	ANOUSHEH SCHOOL OF HAIR	<50
041517	BELLA CAPELLI ACADEMY A PAUL MITCHELL PARTNER SCHOOL	<50
042760	GLITZ SCHOOL OF COSMETOLOGY	<50
042132	KAIZEN BEAUTY ACADEMY	<50
041634	COSMO BEAUTY ACADEMY	<50
041313	CORINTH ACADEMY OF COSMETOLOGY	<50
041649	BARONE BEAUTY ACADEMY	<50
039043	QUALITY COLLEGE OF CULINARY CAREERS	<50
042814	CALIFORNIA HEALTH SCIENCES UNIVERSITY	<50
042156	AMERICAN INSTITUTE OF PHARMACEUTICAL TECHNOLOGY	<50
042889	PEARLANDS INNOVATIVE SCHOOL OF BEAUTY	<50
042157	IBERO AMERICAN COLLEGE	<50
042949	CTK HEALTHCARE & CAREER INSTITUTE	<50
037463	LEGRAND INSTITUTE OF COSMETOLOGY	<50
041650	MERIDIAN INSTITUTE OF SURGICAL ASSISTING	<50
042165	CENTER FOR THE HEALING ARTS	<50
041655	ACAYDIA SPA AND SCHOOL OF AESTHETICS	<50
041166	TAYLOR COLLEGE	<50
038814	EUROPEAN MASSAGE THERAPY SCHOOL (THE)	<50
042176	SESSIONS COLLEGE FOR PROFESSIONAL DESIGN	<50
040933	ACADEMY OF NATURAL THERAPY	<50
038083	INSTITUTE OF BEAUTY AND WELLNESS (THE)	<50
041347	INTERNATIONAL PROFESSIONAL SCHOOL OF BODYWORK	<50
042180	UNITED MEDICAL AND BUSINESS INSTITUTE	<50
001031	NORTHEAST ALABAMA COMMUNITY COLLEGE	<50
041530	RENAISSANCE ACADEMIE	<50
041685	SOLEX COLLEGE	<50
041169	DIGRIGOLI SCHOOL OF COSMETOLOGY	<50
036333	CALIFORNIA LEARNING CENTER	<50
041548	DUVALL'S SCHOOL OF COSMETOLOGY	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
038857	HOUSTON'S TRAINING AND EDUCATION CENTER (H-TEC)	<50
042209	NATIONAL PERSONAL TRAINING INSTITUTE OF COLUMBUS	<50
001065	UNIVERSITY OF ALASKA SOUTHEAST	<50
041551	INSTITUTE OF MEDICAL AND BUSINESS CAREERS	<50
039123	CREDENCE INSTITUTE OF BEAUTY	<50
041559	AVEDA FREDRIC'S INSTITUTE	<50
001111	ALLAN HANCOCK COLLEGE	<50
041571	L3 COMMERCIAL TRAINING SOLUTIONS AIRLINE ACADEMY	<50
041711	PAUL MITCHELL THE SCHOOL—DELAWARE	<50
042220	ARCLABS	<50
041716	SALON PROFESSIONAL ACADEMY OF ELGIN (THE)	<50
041572	LOVE BEAUTY SCHOOL	<50
037693	PC TECH LEARNING CENTER	<50
035564	KUSSAD INSTITUTE OF COURT REPORTING	<50
001104	PHILLIPS COMMUNITY COLLEGE OF THE UNIVERSITY OF ARKANSAS	<50
042239	MIND BODY INSTITUTE	<50
035783	TRI—STATE COLLEGE	<50
042241	COSMETOLOGY ACADEMY OF TEXARKANA	<50
041392	UNIVERSAL BARBER COLLEGE	<50
041575	ACCESS CAREERS	<50
042250	PARISIAN SPA INSTITUTE	<50
041726	SALON 496 BARBER ACADEMY	<50
025460	TRI—STATE COLLEGE OF ACUPUNCTURE	<50
025860	INFINITY CAREER COLLEGE	<50
035514	STATE BEAUTY ACADEMY	<50
023155	TOLEDO ACADEMY OF BEAUTY	<50
031873	STENOTECH CAREER INSTITUTE	<50
025275	HOUSTON TRAINING SCHOOLS	<50
034334	NEW CONCEPT MASSAGE & BEAUTY SCHOOL	<50
026153	PSI INSTITUTE OF WASHINGTON	<50
025837	MUNICIPAL TRAINING CENTER	<50
025330	WESTERN BUSINESS INSTITUTE	<50
031533	AMERICAN COLLEGE OF ACUPUNCTURE & ORIENTAL MEDICINE	<50
025549	MICRO TECHNOLOGY INSTITUTE	<50
023350	PHILLIPS BUSINESS SCHOOL	<50
026163	FRAN BROWN COLLEGE OF BEAUTY	<50
023050	CAREER INSTITUTE OF AMERICA	<50
026165	VISIBLE CHANGES UNIVERSITY	<50
034984	OMEGA INSTITUTE OF COSMETOLOGY	<50
025553	PATSY AND ROB'S ACADEMY OF BEAUTY	<50
024824	PONCE HEALTH SCIENCES UNIVERSITY	<50
025555	TECHNICAL CAREER INSTITUTE	<50
023125	BROOKLYN TRAINING CENTER	<50
025556	ELECTRONIC TECHNICAL INSTITUTE	<50
023188	UNITED STATES TRUCK DRIVING SCHOOL	<50
025337	WESTWOOD EDUCATIONAL	<50
024989	NATIONAL BUSINESS SCHOOL AUTOMOTIVE DIVISION	<50
023409	FLORIDA ACADEMY OF COSMETOLOGY ARTS & SCIENCES	<50
025937	RICHPORT TECHNICAL COLLEGE	<50
025349	PONCE PARAMEDICAL COLLEGE (POPAC)	<50
033193	CREATIVE IMAGES INSTITUTE OF COSMETOLOGY	<50
023111	TRENDMASTERS ACADEMY OF COSMETOLOGY	<50
033713	TONI&GUY HAIRDRESSING ACADEMY I TIGI CREATIVE SCHOOL	<50
025584	SAN ANTONIO COURT REPORTING INSTITUTE	<50
025189	BARRETT & CO SCHOOL OF HAIR DESIGN	<50
030024	GRAHAM WEBB INTERNATIONAL ACADEMY OF HAIR	<50
023386	CHARZANNE BEAUTY COLLEGE	<50
025281	ZENZIS BEAUTY COLLEGE	<50
025230	AVTECH INSTITUTE	<50
030049	AMERICAN NANNY COLLEGE	<50
031068	HOUSTON ALLIED HEALTH CAREERS	<50
023285	MOLER—PICKENS BEAUTY COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
023253	AMERICAN CENTER FOR TECHNICAL ARTS & SCIENCES	<50
023299	FLORIDA INSTITUTE OF ULTRASOUND	<50
031208	KAY HARVEY HAIRDRESSING ACADEMY	<50
023066	NEW WORLD INSTITUTE	<50
025419	BJ'S BEAUTY & BARBER COLLEGE	<50
023159	CAPILO SCHOOL OF HAIR DESIGN	<50
024959	MR JS HAIR ACADEMY	<50
030071	HOT SPRINGS BEAUTY COLLEGE	<50
024974	ACADEMY OF PROFESSIONAL DEVELOPMENT	<50
023432	UNITED BUSINESS INSTITUTE	<50
025893	AMERICAN TECHNICAL COLLEGE	<50
023437	CHICAGO TECHNOLOGICAL COLLEGE	<50
025446	MAGEE BROTHERS BEAUTY SCHOOL	<50
030197	MIDWEST CAREER COLLEGE	<50
032005	YOUNGSTOWN COLLEGE OF MASSOTHERAPY (THE)	<50
030199	CAPSTONE COLLEGE	<50
024995	AMERICAN TRANSPORTATION EDUCATION CENTERS	<50
030213	TRISTATE TRAVEL SCHOOL	<50
032793	MYOTHERAPY INSTITUTE	<50
030234	ARKANSAS TECHNICAL SCHOOL	<50
025019	CARS VOCATIONAL TRAINING SCHOOL	<50
030238	AIMS ACADEMY	<50
025049	BEAUTY ACADEMY	<50
030247	STILLWATER BEAUTY ACADEMY	<50
033893	ACADEMY OF MASSAGE THERAPY	<50
025382	TECHL EDUCATION IN CULINARY AND HEALTH	<50
025496	METROPLITAN BUSINESS COLLEGE	<50
023448	SOUTHERN BUS SCHOOLS	<50
034303	UNIVERSAL THERAPEUTIC MASSAGE INSTITUTE	<50
025644	SOUTHERN COLLEGE OF TECHNOLOGY	<50
026090	EMPEROR'S COLLEGE OF TRADITIONAL ORIENTAL MEDICINE	<50
025388	ALLEGIANCE BEAUTY SCHOOL	<50
023056	NATIONAL BROADCASTING SCHOOL	<50
030311	JGM COSMETOLOGY INSTITUTE	<50
035194	LYNNDALE FUNDAMENTALS OF BEAUTY SCHOOL	<50
030313	XENON INTERNATIONAL ACADEMY IV	<50
026112	NATIONAL CAREER SCHOOL	<50
030322	ALADDIN BEAUTY COLLEGE #32	<50
031057	NEWBRIDGE COLLEGE—MONTEREY PARK	<50
025673	BRAXTON SCHOOL OF BUSINESS	<50
023236	PONCE COLLEGE OF TECHNOLOGY	<50
025674	PRO DRIVE	<50
024917	CORTIVA INSTITUTE— BOSTON	<50
023487	CAREER BLAZERS LEARNING CENTER	<50
025417	COASTAL COLLEGE	<50
030520	MEREDITH MANOR INTERNATIONAL EQUESTRIAN CENTRE	<50
031207	NEW YORK CONSERVATORY FOR DRAMATIC ARTS (THE)	<50
023492	HEADMASTERS SCHOOL OF HAIR DESIGN	<50
023327	ROSSTON COLLEGE	<50
030523	KENNETH SHULER SCHOOL OF COSMETOLOGY & HAIR DESIGN	<50
031243	TODAY'S TRAINING CENTER	<50
030532	ASTRAL ACADEMY OF HAIR	<50
031245	LOS ANGELES PACIFIC COLLEGE	<50
023240	COLLEGE OF THE PALM BEACHES	<50
031266	AMERICAN COLLEGE OF PROFESSIONAL EDUCATION	<50
030612	MIDWEST COLLEGE OF ORIENTAL MEDICINE	<50
031280	SANTA BARBARA COLLEGE OF ORIENTAL MEDICINE	<50
030649	AARON'S ACADEMY OF BEAUTY	<50
025876	ORLO SCHOOL OF HAIR DESIGN AND COSMETOLOGY (THE)	<50
023504	SOUTHEAST TEXAS TECHL INST	<50
031505	A—TECHNICAL COLLEGE	<50
023174	EMORY COLLEGE OF PUERTO RICO	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
025432	LOS ANGELES BROADCASTERS	<50
030661	PTC CAREER INST CLEVELAND	<50
025434	BROWNSON TECHNICAL SCHOOL	<50
025702	DEE BOYA INSTITUTE OF FASHION	<50
025307	SEBRING CAREER SCHOOLS	<50
023524	VOGUE COLLEGE OF COSMETOLOGY #25	<50
031853	PHAGANS' GRANTS PASS COLLEGE OF BEAUTY	<50
030677	RETS ELECTRONIC INSTITUTION	<50
023345	UNITED CAREER CENTER	<50
025398	QUEEN CITY COLLEGE	<50
032053	MODERN BEAUTY SCHOOL	<50
023541	DOOLIN TECHNICAL COLLEGE	<50
025955	OMNI COLLEGE	<50
030720	AVALON VOCATIONAL TECHNICAL INSTITUTE	<50
023346	PAZAZZ HAIR SCHOOL	<50
030726	DCI CAREER INSTITUTE	<50
032773	PATHWAY VOCATIONAL ACADEMY	<50
025708	HOSPITALITY INSTITUTE	<50
032804	CORTIVA INSTITUTE—CHARLOTTESVILLE	<50
030741	WESTLAKE INSTITUTE OF TECHNOLOGY	<50
033223	CULINARY INSTITUTE OF NEW ORLEANS	<50
030744	PHAGANS' NEWPORT ACADEMY OF COSMETOLOGY CAREERS	<50
026011	OPELOUSAS SCHOOL OF COSMETOLOGY	<50
030745	EAST WEST COLLEGE OF THE HEALING ARTS	<50
025462	LAUREL BUSINESS INSTITUTE	<50
025713	VISTA DEL MAR—SCHOOL OF COURT REPORTING	<50
033703	AUDIO RECORDING TECHNOLOGY INSTITUTE	<50
023556	INTERNATIONAL INSTITUTE OF TRANSPORTATION RESOURCES	<50
025103	BEAUTY TECHNICAL COLLEGE	<50
030784	CAMEO BEAUTY ACADEMY	<50
025155	CALIFORNIA BUSINESS INSTITUTE	<50
030802	LOUISIANA TRAINING CENTER	<50
023235	METILS WELDING SCHOOL	<50
030808	ACADEMY (THE)	<50
025499	CONSUMER ELECTRONICS TRAINING CENTER	<50
030879	LIBERTY ACADEMY OF BUSINESS	<50
026088	IAD AMERICAN SCHOOLS	<50
023241	FLAGLER CAREER INSTITUTE	<50
034313	ESI TECHNOLOGY TRAINING CENTER	<50
023597	NORTHEAST CAREER SCHOOLS	<50
023379	COLLEGE OF HAIR DESIGN CAREERS	<50
030948	INDUSTRIAL MANAGEMENT & TRAINING INSTITUTE	<50
023146	CRESTWOOD CAREER ACADEMY	<50
025747	WATTERSON SCHOOL OF BUSINESS AND TECHNOLOGY	<50
034854	JAMES ALBERT SCHOOL OF COSMETOLOGY	<50
030962	CHARLES STUART SCHOOL	<50
034914	AMERICAN ADVANCED TECHNICIANS INSTITUTE	<50
023100	RON THOMAS SCHOOL OF COSMETOLOGY	<50
035165	EZELL'S COSMETOLOGY SCHOOL, LLC	<50
030985	ALLSTATE INSTITUTE OF TECHNOLOGY	<50
035303	KEYSKILLS LEARNING	<50
023310	MARYLAND BEAUTY ACADEMY OF ESSEX	<50
025524	ACADEMY OF HAIR TECHNOLOGY	<50
031001	PARAMOUNT BEAUTY ACADEMY	<50
023094	PARALEGAL INSTITUTE	<50
023605	AMERICAN VOCATIONAL CENTER	<50
031020	RIVERTOWN SCHOOL OF BEAUTY, BARBER, SKIN CARE AND NAILS	<50
025770	PAUL MITCHELL THE SCHOOL—ESANI	<50
021563	MARGATE SCHOOL OF BEAUTY	<50
022477	SOUTH WEST ACADEMY OF TECHNOLOGY	<50
012351	PHAGANS' SCHOOL OF BEAUTY	<50
011914	MIDTOWN SCHOOL OF BUSINESS	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022622	NATIONAL ACADEMY FOR PARALEGAL STUDIES	<50
021162	COMMERCIAL PROGRAMMING UNLIMITED	<50
021617	PACIFIC COAST TECHL INST	<50
010926	BALIN INST OF TECHLG	<50
012403	MEADOWS BUSINESS COLLEGE	<50
021644	INTERNATIONAL TRAINING	<50
022548	TEXAS VOCATIONAL SCHOOL	<50
020584	GORDON PHILLIPS SCHOOL OF BEAUTY CULTURE	<50
021523	SCHOOL OF COMMUNICATION ARTS	<50
020594	INTERNATIONAL BEAUTY ACADEMY	<50
022922	NEBRASKA CUSTOM DIESEL DRIVERS TRAINING	<50
021186	ULTISSMA BEAUTY INST BRENTWOOD	<50
011484	ADVANCED INSTITUTE OF HAIR DESIGN	<50
011572	COLORADO SCHOOL OF TRADES	<50
020717	ARIZONA CAREER COLLEGE (CLOSED)	<50
021687	JACKSONVILLE BUSINESS AND CAREERS INSTITUTE	<50
022411	SIMMONS SCHOOL	<50
011963	DELTA JUNIOR COLLEGE	<50
020756	ANDOVER TRACTOR TRAILER SCHOOL HOME STUDY DIVISION	<50
010910	CASCADE BUSINESS COLLEGE	<50
012551	LAUREL BEAUTY ACADEMY	<50
021743	KEITH METRO HAIR ACADEMY	<50
022737	NATIONAL EDUCATION CENTER NATIONAL INSTITUTE OF TECHNOLOGY	<50
011182	CLIFTON SCHOOL OF BUSINESS	<50
022784	JETT COLLEGE OF COSMETOLOGY & BARBERING	<50
021230	LAVONNES ACADEMY OF BEAUTY	<50
022889	ACCUTECH CAREER INSTITUTE	<50
013240	LYTLE'S REDWOOD EMPIRE BEAUTY COLLEGE	<50
011154	MERIT COLLEGE	<50
020596	AL TATE BEAUTY COLLEGE	<50
022994	ALAMEDA TECHNICAL COLLEGE	<50
021783	VOGUE SCHOOL OF HAIR DESIGN #6	<50
011814	GATEWAY ELECTRONICS INST	<50
010837	SIMMONS INSTITUTE OF FUNERAL SERVICE	<50
022313	CAGUAS COLLEGE OF TECHNOLOGY & SCIENCE	<50
021796	EMPIRE BEAUTY SCHOOLS	<50
022359	ACADEMY OF HAIR DESIGN # 4	<50
012020	VICTORIA BEAUTY AND BARBER COLLEGE	<50
022387	HAIRSTYLING INSTITUTE OF CHARLOTTE	<50
021257	HELENA DYE & FLANARY BEAUTY COLLEGE	<50
012460	APOLLO BUSINESS & TECHNICAL SCHOOL	<50
021813	LONG TECHNICAL COLLEGE	<50
010810	COMMERCIAL COLLEGE OF BATON ROUGE	<50
011596	SYLVAIN MELLOUL INTERNATIONAL HAIR ACADEMY	<50
022538	TEXAS SCHOOLS	<50
021831	BOJACK ACADEMY OF BEAUTY CULTURE	<50
020766	PICCOLO SCHOOL OF HAIR DESIGN	<50
021832	MED HELP TRAINING SCHOOL	<50
011830	BERK TRADE & BUSINESS SCHOOL	<50
021838	EASON'S INST OF TECHLG	<50
022661	EASTERN JACKSON COUNTY COLLEGE OF ALLIED HEALTH	<50
021842	PAROBA COLLEGE OF COSMETOLOGY	<50
022745	ACADEMY OF COSMETOLOGY	<50
021844	JENKS BEAUTY COLLEGE	<50
022760	FRANKLIN BEAUTY SCHOOL	<50
021852	ILLINOIS SCHOOL OF COMMERCE	<50
012782	DEBBIES SCHOOL OF BEAUTY CULTURE	<50
021864	MELBOURNE BEAUTY SCHOOL	<50
011219	COLUMBIA SCHOOL OF BROADCASTING, HOME STUDY	<50
021870	LEONE SCHOOL OF TECHNOLOGY	<50
020563	KENSINGTON BUSINESS INSTITUTE	<50
021874	PARKS COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
022943	TECHNICAL TRAINING CENTER	<50
021888	SULLIVAN EDUCATIONAL CENTERS	<50
013010	LANCASTER BEAUTY SCHOOL	<50
021891	CEM COLLEGE	<50
022982	HEADQUARTERS ACADEMY OF HAIR DESIGN (THE)	<50
021897	CREATIVE SCHOOL OF BEAUTY	<50
023006	CONTINENTAL BEAUTY COLLEGE	<50
021071	TEMPE TECHNICAL INSTITUTE	<50
022225	CINCINNATI SCHOOL OF COURT REPORTING AND BUSINESS	<50
021091	SOUTH CENTRAL CAREER COLLEGE	<50
022238	ROMAR BEAUTY SCHOOL	<50
011799	PAUL MITCHELL THE SCHOOL FAYETTEVILLE	<50
022281	STEVEN PAPAGEORGE HAIR ACADEMY	<50
020959	GUTHRIE ACADEMY	<50
022332	COSMETOLOGY CAREERS UNLIMITED	<50
020921	MASSACHUSETTS SCHOOL OF BARBERING	<50
012381	CLASSIC BEAUTY COLLEGES	<50
023016	CASHIER TRAINING INSTITUTE	<50
020724	PLAZA THREE ACADEMY	<50
023023	ORLANDO ACADEMY OF BEAUTY CULTURE	<50
012920	ACADEMY OF SCIENTIFIC HAIR DESIGN	<50
011800	FREDERICK'S BEAUTY COLLEGE	<50
011098	FLINT INSTITUTE OF BARBERING	<50
011802	ARIZONA ACADEMY OF BEAUTY—NORTH	<50
022443	MISSISSIPPI BARBER ACADEMY	<50
012068	MANSFIELD BEAUTY SCHOOLS	<50
011521	EDUCATION DYNAMICS INSTITUTE	<50
022030	NATIONAL TRAINING	<50
022481	AUSTIN SCHOOL OF BEAUTY CULTURE	<50
021098	MARYCREST COLLEGE	<50
022513	D'OR SCHOOL OF COSMETOLOGY	<50
021322	MCKIM TECHNICAL INSTITUTE	<50
022517	FOSTER'S COSMETOLOGY AND BARBER COLLEGE	<50
021329	MASSACHUSETTS SCHOOL OF BARBER & MENS HAIR	<50
021461	CHAUFFEURS TRAINING SCHOOL	<50
020657	CALIFORNIA BEAUTY COLLEGE	<50
010747	ELECTRONIC COMPUTER PROGRAMMING INST	<50
021344	CONNECTICUT INSTITUTE OF ART	<50
021491	PACE BUSINESS SCHOOL(THE)	<50
011006	AMERICAN INSTITUTE OF DESIGN	<50
021125	CALIFORNIA SCHOOL OF COURT REPORTING	<50
020661	OHIO STATE COLLEGE OF BARBER STYLING	<50
022621	HAIR PROFESSIONALS SCHOOL OF COSMETOLOGY	<50
022056	PALM BEACH BEAUTY & BARBER SCHOOL	<50
012929	SOUTH HILLS BEAUTY ACADEMY	<50
012094	SOUTHWEST SCHOOL OF MEDICAL ASSISTANTS	<50
020791	MILE HIGH COLLEGE	<50
022088	FIRST BUSINESS SCHOOL (THE)	<50
021127	NORTH HAVEN ACADEMY, LLC	<50
022091	STAGE ONE THE HAIR SCHOOL	<50
022752	PROFESSIONAL TRAINING INST (CLOSED)	<50
021346	GENERAL EDUCATION & TRAINING HOME STUDY	<50
022759	MODERN WELDING SCHOOL, INC	<50
022107	CAREER BEAUTY COLLEGE	<50
011629	LEWIS INTERNATIONAL SCHOOL	<50
022114	JAY TRUCK DRIVER TRAINING CENTER	<50
021531	PAUL MITCHELL THE SCHOOL MURFREESBORO	<50
022119	CHEEKS BEAUTY ACADEMY	<50
021003	MED-ASSIST SCHOOL OF HAWAII	<50
022132	UNIVERSAL ACADEMY OF HAIR DESIGN	<50
012810	ASSOCIATED TECHNICAL INSTITUTE	<50
010663	WILMA BOYD CAREER SCHOOLS	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
021581	GOLDEN STATE SCHOOL	<50
012166	CAROUSEL BEAUTY COLLEGE	<50
012823	PAT GOINS RUSTON BEAUTY SCHOOL	<50
022152	PHARR VOCATIONAL SCHOOL	<50
022920	DIESEL TRUCK DRIVER TRAIN SCHOOL	<50
012202	GRIFFIN BELLEVUE BUSINESS COLLEGE	<50
021009	MEDICAL ARTS TRAINING CENTER	<50
022168	CALIFORNIA INSTITUTE	<50
012948	ROB ROY ACADEMY	<50
021387	GROVE SCHOOL OF MUSIC	<50
010887	CONNECTICUT BUSINESS INSTITUTE	<50
011169	INTERNATIONAL TRAINING CENTER (CLOSED)	<50
022975	OEHRLEIN SCHOOL OF COSMETOLOGY	<50
020713	INTERNATIONAL CAREER INSTITUTE	<50
020873	FIRST SCHOOL FOR CAREERS	<50
022200	COLLEEN O'HARA'S BEAUTY ACADEMY	<50
022988	CONTINENTAL COLLEGE OF BEAUTY & BARBER STYLG	<50
012295	JZ TREND ACADEMY PAUL MITCHELL PARTNER SCHOOL	<50
020878	ARTISTIC BEAUTY COLLEGE	<50
022204	CATHERINE HINDS INSTITUTE OF ESTHETICS	<50
023012	CHARLES ALLAN ACADEMY OF BEAUTY CULTURE	<50
022206	BENEDICT SCHOOL OF LANGUAGES AND COMMERCE	<50
011912	NEW YORK BUSINESS SCHOOL	<50
022216	DRET SCHOOL	<50
023019	ALLIED MEDICAL AND TECHNICAL INSTITUTE	<50
021974	WOODBIDGE BUSINESS INSTITUTE	<50
022001	GUTI, THE PREMIER BEAUTY AND WELLNESS ACADEMY	<50
021958	LICEO DE ARTE Y TECNOLOGÍA	<50
010150	FLORIDA BEAUTY COLLEGE	<50
009567	TENNESSEE SCHOOL OF BEAUTY	<50
004473	LOYOLA LAW SCHOOL	<50
030073	OREGON COLLEGE OF ART & CRAFT	<50
009877	HENRI'S SCHOOL OF HAIR DESIGN	<50
042509	INTER AMERICAN UNIVERSITY OF PUERTO RICO—SCHOOL OF LAW	<50
042501	SANTA BARBARA AND VENTURA COLLEGES OF LAW (THE)	<50
007550	NATIONAL EDUCATION CENTER KENTUCKY COLLEGE OF TECHNOLOGY CAMPUS	<50
004493	SIERRA COLLEGE OF BUSINESS	<50
005209	MILLER MOTTE BUSINESS COLLEGE	<50
021187	LONG ISLAND COLLEGE HOSPITAL—SCHOOL OF NURSING	<50
042527	PACIFIC RIM CHRISTIAN UNIVERSITY	<50
036683	BIRTHINGWAY COLLEGE OF MIDWIFERY	<50
007605	ACADEMY PACIFIC TRAVEL COLLEGE	<50
042355	PRESIDIO GRADUATE SCHOOL	<50
022345	BOISE BIBLE COLLEGE	<50
041256	CAREER SCHOOL OF NY	<50
042567	REFORMED UNIVERSITY	<50
034224	COLLEGE OF BIBLICAL STUDIES—HOUSTON	<50
042609	MYSTROS BARBER ACADEMY	<50
009515	J. MICHAEL HARROLD BEAUTY ACADEMY	<50
007619	MEDICAL INSTITUTE OF MINNESOTA	<50
031805	EUGENIO MARIA DE HOSTOS SCHOOL OF LAW	<50
042655	ICOHs COLLEGE	<50
022747	MADISON SCHOOLS	<50
007659	LA' JAMES COLLEGE OF HAIRSTYLING	<50
007482	TAD TECHNICAL INSTITUTE	<50
007674	AMERICAN BEAUTY COLLEGE	<50
010122	PHAGANS' MEDFORD BEAUTY SCHOOL	<50
005210	CLEVELAND INSTITUTE OF ELECTRONICS	<50
023065	PROFESSIONAL BUSINESS COLLEGE	<50
042771	YOUNG AMERICANS COLLEGE OF THE PERFORMING ARTS (THE)	<50
042415	WAVE LEADERSHIP COLLEGE	<50
007780	NEW CASTLE SCHOOL OF TRADES	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
021597	NEW HOPE CHRISTIAN COLLEGE	<50
007790	TRIPLE CITIES SCHOOL OF BEAUTY CULTURE	<50
021073	PENNSYLVANIA ACADEMY OF THE FINE ARTS	<50
037524	SUM BIBLE COLLEGE & THEOLOGICAL SEMINARY	<50
004487	CRISS COLLEGE	<50
030074	LAKESIDE SCHOOL OF MASSAGE THERAPY	<50
009433	SHERMAN KENDALL'S ACADEMY OF BEAUTY ARTS & SCIENCES	<50
041285	SOUTHERN CATHOLIC COLLEGE	<50
007459	PAIER COLLEGE OF ART	<50
021689	KANSAS CHRISTIAN COLLEGE	<50
025459	HYPNOSIS MOTIVATION INSTITUTE	<50
006420	MONTCLAIR HOSPITAL LLC	<50
009600	COSMETOLOGY CAREERS UNLIMITED COLLEGE OF HAIR, SKIN, AND NAILS	<50
007833	TRACEY-WARNER SCHOOL	<50
009670	WRIGHT BEAUTY COLLEGE	<50
021366	WISCONSIN LUTHERAN COLLEGE	<50
009724	DELOUX SCHOOL OF COSMETOLOGY ESCONDIDO	<50
038553	ECCLESIA COLLEGE	<50
022749	VIRGINIA SCHOOLS	<50
007872	SAWYER COLLEGE AT PONOMA	<50
009958	HICKS ACADEMY OF BEAUTY CULTURE	<50
007921	PAUL MITCHELL THE SCHOOL ARKANSAS	<50
034555	NATIONAL LABOR COLLEGE	<50
001394	MORSE SCHOOL OF BUSINESS	<50
004632	SPENCER COLLEGE	<50
041545	STARTING POINTS	<50
010130	WADE COLLEGE	<50
041212	INSTITUTE OF TAOIST EDUCATION AND ACUPUNCTURE	<50
025162	WESLEY BIBLICAL SEMINARY	<50
008140	RICKERSON BEAUTY ACADEMY #5	<50
041433	ELLIS UNIVERSITY	<50
036953	COMMUNITY ENHANCEMENT SERVICES	<50
032583	SOUTHERN METHODIST COLLEGE	<50
008249	NATIONAL EDUCATION CENTER—BRYMAN CAMPUS	<50
023164	INSTITUTO DE EDUCATION UNIVERSAL	<50
008259	EDUCATORS OF BEAUTY COLLEGE OF COSMETOLOGY	<50
004710	KANSAS CITY BUSINESS COLLEGE	<50
030282	TRINITY COLLEGE OF FLORIDA	<50
010478	BLANTOS COLLEGE	<50
007130	NEWBERRY SCHOOL OF BEAUTY	<50
021601	GENEVA GENERAL HOSPITAL	<50
038565	FLORIDA SCHOOL OF TRADITIONAL MIDWIFERY	<50
035033	WINNER INSTITUTE OF ARTS & SCIENCES	<50
022652	GLOBAL BUSINESS INSTITUTE	<50
009380	NATIONAL EDUCATION CENTER TEMPLE SCHOOL CAMPUS	<50
008435	INTERBORO INSTITUTE	<50
004962	DURHAM COLLEGE OF SAN ANTONIO	<50
041331	CALIFORNIA UNIVERSITY OF MANAGEMENT AND SCIENCES	<50
031163	OHIO COLLEGE OF MASSOTHERAPY	<50
025054	ATLANTIC UNIVERSITY COLLEGE	<50
010643	NATIONAL SCHOOL OF HEALTH TECHNOLOGY	<50
041722	NORTHWESTERN INSTITUTE OF HEALTH AND TECHNOLOGY	<50
009457	GEORGE ROGERS CLARK COLLEGE	<50
008548	HICKOX SCHOOL OF INFORMATION TECHNOLOGY	<50
004527	WASHINGTON SCHOOL OF SECRETARIES	<50
008550	DRAUGHONS BUSINESS COLLEGE	<50
031773	SAN JUAN BAUTISTA SCHOOL OF MEDICINE	<50
002543	DANA COLLEGE	<50
009535	STAUNTON SCHOOL OF COSMETOLOGY	<50
030310	AMERICAN CENTER FOR CAREER TRAINING	<50
022740	BRANNON BUS INST	<50
031019	TRINITY BAPTIST COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
037263	OHIO MID-WESTERN COLLEGE	<50
034033	EPIC BIBLE COLLEGE	<50
009660	TIFFIN ACADEMY OF HAIR DESIGN	<50
041795	NORTH AMERICAN UNIVERSITY	<50
042236	ACADEMY OF INTERACTIVE ENTERTAINMENT	<50
003015	BLISS COLLEGE	<50
009713	ALASKA JUNIOR COLLEGE	<50
008658	O'BRIENS AVEDA INSTITUTE	<50
040733	JUNG TAO SCHOOL OF CLASSICAL CHINESE MEDICINE	<50
038943	HUNTSVILLE BIBLE COLLEGE	<50
023305	LAGUNA COLLEGE OF ART AND DESIGN	<50
022664	CENTRAL CHRISTIAN COLLEGE OF THE BIBLE	<50
009831	MODEL COLLEGE OF HAIR DESIGN	<50
007284	EDUTEK PROFESSIONAL COLLEGE	<50
004614	WICHITA BUSINESS COLLEGE	<50
008885	FRANKLIN SCHOOL OF COSMETOLOGY & HAIR DESIGN	<50
022828	INTER AMERICAN UNIVERSITY OF PUERTO RICO—FAJARDO CAMPUS	<50
030329	NORTHWEST INSTITUTE OF ACUPUNCTURE & ORIENTAL MEDICINE	<50
020907	CLEVELAND UNIVERSITY—KANSAS CITY	<50
008891	GORDON PHILLIPS BEAUTY SCHOOL	<50
030070	FRONTIER NURSING UNIVERSITY	<50
007302	BUSINESS CAREER INSTITUTE	<50
010078	ROSWELL COLLEGE OF COSMETOLOGY	<50
008954	PITTSBURGH BEAUTY ACADEMY	<50
010112	BRYAN INSTITUTE	<50
041373	CAYCE/REILLY SCHOOL OF MASSAGE	<50
010129	PHILLIPS JUNIOR COLLEGE OF SPARTANBURG	<50
008997	CDI CAREER DEVELOPEMENT INSTITUTE	<50
010145	ADVANCED BEAUTY COLLEGE	<50
041405	HORIZON UNIVERSITY	<50
010151	VINCENNES BEAUTY COLLEGE	<50
039413	AVE MARIA UNIVERSITY	<50
022230	CLAYTON UNIV	<50
004931	NETTLETON CAREER COLLEGE	<50
010210	PROSPECT HALL SCHOOL OF BUSINESS	<50
036763	FAMILY OF FAITH CHRISTIAN UNIVERSITY	<50
023357	BATON ROUGE GENERAL MEDICAL CENTER	<50
021979	NORTH BENNET STREET SCHOOL	<50
032513	BEACON UNIVERSITY	<50
034114	INTERNATIONAL TRAINING CAREERS	<50
007516	ULTISSMA BEAUTY INSTITUTE (CLOSED)	<50
004891	CHURCHMAN BUSINESS SCHOOL	<50
010397	LAURENWOOD COLLEGE(CLOSED)	<50
030018	WELCH COLLEGE	<50
010406	JOSEF'S SCHOOL OF HAIR, SKIN & BODY	<50
009133	TEXAS INSTITUTE	<50
021554	PENNSYLVANIA COLLEGE OF STRAIGHT CHIROPRACTIC	<50
009186	DEAN INSTITUTE OF TECHNOLOGY	<50
010461	EDUCATION AMERICA—TOPEKA TECHNICAL COLLEGE	<50
041937	JOHN PAUL THE GREAT CATHOLIC UNIVERSITY	<50
010465	LEARNING INSTITUTE FOR BEAUTY SCIENCES	<50
042171	RUDOLF STEINER COLLEGE	<50
010500	DEBBIE'S SCHOOL OF BEAUTY CULTURE	<50
031121	DEWEY UNIVERSITY	<50
010571	CAPITOL BUSINESS COLLEGE	<50
042174	HIGH TECH HIGH GRADUATE SCHOOL OF EDUCATION	<50
010622	BAILE SCHOOL OF BROADCASTING	<50
010632	DEWOLFF HAIRSTYLING AND COSMETOLOGY INSTITUTE	<50
041440	FAIRFAX UNIVERSITY OF AMERICA	<50
039823	VISIBLE MUSIC COLLEGE	<50
007427	SOUTHWEST TECHNICAL COLLEGE	<50
032833	NORTHWEST HVAC/R ASSOCIATION & TRAINING	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
008860	SIT	<50
011941	AMERICAN UNIVERSITY OF PUERTO RICO	<50
003694	SAINT MICHAEL'S COLLEGE	<50
003856	LAWRENCE UNIVERSITY	<50
012744	SOUTHSIDE COLLEGE OF HEALTH SCIENCES	<50
003868	MILWAUKEE SCHOOL OF ENGINEERING	<50
009824	ROBERT MORRIS COLLEGE	<50
003873	MOUNT SENARIO COLLEGE	<50
003713	HAMPDEN SYDNEY COLLEGE	<50
003875	NORTHLAND COLLEGE	<50
003447	SPARTANBURG METHODIST COLLEGE	<50
003892	ST NORBERT COLLEGE	<50
002644	UPSALA COLLEGE	<50
002587	SAINT ANSELM COLLEGE	<50
003396	WILSON COLLEGE	<50
002930	GREENSBORO COLLEGE	<50
003406	PROVIDENCE COLLEGE	<50
002729	HARTWICK COLLEGE	<50
003704	BRIDGEWATER COLLEGE	<50
003285	LANCASTER BIBLE COLLEGE	<50
011685	WENTWORTH TECHNICAL SCHOOL	<50
003939	INTER AMERICAN UNIVERSITY OF PUERTO RICO—AGUADILLA CAMPUS	<50
012248	CENTRAL SCHOOL OF PRACTICAL NURSING	<50
002731	HOBART AND WILLIAM SMITH COLLEGES	<50
012525	CARIBBEAN UNIVERSITY	<50
003109	OHIO WESLEYAN UNIVERSITY	<50
003484	COVENANT COLLEGE	<50
003952	UNIVERSITY OF THE PACIFIC MCGEORGE SCHOOL OF LAW	<50
020771	MILWAUKEE INSTITUTE OF ART & DESIGN	<50
003505	MARYVILLE COLLEGE	<50
003393	WESTMINSTER THEOLOGICAL SEMINARY	<50
002453	CENTRAL METHODIST UNIVERSITY	<50
003011	ART ACADEMY OF CINCINNATI	<50
003511	MILLIGAN UNIVERSITY	<50
003690	MARLBORO COLLEGE	<50
002380	SAINT MARY'S UNIVERSITY OF MINNESOTA	<50
002887	ALBANY MEDICAL COLLEGE	<50
002668	ALFRED UNIVERSITY	<50
002366	CROSSROADS COLLEGE	<50
002943	LOUISBURG COLLEGE	<50
003709	EMORY & HENRY COLLEGE	<50
004002	MCKENZIE COLLEGE	<50
003715	HOLLINS UNIVERSITY	<50
004181	ADVOCATE TRINITY HOSPITAL SCHOOL OF RADIOLOGIC TECHNOLOGY	<50
011859	WORD OF LIFE BIBLE INSTITUTE	<50
002812	TROCAIRE COLLEGE	<50
003440	NEWBERRY COLLEGE	<50
004529	TAMPA COLLEGE ST PETERSBURG CAMPUS	<50
003785	PACIFIC LUTHERAN UNIVERSITY	<50
004641	DUNWOODY COLLEGE OF TECHNOLOGY	<50
003804	WHITWORTH UNIVERSITY	<50
003556	COMMONWEALTH INSTITUTE OF FUNERAL SERVICE	<50
002912	BREVARD COLLEGE	<50
004886	ELECTRONIC INSTITUTES	<50
003830	WEST VIRGINIA WESLEYAN COLLEGE	<50
005029	INTER AMERICAN UNIVERSITY OF PUERTO RICO—PONCE CAMPUS	<50
020637	SHERMAN COLLEGE OF STRAIGHT CHIROPRACTIC	<50
005310	PITTSBURGH INSTITUTE OF AERONAUTICS	<50
002717	ELIZABETH SETON COLLEGE	<50
006228	METHODIST COLLEGE	<50
003389	WASHINGTON AND JEFFERSON COLLEGE	<50
006257	SAINT ELIZABETH SCHOOL OF NURSING	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
003647	TRINITY UNIVERSITY	<50
006273	MERCY COLLEGE OF HEALTH SCIENCES	<50
003224	UNIVERSITY OF PORTLAND	<50
006322	SIGNATURE HEALTHCARE BROCKTON HOSPITAL SCHOOL OF NURSING	<50
009387	PERRY TECHNICAL INSTITUTE	<50
002670	CLARKS SUMMIT UNIVERSITY	<50
002572	COLBY-SAWYER COLLEGE	<50
006389	GOLDFARB SCHOOL OF NURSING AT BARNES-JEWISH COLLEGE	<50
003686	GODDARD COLLEGE	<50
006399	BRYAN COLLEGE OF HEALTH SCIENCES	<50
010153	HELENE FULD COLLEGE OF NURSING	<50
006404	NEBRASKA METHODIST COLLEGE OF NURSING & ALLIED HEALTH	<50
003409	RHODE ISLAND SCHOOL OF DESIGN	<50
006448	ELLIS MEDICINE, THE BELANGER SCHOOL OF NURSING	<50
010501	LAKEVIEW COLLEGE OF NURSING	<50
006461	SAINT ELIZABETH MEDICAL CENTER	<50
003695	TRINITY COLLEGE OF VERMONT	<50
003564	EAST TEXAS BAPTIST UNIVERSITY	<50
003703	BLUEFIELD COLLEGE	<50
006477	CABARRUS COLLEGE OF HEALTH SCIENCES	<50
003708	EASTERN MENNONITE UNIVERSITY	<50
002742	JUILLIARD SCHOOL (THE)	<50
003711	FERRUM COLLEGE	<50
006498	HURON SCHOOL OF NURSING	<50
003238	BUCKNELL UNIVERSITY	<50
006612	COVENANT SCHOOL OF NURSING AND ALLIED HEALTH	<50
003733	RANDOLPH-MACON COLLEGE	<50
002671	BARD COLLEGE	<50
011732	MAYO CLINIC COLLEGE OF MEDICINE AND SCIENCE	<50
003350	UNIVERSITY OF THE ARTS (THE)	<50
011915	DRAKE BUSINESS SCHOOL	<50
003151	OKLAHOMA WESLEYAN UNIVERSITY	<50
002708	BARNARD COLLEGE	<50
002458	COTTEY COLLEGE	<50
003778	GONZAGA UNIVERSITY	<50
002460	CULVER-STOCKTON COLLEGE	<50
002584	NOTRE DAME COLLEGE	<50
002960	SALEM COLLEGE	<50
003445	PRESBYTERIAN COLLEGE	<50
007026	ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI	<50
003041	DEFIANCE COLLEGE	<50
003180	SOUTHWESTERN CHRISTIAN UNIVERSITY	<50
003806	ALDERSON BROADDUS UNIVERSITY	<50
003364	SAINT CHARLES BORROMEO SEMINARY	<50
002711	CORNELL UNIVERSITY	<50
007291	ST. LUKE'S COLLEGE	<50
003469	UNIVERSITY OF SIOUX FALLS	<50
002832	SAINT THOMAS AQUINAS COLLEGE	<50
003265	FRANKLIN & MARSHALL COLLEGE	<50
002978	WAKE FOREST UNIVERSITY	<50
002450	CALVARY UNIVERSITY	<50
007330	CRANFORD COLLEGE	<50
020636	TAD TECHNICAL INSTITUTE KANSAS CITY	<50
002990	UNIVERSITY OF JAMESTOWN	<50
003839	CARTHAGE COLLEGE	<50
002524	WILLIAM JEWELL COLLEGE	<50
020690	NEW YORK SCHOOL OF INTERIOR DESIGN	<50
003206	MULTNOMAH UNIVERSITY	<50
020758	SOUTHERN CALIFORNIA INSTITUTE OF ARCHITECTURE (THE)	<50
003386	VALLEY FORGE MILITARY COLLEGE	<50
003208	BUSHNELL UNIVERSITY	<50
008843	ALASKA BIBLE COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
002275	KALAMAZOO COLLEGE	<50
030954	BOND UNIVERSITY	<50
002023	UNIVERSITY OF HOLY CROSS	<50
001689	ILLINOIS COLLEGE OF OPTOMETRY	<50
008920	UNIVERSITY OF NOTTINGHAM	<50
011780	BRUNEL UNIVERSITY LONDON	<50
001515	ROLLINS COLLEGE	<50
001700	JUDSON UNIVERSITY	<50
041527	Astrodome Career Centers	<50
001704	KNOX COLLEGE	<50
009225	Texas State Technical College Harlingen	<50
001706	LAKE FOREST COLLEGE	<50
001604	YOUNG HARRIS COLLEGE	<50
042439	University of Texas Health Science Center at Tyler (The)	<50
002343	COLLEGE OF SAINT SCHOLASTICA	<50
012539	University of The Arts London IDO—Central Saint Martins College	<50
001986	SUE BENNETT COLLEGE	<50
002254	Michigan State University College of Law	<50
012206	JAMES COOK UNIVERSITY	<50
038073	ROSE BRUFORD COLLEGE OF THEATRE AND PERFORMANCE	<50
008373	TEL AVIV UNIVERSITY	<50
001241	Monterey Institute of International Studies	<50
002133	BRANDEIS UNIVERSITY	<50
001278	SAN FRANCISCO CONSERVATORY OF MUSIC	<50
002154	HELLENIC COLLEGE & HOLY CROSS GREEK ORTHODOX SCHOOL OF THEOLOGY	<50
038463	PACIFIC LIFE BIBLE COLLEGE	<50
003044	Trinity Lutheran Seminary	<50
038974	INTERNATIONAL SPACE UNIVERSITY	<50
010594	RICHMOND, THE AMERICAN INTERNATIONAL UNIVERSITY IN LONDON	<50
004749	Bryant & Stratton Business Institute-Albany	<50
010720	RYERSON UNIVERSITY	<50
040703	RAPHAEL RECANATI INTERNATIONAL SCHOOL, THE INTERDISCIPLINARY CENTER	<50
001688	ILLINOIS COLLEGE	<50
001305	STANFORD UNIVERSITY	<50
005526	South Central Louisiana Technical College	<50
042188	REGENT'S UNIVERSITY LONDON	<50
030333	MANCHESTER METROPOLITAN UNIVERSITY (THE)	<50
025798	New England School of Acupuncture	<50
006839	UNIVERSITY OF EDINBURGH	<50
002228	Wheelock College	<50
001549	ATLANTA COLLEGE OF ART	<50
021810	UNIVERSITY OF SOUTH AUSTRALIA	<50
001122	BIOLA UNIVERSITY	<50
023393	ERASMUS UNIVERSITY ROTTERDAM (EUR)	<50
030843	UNIVERSITY OF LIMERICK	<50
001341	WESTMONT COLLEGE	<50
011950	Corcoran College of Art and Design	<50
001778	VANDERCOOK COLLEGE OF MUSIC	<50
002140	COLLEGE OF OUR LADY OF THE ELMS	<50
020774	North Lake College	<50
002151	BENJAMIN FRANKLIN INSTITUTE OF TECHNOLOGY	<50
021019	ROEHAMPTON UNIVERSITY	<50
008693	CITY, UNIVERSITY OF LONDON	<50
003088	Ohio College of Podiatric Medicine	<50
009249	UNIVERSITY OF LIVERPOOL (THE)	<50
031273	Omaha School of Massage and Healthcare of Herzing University	<50
010188	UNIVERSITY COLLEGE DUBLIN, NATIONAL UNIVERSITY OF IRELAND, DUBLIN	<50
038505	MEDICAL UNIVERSITY OF LODZ	<50
001200	FULLER THEOLOGICAL SEMINARY	<50
001798	FRANKLIN COLLEGE OF INDIANA	<50
010709	Empire Beauty School-Lakewood	<50
001799	GOSHEN COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022
 Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
024579	University of Kansas Medical Center	<50
001385	FAIRFIELD UNIVERSITY	<50
002341	COLLEGE OF SAINT BENEDICT	<50
021069	American Academy of Dramatic Arts-West	<50
002357	LUTHER SEMINARY	<50
013094	Bellingham Beauty School	<50
001099	HENDRIX COLLEGE	<50
001823	ANABAPTIST MENNONITE BIBLICAL SEMINARY	<50
001100	JOHN BROWN UNIVERSITY	<50
001834	CALUMET COLLEGE OF SAINT JOSEPH	<50
006688	UNIVERSITY OF TORONTO	<50
001835	SAINT MARY OF THE WOODS COLLEGE	<50
030295	UNIVERSITY OF NORTHUMBRIA AT NEWCASTLE	<50
001012	BIRMINGHAM-SOUTHERN COLLEGE	<50
006692	UNIVERSITY OF LEEDS	<50
021948	UNIVERSITY OF THE WEST OF ENGLAND, BRISTOL	<50
006697	QUEEN MARY UNIVERSITY OF LONDON	<50
001840	UNIVERSITY OF NOTRE DAME	<50
002039	COLBY COLLEGE	<50
001852	CLARKE UNIVERSITY	<50
009707	Lexington Community Community	<50
001855	DES MOINES UNIVERSITY—OSTEOPATHIC MEDICAL CENTER	<50
002073	GOUCHER COLLEGE	<50
021567	Florida Christian College	<50
030672	UNIVERSITY OF SYDNEY	<50
001690	Dr William M Scholl College of Podiatric Medicine at Finch University	<50
011808	Empire Beauty School—Flagstaff	<50
022164	TYNDALE UNIVERSITY	<50
002116	ANDOVER NEWTON THEOLOGICAL SCHOOL	<50
001876	MARYCREST INTERNATIONAL UNIVERSITY	<50
002121	BABSON COLLEGE	<50
001879	MORNINGSIDE UNIVERSITY	<50
008376	VRJIE UNIVERSITEIT AMSTERDAM	<50
030219	EDIC College	<50
008450	KASTURBA MEDICAL COLLEGE	<50
011881	California School of Professional Psychology, Alameda	<50
002139	CLARK UNIVERSITY	<50
001894	VENNARD COLLEGE	<50
008452	ABERYSTWYTH UNIVERSITY	<50
001896	WARTBURG COLLEGE	<50
008461	UNIVERSITY OF SAINT ANDREWS	<50
039743	ST. GEORGE'S UNIVERSITY, SCHOOL OF VETERINARY MEDICINE	<50
002153	GORDON COLLEGE	<50
001462	WASHINGTON BIBLE COLLEGE	<50
008665	UNIVERSITY OF KENT	<50
001905	BETHEL COLLEGE	<50
008908	UNIVERSITY OF BIRMINGHAM (THE)	<50
001908	CENTRAL CHRISTIAN COLLEGE OF KANSAS	<50
009932	Texas State Technical College West Texas	<50
001914	DONNELLY COLLEGE	<50
010157	CARDIFF UNIVERSITY	<50
001567	Gainesville State College	<50
001597	TRUETT MCCONNELL UNIVERSITY	<50
022736	QUEEN'S UNIVERSITY OF BELFAST (THE)	<50
001600	WESLEYAN COLLEGE	<50
007590	Lakeland Medical & Dental Academy	<50
033333	MEDICAL UNIVERSITY OF LUBLIN	<50
001939	NEWMAN UNIVERSITY	<50
002248	CRANBROOK ACADEMY OF ART	<50
001061	ALASKA PACIFIC UNIVERSITY	<50
002253	DAVENPORT UNIVERSITY—EASTERN REGION	<50
001062	SHELDON JACKSON COLLEGE	<50

Denied Borrower Defense Applications by Institution as of May 2022

Note: Totals may not sum due to rounding.—Continued

OPEID	Primary School Name	Pending Applications
034567	Crossroads Bible College	<50
001945	STERLING COLLEGE	<50
010599	INSTITUT D'ETUDES POLITIQUES DE PARIS	<50
023473	UNIVERSIDAD DE CIENCIAS MEDICAS (UCIMED)	<50
020979	University of New Hampshire School of Law	<50
001487	ECKERD COLLEGE	<50
033503	BOURNEMOUTH UNIVERSITY	<50
001953	ASBURY THEOLOGICAL SEMINARY	<50
010816	KINGSTON UNIVERSITY	<50
012732	Laurel Technical College	<50
001684	GREENVILLE UNIVERSITY	<50
025457	GLASGOW SCHOOL OF ART	<50
001961	CENTRE COLLEGE OF KENTUCKY	<50
030294	UNIVERSITY OF KEELE	<50
	Grand Total	201,900

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, and 2022, 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. 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 July 14, 2022

SCHOOL/SCHOOL GROUP	DIPLOMA PROGRAM(S) IF APPLICABLE	ATTORNEY GENERAL	STATE	STATUS	SUBMISSION DATE
American Career Institute		Maura Healy	Massachusetts	Granted	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	Under Consideration	5/3/2016 7/22/2016 10/19/2016 2/13/2017 3/9/2017 4/4/2017
CEHE	Submission for discharge for students who enrolled in Colorado between 2006–2021	Phillip J. Weiser	Colorado	Under Consideration	6/30/2022
Corinthian Colleges, Inc.		Maura Healy	Massachusetts	Granted	11/30/2015
Corinthian Colleges, Inc.		Brad Schimel	Wisconsin	Granted	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	Granted	12/16/2016 6/3/2019
Corinthian Colleges, Inc.		Bob Ferguson	Washington	Granted	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	Granted	6/5/2017
	Court Reporting Institute	Bob Ferguson	Washington	Partially Granted	11/21/16
	Education Corporation of America (Virginia College, Brightwood, Brightwood Career Institute, Golf Academy of America and Ecotech Institute)	Josh Shapiro Brian E. Frosh Rob Bonta Phillip J. Weiser Jason Miyares Steve Marshall	Pennsylvania Maryland California Colorado Virginia Alabama	Under Consideration	4/28/2022
Globe University & Minnesota School of Business		Lori Swanson	Minnesota	Partially Granted	6/7/2016

Group Submissions by Attorneys General Seeking Relief for Constituents as of July 14, 2022—Continued

SCHOOL/SCHOOL GROUP	DIPLOMA PROGRAM(S) IF APPLICABLE	ATTORNEY GENERAL	STATE	STATUS	SUBMISSION DATE
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	Under Consideration	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 Aaron M. Frey Derek Schmidt Hector Balderas Josh Stein Lettitia James Maura Healey Douglas Peterson Joshua L. Kaul William Tong Aaron D. Ford Herbert Slatery, III	Colorado Oregon Minnesota District of Columbia Washington New Jersey Vermont Hawaii Maryland Idaho Illinois Pennsylvania Iowa Virginia Maine Kansas New Mexico North Carolina New York Massachusetts Nebraska Wisconsin Connecticut Nevada Tennessee		4/1/2021
Kaplan University	Medical Assistant Medical Billing and Coding	Maura Healy	Massachusetts	Under Consideration	5/6/2016 5/31/2016
Lincoln Technical Institute	Criminal Justice	Maura Healy	Massachusetts	Under Consideration	1/14/2016
New England Institute of Art/EDMC	Submission for borrowers who attended from 1999–2015	Maura Healey	Massachusetts	Under Consideration	3/25/2022

Group Submissions by Attorneys General Seeking Relief for Constituents as of July 14, 2022—Continued

SCHOOL/SCHOOL GROUP	DIPLOMA PROGRAM(S) IF APPLICABLE	ATTORNEY GENERAL	STATE	STATUS	SUBMISSION DATE
Premier Education Group	N/A	Maura Healey	Massachusetts	Under Consideration Under Consideration	October 3, 2019 November 22, 2019
Westwood College	Criminal Justice	Lisa Madigan Kwame Raoul	Illinois	Under Consideration	12/13/2016 6/3/2019
Westwood College	N/A	Phil Weiser	Colorado	Under Consideration	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. Please see the AG group submission list provided in (d).

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, and 2022, how many borrowers covered by a group discharge application are in default on their Federal student loans?

Answer. (f) 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, 2021, and 2022, how many loans of the borrowers covered by a group discharge application have been certified by the Department of Education for Treasury offset? 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 16(f), above.

Question. For each of the years 2016, 2017, 2018, 2019, 2020, 2021, and 2022, 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 16(f), above.

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 March 31, 2022, derived from LOC data recorded in the Department's eZ-Audit system and Postsecondary Education Participants System. As of March 31, 2022, the Department held LOCs and other surety from 339 institutions, totaling approximately \$587 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 March 31, 2022. The second tab provides the field definitions and descriptions of the reasons why a LOC was requested from a listed institution. The report does not provide historical context for the LOCs held as of March 31, 2022, 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.

OPE ID	Institution Name	State	Institution Type	Submission Fiscal Year	LOC Request Date	LOC Reason Requested	LOC Received Date	LOC Amount	LOC Percent Funding
04295000	Buckinghamshire New University		Foreign Public	05/07/2021	05/07/2021	Failed Numeric Test	06/25/2021	\$180,026.00	50
00836500	Concordia University		Foreign Private	04/30/2020	05/10/2021	Failed Numeric Test	05/18/2021	889,100.00	50
02235300	London Metropolitan University		Foreign Private	07/31/2019	10/21/2021	Failed Numeric Test	11/03/2021	581,702.00	50
03900300	Medical University of the Americas		Foreign For Profit	04/30/2020	12/18/2020	Failed Numeric Test	02/04/2021	1,961,452.00	10
02180500	Middlesex University		Foreign Private	07/31/2019	06/25/2020	Failed Past Performance Requirements	08/27/2020	80,595.00	10
01276600	National University of Ireland, Galway		Foreign Private	09/30/2019			11/02/2021	179,609.00	10
02087900	Oxford Brookes University		Foreign Private	07/31/2019			06/07/2021	650,557.00	50
04075300	Quest University Canada		Foreign Private	04/30/2020	04/15/2021	Failed Numeric Test	05/20/2021	278,835.00	50
01059400	Richmond, The American International University in London		Foreign Private	07/31/2019	07/23/2020	Failed Past Performance Requirements	01/11/2021	376,231.00	10
03824300	Royal Veterinary College (The), University of London		Foreign Private	07/31/2020	03/12/2021	Failed Past Performance Requirements	04/27/2021	1,555,221.00	10
03780300	Saba University School of Medicine		Foreign For Profit	04/30/2020	12/18/2020	Failed Numeric Test	02/04/2021	1,693,419.00	10
02233300	St. George's University, School of Medicine		Foreign For Profit	06/30/2020	05/17/2021	Failed Numeric Test	06/15/2021	35,827,740.00	10
03974300	St. George's University, School of Veterinary Medicine		Foreign For Profit	06/30/2020	05/17/2021	Failed Numeric Test	06/15/2021	4,517,661.00	10
03764300	St. Matthew's University School of Medicine		Foreign For Profit	04/30/2020	12/18/2020	Failed Numeric Test	02/04/2021	854,655.00	10
04275700	Staffordshire University		Foreign Private	04/30/2020	03/01/2021	Failed Numeric Test	06/29/2021	240,744.00	50
00858600	Swansea University		Foreign Private	07/31/2019	07/24/2020	Failed Past Performance Requirements	09/28/2020	110,772.00	10
00670400	University College Cork		Foreign Private	09/30/2019			08/07/2020	150,509.00	10

01018800	University College Dublin, National University of Ireland, Dublin		Foreign Private	09/30/2019	03/06/2020	Failed Past Performance Requirements	08/28/2020	1,300,626.00	10
03728300	University of Derby		Foreign Private	07/31/2018	03/28/2019	Failed Past Performance Requirements	03/28/2019	38,262.00	10
00684200	University of Dublin Trinity College		Foreign Private	09/30/2019			07/23/2021	429,909.00	10
03045000	University of East London		Foreign Private	07/31/2019	01/14/2021	Failed Past Performance Requirements	03/05/2021	375,189.00	10
00868700	University of Essex		Foreign Private	07/31/2019	07/15/2020	Failed Past Performance Requirements	08/25/2020	312,501.00	10
01045600	University of Haifa		Foreign Private	09/30/2018	03/01/2018	Failed Past Performance Requirements	05/01/2018	25,862.00	10
02229100	University of Leicester		Foreign Private	07/31/2020	05/15/2021	Failed Numeric Test	07/09/2021	326,390.00	50
03084300	University of Limerick		Foreign Private	09/28/2021			09/28/2021	167,476.00	10
00669400	University of London—School of Oriental & African Studies		Foreign Private	07/31/2019	08/10/2020	Failed Numeric Test	06/15/2021	372,092.00	10
04230700	University of the Highlands and Islands		Foreign Private	07/31/2020	03/22/2021	Failed Numeric Test	04/28/2021	173,766.00	50
03945300	University of West London (The)		Foreign Private	07/31/2020	05/15/2021	Failed Numeric Test	05/18/2021	314,737.00	50
04138600	Alaska Christian College	AK	Non Profit	05/31/2020	05/17/2021	Failed Past Performance Requirements	06/29/2021	69,945.00	10
02341000	Fortis College	AL	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,351,760.00	15
03361400	Fortis College	AL	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	540,768.00	15
00105000	Tuskegee University	AL	Non Profit	06/30/2019	09/29/2020	Untimely Refunds	11/17/2020	8,126.00	25
00109500	Crowley's Ridge College	AR	Non Profit	06/30/2020			12/21/2021	170,000.00	10
04233100	Arizona School of Integrative Studies	AZ	Proprietary	04/30/2019			09/14/2020	278,992.00	25
04175300	Penrose Academy	AZ	Proprietary	12/31/2020	02/09/2022	New Owner Missing 2 yrs of Audited Financial Statement	02/16/2022	512,893.00	25

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01168900	Refrigeration School (The)	AZ	Proprietary	09/30/2020	12/15/2021	Failed Numeric Test	12/28/2021	4,800,032.00	10
04244900	Sonoran Desert Institute	AZ	Proprietary	12/31/2020	03/09/2022	Failed Numeric Test	02/24/2022	2,896,951.00	27
03736300	Advance Beauty College	CA	Proprietary	12/31/2019	07/07/2020	Untimely Refunds	07/20/2020	11,428.00	25
04206800	Advance Beauty Techs Academy	CA	Proprietary	12/31/2020	06/29/2021	Failed Past Performance Requirements	08/04/2021	140,477.00	15
04206800	Advance Beauty Techs Academy	CA	Proprietary	12/31/2020	06/29/2021	Failed Past Performance Requirements	12/27/2018	48,145.00	5
04243100	Alhambra Medical University	CA	Proprietary	12/31/2019	02/02/2022	Failed Past Performance Requirements	03/01/2022	35,770.00	10
04227100	America Evangelical University	CA	Non Profit	06/30/2020	02/05/2021	Failed Past Performance Requirements	03/09/2021	9,132.00	10
04265600	American Fitness and Nutrition Academy	CA	Proprietary	12/31/2019	04/22/2021	Failed Numeric Test	09/21/2021	14,243.00	10
04159700	American Medical Sciences Center	CA	Proprietary	12/31/2019	01/07/2021	Failed Numeric Test	04/27/2021	90,942.00	10
03532400	ATA College	CA	Proprietary	12/31/2020	01/05/2022	Failed Numeric Test	03/10/2022	68,626.00	10
03740400	ATI College	CA	Proprietary	12/31/2020	05/19/2021	Failed Past Performance Requirements	06/11/2021	52,565.00	10
04223700	Bay Area Medical Academy	CA	Proprietary	12/31/2020	12/29/2021	Failed Numeric Test	01/04/2022	172,069.00	15
02218800	Brookline College	CA	Proprietary		07/31/2020	New Owner Missing 2 yrs of Audited Financial Statement	08/25/2020	8,497,839.00	25
04277700	California College of Barbering and Cosmetology	CA	Proprietary	12/31/2020			12/29/2020	18,027.00	25
03097700	Central California School of Continuing Education	CA	Proprietary	12/31/2019	10/09/2020	Untimely Refunds	11/17/2020	13,329.00	25
00116500	Church Divinity School of the Pacific	CA	Non Profit	06/30/2019			08/18/2021	254,189.00	50

00128800	Claremont School of Theology	CA	Non Profit	06/30/2020	08/16/2021	Failed Numeric Test	09/27/2021	988,781.00	50
03874400	Community Christian College	CA	Non Profit	06/30/2019	11/09/2020	Failed Numeric Test	02/02/2021	294,114.00	50
04175400	Elite Cosmetology School	CA	Proprietary	03/31/2021			05/07/2020	15,201.00	25
00120000	Fuller Theological Seminary	CA	Non Profit	06/30/2020	05/25/2021	Untimely Refunds	06/22/2021	37,792.00	25
04141700	Healing Hands School of Holistic Health	CA	Proprietary	12/31/2019	05/17/2021	Untimely Refunds	07/16/2021	8,979.00	25
04217500	J D Academy of Salon and Spa	CA	Proprietary	12/31/2019	10/09/2020	New Owner Missing 2 yrs of Audited Financial Statement	12/15/2020	192,562.00	25
04001300	Los Angeles College of Aesthetics	CA	Proprietary		02/28/2022	New Owner Missing 2 yrs of Audited Financial Statement	03/22/2022	161,819.00	25
04037300	Los Angeles Film School (The)	CA	Proprietary	12/31/2020	12/10/2021	Untimely Refunds	01/18/2021	713,469.00	25
01186600	Lu Ross Academy	CA	Proprietary	12/31/2020	09/29/2021	Failed Numeric Test	11/29/2021	729,205.00	50
02161800	Musicians Institute	CA	Proprietary	09/30/2020	08/01/2021	Failed Numeric Test	08/24/2021	1,187,454.00	10
03027700	Pacific College of Health and Science	CA	Proprietary	12/31/2020	09/01/2021	Untimely Refunds	10/18/2021	30,649.00	25
00125800	Pacific Union College	CA	Non Profit	06/30/2019	12/14/2021	Failed Numeric Test	02/16/2022	4,565,247.00	25
03973300	SAE Expression College	CA	Proprietary	06/30/2021	01/04/2022	Failed Numeric Test	02/08/2022	1,002,608.00	25
00130200	Saint Mary's College of California	CA	Non Profit	06/30/2020	09/17/2020	Untimely Refunds	10/13/2020	9,175.00	25
01203100	San Diego Christian College	CA	Non Profit	06/30/2020	02/22/2022	Failed Numeric Test	03/08/2022	634,624.00	11
00394800	San Francisco Art Institute	CA	Non Profit	06/30/2019	07/02/2021	Other	02/18/2022	26,465.00	10
02267600	Sofia University	CA	Proprietary	06/30/2020	03/02/2021	Failed Numeric Test	04/20/2021	497,455.00	17
02267600	Sofia University	CA	Proprietary	06/30/2020	03/02/2021	Failed Numeric Test	04/20/2021	248,757.00	9
02267600	Sofia University	CA	Proprietary	06/30/2020	03/02/2021	Failed Numeric Test	04/20/2021	690,540.00	24
04298200	Southern California College of Barber and Beauty	CA	Proprietary	12/31/2020	07/01/2021	Failed Numeric Test	07/30/2021	219,925.00	50

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02596400	Spartan College of Aeronautics & Technology	CA	Proprietary	12/31/2020	01/04/2022	Failed Numeric Test	01/25/2022	938,422.00	10
04195400	Unitek College	CA	Proprietary	12/31/2020			09/21/2021	1,433,089.00	25
04169700	Unitek College	CA	Proprietary	12/31/2020			09/21/2021	7,099,499.00	25
03995300	University of East-West Medicine	CA	Proprietary	12/31/2019	11/01/2021	Failed Numeric Test	11/16/2021	29,162.00	10
03171300	University of St. Augustine for Health Sciences	CA	Proprietary	12/31/2020	01/12/2022	Failed Numeric Test	01/25/2022	16,242,055.00	10
04114500	Valley College of Medical Careers	CA	Proprietary	12/31/2020	07/14/2021	Other	08/30/2021	113,101.00	10
04249600	Westcliff University	CA	Proprietary	12/31/2019	06/29/2021	Untimely Refunds	07/13/2021	23,499.00	25
04249600	Westcliff University	CA	Proprietary	12/31/2020			09/28/2021	688,744.00	10
04093300	Academy of Natural Therapy	CO	Proprietary	12/31/2019	01/25/2021	Failed Numeric Test	02/17/2021	48,071.00	10
04185000	Colorado Academy of Veterinary Technology	CO	Proprietary	12/31/2019	04/19/2021	Failed Numeric Test	07/28/2021	106,744.00	12
04185000	Colorado Academy of Veterinary Technology	CO	Proprietary	12/31/2019	04/19/2021	Failed Numeric Test	12/20/2018	66,996.00	7
04185000	Colorado Academy of Veterinary Technology	CO	Proprietary	12/31/2019	04/19/2021	Failed Numeric Test	12/20/2018	53,160.00	6
01157200	Colorado School of Trades	CO	Proprietary		06/02/2021	New Owner Missing 2 yrs of Audited Financial Statement	06/08/2021	242,682.00	25
04148300	Denver College of Nursing	CO	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	1,485,152.00	15
03006300	IBMC College	CO	Proprietary	12/31/2020	09/27/2021	Untimely Refunds	12/01/2021	140,520.00	25
04299100	National Institute for Medical Assistant Advancement	CO	Non Profit	06/30/2020	01/04/2022	Failed Numeric Test	01/13/2022	162,375.00	50
04218900	Rocky Vista University	CO	Proprietary	06/30/2020	05/17/2021	Failed Numeric Test	06/15/2021	6,887,740.00	10
04218900	Rocky Vista University	CO	Proprietary	06/30/2021			03/01/2022	116,774,424.00	50

00729700	Spartan College of Aeronautics and Technology	CO	Proprietary	12/31/2020	09/08/2021	Untimely Refunds	09/16/2021	9,529.00	25
00729700	Spartan College of Aeronautics and Technology	CO	Proprietary	12/31/2020	01/04/2022	Failed Numeric Test	01/25/2022	398,789.00	10
04279000	American Institute of Healthcare & Technology	CT	Proprietary		06/11/2021	New Owner Missing 2 yrs of Audited Financial Statement	06/15/2021	117,036.00	25
00730300	Lincoln Technical Institute	CT	Proprietary	12/31/2020	12/29/2021	Untimely Refunds	12/29/2021	106,360.00	25
00140100	Post University	CT	Proprietary	06/30/2020	05/26/2021	Untimely Refunds	07/09/2021	1,575,859.00	25
04148400	TIGI Hairdressing Academy Guilford	CT	Proprietary	12/31/2017	12/21/2018	New Owner Missing 2 yrs of Audited Financial Statement	04/26/2019	51,168.00	25
04142700	Pontifical John Paul II Institute for Studies on Marriage and Family	DC	Non Profit	12/31/2020	12/06/2021	Other	12/14/2021	122,204.00	50
03702300	Delaware Learning Institute of Cosmetology	DE	Proprietary	12/31/2020	05/06/2021	Failed Numeric Test	06/15/2021	58,627.00	10
00143300	Wesley College	DE	Non Profit	06/30/2019	02/12/2021	Going Concern	04/07/2021	2,784,000.00	20
03816300	Artistic Nails & Beauty Academy	FL	Proprietary	12/31/2019	06/21/2021	Untimely Refunds	07/09/2021	14,437.00	25
03801400	Beauty Institute (The)	FL	Proprietary		06/02/2021	New Owner Missing 1 yr of Audited Financial Statement	08/03/2021	7,583.00	10
04217800	Boca Beauty Academy	FL	Proprietary		08/12/2021	New Owner Missing 2 yrs of Audited Financial Statement	08/16/2021	686,954.00	25
04217800	Boca Beauty Academy	FL	Proprietary		02/25/2022	Failed Numeric Test	03/30/2022	411,810.00	10
04249400	Center for Neurosomatic Studies	FL	Proprietary	12/31/2019	06/10/2021	Failed Past Performance Requirements	08/11/2021	7,571.00	10
03434300	Fortis College	FL	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	812,903.00	15
02188900	Hobe Sound Bible College	FL	Non Profit	06/30/2019			11/22/2021	74,766.00	10
01016100	Loraines Academy & Spa	FL	Proprietary	12/31/2020	09/15/2021	Other	01/06/2022	73,577.00	10
04220200	More Tech Institute	FL	Proprietary	12/31/2020	11/10/2021	Failed Past Performance Requirements	02/16/2022	52,455.00	10

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04106300	Palm Beach Academy of Health & Beauty	FL	Proprietary	12/31/2018	08/29/2019	New Owner Missing 2 yrs of Audited Financial Statement	09/19/2019	330,565.00	25
04106300	Palm Beach Academy of Health & Beauty	FL	Proprietary	12/31/2018	09/29/2020	Untimely Refunds	12/29/2020	88,470.00	25
04120400	Paul Mitchell The School Miami	FL	Proprietary		09/03/2021	New Owner Missing 2 yrs of Audited Financial Statement	09/07/2021	214,750.00	25
04254300	Pets Playground Grooming School	FL	Proprietary		02/19/2020	New Owner Missing 2 yrs of Audited Financial Statement	02/20/2020	10,000.00	100
02314100	Schiller International University	FL	Proprietary		02/14/2020	New Owner Missing 2 yrs of Audited Financial Statement	03/03/2020	383,948.00	25
03264300	South Florida Bible College and Theological Seminary	FL	Non Profit	06/30/2020	11/16/2021	Other	01/06/2022	446,558.00	50
03549300	Ultimate Medical Academy	FL	Non Profit	12/31/2020	09/01/2021	Failed Numeric Test	10/26/2021	32,190,088.00	10
00884800	Warner University	FL	Non Profit	06/30/2020	03/11/2022	Failed Numeric Test	03/22/2022	966,762.00	10
03173300	Atlanta's John Marshall Law School	GA	Proprietary	07/31/2020	09/23/2021	Failed Past Performance Requirements	09/23/2021	1,400,451.00	10
04021300	Augusta School of Massage	GA	Proprietary	12/31/2019	02/08/2021	Failed Numeric Test	04/13/2021	54,753.00	50
04260000	Institute of Medical Ultrasound	GA	Proprietary	12/31/2019	01/05/2022	Failed Past Performance Requirements	03/01/2022	38,341.00	10
00158700	Paine College	GA	Non Profit	06/30/2020	10/19/2021	Other	10/19/2021	1,071,831.00	10
04147000	Paul Mitchell the School Atlanta	GA	Proprietary	12/31/2020	08/06/2020	Other	10/05/2021	349,860.00	10
03438300	Pacific Islands University	GU	Non Profit	06/30/2019			01/18/2022	85,991.00	24
04182200	Hawaii Medical College	HI	Proprietary	12/31/2020			03/15/2022	63,486.00	25
00184600	Briar Cliff University	IA	Non Profit	05/31/2020	09/02/2021	Untimely Refunds	11/17/2020	10,090.00	25
00186600	Graceland University	IA	Non Profit	05/31/2019	08/26/2020	Untimely Refunds	10/20/2020	42,623.00	25

00187100	Iowa Wesleyan University	IA	Non Profit	05/31/2020	06/11/2021	Failed Numeric Test	09/28/2021	514,898.00	10
00794100	Salon Professional Academy (The)	IA	Proprietary	12/31/2020	11/15/2021	Failed Past Performance Requirements	12/21/2021	69,275.00	10
00162500	Brigham Young University—Idaho	ID	Non Profit	12/31/2020	06/15/2020	Untimely Refunds	07/28/2020	168,817.00	25
04168600	College of Massage Therapy	ID	Proprietary		03/14/2022	New Owner Missing 2 yrs of Audited Financial Statement	03/30/2022	31,000.00	25
04150600	Urban 113 School of Cosmetology	ID	Proprietary		08/12/2020	New Owner Missing 2 yrs of Audited Financial Statement	08/25/2020	43,762.00	25
00162800	American Academy of Art College	IL	Proprietary	12/31/2020	10/22/2021	Failed Numeric Test	12/21/2021	301,614.00	10
03914300	CALC, Institute of Technology	IL	Proprietary		01/07/2022	New Owner Missing 2 yrs of Audited Financial Statement	03/22/2022	160,000.00	25
03078400	Cameo Beauty Academy	IL	Proprietary	12/31/2020	07/19/2021	Going Concern	01/14/2022	325,827.00	50
02349500	Cannella School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 yr of Audited Financial Statement	05/12/2021	16,953.00	10
02202600	Cannella School of Hair Design	IL	Proprietary	12/31/2019	03/25/2021	New Owner Missing 1 yr of Audited Financial Statement	05/12/2021	14,081.00	10
02556100	ETI School of Skilled Trades	IL	Proprietary	12/31/2018	11/21/2019	Failed Past Performance Requirements	03/06/2020	248,658.00	10
02556600	John Amico School of Hair Design ²	IL	Proprietary	12/31/2019	09/04/2019	Failed Past Performance Requirements	09/25/2019	12,802.00	10
00170000	Judson University	IL	Non Profit	05/31/2020	06/28/2021	Failed Numeric Test	08/11/2021	1,001,479.00	10
00171200	Lutheran School of Theology at Chicago	IL	Non Profit	06/30/2020	07/13/2021	Failed Numeric Test	10/26/2021	175,456.00	50
03368300	Midwest Technical Institute	IL	Proprietary	12/31/2020	10/19/2021	Failed Numeric Test	12/21/2021	3,760,272.00	10
03128500	National Latino Education Institute	IL	Non Profit	06/30/2018	07/08/2019	Failed Past Performance Requirements	09/27/2019	15,509.00	10
01236200	Northwestern College	IL	Proprietary	07/31/2020	05/18/2021	Failed Numeric Test	09/18/2020	1,162,580.00	10
02185400	Saint Augustine College	IL	Non Profit	06/30/2020	06/16/2021	Failed Numeric Test	09/14/2021	2,034,307.00	50

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04189200	Salon Professional Academy (The)	IL	Proprietary	12/31/2019	05/20/2021	Going Concern	06/10/2021	113,170.00	20
00166300	Sperthus College of Judaica	IL	Non Profit	06/30/2020	05/20/2021	Failed Numeric Test	08/11/2021	1,158.00	10
01181000	Taylor Business Institute	IL	Proprietary	12/31/2020	10/15/2021	Failed Numeric Test	11/02/2021	39,664.00	10
00178300	Worsham College of Mortuary Science	IL	Proprietary	12/31/2020	10/29/2021	Failed Numeric Test	12/01/2021	700,000.00	50
04258200	Christina and Company Education Center	IN	Proprietary	12/31/2018	09/05/2019	Failed Past Performance Requirements	12/19/2019	2,291.00	10
04256100	Indiana College of Sports & Medical Massage	IN	Proprietary	12/31/2019	03/24/2021	Failed Numeric Test	06/14/2021	83,432.00	10
04246600	Textures Institute of Cosmetology	IN	Proprietary	12/31/2017	03/07/2019	Failed Past Performance Requirements	04/05/2019	26,800.00	10
00190400	Bethany College	KS	Non Profit	06/30/2020	10/14/2021	Failed Numeric Test	10/20/2021	788,371.00	10
00190800	Central Christian College of Kansas	KS	Non Profit	06/30/2020	09/27/2021	Failed Numeric Test	10/05/2021	692,002.00	10
02168900	Kansas Christian College	KS	Non Profit	06/30/2020	12/07/2021	Failed Numeric Test	12/07/2021	127,799.00	10
04205300	Mitsu Sato Hair Academy	KS	Proprietary	12/31/2020	08/17/2021	Failed Past Performance Requirements	08/31/2021	75,279.00	10
00194000	Southwestern College	KS	Non Profit	06/30/2020	07/11/2021	Failed Numeric Test	07/29/2021	1,290,263.00	10
01050300	Wichita Technical Institute	KS	Proprietary	12/31/2019	08/26/2020	Untimely Refunds	09/18/2020	28,966.00	25
04038300	ATA College	KY	Proprietary	09/30/2021	04/14/2022	Failed Past Performance Requirements	03/15/2022	2,072,183.00	12
03083700	Galen Health Institutes	KY	Proprietary		03/03/2021	Other	07/28/2021	42,455,916.00	40
03083700	Galen Health Institutes	KY	Proprietary		12/31/2021	Other	03/01/2022	8,115,412.00	10
02526100	Jenny Lea Academy of Cosmetology	KY	Proprietary		09/14/2021	New Owner Missing 2 yrs of Audited Financial Statement	11/16/2021	25,341.00	25

04249000	Medical Career and Technical College	KY	Proprietary	06/30/2016	08/28/2017	Failed Past Performance Requirements	09/11/2017	62,711.00	10
03294300	Blue Cliff College	LA	Proprietary	12/31/2020	01/10/2022	Failed Numeric Test	01/25/2022	2,900,674.00	10
03480300	Fortis College	LA	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,520,238.00	15
02554800	Vanguard College of Cosmetology A Paul Mitchell Partner School/Metairie	LA	Proprietary		10/01/2021	New Owner Missing 2 yrs of Audited Financial Statement	10/12/2021	596,463.00	25
00215100	Benjamin Franklin Institute of Technology	MA	Non Profit	06/30/2019	08/04/2020	Failed Numeric Test	10/06/2020	480,760.00	10
03248300	Boston Baptist College	MA	Non Profit	06/30/2020	01/18/2022	Failed Numeric Test	01/13/2020	77,165.00	25
02274300	Conway School of Landscape Design	MA	Non Profit	06/30/2019	12/14/2020	Failed Past Performance Requirements	09/16/2019	37,915.00	10
04116900	DiGrigoli School of Cosmetology	MA	Proprietary	12/31/2020	11/05/2021	Failed Past Performance Requirements	12/22/2021	26,673.00	10
00215400	Hellenic College & Holy Cross Greek Orthodox School of Theology	MA	Non Profit	06/30/2019	11/12/2020	Failed Past Performance Requirements	10/18/2018	189,199.00	15
00220100	Pine Manor College	MA	Non Profit	06/30/2020	11/16/2021	Other	12/21/2021	525,683.00	15
00632200	Signature Healthcare Brockton Hospital School of Nursing	MA	Non Profit	09/30/2019	06/12/2020	Failed Numeric Test	11/17/2020	194,922.00	10
03130500	Urban College of Boston	MA	Non Profit	08/31/2017	08/27/2018	Failed Past Performance Requirements	12/07/2018	165,364.00	10
03493300	All-State Career	MD	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,717,579.00	15
01031900	Fortis Institute—Towson	MD	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	8,198,786.00	15
03822400	Maple Springs Baptist Bible College & Seminary	MD	Non Profit	06/30/2013			01/21/2015	7,000.00	10
00223400	Adrian College	MI	Non Profit	06/30/2021	03/02/2022	Failed Numeric Test	11/02/2021	1,886,250.00	10
03005700	Detroit Business Institute—Downriver	MI	Proprietary	06/30/2021	01/07/2022	New Owner Missing 1 yr of Audited Financial Statement	01/25/2022	162,627.00	10

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02588200	Douglas J Aveda Institute	MI	Proprietary	12/31/2020	09/28/2021	Untimely Refunds	10/06/2021	36,674.00	25
00232200	Finlandia University	MI	Non Profit	06/30/2020	10/26/2021	Failed Numeric Test	12/07/2021	445,938.00	10
04280000	Great Lakes Boat Building School	MI	Non Profit	12/31/2019	02/25/2021	Failed Numeric Test	03/15/2021	26,688.00	50
03588300	Irene's Myomassology Institute	MI	Proprietary	08/31/2019	07/22/2020	Untimely Refunds	08/25/2020	19,940.00	25
01321800	M.J. Murphy Beauty College	MI	Proprietary	12/31/2018	12/04/2019	Failed Past Performance Requirements	11/25/2019	29,075.00	10
00228200	Madonna University	MI	Non Profit	06/30/2020	09/27/2021	Untimely Refunds	10/13/2021	23,813.00	25
00894600	Port Huron Cosmetology College	MI	Proprietary	12/31/2019	11/05/2020	Failed Numeric Test	03/04/2021	20,964.00	10
00228800	Rochester University	MI	Non Profit	05/31/2020	02/11/2021	Failed Numeric Test	03/02/2021	774,750.00	10
04138400	Salon Professional Academy (The)	MI	Proprietary	12/31/2020	04/08/2021	Failed Past Performance Requirements	06/01/2021	45,492.00	10
04255100	U.S. Truck Driver Training School	MI	Proprietary	12/31/2018	09/05/2019	Failed Numeric Test	10/15/2019	21,296.00	10
00983100	Model College of Hair Design	MN	Proprietary	12/31/2018	08/20/2019	Failed Past Performance Requirements	11/06/2019	59,787.00	10
00869400	Rasmussen University	MN	Proprietary	09/30/2020	04/02/2021	Failed Numeric Test	05/10/2021	23,071,270.00	10
02504200	Walden University	MN	Proprietary	12/31/2020	12/01/2021	Failed Numeric Test	12/16/2021	83,962,403.00	10
03110900	Academy of Beauty Professionals	MO	Proprietary		03/01/2021	New Owner Missing 2 yrs of Audited Financial Statement	03/16/2021	28,076.00	25
03110900	Academy of Beauty Professionals	MO	Proprietary	06/30/2020	05/21/2021	Failed Numeric Test	07/09/2021	29,118.00	1
04295100	AESTHETICS INSTITUTE	MO	Non Profit	12/31/2020	04/16/2021	Failed Numeric Test	05/04/2021	223,920.00	50
04118700	American Business & Technology University	MO	Proprietary	12/31/2020	11/30/2021	Failed Numeric Test	12/14/2021	101,305.00	60
04174800	American Trade School	MO	Proprietary	12/31/2019	11/29/2021	Failed Past Performance Requirements	01/25/2022	98,180.00	10

04174800	American Trade School	MO	Proprietary	12/31/2020	07/28/2021	Failed Numeric Test	07/28/2021	556,307.00	50
00244900	Avila University	MO	Non Profit	06/30/2019	01/14/2020	Untimely Refunds	01/29/2020	26,368.00	25
00246300	Evangel University	MO	Non Profit	04/30/2020	06/09/2021	Failed Numeric Test	06/29/2021	1,718,200.00	10
04173900	Evolve Beauty Academy	MO	Proprietary	12/31/2017	11/06/2018	Failed Past Performance Requirements	01/22/2019	28,533.00	15
00908900	Hannibal—LaGrange University	MO	Non Profit	06/30/2020	08/09/2021	Failed Numeric Test	10/19/2021	604,329.00	10
04130600	Healing Arts Center	MO	Proprietary	12/31/2020	01/28/2022	Other	03/22/2022	294,503.00	50
02277500	House of Heavilin Beauty College	MO	Proprietary	06/30/2020	05/21/2021	Failed Numeric Test	07/09/2021	192,873.00	8
00960700	House of Heavilin Beauty College	MO	Proprietary	06/30/2020	05/21/2021	Failed Numeric Test	07/09/2021	25,902.00	1
03519300	Missouri College of Cosmetology North	MO	Proprietary	12/31/2020	02/10/2022	Failed Numeric Test	03/30/2022	43,601.00	10
00639200	Research Medical Center	MO	Proprietary	12/31/2019	11/04/2020	Failed Numeric Test	11/23/2020	443,967.00	50
04282700	Urshan College	MO	Non Profit	06/30/2020	12/06/2021	Failed Past Performance Requirements	02/22/2022	137,065.00	10
03970400	WellSpring School of Allied Health	MO	Proprietary	06/30/2020	04/07/2021	Failed Numeric Test	06/17/2021	49,277.00	1
03970400	WellSpring School of Allied Health	MO	Proprietary	06/30/2020	04/07/2021	Failed Numeric Test	06/15/2021	188,709.00	4
03970400	WellSpring School of Allied Health	MO	Proprietary	06/30/2020	04/07/2021	Failed Numeric Test	06/22/2021	463,821.00	10
04131300	Corinth Academy of Cosmetology	MS	Proprietary	12/31/2020	09/30/2021	Untimely Refunds	09/30/2021	15,452.00	25
00243500	Southeastern Baptist College	MS	Non Profit	06/30/2018	07/17/2017	Failed Past Performance Requirements	10/04/2017	12,157.00	13
04282400	Vaughn Beauty College	MS	Proprietary	06/30/2020	04/22/2021	Failed Numeric Test	06/22/2021	51,725.00	50
02621300	Academy of Cosmetology	MT	Proprietary	12/31/2019	09/11/2020	Failed Past Performance Requirements	12/28/2018	13,285.00	10
04163700	Bitterroot School of Cosmetology	MT	Proprietary	12/31/2020			10/12/2021	20,574.00	10
04249900	Yellowstone Christian College	MT	Non Profit	06/30/2019	02/24/2020	Failed Numeric Test	05/08/2020	133,500.00	50

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03570300	Carolina Christian College	NC	Non Profit	06/30/2019	11/06/2020	Going Concern	01/12/2021	49,200.00	5
03570300	Carolina Christian College	NC	Non Profit	06/30/2019	08/01/2021	Going Concern	08/14/2021	51,861.00	5
00292700	Elon University	NC	Non Profit	05/31/2019	08/03/2020	Untimely Refunds	08/14/2020	93,621.00	25
00294800	Montreat College	NC	Non Profit	06/30/2019	06/25/2020	Failed Numeric Test	08/03/2021	849,790.00	10
01179900	Paul Mitchell The School Fayetteville	NC	Proprietary	09/30/2020	09/27/2021	Failed Numeric Test	12/21/2021	3,501,787.00	50
00295500	Pfeiffer University	NC	Non Profit	06/30/2020	09/01/2021	Failed Numeric Test	11/09/2021	7,111,351.00	50
00296000	Salem College	NC	Non Profit	06/30/2016	06/21/2017	Failed Past Performance Requirements	09/06/2017	961,226.00	10
04173000	Shepherds Theological Seminary	NC	Non Profit	06/30/2020	04/02/2021	Failed Numeric Test	06/01/2021	59,667.00	50
04139400	Hair Academy (The)	ND	Proprietary		02/09/2022	New Owner Missing 2 yrs of Audited Financial Statement	02/10/2022	110,700.00	25
01040600	Josef's School of Hair, Skin & Body	ND	Proprietary	12/31/2019	09/18/2020	Failed Numeric Test	03/16/2021	126,640.00	10
04234400	American Institute of Alternative Medicine	NJ	Proprietary	12/31/2019	01/24/2021	Failed Past Performance Requirements	03/03/2022	5,000.00	59
04181400	Best Care College	NJ	Proprietary	12/31/2020	01/14/2022	Failed Past Performance Requirements	02/25/2022	145,156.00	10
02132300	Fortis Institute	NJ	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,504,992.00	15
01246100	Lincoln Technical Institute	NJ	Proprietary	12/31/2020	12/29/2021	Untimely Refunds	12/29/2021	493,660.00	25
04271600	Avenue Academy, A Cosmetology Institute (The)	NM	Proprietary	12/31/2019	05/18/2021	Failed Numeric Test	07/09/2021	60,207.00	10
04259300	Burrell College of Osteopathic Medicine	NM	Proprietary	06/30/2021	02/10/2022	New Owner Missing 2 yrs of Audited Financial Statement	02/22/2022	4,515,149.00	25
02622000	Southwest Acupuncture College	NM	Proprietary	12/31/2020	12/10/2021	Failed Past Performance Requirements	12/21/2021	65,081.00	10

04156000	Academy of Cosmetology & Esthetics NYC (The)	NY	Proprietary			09/08/2021	New Owner Missing 2 yrs of Audited Financial Statement	09/15/2021	86,134.00	25
03903400	American Beauty School	NY	Proprietary			06/16/2021	New Owner Missing 2 yrs of Audited Financial Statement	09/28/2021	229,906.00	25
00751800	Apex Technical School	NY	Proprietary			10/20/2020	New Owner Missing 1 yr of Audited Financial Statement	10/06/2020	1,078,463.00	10
04223100	ARRJO Cosmetology School	NY	Proprietary		12/31/2019	06/21/2021	Going Concern	07/27/2021	97,509.00	10
04234200	Center for Ultrasound Research & Education	NY	Proprietary		12/31/2018	10/25/2019	Failed Past Performance Requirements	02/14/2020	61,654.00	10
04282800	Glasgow Caledonian New York College	NY	Non Profit		07/31/2018	04/08/2019	Failed Numeric Test	05/29/2019	410,000.00	50
01302600	Machzikei Hadath Rabbinical College	NY	Non Profit		12/31/2019	05/03/2021	Failed Past Performance Requirements	06/29/2021	80,744.00	10
02182200	New School Center for Media	NY	Proprietary		12/31/2019	03/22/2021	Failed Numeric Test	05/04/2021	177,029.00	50
03203300	New York Institute of Massage	NY	Proprietary		12/31/2020	02/10/2022	Untimely Refunds	03/03/2022	10,670.00	25
01055100	New York School for Medical & Dental Assistants	NY	Proprietary		06/30/2019	03/26/2021	Untimely Refunds	05/20/2021	25,593.00	25
04190500	New York School of Esthetics & Day Spa	NY	Proprietary			02/23/2022	New Owner Missing 2 yrs of Audited Financial Statement	02/25/2022	122,502.00	25
00267400	New York Theological Seminary	NY	Non Profit		06/30/2020	11/09/2021	Failed Numeric Test	11/09/2021	311,847.00	10
00279000	Nyack College	NY	Non Profit		06/30/2020	04/29/2021	Failed Numeric Test	10/26/2021	1,870,252.00	12
00643800	Phillips School of Nursing at Mount Sinai Beth Israel	NY	Non Profit		12/31/2019	04/13/2021	Failed Numeric Test	06/01/2021	999,946.00	50
00397800	Rabbinical Seminary of America	NY	Non Profit		12/31/2019	01/20/2021	Failed Numeric Test	04/27/2021	140,735.00	50
00646100	Saint Elizabeth Medical Center	NY	Non Profit		12/31/2019	04/09/2021	Failed Numeric Test	05/04/2021	176,583.00	10
02556700	Seminar L Moros Bais Yaakov	NY	Non Profit		08/31/2019	08/09/2021	Failed Past Performance Requirements	01/17/2022	138,347.00	10
04179800	Sotheby's Institute of Art—NY	NY	Proprietary		08/31/2019	12/16/2021	Other	02/16/2022	418,333.00	50

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01236400	St. Paul's School of Nursing	NY	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	1,279,712.00	15
00947900	St. Paul's School of Nursing	NY	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	1,240,355.00	15
02170000	Swedish Institute	NY	Proprietary	12/31/2020	01/12/2022	Failed Numeric Test	01/31/2022	1,397,089.00	10
01224800	Central School of Practical Nursing	OH	Non Profit	12/31/2019	01/14/2021	Failed Numeric Test	03/02/2021	361,667.00	50
01090600	Cincinnati College of Mortuary Science	OH	Non Profit	06/30/2019	03/29/2021	Disclaimer	05/12/2021	99,022.00	10
04254900	Cincinnati School of Barbering & Hair Design	OH	Proprietary	12/31/2020	11/22/2021	Failed Past Performance Requirements	12/28/2021	17,492.00	10
04206700	Elite Welding Academy	OH	Proprietary	09/30/2017			10/22/2018	72,824.00	10
00941200	Fortis College	OH	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,510,293.00	15
02190700	Fortis College	OH	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	2,634,376.00	15
00953000	Gerber Akron Beauty School	OH	Proprietary	06/30/2020	04/22/2020	Failed Past Performance Requirements	07/14/2017	28,613.00	10
00307200	Malone University	OH	Non Profit	06/30/2018	07/03/2019	Failed Past Performance Requirements	09/06/2019	1,600,931.00	10
02328500	Moler—Pickens Beauty College	OH	Proprietary	12/31/2019	04/08/2021	Failed Past Performance Requirements	03/03/2020	38,116.00	10
01284800	Moler Hollywood Beauty Academy	OH	Proprietary	12/31/2019	04/08/2021	Failed Past Performance Requirements	03/03/2020	46,452.00	10
03583300	Ohio Institute of Allied Health	OH	Non Profit	06/30/2019	02/05/2020	Failed Past Performance Requirements	06/18/2020	33,286.00	10
02287900	Raphael's School of Beauty Culture	OH	Proprietary	12/31/2020	01/20/2022	Untimely Refunds	03/01/2022	40,533.00	25
02315500	Toledo Academy of Beauty	OH	Proprietary	08/31/2019	04/12/2021	New Owner Missing 1 yr of Audited Financial Statement	06/01/2021	30,433.00	10
00311600	University of Rio Grande	OH	Non Profit	06/30/2020	08/20/2021	Failed Numeric Test	09/14/2021	949,000.00	10

00314100	Wilberforce University	OH	Non Profit	06/30/2019	07/07/2020	Going Concern	10/23/2020	1,242,320.00	10
04144400	Academy of Hair Design (The)	OK	Proprietary	12/31/2020	12/01/2021	Failed Numeric Test	12/07/2021	338,791.00	50
00314700	Bacone College	OK	Non Profit	07/31/2020	12/15/2021	Going Concern	01/10/2022	213,188.00	10
00314700	Bacone College	OK	Non Profit	07/31/2020	12/20/2021	Untimely Refunds	01/18/2022	36,028.00	25
03367400	Community Care College	OK	Non Profit	06/30/2020			01/06/2022	1,236,640.00	10
00970800	Elite Academy of Cosmetology	OK	Proprietary	12/31/2018	06/20/2019	Failed Past Performance Requirements	09/03/2019	98,729.00	10
02531200	Formations Institute	OK	Proprietary	12/31/2019	07/02/2021	New Owner Missing 1 yr of Audited Financial Statement	07/09/2021	43,460.00	10
04224700	JB's Hair Design and Barber College	OK	Proprietary	12/31/2019	04/01/2021	Failed Numeric Test	06/15/2021	29,414.00	10
00318000	Southwestern Christian University	OK	Non Profit	06/30/2020	11/05/2021	Going Concern	11/22/2021	419,077.00	10
00767800	Spartan College of Aeronautics and Technology	OK	Proprietary	12/31/2020	01/04/2022	Failed Numeric Test	01/25/2022	1,164,434.00	15
00961800	Tulsa Welding School	OK	Proprietary	09/30/2020	12/15/2021	Failed Numeric Test	12/28/2021	1,096,813.00	10
03074500	East West College of The Healing Arts	OR	Proprietary	06/30/2020	03/08/2021	Failed Numeric Test	07/21/2021	126,631.00	10
02495500	All-State Career School	PA	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	1,106,125.00	15
04127500	CDE Career Institute	PA	Proprietary	12/31/2019	03/18/2021	Failed Past Performance Requirements	12/04/2019	401,000.00	10
00966400	Empire Beauty School	PA	Proprietary	06/30/2021	09/09/2021	Other	10/13/2021	211,716.00	10
03011600	Fortis Institute	PA	Proprietary	06/30/2020	06/01/2021	Failed Numeric Test	06/23/2021	505,172.00	15
00328000	Keystone College	PA	Non Profit	05/31/2019	06/26/2020	Failed Numeric Test	07/31/2021	1,395,000.00	10
00777900	Lansdale School of Business	PA	Proprietary	08/31/2020	07/16/2021	Going Concern	01/18/2022	492,113.00	50
04288000	Rapha School (The)	PA	Proprietary	12/31/2019	02/24/2021	Failed Numeric Test	04/08/2021	158,450.00	100
00657800	Sharon Regional School of Nursing	PA	Proprietary	12/31/2019	05/03/2021	Failed Numeric Test	05/18/2021	243,000.00	10

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02192800	Walnut Hill College	PA	Proprietary	12/31/2019	08/21/2020	Failed Numeric Test	10/13/2020	372,443.00	10
03469300	Ivaem College	PR	Proprietary		01/20/2022	New Owner Missing 2 yrs of Audited Financial Statement	03/15/2022	31,371.00	25
04240900	PPG Technical College	PR	Proprietary		11/04/2021	New Owner Missing 2 yrs of Audited Financial Statement	06/08/2021	228,517.00	25
03638300	Roslyn Training Academy of Cosmetology	PR	Proprietary	12/31/2019	04/22/2021	Going Concern	06/15/2021	39,090.00	50
02588600	Seminario Evangelico de Puerto Rico	PR	Non Profit	12/31/2019	08/04/2021	Failed Past Performance Requirements	09/29/2021	29,957.00	10
03531300	Universidad Pentecostal Mizpa	PR	Non Profit	06/30/2020	01/24/2022	Failed Numeric Test	03/14/2022	310,069.00	50
04239000	B-Unique Beauty and Barber Academy	SC	Proprietary	12/31/2018	09/26/2019	Failed Past Performance Requirements	06/04/2019	22,936.00	10
00405700	National American University	SD	Proprietary	05/31/2020	06/17/2021	Failed Numeric Test	06/29/2021	4,755,426.00	10
04253100	Allied Health Careers Institute	TN	Proprietary	12/31/2020	12/16/2021	Failed Past Performance Requirements	02/16/2022	25,000.00	10
02257400	Arnold's Beauty School	TN	Proprietary	12/31/2020	02/05/2019	Failed Past Performance Requirements	04/05/2019	43,902.00	10
03008800	Brillare Beauty Institute	TN	Non Profit	12/31/2020	09/20/2021	Untimely Refunds	03/02/2021	8,462.00	25
00348100	Carson—Newman University	TN	Non Profit	07/31/2020	11/30/2022	Failed Numeric Test	12/01/2021	2,266,541.00	10
00348200	Christian Brothers University	TN	Non Profit	05/31/2019	05/27/2020	Untimely Refunds	08/25/2020	12,660.00	25
02275000	Jenny Lea Academy of Cosmetology	TN	Proprietary	12/31/2020	09/14/2021	New Owner Missing 2 yrs of Audited Financial Statement	12/21/2021	289,688.00	25
04246500	Massage Institute of Memphis (The)	TN	Proprietary	12/31/2019	03/31/2021	Failed Numeric Test	07/29/2021	56,826.00	50
04223900	Mind Body Institute	TN	Proprietary	06/30/2020	03/05/2021	Other	08/19/2021	136,452.00	50
04246100	Nashville Film Institute	TN	Proprietary	12/31/2020	01/05/2022	Failed Numeric Test	03/01/2022	38,745.00	10

02153100	Paul Mitchell the School Murfreesboro	TN	Proprietary	12/31/2020			03/01/2022	20,796.00	25
03830300	SAE Institute of Technology	TN	Proprietary	06/30/2021	01/04/2022	Failed Numeric Test	01/25/2022	5,150,692.00	25
00352800	Union University	TN	Non Profit	07/31/2020	12/15/2021	Untimely Refunds	01/12/2022	9,308.00	25
01155300	William R Moore College of Technology	TN	Non Profit	08/31/2020	11/15/2021	Failed Past Performance Requirements	02/16/2022	51,175.00	10
03513500	Williamson Christian College	TN	Non Profit	06/30/2020	08/25/2021	Failed Numeric Test	10/12/2021	105,241.00	50
04267200	Allgood Beauty Institute	TX	Proprietary	12/31/2018	01/17/2020	Untimely Refunds	12/15/2020	8,851.00	25
00660600	Baptist Health System School of Health Professions	TX	Proprietary	12/31/2019			12/21/2021	3,631,429.00	50
02058600	BK Cosmo College of Cosmetology	TX	Proprietary	12/31/2020	06/24/2021	New Owner Missing 2 yrs of Audited Financial Statement	07/13/2021	77,424.00	25
04177900	Buckner Barber School	TX	Proprietary	12/31/2020	11/04/2021	New Owner Missing 2 yrs of Audited Financial Statement	11/16/2021	22,736.00	25
04169100	Diamonds Cosmetology College	TX	Proprietary	06/30/2020	03/05/2021	New Owner Missing 1 yr of Audited Financial Statement	03/30/2021	44,233.00	10
00356400	East Texas Baptist University	TX	Non Profit	05/31/2020	05/25/2021	Untimely Refunds	07/21/2021	39,404.00	25
04277900	Houston School of Carpentry	TX	Proprietary	12/31/2019	09/10/2021	Failed Past Performance Requirements	10/26/2021	137,336.00	10
02527500	Houston Training Schools	TX	Proprietary	12/31/2020	11/17/2021	Untimely Refunds	12/07/2021	47,676.00	25
00357700	Huston—Tillotson University	TX	Non Profit	06/30/2016	06/30/2017	Failed Past Performance Requirements	02/23/2018	1,339,569.00	10
02318200	KD Conservatory College of Film and Dramatic Arts	TX	Proprietary	12/31/2020	12/10/2021	Failed Numeric Test	01/06/2022	175,608.00	10
04129800	MediaTech Institute	TX	Proprietary	12/31/2019	10/14/2021	Untimely Refunds	02/22/2022	74,937.00	25
03092600	Messenger College	TX	Non Profit	06/30/2020	04/01/2021	Failed Past Performance Requirements	06/01/2021	57,166.00	10
03422300	Milan Institute	TX	Proprietary	12/31/2016	04/19/2018	Untimely Refunds	05/22/2018	193,644.00	25

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04226400	MT Training Center	TX	Proprietary	12/31/2017	10/04/2018	Failed Past Performance Requirements	12/20/2018	146,262.00	10
01301600	Ogle School Hair Skin Nails	TX	Proprietary	12/31/2020	09/03/2021	New Owner Missing 2 yrs of Audited Financial Statement	09/21/2021	7,261,890.00	25
04168700	Peloton College	TX	Proprietary	12/31/2020	12/02/2021	Failed Past Performance Requirements	12/21/2021	281,854.00	10
02176100	Pipo Academy of Hair Design	TX	Proprietary	12/31/2018	05/30/2019	Failed Past Performance Requirements	07/20/2019	8,307.00	10
03400300	Quest College	TX	Proprietary		10/13/2021	New Owner Missing 2 yrs of Audited Financial Statement	02/08/2022	1,027,012.00	25
03026500	Remington College	TX	Non Profit		10/29/2021	Failed Numeric Test	02/17/2022	477,635.00	1
03026500	Remington College	TX	Non Profit		10/29/2021	Failed Numeric Test	02/17/2022	6,710,709.00	9
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	12/31/2020	12/15/2021	Failed Numeric Test	12/28/2021	135,670.00	50
00361800	Southwestern Christian College	TX	Non Profit	06/30/2018	06/14/2019	Failed Past Performance Requirements	10/31/2019	104,123.00	10
03035200	Tint School of Makeup & Cosmetology	TX	Proprietary	12/31/2020	07/19/2021	Failed Past Performance Requirements	08/18/2021	227,394.00	10
03714300	Trend Barber College	TX	Proprietary	12/31/2019	05/18/2021	Failed Numeric Test	07/01/2021	153,193.00	10
01202000	Victoria Beauty and Barber College	TX	Proprietary	12/31/2020	08/25/2021	Failed Numeric Test	09/14/2021	117,019.00	10
00366900	Wiley College	TX	Non Profit	06/30/2020	10/29/2021	Going Concern	11/18/2019	1,352,151.00	12
02178500	Eagle Gate College	UT	Proprietary	12/31/2020			09/21/2021	1,479,136.00	25
02556800	Paul Mitchell the School Salt Lake City	UT	Proprietary	12/31/2019	01/14/2021	Untimely Refunds	03/09/2021	35,203.00	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
02360800	Provo College	UT	Proprietary	12/31/2020			09/21/2021	1,642,182.00	25
00368100	Westminster College	UT	Non Profit	06/30/2019	10/26/2020	Untimely Refunds	11/17/2020	21,550.00	25
04180600	Appalachian College of Pharmacy	VA	Non Profit		03/25/2021	Other	05/12/2021	1,525,164.00	15
00370300	Bluefield College	VA	Non Profit		03/16/2021	Other	04/13/2021	2,046,836.00	15
04269400	Crown Cutz Academy Bristol	VA	Proprietary		12/08/2020	New Owner Missing 2 yrs of Audited Financial Statement	02/02/2021	43,172.00	25
04219000	IGlobal University	VA	Proprietary		05/27/2021	Failed Numeric Test	06/14/2021	5,738.00	10
04219000	IGlobal University	VA	Proprietary	12/31/2020	02/23/2022	New Owner Missing 2 yrs of Audited Financial Statement	02/28/2022	13,602.00	25
01274400	Southside College of Health Sciences	VA	Proprietary	12/31/2019	02/12/2021	Failed Numeric Test	03/23/2021	349,176.00	35
00865800	O'Briens Aveda Institute	VT	Proprietary	04/26/2020	01/14/2021	Failed Numeric Test	03/04/2021	250,938.00	50
02541900	BJ's Beauty & Barber College	WA	Proprietary	12/31/2020	07/16/2021	Failed Numeric Test	07/16/2021	128,555.00	25
03689400	Faith International University	WA	Non Profit	06/30/2020	04/30/2022	Failed Numeric Test	06/01/2021	687,495.00	30
04149400	Gary Manuel Aveda Institute	WA	Proprietary	12/31/2019	03/23/2021	Failed Numeric Test	12/17/2019	85,421.00	10
02203300	Gene Juarez Beauty Schools	WA	Proprietary	12/31/2020	12/21/2021	New Owner Missing 1 yr of Audited Financial Statement	02/22/2022	210,434.00	10
04191900	Paul Mitchell The School Spokane	WA	Proprietary		11/08/2021	New Owner Missing 2 yrs of Audited Financial Statement	11/16/2021	250,000.00	25
04182100	First Class Cosmetology School	WI	Proprietary	12/31/2018	01/08/2020	Untimely Refunds	02/04/2020	8,127.00	25
00387400	Nashotah House	WI	Non Profit	06/30/2019	09/02/2020	Failed Numeric Test	12/12/2018	22,808.00	10
00380600	Alderson Broadus University	WV	Non Profit	06/30/2020	07/26/2021	Failed Numeric Test	09/28/2021	2,348,198.00	15
00380800	Bethany College	WV	Non Profit	06/30/2018	11/25/2019	Failed Past Performance Requirements	07/20/2019	766,000.00	10

OPE ID	Institution Name	State	Institution Type	Submission Fiscal Year	LOC Request Date	LOC Reason Requested	LOC Received Date	LOC Amount	LOC Percent Funding
04028300	Mountain State School of Massage	WV	Proprietary	12/31/2019	05/27/2021	Failed Numeric Test	07/13/2021	148,000.00	50
00915700	WyoTech	WY	Proprietary	12/31/2020			07/13/2021	495,000.00	25

Notes Regarding the Report:

- The report identifies Letters of Credit held as of March 31, 2022.
- 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.
- In some cases, a school provided an updated LOC before ED formally requested the LOC renewal.

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.

Reason LOC Requested	Description
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 institution 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. 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, whose collapse left 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. Since Jan. 1, 2012, the Department has received 76 applications for a for-profit to nonprofit conversion. Six applications reported on our prior report have been removed because they were submitted prior to Jan. 1, 2012. Since our last report five more applications were received: one Change in Ownership (CIO) transaction occurred with the for-profit institution requesting recognition as a nonprofit institution status; two other CIO transactions occurred with the for-profit institutions requesting recognition as public institutions; one pre-acquisition review is in process for prospective

CIO transaction where the for-profit institution will intend to request recognition as a nonprofit institution, and one pre-acquisition review was completed but the actual transaction was withdrawn. Additionally, we de-duplicated a record for one school that submitted a pre-acquisition review application but where the school closed a materially different transaction.

Of those 76 applications received since Jan. 1, 2012, the Department has made final decisions on 38 conversion requests as of July 18, 2022. Of those 38 decisions, 35 conversion requests were approved.* The Department denied Argosy University's request for nonprofit recognition and denied Argosy's continued participation in the Title IV, HEA programs. 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, which allowed those institutions to continue to participate in the Title IV, HEA programs as proprietary institutions.

Regarding the remaining 38 applications that do not have an issued agency decision, 20 applications (including pre-acquisition review applications) did not require a final agency decision because the applicant institutions either closed or voluntarily withdrew their applications while the applications were under review. Consequently, there are 18 conversion applications pending a decision by the Department, including 17 applications for CIO transactions which have occurred, and one pre-acquisition review application for a future anticipated conversion transaction.

*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 CIO transaction involving Kaplan University and Purdue University resulted in Kaplan University's conversion to a public institution status rather than to a nonprofit institution status.

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
0016200	American Academy of Art	North Central Association of Colleges and Schools (Higher Learning Commission).	American Academy of Art, Inc.—Richard Otto—100% owner.	363778650	Council on Postsecondary Education, Inc. (changed name to American Academy of Art).	463291995	Change in Ownership occurred 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	Helms Career Institute	Council on Occupational Education (COE).	American Professional Institute.	582641179	Godwill Industries of Middle Georgia, Inc..	581249883	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	Dallas Nursing Institute	Accrediting Bureau of Health Education Schools (ABHES).	ATI, Inc.	752060087	TCS Education—Texas, Inc.	364769556	Change in Ownership and conversion—Approved PPPA issued 12/29/14.	10/18/2013		12/29/2014	Approved	
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).	200551503	Application submitted 3/4/2021; TPPPA issued 4/21/2021; application under review.	3/4/2021	4/21/2021		Pending	
00342100	Bob Jones University	Transnational Association of Christian Colleges and Schools (TRACS).	Bob Jones University, Inc.	570360095	BJU, Inc.	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	Apex Technical School	Accrediting Commission of Career Schools and Colleges (ACCSC).	Bretton International Inc.	131949995	Fedcap Group, Inc.	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	Ashford University	WASC Senior College and University Commission (WASC).	Bridgepoint Education, Inc	595551629	University of Arizona Foundation	866060388	Application submitted 10/2/2020; application under review.	10/2/2020	1/1/2021		Pending	

00188100	Ashted University	WASC Senior College and University Commission (WSCUC)	Bridgepoint Education, Inc	595551629	AU NFP	830529332	Change of ownership and conversion application originally submitted 11/7/2018; revised transaction information submitted on 2/12/2020. In July 2019, ED issued preacquisition review letter identifying a \$103 million LOC requirement for the 2018 proposed 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
00257800	Bryant & Stratton College	Middle States Commission on Higher Education.	Bryant & Stratton College, Inc..	180364420	Prelice Family Foundation, Inc.	202557112	Application submitted 2/26/2020; application under review.	2/26/2020	12/10/2020	Pending
02110800	California College San Diego.	Accrediting Commission of Career Schools and Colleges (ACCSC).	California College San Diego, Inc..	562564005	Center for Excellence in Higher Education.	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 PPPAs issued 12/19/18.	11/7/2012	12/19/2018	Approved—Inst Closed
00489000	Central Penn College	Middle States Commission on Higher Education.	Central Pennsylvania Business School, Inc./Central Penn, Inc. Employee Stock Ownership Plan Trust.	231857027 235527882	Central Penn 1801	822896768	Abbreviated pre-acquisition review determination letter issued 6/11/2021; transaction closing scheduled for 8/22/2021.	3/26/2021		Pending—Pre-acq
00489000	Central Penn College	Middle States Commission on Higher Education.	Central Pennsylvania Business School, Inc./Central Penn, Inc. Employee Stock Ownership Plan Trust.	231857027 235527882	Central Pennsylvania Educational Institution.	821929393	Application submitted 12/14/2018. Institution requested application be purged 9/6/19.	12/14/2018		Withdrawn

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
03120300	CollegAmerica Arizona ...	Accrediting Commission of Career Schools and Colleges (ACCSC).	CollegAmerica Arizona, Inc...	84611427	Center for Excellence in Higher Education.	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 PPPAs issued 12/19/16.	11/7/2012		12/19/2018	Approved—Inst Closed	
02594300	CollegAmerica Denver	Accrediting Commission of Career Schools and Colleges (ACCSC).	CollegAmerica Denver, Inc...	84125827	Center for Excellence in Higher Education.	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 PPPAs issued 12/19/16.	11/7/2012		12/19/2018	Approved—Inst Closed	
01274400	Southside College of Health Sciences.	Accrediting Bureau of Health Education Schools (ABHES).	Community Health Systems, Inc.	133893191	Bon Secours Mercy Health, Inc.	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	Everest University—Orlando, FL	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPPA issued 7/24/15.	4/10/2014		7/24/2015	Approved	
00450700	Everest College—Thompson, CO.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPPA issued 7/24/15; Institution closed 6/30/15.	4/10/2014		7/24/2015	Approved—Inst Closed	6/30/2019
02237500	Everest College—Henderson, NV.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPPA issued 7/24/15. Sold by Zenith to for-profit owner, Nevada Career Education, Inc. on 11/9/16.	4/10/2014		7/24/2015	Approved	
00915700	WyTech—Laramie, WY ...	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPPA issued 7/24/15. Sold by Zenith to for-profit owner, 083108 Enterpriss LLC on 7/1/16.	4/10/2014		7/24/2015	Approved	

00450300	Everest College—Colorado Springs CO.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest Institute—Pittsburgh, PA.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest College—Portland, OR.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest College—Newport News, VA.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest Institute—Southfield, MI.	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest College—Shake, IL.	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest College—Springfield, MO.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest Institute—San Antonio, TX.	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	Everest College—Bremerton, WA.	Accrediting Council for Independent Colleges and Schools (ACICS).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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	WyTech—Ormond Beach, FL.	Accrediting Commission of Career Schools and Colleges (ACCSC).	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	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

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit	TIN (Non Profit)	Current Status	Application Date	TPPA Date	PPA Date	Status	Closed Date
02606200	Everest College—Renton, WA	Accrediting Commission of Career Schools and Colleges (ACCSC)	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPA issued 7/24/15; Institution closed 7/29/16.	4/10/2014		7/24/2015	Approved—Inst Closed	7/25/2016
02617500	Everest College—Seattle, WA	Accrediting Council for Independent Colleges and Schools (ACICS)	Corinthian Colleges, Inc. ..	330717312	Zenith Education Group, Inc.	472237488	Change in Ownership and conversion—Approved PPA issued 7/24/15; Institution closed 9/30/18.	4/10/2014		7/24/2015	Approved—Inst Closed	9/30/2018
03367400	Community Care College ..	Accrediting Commission of Career Schools and Colleges (ACCSC)	Dental Directions, Inc.—Teesa Knox—100% owner.	731480285	Community HigherEd Institute ..	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	Remington College—Tampa, FL	Accrediting Commission of Career Schools and Colleges (ACCSC)	Education America, Inc. ...	710641858	Remington College	273339369	Change in Ownership and conversion—Approved PPA 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	Remington College—Cleveland, OH	Accrediting Commission of Career Schools and Colleges (ACCSC)	Education America, Inc. ...	710641858	Remington College	273339369	Change in Ownership and conversion—Approved PPA 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	Remington College—Mobile, AL	Accrediting Commission of Career Schools and Colleges (ACCSC)	Education America, Inc. ...	710641858	Remington College	273339369	Change in Ownership and conversion—Approved PPA 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	Remington College—Houston, TX	Accrediting Commission of Career Schools and Colleges (ACCSC)	Education America, Inc. ...	710641858	Remington College	273339369	Change in Ownership and conversion—Approved PPA issued 12/15/11.	11/16/2010		12/15/2011	Approved	
03012100	Remington College—Colorado Springs, CO	Accrediting Council for Independent Colleges and Schools (ACICS)	Education America, Inc. ...	710641858	Remington College	273339369	Change in Ownership and conversion—Approved PPA issued 12/15/11. Withdrew from Title IV 5/20/14.	11/16/2010		12/15/2011	Approved—Inst Closed	5/20/2014

02179000	Argosy University	WASC Senior College and University Commission (WSCUC)	Education Management Corporation	251119571	The Dream Center Foundation ..	412269686	Prerequisite 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 renews filed in January 2013. The Department denied Argosy's request for change of ownership and conversion to nonprofit status on February 27, 2013, thereby terminating its eligibility. In March 2013 the center 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	The Art Institute of Las Vegas (Closed 12/13/13).	Accrediting Council for Independent Colleges and Schools (ACICS)	Education Management Corporation	251119571	The Dream Center Foundation ..	412269686	Prerequisite 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 renews filed in January 2013. The institution closed due to loss of accreditation on 12/13/13. 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

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
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 ...	412269686	Pracquisition 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	The Art Institute of Colorado (closed 12/14/18).	Higher Learning Commission (HLC).	Education Management Corporation.	251119571	The Dream Center Foundation ...	412269686	Pracquisition 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	The Art Institute of Pittsburgh.	Middle States Commission on Higher Education.	Education Management Corporation.	251119571	The Dream Center Foundation --	412269686	Pracquisition 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 2013. 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	3/6/2019
00781900	The Art Institute of Portland (closed 12/14/18).	Northwest Commission on Colleges and Universities.	Education Management Corporation.	251119571	The Dream Center Foundation --	412269686	Pracquisition 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 2013. 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

OPE ID	Institution Name	Accreditation	Ownership as For Profit	TIN (For Profit)	Ownership as Non Profit	TIN (Non Profit)	Current Status	Application Date	TPPPA Date	PPPA Date	Status	Closed Date
0085000	The Art Institute of Philadelphia (closed 12/14/18).	Middle States Commission on Higher Education.	Education Management Corporation.	251119571	The Dream Center Foundation ...	412269686	Pracquisition 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
02291300	The Art Institute of Seattle	Northwest Commission on Colleges and Universities.	Education Management Corporation.	251119571	The Dream Center Foundation ...	412269686	Pracquisition 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	The Illinois Institute of Art (closed 12/14/18).	Higher Learning Commission (HLC).	Education Management Corporation.	251119571	The Dream Center Foundation ...	412269686	Pracquisition 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	Miami International University of Art & Design.	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation.	251119571	Educational Principles Foundation.	464265864	Prior to the institution's acquisition by EFF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EFF and conversion to nonprofit status is currently under review.	9/25/2017	2/28/2019	Pending
01303900	South University	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation.	251119571	Educational Principles Foundation.	464265864	Prior to the institution's acquisition by EFF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EFF and conversion to nonprofit status is currently under review.	1/18/2019	2/28/2019	Pending
00927000	The Art Institute of Atlanta.	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation.	251119571	Educational Principles Foundation.	464265864	Prior to the institution's acquisition by EFF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EFF and conversion to nonprofit status is currently under review.	1/18/2019	2/28/2019	Pending
02117100	The Art Institute of Houston.	Southern Association of Colleges and Schools Commission (SACS).	Education Management Corporation.	251119571	Educational Principles Foundation.	464265864	Prior to the institution's acquisition by EFF, the institution was owned by Dream Center Foundation, another nonprofit. The change of ownership to EFF and conversion to nonprofit status is currently under review.	1/18/2019	2/28/2019	Pending
02547600	Florida National University	Southern Association of Colleges and Schools Commission (SACS).	Florida National University, Inc..	650021295			Application Purged 12/20/2018	10/17/2018		Withdrawn
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..		Institution closed on March 9, 2018.			Withdrawn
00458600	Kaplan University	North Central Association of Colleges and Schools (Higher Learning Commission).	Graham Holdings Company.	530182885	Purdue University	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

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00107400	Grand Canyon University ..	Higher Learning Commission (HLC).	Grand Canyon Education, Inc...	203356009	Gazelle University (changed name to Grand Canyon University).	472507725	Grand Canyon announced the closing of its sale to a non-profit 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 3/9/2020 and 3/12/2020. 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 version on 2/22/2021 in US District Court in Arizona..	1/18/2018		11/14/2019	CIO approved—conversion to non-profit denied.	
01050900	Hallmark University	Accrediting Commission of Career Schools and Colleges (ACCS).	Hallmark Aero-Tech, LP ...	741684588	Hallmark University, Inc.	45462000	Change in Ownership and conversion—Approved PPPA issued 6/12/14.	11/15/2012		6/12/2014	Approved	
00962100	Herzing University	North Central Association of Colleges and Schools (Higher Learning Commission).	Herzing Inc.	391040865	Herzing Educational Foundation	271503981	Change in Ownership and conversion—Approved PPPA issued on 2/13/18.	6/27/2014		2/13/2018	Approved	
03374200	Florida Coastal School of Law.	American Bar Association (ABA).	Inflaw Holding, LLC	113790327	Phoenidlaw Foundation		The school intended to contribute all of its assets and liabilities to a non-profit foundation, the Phoenidlaw 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	

03173200	Atlanta's John Marshall Law School.	American Bar Association	John Marshall Law School, LLC.	200209197	John Marshall Law School, Inc.	811827820	Application submitted 2/13/2020; comprehensive pre-acquisition review letter issued 1/19/2020; transaction closed 12/31/2020; TPPA issued 3/31/2021; application under review.	2/13/2020	3/31/2021	Pending	
03001200	McNelly Smith College of Music.	National Association of Schools of Music.	McNelly Smith, Inc.	411540201	MSP College of Music		The Prerequisite review was completed, but the institution closed on December 15, 2017.	12/19/2016		Institution Closed	12/15/2017
03813300	Northeastern University	WASC Senior College and University Commission (WASC).	NCU Holdings, LLC/Innova Management Group, Inc./Northeastern University, Inc.	88930557	WestMed (changed name to Northeastern University) (affiliated with National University System).	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	Pittsburgh Technical Institute.	Middle States Commission on Higher Education.	Pittsburgh Technical Institute Employee Stock Ownership Plan.	27093054	Center for Excellence in Education, Inc..	810903939	Change in Ownership and conversion—Approved PPPA issued on 3/27/17.	5/26/2016	9/27/2017	Approved	
02533600	Ross Medical Education Center.	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC.	20222476	Ross Education Holdings, LLC ..	20222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021	Pending	
02099700	Ross Medical Education Center.	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC.	20222476	Ross Education Holdings, LLC ..	20222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021	Pending	
02246300	Ross Medical Education Center.	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC.	20222476	Ross Education Holdings, LLC ..	20222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021	Pending	
02397700	Ross Medical Education Center.	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC.	20222476	Ross Education Holdings, LLC ..	20222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/1/2021; TPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021	Pending	

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02180100	Ross Medical Education Center.	Accrediting Bureau of Health Education Schools (ABHES).	Ross Education Holdings, LLC.	202222476	Ross Education Holdings, LLC ..	202222476	Application submitted on 2/18/2019; abbreviated pre-acquisition review letter issued on 12/8/2020; transaction closed on 2/17/2021; TPPPA issued on 3/31/2021; application under review.	2/18/2019	3/31/2021		Pending	
00746800	School of Visual Arts	Middle States Commission on Higher Education.	School of Visual Arts, Inc.	135568364	SVA Alumni Association, Inc.		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	School of Visual Arts	Middle States Commission on Higher Education.	School of Visual Arts, Inc.	135568364	SVA Alumni Society, Inc. [501(c)(3)].	237193748	Prerequisite Review completed. Application purged on 6/22/18.	9/12/2019			Withdrawn	
03280300	Seattle Institute of East Asian Medicine.	Accreditation Commission for Acupuncture and Oriental Medicine (ACAO).	Seattle Inst. of Oriental Medicine.	911637769	Center for Integrated Care	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	Tribea Flashpoint College	Accrediting Council for Independent Colleges and Schools (ACICS).	Sterling Partners—Small Market Growth 2008, L.P..	263922906	Columbia College Hollywood	952077629	Acquisition of Tribea as an additional location of Columbia closed on 3/20/18. Meigs approved, full PPAs reflecting merger issued 6/17/18. No longer separately eligible.	1/3/2017		6/11/2018	Approved	
00367400	Stevens Henager College ..	Accrediting Commission of Career Schools and Colleges (ACSC).	Stevens Henager College, Inc....	87050023	Center for Excellence in Higher Education.	208091013	Change in Ownership Approved and PPAs 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 PPAs issued 12/19/18.	1/17/2012		12/19/2018	Approved—Just Closed	8/1/2021
02326900	Sunstate Academy—Fl. Myers.	Accrediting Commission of Career Schools and Colleges (ACSC).	Sunstate College, Inc.	592390702	Compass Rose Foundation, Inc.	59097013	Change in Ownership and conversion—Approved PPAs issued on 10/18/17.	9/11/2015		10/18/2017	Approved	
02524000	Sunstate Academy—Clearwater.	Accrediting Commission of Career Schools and Colleges (ACSC).	Sunstate College, Inc.	592390702	Compass Rose Foundation, Inc.	59097013	Change in Ownership and conversion—Approved PPAs issued on 10/18/17.	9/11/2015		10/18/2017	Approved	

02491900	Southwest University of Visual Arts	Higher Learning Commission (HLC)	The Art Center (a Subchapter S Corporation)	889567728	The Art Center	889567728	SUVA has changed its tax status under an Arizona law that allows an existing corporation to transition to nonprofit. That transaction has occurred and a PPPA 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	4/7/2019	Institution Closed	11/30/2020
02151900	Keiser University	Southern Association of Colleges and Schools Commission (SACS)	The Keiser School, Inc.	591829662	Everglades College	650216638	Change in Ownership and conversion—Approved PPA issued 8/10/11.	11/11/2010	8/10/2011	Approved	
03549300	Ultimate Medical Academy	Accrediting Council for Independent Colleges and Schools (ACICS)	Ultimate Medical Academy, LLC	202000570	UMA Education, Inc.	472578950	Change in Ownership and conversion—Approved PPA issued 7/9/15.	4/12/2015	7/9/2015	Approved	
00170300	Kendall College	North Central Association of Colleges and Schools (Higher Learning Commission)	Wengen Alberto, Limited Partnership (Laureate Education)	208658661	National Louis University	362167804	Acquisition of Kendall as an additional location of National Louis. Merger approved, full PPAs reflecting merger issued 9/20/18. No longer separately eligible.	1/17/2018	9/20/2018	Approved	
03874300	Cambridge Junior College	Accrediting Council for Independent Colleges and Schools (ACICS)	Workforce Training Solutions, Inc.	688466305	ASPRA Inc. of Pennsylvania		Application voluntarily withdrawn by ownership (purged 10/11/2016).	6/5/2015		Withdrawn.	

Question. Former Secretary DeVos allowed borrower defense claims to balloon at the Department without processing any claim for more than a year. At one point, the backlog grew to several hundred thousand claims. As pressure mounted to clear the backlog she created, former Secretary DeVos issued blanket and cursory denials of tens of thousands of claims. Many of these are potentially meritorious claims that were cast aside by the previous Administration, which viewed borrower defense as a problem to ignore rather than a mechanism for justice and fairness. You previously responded that Federal Student Aid would be conducting outreach to state Attorneys General, other government agencies, and other parties that might be in possession of evidence showing institutional misconduct. Based on your outreach and your intent to reopen borrower defense denials when evidence indicates misconduct or other concerns that were not considered during the initial adjudication:

How many denied applications has the Department reopened?

Answer. Under the proposed Sweet v. Cardona (Sweet) settlement, the Department would void all denials issued in December 2019 or later and re-adjudicate the applications under the terms of the settlement.

Question. How many of those applications has the Department approved?

Answer. As stated above, under the proposed Sweet settlement, the Department would void all denials issued in December 2019 or later and re-adjudicate the applications under the terms of the settlement. That process has not happened yet because the Court has not approved the settlement.

Question. What steps will you take to further review the DeVos Department's borrower defense denials?

Answer. The Department believes that the Sweet settlement, if approved, will address the DeVos Department's borrower defense denials.

Question. In the fall of 2021 and the winter of 2022, the Department conducted negotiated rulemaking to make regulatory changes for programs authorized by Title IV of the Higher Education Act. Topics included gainful employment, for-profit conversions, borrower defense, the 90/10 rule, financial responsibility, and administrative capability. While I'm glad the Department is undertaking this process, it is lengthy and the Department's rules are subject to litigation; however, students and borrowers need protection now.

When does the Department plan to send the draft of the gainful employment rule to the Office of Information and Regulatory Affairs for review?

When does the Department plan to release the Notice of Proposed Rulemaking?

Does the Department plan to release all the topics at once?

Does the Department plan to have the final rule published by November 1, 2022, so that important rules on institutional accountability go into effect by July 1, 2023?

Answer. Response to all questions:

We are working to publish a proposed rule in a timely manner, given the critical importance of the issue. On July 26, 2022 we announced regulations to address the loophole in the 90/10 rule and to strengthen rules related to changes in ownership. On the Spring 2022 unified agenda, the Department noted that we hope to publish proposed rules for gainful employment, certification procedures, financial responsibility, administrative capability, and ability to benefit—the remainder of the issues negotiated by the Institutional and Programmatic Eligibility Committee—in Spring 2023. Pursuant to master calendar requirements in the Higher Education Act, the soonest those rules could take effect if published by November 1, 2023, is July 1, 2024.

Question. During the Obama Administration, former Secretary Arne Duncan created a Federal interagency task force to coordinate oversight and enforcement efforts related to for-profit colleges. The task force was based on a bill that I introduced 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. The Department has expressed its deep interest in strengthening oversight and accountability for higher education institutions, including for-profit colleges.

Would the Department consider recreating an interagency task force?

Answer. The Department believes our work is stronger when we are able to collaborate with other key parties that investigate institutions. During the first year-plus of the administration we have worked hard to strengthen relationships both with other Federal agencies as well as with State Attorneys General. This has included reinvigorating the Principles of Excellence work in which the Departments of Education, Defense, and Veterans Affairs, and the Consumer Financial Protection Bureau collaborate on issues affecting veteran and military students. Many of these issues relate to the concerns you have raised. We are continuing to identify opportu-

ities to make the Federal Government more effectively collaborate on important issues and will keep this idea in mind as we explore options.

Question. What steps has the Department taken to reestablish relationships with other Federal agencies and state Attorneys General?

Answer. The Department views State Attorneys General as critical partners in our oversight and enforcement work. Since the early days of the Administration, we have been conducting additional outreach to strengthen relationships. For instance, we have been reaching out to Attorneys General to obtain additional information that can assist us in the review of borrower defense applications. This information was critical to the approval of findings against ITT Technical Institute, Westwood College, Minnesota School of Business/Globe University, and the Court Reporting Institute. Federal Student Aid also has regular calls with the Attorneys General to discuss ongoing issues. We believe that collaboration will continue to be useful for ongoing reviews of borrower defense claims and investigations and reviews of institutions.

Question. What further steps does the Department plan to take to strengthen these relationships?

Answer. In addition to the continued collaboration discussed above, the Department proposed in its draft regulations for borrower defense to repayment to create a formal process for a State representative, including attorneys general, to submit requests for consideration of group claims. We also anticipate that the newly reconstituted Office of Enforcement within Federal Student Aid to collaborate with relevant Federal and State actors as their investigations continue.

Question. Over the last five fiscal years, this Subcommittee—with the support of Chair Murray and Ranking Member Blunt—has provided \$35 million for an Open Textbooks Pilot to expand the use of open textbooks on college campuses and 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 do not purchase required course materials because they are too costly, which affects student outcomes. The College Board estimates that the average student budget at a four-year public institution of higher education for books and supplies was \$1,240 during the 2021–22 academic year. These costs disproportionately affect low-income, first-generation, and students of color. In June 2020, the Department made nine new awards with its fiscal year (FY) 2021 appropriation. Using fiscal year 2022 funds, the Department fully funded the nine additional fiscal year 2021 awardees. Research shows that projects supported by the grant program are estimated to save students \$220 million.

Given the initial success of the pilot program, will the Department request funding for the Open Textbooks Pilot in the fiscal year 2024 President's Budget Request?

Answer. Thank you for your question regarding the Open Textbook Pilot. The Department has not yet finalized plans for the fiscal year 2024 President's Budget Request.

Question. The Public Service Loan Forgiveness Program offers loan forgiveness for public servants after 120 qualifying student loan payments. This well-intentioned program is meant to encourage individuals to enter into public service careers without having to worry about looming student loan debt. However, due to the Department and loan servicers' failures in running the program, 99 percent of those who applied were denied before President Biden implemented the PSLF waiver. The waiver, which qualifies almost all types of Federal loans, all repayment plans, and some kinds of forbearance and deferment for PSFL forgiveness, has provided more than 100,000 borrowers with forgiveness. I applaud the Administration's efforts to make up for the previous mistakes in the program's implementation. Although forgiveness through PSFL has risen, according to the Education Data Initiative, the total dollar amount forgiven was less than 1 percent of national outstanding student loan debt balance in 2021. 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 and simplify the problems with PSLF?

Answer. Since Day One, the Biden Administration has worked to ensure that students and student loan borrowers can depend on the Department for support in repaying their loans and have access to quality student loan servicing. To that end, ED has taken decisive action to increase oversight over the student loan program and clean up past wrongs.

In fall 2021, ED announced a change to the PSLF program rules for a limited time as a result of the COVID-19 emergency. Now, for a limited time, borrowers may receive credit for past periods of repayment that would otherwise not qualify for PSLF. Since implementing the waiver, this Administration has helped approxi-

mately 150,000 borrowers earn PSLF forgiveness, increasing beneficiaries by more than 2,000 percent. We are launching a four-month sprint to increase usage of the waiver.

Long-term, The Department is working to ensure more borrowers have access to the PSLF program and can consider careers in public service by automating PSLF eligibility through data matches with qualifying employers so borrowers can focus on giving back. For example, Federal Student Aid (FSA) is currently building data exchanges with other Federal agencies, and we are also actively recruiting state and local agencies to participate.

We also look forward to creating new regulations that intend to end bureaucratic barriers that prevented millions of borrowers from earning monthly PSLF credit for paying too much, too little, or on the wrong day, or by resetting their progress toward forgiveness just for consolidating their loans.

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 more than half of Pell-eligible applicants were selected for verification in the 2015–2016 Award Year. It is estimated that more than one in five low-income students selected for verification never complete the process, and thus never receive 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 aid. It is possible that the verification process is disproportionately harming the educational success of low-income students, which runs counter to the intention of the Pell Grant program. The Department recognized the need to be flexible for the 2021–2022 Award Year due to the COVID–19 pandemic and verified students' FAFSA applications based on identity, high school completion, and their Statement of Educational Purpose instead of family financial information. I applaud this move, and with the implementation of the FAFSA Simplification Act, I urge continued ease for low-income students during the verification process.

Please provide the percentage of students who were chosen for verification out of the total number of students who applied for Federal financial aid during the most recent award year.

Answer. The verification selection rate for all FAFSA applications for the 2021–22 cycle was 20.27 percent (note that 3.98 percent of that total was verification for identity theft and fraud). The data is accurate as of the last transaction on file through July 8, 2022. The verification selection rate for the 2022–23 cycle through the transaction on file as of June 30, 2022 is 9.53 percent. In both of these years, we expect that the actual verification rate for FAFSA filers was lower than the numbers above due to waivers issued for income verification by the Department for both cycles. The waivers of income verification for 2021–2022 would have enabled schools to verify as little as 3.98 percent, but schools had the final say in whether to conduct income verification or not.

Question. What percentage of students chosen for verification did not complete and failed their verification during the most recent award year?

Answer. FSA uses the receipt of either a Pell Grant or Direct Loan as a measure of whether an applicant successfully completes verification once selected. Of those selected for verification during the 2021–22 FAFSA cycle, 63.7 percent received either a Pell Grant or a Direct Loan, leaving 36.3 percent who did not receive a Pell Grant or Direct Loan. Please note this data is as of July 13, 2022 and may change slightly as Award Year 2022 aid is finalized.

Question. Please provide the metrics by which the Department will select which applications are to be verified after implementation of the FAFSA Simplification Act.

Answer. The metrics that will be used are the probability of aid, the estimated under-award, and the estimated over-award amounts associated with a FAFSA. We do know that more FAFSA filers will have data pulled directly from the IRS following implementation of the FAFSA Simplification Act, so we expect future verification rates to be lower than current rates.

Question. On March 31, 2022, I wrote to you and urged you to update the Department's 2015 guidance on undue hardship adversary proceedings to make it simpler and fairer for borrowers who have demonstrated legitimate hardships to receive a bankruptcy discharge for student loans. On June 3, Under Secretary Kvaal responded and said: "the Department of Education will update relevant guidance documents as necessary, including the 2015 Dear Colleague Letter (DCL GEN–15–13) you referred to in your letter. We have been pursuing this work diligently and hope to be able to provide your office an update on our progress in the near future." I

appreciate this response, but want to stress the urgent need for this updated guidance to be issued without delay.

When will the updated guidance be issued?

Answer. Federal law requires borrowers to prove that they face an undue hardship to discharge their loans in bankruptcy. The Department of Education cannot change the law, but we want to ensure that the law is implemented fairly and broadly. The Secretary of Education is not solely in charge of this issue, so we are working with the Department of Justice to get there. We want to make sure that borrowers are not harmed while this process is ongoing. That's why we have worked with DOJ to assent to stays in any active student loan bankruptcy proceeding, so those borrowers can get the benefit of our new policy when it is finalized.

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 an individual two times less likely to graduate high school, and make an individual 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. An entire generation of kids is being traumatized by gun violence. The pandemic has magnified this problem, with the CDC recently reporting that guns have surpassed auto accidents as the leading cause of death for children and teenagers in America. 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 Health and Human Services (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 was funded at \$7 million in fiscal year 2022. 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. The Biden Administration has proposed \$1 billion to support more counselors in schools, and I also signed onto the fiscal year 2023 Dear Colleague letter to support funding at the same level.

Do you support appropriations for Section 7134 of the SUPPORT Act, which is already an authorized program, to address the breadth of trauma needs in schools, including setting up comprehensive plans, trainings, and partnerships?

Answer. The Administration is committed to improving access to school-based mental services, and we will consider funding for the Grants to Improve Trauma Support Services and Mental Health Care for Children and Youth in Educational Settings program, which is authorized by section 7134 of the SUPPORT Act, as we develop the President's budget request for fiscal year 2024.

Question. What more does the Department plan to do to address childhood trauma and the mental health toll facing children across America?

Answer. The Department of Education (Department) and its Office of Safe and Supportive Schools (OSSS), has long supported increasing access to mental health services to make it easier for individuals struggling with these issues to get the help they need, supporting school's efforts to recognize psychological distress and helping States, school districts, and schools ensure access to the care and services needed to diagnose and treat mental health needs in students. The Department continues to actively work to identify ways to support social, emotional, and mental health services for students, including administering grant programs that will allow school districts to increase the number of trained mental health service providers in schools and providing information and resources for stakeholders directly through the Department and through our numerous technical assistance centers. This work has been enhanced in recent years with several appropriations and legislation in support of student mental health, most recently in the Bipartisan Safer Communities Act which provided unprecedented funding for this work through the Department of Education and other Federal agencies. For the Department, this legislation provides funding to two extant mental health programs—the Mental Health Service Professionals grant and the School-Based Mental Health Services grant.

Generally, Title IV, Part A Student Support and Academic Enrichment (SSAE) program funds may be used under section 4108 for any program or activity that fosters safe, healthy, supportive, and drug-free school environments, which may include school-based health and mental health services, trauma-informed classroom management, mentoring and school counseling, schoolwide positive behavioral interventions, etc. Additionally, the T4PA Center has provided State educational agen-

cies (SEA) and the SSAE State Coordinators with numerous mental health resources and trainings so that the SEA can help LEAs use funds more creatively.

The Department of Education's Office of Safe and Supportive Schools (OSSS), the White House's Office of National Drug Control Policy (ONDCP), and OSSS' TA center the National Center on Safe Supportive Learning Environments (NCSSLE) will be hosting a 3-part webinar series in August-September 2022 that will highlight mental health and substance use disorder data trends; best practices from the field; and Federal funding to support mental health and drug prevention activities in schools. HHS and its many subagencies (e.g., SAMHSA, CDC, HRSA, NIH, ACF) have been invited as guest presenters.

OSSS continues to support other grant programs that recognize related areas of the mental health crises facing children including the:

- Project Prevent Grant Program, which enhances schools' and school districts' ability to identify, assess, and serve students exposed to pervasive violence;
- School Climate Transformation Grant Program -Local Educational Agency (LEA), which helps schools and school districts develop, enhance, or expand their systems of support related school climate programs; and
- School Climate Transformation Grant Program -State Educational Agency (SEA), which provides to develop, enhance, or expand systems of support for, and technical assistance to, local educational agencies (LEAs) and schools implementing an evidence-based, multi-tiered behavioral framework for improving behavioral outcomes and learning conditions for all students.

Question. How does the Department plan to coordinate with HHS on these efforts?

Answer. Public Law 115–271; Subtitle N—Trauma-Informed Care SEC. 7132. TASK FORCE TO DEVELOP BEST PRACTICES FOR TRAUMAINFORMED IDENTIFICATION, REFERRAL, AND SUPPORT. The Interagency Task Force on Trauma-Informed Care, led by HHS' SAMHSA, was created to identify, evaluate, and make recommendations regarding ways in which Federal agencies can better coordinate to improve the Federal response to families impacted by substance use disorders and other forms of trauma. The duty of the Task Force is to create a national strategy on how the task force and member agencies will collaborate, prioritize options for, and implement a coordinated approach. This strategy now has an operating plan that provides an explanation of Federal agency involvement and coordination needed to carry out such activities, including any statutory or regulatory barriers to such coordination. The Department of Education has representation on the Task Force from several offices, including the Office of Elementary and Secondary Education's Office of Safe and Supportive Schools. The Task Force has four pillars that work to achieve the purpose of the Task Force: (1) Best Practices; (2) Research; (3) Data; and (4) Federal Coordination. The Task Force has divided up into subgroups to focus on coordination for each of the pillars.

First, OSSS and NCSSLE have sent initial invitations to guest speakers from HHS subagencies to participate in our 3-part webinar series in August-September 2022. OSSS, ONDCP, and NCSSLE will organize planning calls with confirmed speakers to finalize presentation content and identify practitioners from the field to participation in the upcoming webinars.

Additionally, the Departments of Health and Human Services and Education continue to collaborate on strategies to increase access to mental health services elementary and secondary education students. In addition to providing additional funding for key programs, the Bipartisan Safer Communities Act also directs HHS to collaborate with Education to develop guidance on how local educational agencies can partner with their state's Medicaid program to increase the availability of health services, including mental health services in schools. In addition, the law establishes a national technical assistance center to assist with this process and provides \$50 million to states to address this work. We anticipate strong collaboration between ED and HHS that will increase access to mental health and other services in schools.

QUESTIONS SUBMITTED BY SENATOR JEFF MERKLEY

Question. Secretary Cardona, thank you for the work that you and the Administration have done so far to help student loan borrowers. However, I remain concerned about increasing access to income-driven repayment (IDR) plans. Right now, the system remains complicated for borrowers across the country, with four different IDR plans from which students can choose.

Can you explain the Department's priorities as they relate to IDR, and where the committee can provide additional support to the Department to help in streamlining the number of IDR plans to simplify the system for borrowers?

Answer. The Department thinks that income-driven repayment can be a crucial way to help borrowers keep their payments manageable. In considering improvements to income-driven repayment we are looking at concerns raised by stakeholders to identify problems that might need addressing. This includes both the design of the plan as well as operational items, such as what it takes to enroll. We ultimately want to make sure that it is easier for borrowers to choose the best repayment plan for them, that it gives them affordable payments, and that we do more to reach the borrowers who would likely benefit from IDR as a way to avoid delinquency and default but unfortunately do not make use of these options in sufficiently large numbers today.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

Question. School safety has become a major topic recently, especially following the tragic school shooting in Uvalde. In March 2018, President Trump appointed then Secretary DeVos to lead a Federal Commission on School Safety. The Commission found that while there is no universal school safety plan that will work for every school across the country, the Federal Government can play a role in enhancing school safety. The Department's budget asks for \$129 million to address School Safety National Activities, a \$23 million increase. This includes \$24.7 million for new grants under Project Prevent, and just \$2 million for a proposed National Clearinghouse on School Infrastructure and Sustainability to help with technical assistance on school facility construction and improvement. Issues, such as self-locking doors, armed security guards, active shooter training for teachers and students, bullet proof windows, and other training, have all been discussed as ways to help improve student safety.

One of the findings of the 2018 School Safety Report was on Active Shooter Preparedness and Mitigation. The Department has undertaken a review of that Report. What is the status of that review?

Answer. The report remains under review by the White House and all agencies that contributed to the report.

Question. What, if anything, has the Department done to implement the recommendations contained in the Report?

Answer. As the report is still under review, ED is unable to report on implementation of the recommendations therein.

Question. What incentives are currently in place to encourage schools and school districts to implement safety procedures?

Answer. The Department has many technical assistance centers and resources available to encourage safe, thoughtful, and age-appropriate implementation of safety procedures. The primary source of support for k-12 schools is the Office of Elementary and Secondary Education's Readiness and Emergency Management for Schools (REMS) Technical Assistance Center, which helps educational agencies and their community partners develop, for free, their readiness and capacity to manage emergencies, including prevention, protection, mitigation, response, and recovery efforts.

Question. How many school districts are utilizing these grants to improve training and physical safety of their schools?

Answer. Approximately 108 of the current grant recipients, both State educational agencies and local educational agencies, may use grant funds to assist multiple schools to establish school safety plans. According to the National Center for Education Statistics, as of school year 2019–2020, 96.2 percent of public schools reported having written plans to address a shooting on campus and 93.3 percent reported having written plans to address bomb threat incidents.

Question. Last month, the Administration released its National Drug Control Strategy. This strategy lays out the steps the Administration, in coordination with Federal agency staff across the government, will take to address the drug epidemic, which continues to grow in West Virginia and across the nation. Prevention and early intervention are listed in the National Drug Control Strategy as priorities. In 2020, the Substance Abuse and Mental Health Services Administration issued its annual report on substance use. The report found that 158,000 people ages 12 to 17 started using prescription pain relievers for the first time in 2020. While this a decline from previous years, youth substance use needs our full attention before we lose the next generation of leaders to the drug epidemic. Senator Manchin's bill, the Saving America's Future by Educating (SAFE) Kids Act, directs the Department of Education and several other agencies to develop evidence-based, age appropriate curriculum on the negative impacts of substance use—including but not limited to

opioids, tobacco and vaping. The bill also establishes a competitive grant program for states to implement the curriculum in school if they choose to do so.

What efforts are underway at the Department to address substance use by the youngest and most vulnerable populations?

Answer. The Department is considering options for supporting the National Drug Control Strategy, including possible efforts to prevent substance abuse by children and youth, during development of the President's fiscal year 2024 budget request.

When parents send their children to school, they expect them to be safe. However, this is not always the case. In 1997, a young student from Fayette County was killed by his teacher. That same teacher had previously taught at a school in Pennsylvania, but was dismissed following a string of allegations involving sexual misconduct with students. The teacher somehow received a positive recommendation and was able to transfer schools without consequences. Senators Manchin and Toomey (R-PA) introduced a bill to ensure that what happened in West Virginia could never happen again. The bill, which was signed into law as part of a larger education reform package, requires states, state educational agencies and local educational agencies to institute policies, laws or regulations to prohibit the practice of allowing teachers with a history of abusing students to transfer schools without facing any consequences. However, almost 8 years later, many states are out of compliance with the law. The vast majority of teachers are doing important work to educate our next generation, however, so far this year, more than 130 teachers and teachers' aides have reportedly been arrested on sex-related crimes. While that is 130 too many, it is important to acknowledge that it represents a small portion of teachers and teachers aides nationwide. In February, Senators Manchin and Toomey wrote Secretary Cardona to express concerns regarding the lack of state compliance with the law, as well as the Department's lack of enforcement of the law. In the Department's response, the Department wrote that each state has provided the Department with assurances that they will comply with "all applicable statutory provisions," and that the Department will develop a further plan to monitor those assurances in "future monitoring."

Question. Why are states that are not complying with this law still receiving funding from the Department of Education?

Answer. When needed, the Department's typical process is to consider enforcement actions on a case-by-case basis, depending on the nature of the non-compliance or violation. These actions may include 1) requiring a corrective action plan and closely monitoring implementation of that plan to ensure resolution of the instance of non-compliance, 2) attaching a specific condition to a grant award, or 3) designating a grantee as a "high-risk grantee." Withholding is also an available enforcement action under the General Education Provisions Act, after notice and an opportunity for a hearing.

Question. How does the Department plan to monitor these assurances from states, and whether states are doing what they said they would?

Answer. Consistent with our ongoing monitoring, technical assistance, and oversight processes, the Department is committed to helping States better understand their responsibilities under Section 8546. In the coming months, we will provide further outreach and technical assistance so that States may take steps to ensure that they are in compliance in as timely a manner as possible given the specific processes necessary in that State to implement new laws, regulations, rules, or policies.

Question. How will the Department ensure that states are brought into compliance with this statutory requirement?

Answer. As noted above, we will work with States to ensure that they are brought into compliance with section 8546.

Question. The Upward Bound Program is one of eight Federal TRIO Programs managed by the Department of Education. Upward Bound programs in West Virginia provide both educational and living options for students during the summer, which are invaluable experiences for students who are interested in pursuing undergraduate or graduate degrees, especially because Federal TRIO Programs are designed to support students who are low-income or come from disadvantaged backgrounds. Last month, more than 30 students from West Virginia wrote to Senator Manchin to describe how much these programs mean to them, including James from Webster County. James told Senator Manchin that within a short span of time, TRIO has offered him access to "college prep, tutoring, financial knowledge," as well as friends and family and so much more. He wrote that these programs would impact him for the rest of his life. Despite its importance, the Upward Bound grant awards were released just one week before previous funding was set to expire. This caused great uncertainty for not only the programs, but also the students who attend them. It is unacceptable that these programs and students were caused uncer-

tainty that they would be funded. At a time when youth mental health is at an all-time low, students and families do not need more stress and anxiety.

Why did the Department wait until there was only one week of funding left to make the highly anticipated announcement about the Upward Bound slate?

Answer. We agree that it is important to ensure that grantees know their funding status as soon as possible, and we make every effort to complete the large and complex Upward Bound competition in a timely manner. While our fiscal year 2022 award announcements were made in late May, close to the end of the 2021–2022 academic year, these announcements arrived well in advance of the 2022–2023 program year funded by the first year of the new grants.

Question. Is there a way Congress can provide the Department with additional support to streamline the application review and determination process?

Answer. As one of the largest discretionary grant programs in the Department, the Upward Bound competitions are administratively complex and require considerable Department resources to implement. The Department administered the fiscal year 2022 Upward Bound peer review remotely with approximately 441 peer reviewers across 147 panels. For future grant competitions the Department is considering returning to a hybrid peer review process where reviewers would remotely participate in the peer review during the first week and then travel to Washington DC for a one week in-person peer review.

The Department believes that, specific to the Upward Bound program, the hybrid peer review process will allow for a shorter peer review with increased peer review engagement and accountability. An in-person peer review for a program as large as Upward Bound would have significant travel, hotel, and logistical costs and also require additional Department staff for effective oversight of the review.

Question. The Department of Education manages the Gaining Early Awareness and Readiness for Undergraduate Programs, or GEAR UP. This program provides competitive grants to states to help prepare low-income and first-generation students for post-secondary education starting as early as seventh grade. Grant funds may be used to offer services to students at high-poverty middle and high schools, such as professional development for counselors and instructors, college and career planning, counseling and tutoring services to support college enrollment. The President's Budget requests \$408 million for GEAR UP in fiscal year 2023, a significant increase over the past fiscal year. GEAR UP has been incredibly successful in helping students achieve their dreams to attend college, no matter their background. According to the Department of Education, 77 percent of GEAR UP students enroll in post-secondary education immediately after graduating from high school, as opposed to 45.5 percent of low-income students that do not participate in the program.

Can the successes of this program be applied to other grant programs offered by the Department to ensure every program is as successful as this one?

Answer. GEAR UP benefits in this case from a very clear primary program purpose and easily measured performance goal related to that purpose. Performance measurement for other programs is not always so straightforward, but the Department is committed to working with all grantees to promote successful outcomes in each program administered by the agency. The Department develops and publicly reports measurable and relevant program performance measures to provide an accountability framework for meeting long-term program goals. Furthermore, the Department supports its grantees with Technical Assistance, including webinars, workshops and regular communications, and performance monitoring, such as annual substantial progress reviews, to assist each grantee in meeting its project goals.

Question. How will the Department coordinate with states and other organizations to ensure that students who receive aid from a state or local entity are not disqualified for GEAR UP scholarships?

Answer. The Department is committed to ensuring that all students who are eligible to receive a GEAR UP scholarship are provided one. State applicants are required to have a scholarship component unless granted a waiver; however, Partnership applicants are not required to have a scholarship component as part of their project.

GEAR UP students are eligible to receive scholarships if they:

- have participated in a GEAR UP project;
- are under 22 years of age;
- possess a high school diploma or equivalent; and
- are enrolled or accepted for enrollment at a program of undergraduate instruction at an IHE that is located in the State's boundaries, except that, at the grantee's option, a State or Partnership may offer scholarships to students who attend institutions of higher education outside the State. (See 20 USC § 1070a-25(g)(3); 34 CFR § 694.14.)

The Department does not allow State applicants to add other criteria or requirements for students to receive GEAR UP scholarships. Assuming that a GEAR UP student meets all of the above criteria, they would not be disqualified from receiving a scholarship. A student may also receive a scholarship if the student transfers from the originating school and graduates from a high school that does not serve a “substantial majority” of GEAR UP students. In addition, projects have the option of providing scholarships to students that attend IHEs that are outside of their State; however, this is done at the State grantee’s discretion.

The minimum amount a project must award to a student is the minimum Pell grant amount for the year the student will be utilizing the GEAR UP scholarship. In order to ensure scholarship funds are available for all eligible students, scholarship funds must be held in reserve with at least an amount equal to the minimum scholarship amount multiplied by the estimated number of eligible students. However, State projects using a priority model may award scholarships directly rather than holding funds in reserve, as applicable.

Although GEAR UP State applicants may request a waiver to the GEAR UP scholarship requirement in their application (See 20 USC § 1070a–25(b)(2)), this does not preclude the State from guaranteeing a scholarship to all eligible GEAR UP participants; rather it allows the State to use other State or local resources to provide these scholarships.

In order to receive a waiver, the State applicant must demonstrate and describe in its scholarship waiver request the following information:

- Sec. 404E(b)(2) of the HEA- (1) Did the eligible entity demonstrate (show either historical or current available data on stated financial assistance to students in the state) that the eligible entity has another means of providing the students with the financial assistance described in this section and (2) Did the eligible entity describe (how much funding, what is the source of funding (private, state, other) and is there any criteria attached to cited financial assistance (income based, GPA, etc.) that could potential disqualify a GEAR UP participant from receiving such assistance.
- 34 CFR 694.14(c)(3)- Assurance of one-time minimum Pell to a GEAR UP participant that does not meet the requirements of any of the resources identified as other means for providing the student with the financial assistance described in Sec. 402E(b)(2) of the HEA.

In short, the Department requires each State to give assurances that they have another source of funds to provide all eligible GEAR UP students with the required scholarships, and that the State grantee will provide the required scholarship to any eligible GEAR UP student who does not meet eligibility requirements of the other proposed sources of scholarship funding.

Question. The McKinney-Vento Education for Homeless Children and Youth program provides critical assistance for community organizations, schools, and state agencies to help address the needs of homeless children and youth. The President’s Budget requests \$110 million for Education for Homeless Children and Youths. It is critical that this funding gets to states and local entities that can target funding to help the students that need it most. The West Virginia Department of Education has identified more than 9,500 students who experienced homelessness during the 2021 school year, and after hearing from individuals on the front lines who are providing needed services to these individuals, it is likely these numbers will increase further during the 2022–2023 school year.

How would the Department use increased funding to ensure that all children can have the education they deserve, especially our most vulnerable?

Answer. Increased funding under the McKinney-Vento Education for Homeless Children and Youth program will provide additional resources to States and local educational services to identify and serve eligible students and provide them with the access and support services they need to participate in academic and extra-curricular activities as other children and youths.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

Student Loan Forgiveness

Question. Mr. Secretary, as I highlighted in my opening statement, I’m alarmed by the potential of widespread loan forgiveness currently under discussion by the administration. It’s an illegal, regressive, unfair, and expensive proposal that does nothing to address the real issues with college costs and is likely to exacerbate them further. Why should American taxpayers who never went to college, those who worked through college to keep their debt low, or those that worked hard to repay their loans have to pay this for this political giveaway?

Answer. As you note there has been no decision made with regard to broad-based student loan forgiveness and discussions are ongoing. Overall, student loans should help finance a ticket to opportunity, not become a lifelong burden for borrowers. And there is evidence that while many students can successfully repay debt, many cannot. Over the past 2 years, the Department has engaged in a multi-pronged effort to remedy the financial harms to borrowers related to the COVID-19 pandemic. We have also worked hard to ensure that the different programs authorized to discharge borrowers' loans are living up to the promises and intents of Congress. We believe these efforts are about ensuring borrowers receive the benefits to which they are legally entitled.

Question. Furthermore, widespread loan forgiveness would disproportionately benefit high income households as the top 40 percent of household hold nearly 60 percent of education debt. Why do you think high income borrowers shouldn't have to pay back their loans?

Answer. The Department maintains that it expects student loan borrowers to repay their loans under the terms of the various loan repayment plans and other benefits available to them. We note that while there are high-income individuals who have student loans, there are also significant numbers of borrowers who are not. We are particularly concerned about taking steps to address the fact that prior to the COVID-19 national emergency there were more than 1 million borrowers defaulting on their loans each year, most of whom never finished their program, and many of whom were low-income.

Question. And for low-income borrowers, we have several income-driven repayment plans that allow them to pay as little as \$0 per month and eventually do result in forgiveness if their income remains low. Why is this not sufficient?

Answer. The Department believes that income-driven repayment plans are an important tool for helping borrowers to repay their loans. But as we have discussed during our ongoing regulatory process considering new rules in this area, we are concerned that far too many borrowers who might be eligible for income-driven repayment are not making use of these plans. And that even with the presence of these plans we have seen more than 1 million borrowers defaulting on their loans each year prior to the national pause on student loan repayment.

Question. I'm also concerned about the moral hazard this would create with colleges raising prices and future students taking on more debt than necessary because both expect another round of forgiveness. How would forgiveness not lead to these outcomes?

Answer. We believe that borrowers intend to repay their loans when they take them out. We do, however, share your concerns that more must be done to make college more affordable and ensure that borrowers receive sufficient value for their investments. The administration has unveiled a number of proposals, such as putting Pell Grants on a path to doubling by 2029, that we believe would be critical for addressing affordability upfront and we would be interested in collaborating on further steps to improve postsecondary accountability.

Question. Do you expect this forgiveness to be one time only or are future borrowers right to expect future rounds of forgiveness?

Answer. We believe it is critical to build a durable and successful student loan program for the long-term. For instance, the proposed durable improvements to the discharge programs authorized by Congress that we unveiled on July 13, 2022 will make much-needed fixes that will ensure these options for borrowers live up to their promises. We are also working to make significant improvements to FSA operational systems and to stand up a new vision for student loan servicing that we believe will deliver higher-quality service to borrowers and assist with repayment.

Question. Given all the comments from the Administration on the student loan system being broken, I would have expected to see some sort of student loan proposals in your budget, yet there are none. Why is that? Do you think we should continue to have a Federal student loan program?

If so, then why wouldn't you propose reforms to simplify and improve the repayment process?

Answer. We believe that a significant area of work is for the Department to ensure that the programs Congress has authorized for us to administer are working effectively. Since the beginning of the administration, we have been taking a close look at the various authorized discharge programs that far too often failed to deliver on their promises. We have been working through executive action and regulatory proposals to make those programs more effective and efficient, so they better reflect the goals laid out by Congress. We believe the changes in the proposed regulations that are currently out for public comment will make significant strides to improve the repayment experience for borrowers.

Charter Schools

Question. The Department of Education proposed an unprecedented number of new regulations for the Charter School Program (CSP) for this fiscal year, which ends on September 30th, with no prior stakeholder engagement. These regulations were posted on March 11th and comments were due on April 18th. The Department has received almost 30,000 comments that it must respond to in addition to finalizing the applications and priorities for several separate CSP programs.

It is essential that eligible applicants have ample time to address any new application requirements, and the funds for all but one of the programs must be awarded by September 30th. This is a narrow window for so many complex tasks and provides no time for the Department to authentically respond to real implementation issues with the proposed rule. You are already way behind schedule for conducting the State Entities and Developers competitions. Are you certain that you have enough time to make those grants, along with the Credit Enhancement awards which are also planned for this fiscal year?

Isn't this another reason to run the fiscal year 2022 competitions under the existing rules?

Answer. The Department issued the final rules and Notices Inviting Applications for the State Entities and Developer competitions on July 1st. The Department is fully committed to providing the technical assistance needed to support high-quality applications and a diversity of applicants. To support these efforts, the Department:

- Released a Fact Sheet and Blog summarizing the key changes, timelines, and funding available.
- Hosted four webinars to support applicants, one for State Entity applicants and one for Developer applicants on Monday, July 11th and two follow-up webinars, one for each program on Monday, July 18th to answer any additional questions applicants might have after participating in this week's webinars.
- Provided an email address to submit questions related to the application process.

The Department also made changes in the final notice to address concerns raised during public comment and in recognition of the 30-day application window. These include:

- Encouraging—but not requiring—collaboration between charter schools and traditional school systems. We are also providing more flexibility regarding the types of collaborations that can meet the priority, including being clear that existing collaborations may qualify for the priority, as well as allowing more flexibility for how a charter might demonstrate evidence of the collaboration. For example, in the fiscal year 2022 competition, the Department encouraged these collaborations through an invitational priority in the Developer competition and has indicated that the Department will not use this as an absolute priority in future competitions during this Administration.
- Clarifying that applicants can provide a range of information and evidence to meet the needs analysis requirements. Further, the Department is not applying the needs analysis requirement to the Developer competition this year, recognizing the capacity constraints for independent charter school operators during a 30-day application window.
- Streamlining application requirements. The final rules reflect efforts to streamline requirements and reduce burden, for example by allowing applicants to submit information that they have already submitted to their authorizer to meet the needs analysis requirement.

Question. The proposed regulations state that CSP applicants must provide information on “how the applicant plans to establish and maintain racially and socio-economically diverse student and staff populations.” Charter advocates oppose this proposed requirement because it appears to make ineligible for funding schools supporting students that live in racially isolated communities, as well as those that are designed to meet the cultural and language needs of tribes and native populations.

Given this requirement and selection criteria that you are proposing, do you agree that all other things being equal, this notice, for example, would prioritize funds for a school with more affluent white students that is more “diverse” over a tribal application that proposes to meet the cultural and unique educational needs of their students in a school district?

Answer. The Administration is committed to supporting state and local efforts to increase school diversity and reduce racial and socio-economic isolation in schools, both to ensure that all families can see a place for their child in their local public school, whether traditional or charter, and in recognition of the significant benefits that diverse schools confer—including higher graduation rates, improved academic outcomes, and increased levels of college enrollment for students of all races.

Accordingly, the final rule requires CSP applicants to perform analyses of a proposed charter school's projected student demographics, and share information on the demographics of the local community in which the charter school will be located or from which it would draw students; to outline plans to establish and maintain a racially and socio-economically diverse student body or describe how its student body promotes the CSP's mission to provide high-quality educational opportunities to underserved students; and to assure that a proposed charter school will not negatively affect any desegregation efforts in the local community in which the charter school would be located.

The final rule acknowledges the complexities of recruiting and enrolling a diverse student body in certain isolated or racially homogeneous communities or where the charter school has a unique educational mission, such as primarily serving underserved students, and provides such charter schools with a framework for demonstrating compliance with CSP requirements. An applicant that proposes to create, replicate, or expand a charter school in a racially or socio-economically segregated or isolated community or a charter school with a unique educational mission would not be ineligible or at a competitive disadvantage for funding.

Question. Does the Department consider a school on an Indian reservation or a school serving a heavily minority urban community an effort to resegregate schools?

Answer. As previously stated, the final rule acknowledges the complexities of recruiting and enrolling a diverse student body in certain isolated or racially homogeneous communities or where the charter school has a unique educational mission, such as primarily serving underserved students, and provides such charter schools with a framework for demonstrating compliance with CSP requirements. An applicant that proposes to create, replicate, or expand a charter school in a racially or socio-economically segregated or isolated community or a charter school with a unique educational mission would not be ineligible or at a competitive disadvantage for funding.

Question. In addition to the proposed regulations, you have also included new language in your fiscal year 2023 budget request related to whether Charter Schools Program grantees can contract with for-profit management companies. The Department's justification is that the language would merely clarify Congressional "intent" about these types of arrangements, yet Congress rejected the inclusion of similar language in the final fiscal year 2022 Omnibus appropriations bill. Moreover, the two proposals (the regulations and the proposed appropriations language) use inconsistent language. For example, the proposed regulations address charter schools based on whether the for-profit entity has full or "substantial" control, but the proposed fiscal year 2023 language does not use those terms.

Agencies typically ask the appropriators for legislative fixes when they cannot achieve their policy objectives through regulations or other administrative means. Should the Committee consider the Department's request as an admission that you don't have the authority to address for-profit charter school issues through regulation? If not, why did you make two overlapping and inconsistent proposals?

Answer. Given the significant risks to public funds that fall under the purview of for-profit charter school operators, the Department's rulemaking is in alignment with Federal statute that expressly prohibits for-profit organizations from applying for grants or subgrants under the CSP. To ensure additional safeguards, the Department's rulemaking requires CSP applicants to: (1) Provide detailed information on proposed school governance and ensure meaningful, ongoing opportunities for family, educator, and community input into school decisionmaking; (2) State whether they have entered, or plan to enter into, a contract with a for-profit management organization and if so, provide detailed information regarding such contract; (3) Report on individuals who have a financial interest in the for-profit management organization, including any affiliations or conflicts of interest involving charter school staff or board members; (4) Detail descriptions of any actual or perceived conflicts of interest and the steps the applicant took, or will take, to avoid conflicts of interest; and (5) Assure that any for-profit management contract is subject to important controls.

While the fiscal year 2022 rulemaking serves to shine an important light on CSP-funded schools that contract with for-profit management organizations, it does not and cannot prohibit such relationships. The Administration strongly believes, however, that CSP funds should not support schools that are managed by organizations with a profit motive. Accordingly, the requested legislative language would ensure that CSP-funded schools are operated only by nonprofit entities, beginning with new awards made with fiscal year 2023 funds.

Question. In the fiscal year 2022 Senate report, the Committee expressed concern about adequate staffing in the Charter Schools Program office. Nearly every CSP grantee has had numerous Department of Education program officers—some as

many as 7 over 2 years. The office has been reorganized and in flux since the changes made by The Every Student Succeeds Act (ESSA) reauthorization were implemented, and the 2014 CSP guidance has not been updated to incorporate the ESSA changes. Given the lack of technical assistance and support at the Federal level that has existed for years now, why is the Department prioritizing placing even more requirements on grantees without first addressing these other issues? Will the program office be able to respond quickly and effectively to the many questions that the new regulations will generate? Can you ensure the applicants will have at least 60 days to respond to the application process?

Answer. The Department believes the final priorities and requirements are critical to ensuring that schools that receive Charter Schools Program funds are subject to strong accountability, transparency, and oversight, show demonstrated family and community support, provide access for students with disabilities and English learners, and serve students from diverse racial and socioeconomic backgrounds. We will continue to support applicants and grantees in advancing these goals, both directly and through expanded technical assistance offerings of the CSP-funded National Charter School Resource Center.

To ensure we can make awards before the end of the fiscal year, the Department has allowed applicants for State Entity and Developer grants 30 days to submit applications after the notices inviting applications were issued. We recognize that this might be not ideal; however, we anticipate that many prospective applicants will have begun preparing to submit applications during the rulemaking process and will be able to submit high-quality applications by the established deadline.

Student Loan Pause

Question. Mr. Secretary, I am concerned that there is no plan in place to transition borrowers back into student loan repayment. At the height of the pandemic, it made sense to give borrowers limited relief from repaying student loans, and Congress provided that relief through the CARES Act. However, the pause has been extended six times via executive action, including four times under the current administration. The unemployment rate is now back to pre-pandemic rates and individuals have largely returned to their normal lives. Is the pause going to end on August 31st?

Answer. Over the past 2 years, the Department has engaged in a multi-pronged effort to remedy the financial harms to borrowers related to the COVID-19 pandemic. Among other measures, the Department has continued the pause in interest and payments on student loans started by the prior Administration. As the Department plans for the resumption of payments, it will consider additional measures to reduce delinquency and defaults.

Question. And if you can't commit to restarting repayment in September, what metrics are you using to determine when repayment should restart?

Answer. The Department's actions to provide relief to struggling borrowers considers the continuing COVID-19 national emergency and the resulting financial impacts on student loan borrowers.

Student Loan Servicing

Question. I am concerned that the Department just released a solicitation for student loan servicing last month. Using the extension we provided you in the fiscal year 2021 Labor/HHS bill, legacy loan servicing contracts are now set to expire in December 2023. While that may feel far away, you and I both know that it is a very short time to complete the procurement process, particularly for something that has been so fraught with challenges like student loan servicing. When do you expect to make awards for new student loan contracts and have you accounted for the very likely possibility of bid protests in that timeline?

Do you think it will be possible to fully transition the 35 million borrowers with federally managed student loans over to servicers awarded contracts under the Unified Servicing and Data Solution before the legacy contracts expire, given that a solicitation was just recently released?

Answer. The Department anticipates making new contract awards under the Unified Servicing and Data Solution (USDS) procurement this coming winter. While acquisitions schedules can be challenging to manage, we have actively worked to reduce procurement and development timelines, mitigate risks, and develop contingencies where possible in order to go live with the new USDS contracts by the time the legacy contracts expire in December 2023. This plan includes transitioning borrowers away from incumbent servicers who do not receive a USDS award to incumbents who are awarded a USDS contract before December 2023, then allocating accounts to new USDS servicers after go-live, if necessary. To the greatest extent pos-

sible, the Department is dedicated to ensuring borrowers do not experience more than one transfer during the transition period.

Question. Over the last year, several Federal student loan servicers have quit the program, representing nearly 20 million borrower accounts, and it is possible that additional vendors may leave in the future. These departures seem driven by the fact that the economics of their contracts are upside down, and even nonprofit organizations are losing millions of dollars each year servicing Direct Loans. What is your plan under the Unified Servicing and Data Solution to ensure that the Office of Federal Student Aid (FSA) does not continue to lose qualified loan servicers? Will you commit to compensating the Department's servicers fairly for the additional work they currently are doing and will do to prepare millions of student and parent borrowers for repayment later this year?

Answer. USDS was strategically developed to address the pain points that borrowers, servicers, and FSA experience in the current servicing environment. USDS includes a pricing structure that we feel better accounts for the costs borne by servicers across several areas of operations, including processing systems, contact centers, fulfillment, web functionality, and cybersecurity. Through this new pricing structure, we believe we will be able to better compensate servicers for the true cost of servicing loans, work to realize efficiencies that come with greater self-service functionality and economies of scale, and manage a complex oversight environment. We will leverage this pricing information to construct our budget requests for fiscal year 2023 and beyond and look forward to collaboration with Congress to appropriately fund the student loan servicing environment.

Question. Mr. Secretary, your budget requests \$2.7 billion to administer student aid programs, which is an increase of \$620 million from the fiscal year 2022 level. Every year, we provide this account with significant increases and we've yet to see a new student loan servicing solution come to fruition. FSA's management plans for the Federal student loan program seem to change every few months, and the true costs for current and future loan servicing contracts are unknown. Will you commit that FSA will provide increased transparency on current and future loan servicing contract plans, and that you will brief this subcommittee on the proposed structure and associated costs for future loan servicing contracts in advance of any public announcements?

Answer. The fiscal year 2023 President's Budget Request includes funding for loan servicing operations and maintenance, as well as funding to implement reforms that improve FSA's ability to serve students and borrowers, including fully implementing the FAFSA® Simplification Act and FUTURE Act, improving access to Public Service Loan Forgiveness (PSLF), expanding enforcement efforts to ensure program compliance, and ultimately holding vendors more accountable for providing high quality loan servicing to more than 42 million student loan borrowers. A major portion of this increased budget request is attributed to the Unified Servicing and Data Solution (USDS), FSA's recompetes of loan servicing.

The Committee is aware that the Federal procurement process is highly confidential and that, in order to protect the integrity of the process for all offerors, FSA cannot share procurement-sensitive information before it is made public. However, throughout the USDS procurement, FSA has been committed to transparency in the earliest possible stages of the process, publishing a Request for Information prior to briefing Congress in February 2022 and providing staff with several individual and group briefings since that time, including after the procurement was published. In addition, the Department holds a bi-weekly call with both Appropriations and Authorizing Committee staff; previous calls have included discussions of FSA's current and future servicing contract plans as well as updates on servicing cost estimates. We are committed to continuing this level of communication, providing information, and requesting feedback, provided the information shared does not violate Federal procurement laws or regulations.

Proprietary Colleges

Question. Mr. Secretary, I am concerned about this administration's treatment of proprietary colleges. There are many high-performing proprietary schools in my state and across the country that are providing an invaluable service by generating high-skilled graduates for vital economic industries that have tight labor markets. How is the Administration ensuring that proprietary colleges are being evaluated based on their merit and not merely their tax status? Do you believe that all programs of higher education, and not just those at proprietary colleges, should be held to the same accountability standards?

Answer. The Department agrees that there are high-quality—and low-quality—programs in every sector; and we are concerned about programs where graduates see earnings that are too low, or debts that are too high, across the board. That is

why the Department proposed during negotiations with the field to require disclosures to students at all institutions of key data points about their programs, which may include typical debt levels and typical earnings. However, we are also seeking to clarify long-standing eligibility requirements in the Higher Education Act that are specific to gainful employment programs, defined as for-profit and certificate programs. We also see a particular need for this clarity in the proprietary sector, given a concentration of programs that leave graduates in very low-wage jobs or with debts they cannot afford.

QUESTIONS SUBMITTED BY SENATOR LINDSEY GRAHAM

Question. Secretary Cardona, it has been reported that you were, “Excited about short-term Pell” when asked if you were supportive of a provision in the COMPETES Act modeled off of the JOBS Act. As you know, the JOBS Act legislation aims to expand Pell grant program eligibility for shorter-term career education programs. However, as currently proposed in the House’s COMPETES legislation this much-needed expansion would prohibit postsecondary programs from being delivered in virtual settings and would place a number of overly restrictive requirements on these efforts. This would have the practical effect of preventing students from using short-term Pell grants to pursue in-demand credentials in the rapidly growing field of Information Technology, where the workplace is entirely virtual. Many other sectors of our economy are also moving in this direction.

Would a better way to expand access for adult learners to life-changing technical training be to set guardrails for outcomes in terms of graduation, job placement, and salary attainment, and then to allow all providers -whether in-person or virtual—to compete to create the best offering?

Answer. Many short-term programs deliver great value to students. They deserve equal respect to academic programs and four-year degrees, and they are worthy of Federal investment. Additionally, many workers need to reskill or upskill quickly and often pursue short-term credentials to do so. I want to make sure those credentials are high-quality and provide students with real economic opportunity. I do support the idea of investing in high-quality short-term training programs. While the Administration hasn’t yet taken a position on particular legislation, the President has proposed significant workforce development programs, and we look forward to working with Congress to ensure that workers have access to high-quality credentials through those investments.?

QUESTIONS SUBMITTED BY SENATOR CINDY HYDE-SMITH

Question. As you know, Medicaid reimbursement for school-based health services to eligible students is a significant source of revenue for school districts. I’ve heard from educators in my community about the immense administrative burden experienced by school-based providers who utilize IDEA funding and bill Medicaid, which often duplicates needless paperwork and hinders their ability to deliver the appropriate individualization, frequency, and intensity of services that children with disabilities are entitled to under law. For example, the American Speech-Language-Hearing Association’s 2020 Schools Survey found that school-based SLP and educational audiologists identified excessive paperwork, high workload/caseload, and Medicaid reimbursement as critical challenges in their workplace.

Can the Department of Education increase its support for addressing these challenges, such as through the establishment of dedicated technical assistance centers to address Medicaid Services and Reimbursement; Workload Mitigation; and Telepractice Services?

Answer. Thank you for raising these important issues. Every day, talented related services providers, like speech language pathologists, occupational therapists, and audiologists, provide our nation’s students with a wide range of valuable and necessary supports, and I believe it is critical that we work to ensure that they, and all school staff, have the resources they need to be successful. The Department carefully considers its technical assistance investments to ensure that they meet the needs of the field, and we will take your suggestions under advisement.

In addition, I can specifically assure you that the Department will work with the Department of Health and Human Services to implement the Bipartisan Safer Communities Act requirement that the Departments establish a technical assistance center to support State Medicaid agencies, LEAs and school-based entities to expand their capacity to provide Medicaid-funded school-based services, and to reduce administrative burden

QUESTIONS SUBMITTED BY SENATOR MIKE BRAUN

Question. Section 4307 of the Elementary and Secondary Education Act requires the Department to consult with administrators, teachers, and other individuals involved in the operation of charter schools in the development of any regulations that impact charter schools. Leaders in the charter school community could not identify any members of that community who were consulted with in the development of the Notice of Proposed Priorities (NPP). Your department has proposed an unprecedented number of new regulations for the CSP for this fiscal year, with seemingly no prior stakeholder engagement.

How did the Department comply with Section 4307 and which specific individuals or groups did you consult with?

Answer. The rulemaking process included a dedicated opportunity for written public comment. Public comment is an important opportunity for the Department to hear from individuals and entities most connected to the work and who represent the students and families most impacted by a particular program. The resulting public comments—which involved more than 25,000 submissions that were read and given careful consideration—revealed ways to further strengthen our proposal for this grant program. We appreciate the robust stakeholder feedback. The final rules reflect the numerous changes in response to stakeholder comments to clarify intent, and to maintain our commitment to providing all students with a high-quality education, in particular to our most underserved students. The Department is grateful for the thoughtful input and comments received as the Department worked to finalize rules under the Charter School Program. We are all working toward the same goal of ensuring students from all ages, backgrounds, and communities have access to high-quality education, including through high-quality public schools.

Question. Student loan debt recently reached a record \$1.7 trillion. The student loan repayment pause in the name of pandemic relief has already added nearly \$100 billion to the national debt. According to the Committee for a Responsible Federal Budget, student loan forgiveness would increase inflation rate forecasts between 4 percent and 20 percent, forcing millions of families that hold no student loan debt to suffer higher inflation. It would also worsen inequality since nearly one-third of all student debt is owed by the wealthiest 20 percent and only 8 percent is owed by the bottom 20 percent, according to a Brookings Institution study. The Biden Administration continues to float the idea of student loan forgiveness to appease far-left activists even though it is unlikely that your Department has the legal authority to do so.

Do you believe that even though most Americans do not have college degrees that they should be forced to pick up the cost of student debt forgiveness?

Answer. At this time, the Department of Education's work with the White House and Department of Justice on the question of the Administration's authority to cancel student debt is ongoing. The Department believes it is crucial congressional action address affordability going forward to ensure debt is more manageable in the first place and more Americans have access to an affordable education.

Question. Can you detail the legal authority that the Executive Branch has to unilaterally engage in mass student debt cancellation?

Answer. The Department of Education's work with the White House and Department of Justice on the question of the Administration's authority to cancel student debt is ongoing. As a result, we are unable to share any legal analyses at this time.

SUBCOMMITTEE RECESS

Senator MURRAY. The committee will next meet in Dirksen 138, Wednesday, June 15, at 9:30 a.m. for a hearing on the Biden Administration's budget request for the Department of Labor. The hearing is closed.

[Whereupon, at 11:55 a.m., Tuesday, June 7, the subcommittee was recessed, to reconvene at 9:30 a.m., Wednesday, June 15.]

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

WEDNESDAY, JUNE 15, 2022

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

The subcommittee met at 9:32 a.m. in room SD-138, Dirksen Senate Office Building, Hon. Patty Murray (chairwoman) presiding.

Present: Senators Murray, Schatz, Baldwin, Blunt, Capito, Hyde-Smith, and Braun.

DEPARTMENT OF LABOR

STATEMENT OF HON. MARTIN J. WALSH, 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 2023 budget request for the Department of Labor.

Senator Blunt and I will each have an opening statement. Then I will introduce our witness. And after his testimony Senators will each have 5 minutes for a round of questions.

We are not able to have this hearing fully open to the public yet, or for media and for in-person attendance, but live video is available on our committee website. If you are in need of accommodations, including closed captioning, please reach out to the Committee, or the Office of Congressional Accessibility Services.

Well, this is the last hearings we have scheduled for this subcommittee to discuss the President's budget for fiscal year 2023; and of course the last hearing with Senator Blunt on the other side of the dais.

And after all of the issues that we have worked through together, I can't think of a more fitting tribute to that partnership than a bill that continues that legacy of making meaningful bipartisan investments to help families in my Home State of Washington, in Missouri, and across the country.

So I just want to say that my hope is, after today, we will be able to come together quickly in a bipartisan way, as we have so many times in the past, to turn to the hard work of writing our fiscal

year 2023 appropriations bills, and getting in a good position to pass everything before the end of the year. Families are counting on us to get that done.

I hope we can all agree it is critical to continue strengthening our economy, building off the progress we made thanks to the American Rescue Plan, and last year's appropriations bills.

Under President Biden we have added around 8.7 million jobs. That is an all-time high. And unemployment is near all-time lows at 3.6 percent. Meanwhile, the Pension Relief we passed has already given a lifeline to struggling businesses, and saved the pensions of tens of thousands of workers and retirees who were at risk of having their financial situation turned upside down.

Now, that progress is good, but we still have a lot of work ahead to build a stronger, fairer economy that truly works for workers not just those at the very top and giant corporations.

And right now inflation is a serious challenge that we need to get our arms around, so we need to bring down everyday costs for the basics, like groceries, and gas, and more, that so many families are struggling with today. That is why Democrats are working to lower the cost of prescription drugs and health coverage, and why I believe we need to lower the child care costs for families, and fix our broken child care system that is on the verge of collapse.

We have to get it done through reconciliation before it is too late, because it is plain as day, the child care crisis is holding our economy back. It is keeping so many parents, especially moms, out of the workforce, and making it so much harder for businesses to find the workers that they need.

I have put forward a plan that will lower child care costs for families across the country by thousands of a year, reach more than a million new children and their families, raise wages for child care workers and stabilize the sector, keeping providers' doors open, and making more options available to families, and ultimately to strengthen our entire economy. I am going to keep pushing with everything I have to get that done.

Now, Secretary Walsh, I am glad you were able to hear directly from workers in my Home State of Washington about the challenges that they are facing when you visited a few months ago. And I am especially glad to see that President Biden's budget takes to heart so much of what the people in my State had to share with you.

We have important work ahead to protect workers' rights, to raise wages, to make sure we have decent, safe, fair working conditions, and deliver high quality workforce development opportunities. And the increased funding for the Labor Department in this budget will help us get it done with many much needed investments.

First, it would provide resources to help fix and strengthen our unemployment insurance systems, which so many people rely on when they hit hard times and are looking for their next job, and which this pandemic has shown, is broken in far too many ways. This should be a reliable lifeline for people so they can get back on their feet. But back in my State and in several others, our unemployment programs have been undermined by fraud, outdated technology, and massive data hacks.

We have to do better for families, and that starts with providing the resources we need to actually update IT programs, and fix the system.

This budget will also help people who are working to find good, high-paying jobs by increasing support for registered apprenticeships, and other high-quality workforce development programs so they can provide quality opportunities in even more industries and occupations. And reach more women, people of color, formerly incarcerated individuals, people with disabilities, and others who are too often left out, because you shouldn't have to have a college degree to make a decent living in this country.

Of course, the Department must do more than provide workers new opportunities; we need to be bold in protecting their rights as well. That is why it is so important this budget invest in the worker protection agencies charged with ensuring employers respect workers' rights and follow Federal laws.

Better enforcing these laws will help make sure workers are paid the wages they have earned, not shortchanged on overtime, or denied minimum wage, get the family and medical leave they are eligible for, and go to work in a safe and healthy workplace.

For too long the number of investigators in the Wage and Hour Division has been declining. We actually just hit a 50-year low. Too often, the division simply cannot investigate wage theft at huge, very well resourced corporations. So I think we need to level the playing field for workers to make sure they are getting a fair shake. And these resources will allow us to crack down on employers who don't pay employees the overtime pay they are owed, pay workers less than prevailing wages required under law and, otherwise, cheat employees out of the pay they earned.

These investments will not just provide accountability to businesses; they will put money directly back in workers' pockets where it belongs.

Meanwhile, increased resources for the International Labor Affairs Bureau will protect workers here at home from unfair competition when foreign companies do not play by the rules, ensuring our trading partners follow through on their commitment to workers' rights and keep our Nation competitive on the world stage.

And increased investments in the Office of Federal Contract Compliance, will help ensure employers working for the government follow the law, including protecting against workplace discrimination and harassment. And when it comes to enforcing labor laws, this pandemic has put a harsh spotlight on how critical workplace health and safety laws are. We need the occupational Safety and Health Administration to do more to live up to its responsibility here.

WORKPLACE SAFETY

In 2020, our country lost an average of 15 people to workplace injuries every day. Everyday 15 loved ones never made it home. And workplace deaths like these are disproportionately workers of color. That is heartbreaking, we have to do better, which is why it is critical this budget bolsters support for OSHA's (Occupational Safety and Health Administration) mission to keep workers safe on

the job, and protected from retaliation for calling out safety and health issues in the workplace.

PERMANENT COVID SAFETY STANDARD

It is also why I am continuing to push OSHA to move quickly to finally issue a permanent COVID-19 standard for healthcare workers, and work on a permanent infectious disease standard as well. Healthcare workers have been on the frontline of this pandemic. They have worked tirelessly to save the lives of countless patients, but they have faced grave danger during this pandemic just trying to do their jobs.

COVID-19 has killed over 5,000 nurses and healthcare professionals. We owe it to each, and every one of our healthcare heroes to keep them safe.

So Mr. Secretary, I expect to see the Permanent COVID Safety Standard from the Department soon. We should have had one already. Workers cannot keep waiting. It is clear to me, and I think it is clear to everyone listening, that we have more work to do to support our workers and their families. So I am going to keep pushing to make sure families have a little less stress on their shoulders; and a little more money in their pockets.

That means bringing down costs across the board on things like groceries, and gas, and healthcare, and child care, and everyday essentials. It means ensuring workers get paid a fair living wage, and are not cheated out of it, and go to work confident they will be coming home safely. It means making sure they can choose to care for themselves and their loved ones without losing the paycheck they need, and can learn new skills if they want to pursue a new career in a higher paying field.

And it absolutely means ensuring we protect workers' rights, especially the right to join, or form, a union, to collectively bargain for better benefits, better healthcare, better retirement plans, and higher wages.

BUDGET PRIORITIES IMPACTING WORKERS

I am glad to say this budget makes clear the Biden administration is also committed to these goals, and President Biden understands, as well as anyone, that working families are the heart of our country and the backbone of our economy.

Democrats are focused on the economy, Mr. Secretary. We are focused on tackling inflation, lowering costs, and making sure working people get a fair shake and their fair share. So I look forward to working with you and the President to keep building an economy that puts those working people first.

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. And good morning to everybody participating in the hearing; and welcome Secretary Walsh. I look forward to your testimony on the Department of Labor's fiscal year 2023 budget request.

Last year when you testified before the subcommittee a principal topic, and certainly a topic I raised, was how the COVID-19 pan-

demic had put an unprecedented strain on our economy and on our workforce. At the time, I had serious concerns that our country would not return to our pre-pandemic unemployment levels, which had been the lowest since the late 1960s.

And while I am pleased that we are making real progress in lowering the unemployment rate, I am concerned about the very real economic and labor shifts that have occurred since the last time we had a hearing, and you were before this committee. I am talking of course about the economic impact of inflation, an invisible tax that takes its toll on every American, but it is particularly burdensome for those who can least afford it.

Many of the increases in paychecks have been more than offset by increases in what you have to pay for, and it only takes a trip to the gas station or the grocery store to know, for most families, exactly what that means. In recent months that inflation number has been above 8 percent, the highest rate in over 40 years, and the Treasury Secretary recently testified before the Senate Finance Committee that inflation was here to stay for any foreseeable future.

This administration's inflation forecast has already showed prices rising this year at nearly twice the pre-pandemic rate. And while we might disagree on the root causes of this historic inflation, that is really reversing those economic gains made in the past, I do believe we can agree that every American is feeling the impact.

History has told us that we can't spend our way out of inflation. Instead we have to exercise fiscal responsibility and be prudent about determining what is truly needed to right the ship, and begin to head things in a different direction. Additionally, we are seeing major labor shifts that I think will impact the labor market for years to come, dubbed by some the "Great Resignation", we have watched record numbers of employees resign following the COVID-19 pandemic, and that was particularly apparent and evident in the young adult population.

Simultaneously help-wanted signs are still visible almost everywhere across the country as businesses and employers continue to search for workers to fill the vacancies they have. There is no question that this is a turbulent moment in our country's history, particularly our economic history. But often during times like this, of economic and market uncertainty, we have the opportunity to rethink the way we have been doing things, and prioritize programs that provide the most benefit—in the case of the Department of Labor—to workers and employers alike.

This is why I was surprised to see the fiscal year 2023 budget doubling down on new programs, and funding levels rejected just 3 months ago in the fiscal year 2022 bill.

The fiscal year 2023 proposed budget for the Department of Labor totals \$14.9 billion, an increase of almost \$2 billion, and nearly 13 percent over the appropriations bill that we just passed. That is nearly triple the increase that was provided in that bill. I wouldn't expect to see that if I were you. And we want to be talking about what those priorities really are, funding such as \$100 million for the POWER Plus initiative which will transition workers away from jobs in the fossil fuel industry, to what would be

considered generally green jobs, is not included in the fiscal year 2022 final bill, and here it is that \$100 million is right back in this budget request.

Similarly, a Career Pathways for Youth Grants, a program that I began as Chairman in 2020, to ensure that young adults in this country have adequate knowledge, before they get there, of all the post-secondary options that they need to know about, to be informed about what their pathway really is.

I agree with the Chairman's view that there are a lot of ways to get to a successful career, and a successful life that allows you to do the things that are best suited for the kind of life you want to lead, and we need to be sure that we are not just looking at one pathway. I think so much of education, secondary education has been focused on only one way forward for a long time, and that is why we try to fund, I think the funding was about \$15 million, to look at career pathways early in the education process so that people in junior high school, middle school, and high school begin to get a sense of what kinds of jobs that are out there.

I was surprised you didn't ask for the continuation of that program. Why is the funding for workers to transition out of their current stable career for jobs and industries that the administration prefers being prioritized, and looking at how the future labor force gets ready for the work that they would want to do, isn't?

We need to ensure that our labor programs are nimble, and quite adequately and appropriately address unexpected workforce challenges. For example, while I supported funding for registered apprenticeships, the registered apprenticeship model is underutilized by industries that need it the most, such as healthcare, and IT, and cybersecurity, because it has just not been a very flexible model.

And I hope we can work with you to find more flexibility in that whole concept of apprenticeships. I have said it before, and I will say it again, we need to create an environment for Americans to thrive, and we need to target our Federal resources to cultivating the workforce of the future.

It is wrong for the Federal Government to dictate what that workforce should look like, and for bureaucrats in Washington to determine the speed in which we get there, that should be left up to States, and communities, and local economies. I believe we can work together to find consensus on the Department's budget.

I look forward to working with you, Mr. Secretary, as well as Chair Murray, and our colleagues on the subcommittee, to once again, come up with a bill that prioritizes bipartisan initiatives, and innovation in the workforce system.

As the Chair mentioned, this is my last likely hearing on the Labor Appropriations part of this budget, but we have had good success working together, finding ways to find a path forward. I certainly hope we can do that.

I want to thank all my colleagues for their support over the time I have been on this committee, and particularly Chair Murray for the great working relationship we have had.

Again, thank you for your time here today, Secretary Walsh. I look forward to working with you to strengthen our Nation's workforce, and create a more prosperous economy for all Americans.

Thank you, Chairman.

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 2023 budget request.

Last year, when you testified before this Subcommittee, I spoke a great deal about how the COVID-19 pandemic put an unprecedented strain on our economy and its workforce.

At the time, I had serious concerns that our nation wouldn't return to our pre-pandemic unemployment levels, which were the lowest since the late 1960s. While I am pleased that we are making progress in lowering the unemployment rate, I am concerned about the very real economic and labor shifts that have occurred since the last time you came before this Subcommittee.

I'm talking about inflation, of course, which is an invisible tax that takes its toll on every American, but is particularly burdensome to those who truly can't afford it.

In recent months, consumer inflation in the United States has trended above 8 percent, the highest rate in over 40 years, and the Treasury Secretary recently testified before the Senate Finance Committee that inflation was here to stay.

This Administration's inflation forecast has already showed prices rising this year at nearly twice the pre-pandemic rate.

While we may disagree on the root causes of this historic inflation that's reversing the economic gains made under the previous Administration, I do think we can agree that every American is feeling the impact.

And history has told us that we cannot spend our way out of inflation; instead, we must exercise fiscal responsibility and be prudent about determining what is truly needed to right the ship.

Additionally, we are seeing major labor shifts that I think will impact the labor market for years to come. Dubbed the "Great Resignation," we've watched record numbers of employees resign following the COVID-19 pandemic, particularly amongst the young adult population.

Simultaneously, "help wanted" signs are still visible across the country, as businesses and employers continue to search for workers to fill the vacancies.

There's no question that this is a turbulent moment in our Nation's history—but often during economic and market uncertainty, we have an opportunity to rethink the status quo and prioritize programs that provide the most benefit to workers and employers alike.

This is why I was surprised to see the fiscal year 2023 budget doubling down on new activities and funding levels that were rejected just 3 months ago in the fiscal year 2022 bill.

The fiscal year 2023 budget for the Department of Labor totals \$14.9 billion, an increase of \$1.7 billion and nearly 13 percent over fiscal year 2022, which is nearly triple the increase that was provided in fiscal year 2022.

Funding, such as \$100 million for the POWER+ Initiative, which will transition workers away from jobs in the fossil fuel industry to what some consider "green jobs" was not included in our fiscal year 2022 final bill, and yet it appears again in your budget request.

Simultaneously, "Career Pathways for Youth" grants, a program that I began as Chairman in fiscal year 2020 to ensure the young adults in this country have adequate knowledge of all post-secondary options to make an informed decision about their career trajectory, was excluded from the budget request.

Which begs the question: why is funding for workers to transition out of their current, stable careers for jobs in industries this Administration prefers prioritized over funding for informing the future of our workforce about all of their options?

We need to ensure that our labor programs are nimble and can adequately and appropriately address unexpected workforce challenges.

For example, while I supported funding for registered apprenticeships, the registered apprenticeship model is underutilized by industries that need it the most, such as healthcare, IT, and cybersecurity, due to its lack of flexibility.

I've said it before and I'll say it again: we need to create an environment for Americans to thrive, and we need to target our Federal resources to cultivating the workforce of the future.

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.

I believe we can work toward consensus on the Department's budget.

I'm looking forward to working with you, Mr. Secretary, as well as Chair Murray our colleagues on the Subcommittee to once again put forth a bill that prioritizes bipartisan initiatives and innovation in the workforce system for fiscal year 2023.

Finally, I'd like to thank all of my colleagues for their support over the years on this Committee, especially Chair Murray.

This is likely my last Labor/HHS hearing, and I'd like to take the opportunity to say that it has been a tremendous honor to serve with you on this Subcommittee on behalf of the great State of Missouri.

Again, thank you for your time here today, Mr. Secretary. 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 Blunt.

With that, our witness today is Marty Walsh, Secretary of the Department of Labor. Secretary Walsh, thank you for joining us today. I look forward to your testimony. You may begin.

SUMMARY STATEMENT OF HON. MARTIN J. WALSH

Secretary WALSH. Thank you very much, Chairwoman Murray; and Ranking Member Blunt, thank you as well; members of the committee that are here today, and that will be coming in and out, I want to thank you for the opportunity to testify in front of you today.

STRENGTHENING THE AMERICAN WORKFORCE

I am certainly pleased to outline the Biden-Harris administration's priority for the Department of Labor's fiscal year 2023 budget. My mission as Secretary, quite honestly, of Labor, is to empower all workers morning, noon, and night. Frontline workers who carried us through the worst days of the pandemic, the marginalized workers who face barriers to employment opportunities, the veterans who serve our Nation, the rural workers who we serve through targeted workforce grants. The Department of Labor, quite honestly, stands with all workers in every community to build stronger, more resilient, and a more inclusive economy.

I am certainly proud of all that the Department has accomplished in the past year, and the folks that work with me every single day. We implemented key provisions of the President's American Rescue Plan, supporting healthcare, and pensions, and unemployment insurance. We protected workers from COVID-19 and heat exposure. We strengthened retirement security, and access to mental health services. We expanded career-training programs to connect more Americans to opportunities that they, quite honestly, need.

Ranking Member Blunt talked a little bit about, you know, people resigning, putting those people back into better paying jobs, connecting more industry as well to skilled workers. We implemented the President's \$15 an hour minimum wage for Federal contracts, legislation to stop surprise billing, medical billing, protections for Tip workers, we advanced government-wide initiatives to support workers organizing rights, climate action, and infrastructure implementation.

In all of our work, we are committed to equity for the most vulnerable workers in communities all across America. And we have in this moment a unique opportunity to help all workers thrive. The President's plan has produced historic job recovery and Con-

gress has made major investments in workers through the Bipartisan Infrastructure Law.

GOOD JOBS INITIATIVE

In the Department of Labor the Good Jobs Initiative we are partnering across government to make sure these investments create good jobs and access to all. And I am committed to supporting the congressional efforts to invest in the workforce training, child care support, education, healthcare, and work things that, quite honestly, families depend upon.

WORKFORCE DEVELOPMENT INITIATIVES

The fiscal 2023 budget submission builds on these investments and renews our pledge to serve workers, job seekers, and retirees all across America. Workforce development is a vitally important area of opportunity, high quality job training lifts workers into the middle class, and increases equity in our economy, and these programs meet the talent needs of employers, and strengthens our supply chain. That is why the President's budget requests \$303 million, we are looking to expand registered apprenticeships.

I agree with you Senator Blunt, about creating opportunities into other industries, and we have been working on that, and that is really, what we need to do in America more. We have \$100 million for career training and growing industry sectors, \$100 million for community college partnerships with employers.

I have visited community colleges in dozens of States across this country. I visited dozens of Job Corps centers around this country. And I see innovative programs designed in collaboration with employers working for students of all backgrounds. We need to invest in these partnerships and reach out to more employers, and we need to provide more workers with better opportunities for their future.

This budget also increased funding for veterans through our Veterans Employment and Training Service Agency. It increases funding for our Women's Bureau to expand access for women's careers where they are under representative—represented, excuse me.

INVESTING IN WORKER PROTECTION

This budget invests \$2.2 billion in the Department's worker protection agencies. This work is more essential now than ever to rebuild our staffing levels, as you said Madam Chair, in your very first line. That includes OSHA's efforts to double the number of inspectors by the end of the President's first term. It will restore MSHA's (Mine Safety and Health Administration) capacity for enforcement in mine plant equipment reviews. It would restore staffing for unemployment benefit, and security administration to protect workers' health, retirements, and disabilities.

It would increase funding for Wage and Hour to safeguard our wages for the most vulnerable workers. It would fund the Office of Federal Contract Compliance to ensure Federal contracting advances America's promise of fairness for all workers.

This budget increases funding to the Office of Labor Solicitor to rebuild the entire Department's capacity to enforce the laws that

are on the books; we also have requested the resources for the Bureau Of International Labor Affairs, ILAB, to ensure our training partners uphold their labor commitments so America's workers can compete on a level playing field.

UNEMPLOYMENT INSURANCE REFORM

The budget fully funds and updates the State funding formula for unemployment insurance that will be the first comprehensive update in decades. It allows States to serve claimants more effectively. And our request includes \$150 million to strengthen the integrity of the system.

Finally, the budget requests nearly \$4 million to support the Good Jobs Initiative. This will enable us to advance the President's priorities of good jobs, and free and fair choice to join a union.

CONFRONTING INFLATIONARY PRESSURES

And I just want to touch briefly, before I end my remarks, on inflation. Certainly, the President has talked to all the Cabinet. It is an all-of-government approach to bring down those pressures at the kitchen table, to bring down those pressures at the gas pump, to bring down those pressures at the grocery store.

The President, his administration did not cause inflation, but we certainly are not running away from inflation because it impacts every single American person, and we need to do everything in our power to bring those pressures down. This is a worldwide challenge that is happening in other countries around the globe, but we need to focus on what we are doing here in America. So I look forward to talking about that a little later.

I see all of what we do everywhere I travel, workers are showing up each and every day to move our communities and our Nation forward, and in return we must do everything we can to ensure the well-being and empower them with opportunity.

I want to thank you, both, and all the committee members once again for the opportunity to testify today. I look forward to discussing our budget requests here with the committee and certainly any time that anyone needs to reach out to the Department of Labor, do feel free to call me. Thank you.

[The statement follows:]

PREPARED STATEMENT OF MARTIN J. WALSH

Chair 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 and to outline the Biden Administration's vision and priorities for the Department of Labor in fiscal year (FY) 2023. I am honored and humbled to lead the Department in its critical work.

My vision as the Secretary of Labor is to empower workers morning, noon, and night. This includes centering our work on the most vulnerable workers, those facing barriers to employment, misclassified workers, and workers in temporary jobs or other jobs that heighten their economic insecurity and vulnerability. The Department honors the nurses, doctors, first responders, farm workers, construction workers, communication workers, warehouse workers, grocery store workers, servers, teachers, childcare providers, and government workers who have carried us this far through the COVID-19 pandemic. The Department also acknowledges that many of the workers and families on the frontlines of the COVID-19 pandemic are among the lowest paid, and most marginalized. As Labor Secretary, I am focused on advancing equity, creating good jobs, and empowering workers to organize and suc-

cessfully bargain with their employers. The Department stands shoulder to shoulder with all workers to build a better and brighter future.

DOL ACCOMPLISHMENTS

When I testified before this Committee last year, I was new to the Department of Labor. A little more than year later—I am proud of everything the Department has accomplished. We have issued standards and guidance and pursued strong enforcement strategies to keep workers in healthcare and other key industries safe and fight the spread of COVID-19. We extended and expanded unemployment relief for workers during the pandemic.

During this past year, the Department has worked tirelessly to address acute and long-term supply chain issues, and issues affecting retirement, wages, tipped workers, workers' rights, and collective bargaining. In collaboration with the Department of Transportation, the Department recently announced a Trucking Action Plan to expand Registered Apprenticeship and to improve job quality in the industry overall through the "Driving Good Jobs" Initiative. The American Rescue Plan (ARP) authorized special financial assistance (SFA) through the Pension Benefit Guaranty Corporation (PBGC) to help save severely underfunded multiemployer plans and enabled over three million participants and beneficiaries to continue to receive their pension benefits now and in the future. PBGC estimates that ARP will provide an estimated \$94 billion in assistance to eligible plans that apply for SFA.

The Department continued to strengthen enforcement by using every tool available in order to keep workers in America safe and healthy on the job and ensure that they receive the wages that they have earned. The Department's Wage and Hour Division (WHD) has recovered over \$230 million in back wages for more than 190,000 workers, averaging \$1,200 in back wages per employee. The Department also issued final rules to restore protections for tipped workers, including protections that Chair Murray and Chair DeLauro were integral to enacting in 2018.

The Employee Benefits Security Administration (EBSA) worked with the Departments of Health and Human Services and Treasury to implement the provisions of the No Surprises Act, preventing patients in need of care from being saddled with large, unexpected out-of-network medical bills. In 2021, EBSA recovered over \$2.5 billion in retirement savings and healthcare benefits owed to workers. This is real money—money people earned and were owed—and the Department's staff returned it into people's pockets and retirement accounts.

Additionally, despite unions' long history of fighting for higher wages and lifting up workers' voices, only 10.3 percent of the U.S. workforce is unionized, even as a full 52 percent of non-union workers say they want to join a union. The Biden-Harris Administration took action and established the White House Task Force on Worker Organizing and Empowerment. This first-of-its-kind government-wide effort is promoting policies, programs, and practices to help more workers organize and successfully bargain with their employers, and to lift up as models cooperative labor-management relations where unions and employers jointly solve problems advancing both workers and employers' interests, though we continue to urge Congress to pass the Protecting the Right to Organize (PRO) Act. The Department also continues to support efforts to raise the minimum wage for workers in America. One significant step and progress is implementing President Biden's Executive Order raising the minimum wage to \$15 an hour for 300,000 workers on Federal contracts.

We will continue to take steps to unleash the full power of the Department to continue addressing wage theft, keeping workers safe and healthy, and expanding access to good jobs for all.

COMMITMENT TO EQUITY

Shortly after being sworn in, President Biden issued several groundbreaking executive orders to dismantle entrenched disparities in our laws and public policies: E.O. 13985 calls for the Federal Government to advance racial equity and support underserved communities through immediate and sustained action and E.O. 14035 charges Federal agencies with cultivating a workforce that draws from the full diversity of the Nation. The Department has been hard at work delivering on both of these mandates. The Department continues to strive to be a model workplace and make the Federal government a model employer. Indeed, our Chief Evaluation Office is leading efforts to evaluate how we can improve diversity, equity, inclusion, and accessibility across the Federal workforce. In addition, we are focused on understanding how well our programs, protections, and contracting opportunities reach different communities and what barriers to access they face, as well as what data we have or need to understand how the Department is serving different communities. We have taken a number of important steps across our rulemaking,

grantmaking, and enforcement programs to better reach the most underserved and disadvantaged populations.

Both with the funding already appropriated to us, and as outlined in our fiscal year 2023 budget request, these questions guide our efforts. For example, we recently announced the availability of \$260 million in American Rescue Plan funding available to states to promote equitable access to unemployment compensation programs. The fiscal year 2023 Budget also includes \$15.4 million in the Office of Disability Employment Policy to plan and implement Equitable Transition Model projects to develop the strategies we need to ensure youth with disabilities can get good jobs. These resources will help the Department tackle the inequities facing youth with disabilities, including youth who are experiencing homelessness, leaving foster care, or involved in the justice system.

We have accomplished a lot over the past year, but we have a lot more we need to do. We see that even as the economy recovers from the pandemic, most of the job gains have gone to men. In the May jobs report, there are still 812,000 (1.1 percent) fewer employed adult women than there were pre-pandemic, whereas the number of employed adult men, at 81.4 million, has returned to the pre-pandemic level. Black women's unemployment rate (5.9 percent) is the highest among women by race and ethnicity. The intersection of racism and sexism means that Black women are experiencing a different, and more difficult, recovery not just because of the types of jobs they are likely to hold, but also because they are often treated differently within those jobs.

We must embed equity into how we recruit, hire, and retain all workers, including leave and scheduling policies that support families. An economy that works only for some in our country means that economy is fundamentally broken. I welcome all of you to join me in these efforts.

INVESTMENT IN WORKERS IS LONG OVERDUE

Over the past year, Congress has made historic investments in workers—in the Unemployment Insurance (UI) system, in resources to better protect workers, and in the bipartisan infrastructure investments. The UI system, in particular the emergency unemployment compensation programs extended by the American Rescue Plan, provided life-saving benefits to American families throughout the COVID-19 pandemic. During the pandemic, UI benefits helped over 53 million workers who lost their jobs through no fault of their own and put some \$870 billion back into the economy. These benefits helped Americans across the country stay in their homes and support their families and protected the economy from even more devastating consequences. Studies have shown that every \$1 paid in UI benefits translates into \$2 to boost the economy.

However, the pandemic also highlighted that more can be done to ensure that workers have timely and equitable access to UI benefits and that fraudsters, particularly sophisticated international criminal rings, do not flood the UI system with false claims to wrongly acquire taxpayer funds while creating further delays and barriers for genuine claimants in need. With the \$2 billion provided in the American Rescue Plan, the Department is making progress to modernize the UI system to be more timely, equitable, and safe. The Department has already provided significant funding to states to strengthen their UI identity verification systems, enhance their fraud detection and prevention strategies, and increase cybersecurity. We have made additional funds available to help workers learn about, apply for, and better navigate the UI system and to provide states with a comprehensive, multi-disciplinary assessment of their UI systems and the resources to implement improvements identified in the assessment.

The American Rescue Plan also provided \$200 million for the Department's worker protection activities. The Department continues to provide outreach to essential COVID-19 frontline workers most vulnerable to violations of worker protection laws as well as compliance assistance to employers delivering essential services.

Through your coordination and cooperation, Congress delivered a \$1 trillion Bipartisan Infrastructure Law (BIL) to build a better America. This represents an investment in well-paid, union and middle-class jobs for every single community in America. Our goal is to ensure these Federal resources are leveraged to create economic opportunities for workers in the communities in which they live. In support of this goal, in March of this year, the Department published a proposed rule to update and modernize the regulations implementing the Davis-Bacon and Related Acts, proposing changes that will be good for workers and good for building high-quality infrastructure and for a strong construction industry.

The Administration is committed to working with Congress to enact the President's plan to lower healthcare, child care, energy, and other costs for families; re-

duce the deficit; and expand our economy's productive capacity. If enacted, the Department will use these resources to get our programs where they need to be to operate effectively and efficiently while transforming them to address what we value including worker empowerment, equity, program access, and the other areas of emphasis set out by this Administration. I am committed to doing what I can to help Congress get this important legislation passed.

We appreciate Congress enacting additional funding in fiscal year 2022 for investments in job training, apprenticeship programs, and protecting workers through the Department's worker protection agencies. Through the Good Jobs Initiative, we are coordinating the Department's on-going efforts to advance job quality for all workers, including people of color, LGBTQ+ individuals, women, immigrants, veterans, people with disabilities, justice-involved individuals, and individuals in rural communities. Additionally, we are partnering across Federal agencies to enhance implementation of job quality and equity standards into Federal investments. This funding, together with the already-appropriated resources through the American Rescue Plan, lays the groundwork for ensuring that all workers can participate and thrive in a growing economy.

FISCAL YEAR 2023 BUDGET REQUEST

The fiscal year 2023 President's Budget builds on these investments and renews DOL's pledge to help all workers and job seekers in America—particularly those from disadvantaged communities—access training and find pathways to high-quality jobs that can support a middle-class life.

The Budget requests \$303 million 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. RA is a proven earn-and-learn model that raises participants' wages and is a reliable pathway to the middle class. This investment would provide critical funding to support capacity-building, including expanding and diversifying RA programs as well as expanding pre-apprenticeship programs to increase access to RA. Community colleges play a critical role in providing accessible, low-cost, and high-quality training. The Budget invests \$100 million to build their capacity to work with the public workforce development system and employers to design and deliver high-quality training for in-demand jobs. The Budget also includes \$100 million for a new Sectoral Employment through Career Training for Occupational Readiness (SECTOR) program, which will support evidence-based training programs focused on growing industries, enabling underserved and underrepresented workers to access good jobs and creating the skilled workforce the economy needs to thrive.

The Budget advances the goal of developing pathways for diverse workers, including those from disadvantaged groups, to access training and career opportunities through increased investments in programs that serve justice-involved individuals, at-risk youth, and American Indian, Alaska Native, and Native Hawaiian individuals. No economic recovery can be complete if some communities are left behind, and this Budget reflects the Department's commitment to helping all workers get back on their feet.

The pandemic has been particularly damaging for women workers, specifically women of color and low-wage workers, many of whom have faced the loss of childcare while trying to protect the safety of themselves and their families and still put food on the table. The fiscal year 2023 Budget requests more than \$25 million for the Women's Bureau, including additional funding to strengthen the Women in Apprenticeship and Nontraditional Occupations program and expand the Fostering Access, Rights, and Equity program. This grant program is designed to support targeted education and outreach efforts by "trusted messengers" and community intermediaries to ensure that marginalized workers—disproportionately women of color—avail themselves of critical and timely income supports and employment rights and benefits.

Our nation's veterans, transitioning service members, and their spouses deserve every opportunity to successfully transition from active duty to civilian life, receive access to benefits and protections, and find good jobs with family-sustaining wages. The Budget provides funding for the Veterans' Employment and Training Service's core programs, which help improve skills and provide employment opportunities for veterans across the country. The Budget increases funding for VETS' Homeless Veterans' Reintegration Program to more than \$62 million, enabling the program to serve over 1,000 additional veterans experiencing homelessness.

Throughout the pandemic, workers have shown up for America, helping to keep the economy growing, hospitals operating, food in stores, and construction projects booming. In appreciation of the incredible dedication of workers in America, DOL

must ensure workers are treated with dignity and respect in the workplace. The fiscal year 2023 Budget invests \$2.2 billion in the Department's worker protection agencies.

Staff losses at the Occupational Safety and Health Administration (OSHA) and the Mine Safety and Health Administration (MSHA) have left workers less safe on the job, particularly amid the increased threats to workplace health and safety created by the pandemic. The fiscal year 2023 Budget provides resources to help OSHA rebuild its rulemaking and enforcement capacity, expand its whistleblower protection program, and increase its outreach and compliance assistance. This investment will support OSHA's efforts to double the number of inspectors by the end of President Biden's first term. The request also includes resources to restore MSHA's capabilities in enforcement to help ensure miners' health and safety amid a projected increase in workload stemming from the BIL.

Losses to front-line enforcement, regulatory, and compliance assistance staff at the Employee Benefits Security Administration have similarly compromised the Agency's ability to ensure the solvency of self-funded health plans, the security of retirement benefits, the integrity of plan assets, the payment of promised benefits, the cybersecurity of plan accounts, and the integrity of health and disability plans. The requested fiscal year 2023 Budget would restore lost staff and enable the agency to protect workers' interest in their health, retirement, and disability benefits. The return on the taxpayer's investment is significant, as reflected in the \$2.5 billion it recovered last year. The additional funds requested would contribute greatly to the benefit of the more than 158 million workers, retirees, and their families who depend on ERISA-covered plans for their medical benefits and for the security of their retirement in old age.

Currently, WHD enforcement staffing is near historic lows, impacting the ability of the agency to enforce fundamental labor protections including minimum wage, overtime, and family and medical leave for 148 million workers across the country. In particular, retaliation against workers for coming forward with a complaint about their pay or the misclassification of employees as independent contractors robs workers of their rightful wages, benefits, and protections. The fiscal year 2023 Budget increases funding to the WHD by more than \$56 million over the fiscal year 2022 enacted level. This funding increase will enable WHD to hire, train, and equip enforcement staff to better protect essential workers by safeguarding their pay and recovering back wages, with particular emphasis on the workers most vulnerable to wage violations and exploitive labor conditions.

The Budget requests to increase funding for the Office of Federal Contract Compliance Programs (OFCCP) by nearly \$39 million above the fiscal year 2022 enacted level, enabling it to fully enforce employment antidiscrimination requirements to ensure Federal contracting consistent with America's promise to all workers in America. Included in this increase is \$3.2 million to enable OFCCP to meet the increased need for its services as a result of the BIL. This funding will allow OFCCP to build its capacity to remove systemic barriers that workers in underrepresented communities face to accessing good jobs in construction and other growth industries that the BIL will bolster.

Critical to all these investments in protecting workers' pay, benefits, safety and health, and rights is rebuilding the Department's capacity to actually enforce the law. This can only be accomplished if the Office of the Solicitor is fully funded. SOL, the legal enforcement and support arm of the Department, has been kept approximately level-funded since fiscal year 2013 despite increasing operational costs and rising demand for legal support in litigation, investigative assistance, advice, and regulatory work. As a result, SOL has lost over 100 staff since 2013, resulting in a severe diminution in enforcement actions. The Budget recognizes that without adequate resources for SOL, DOL will not be able to achieve its mission in any area. To avoid this, the Budget increases funding to SOL by \$52 million above the fiscal year 2022 enacted level to support a total of 740 FTE.

The Budget also includes resources for the Department's Bureau of International Labor Affairs (ILAB) which safeguards dignity at work, both at home and abroad. ILAB ensures that our trading partners uphold their labor commitments so that America's workers can compete on a level playing field. Just this year, ILAB has been integral in supporting the first independent union elections at the General Motors plant in Silao, Mexico and the Tridonex auto parts facility in Matamoros, Mexico. We are proud to support these efforts to ensure that all workers can exercise their right to freedom of association and collective bargaining. Supporting workplace democracy across the world improves working conditions abroad, combats forced labor and child labor, improves livelihoods for vulnerable workers, and creates a fairer global economy for America's workers.

President Biden has made the creation of good jobs with the free and fair choice to join a union a cornerstone of this Administration. Fulfilling this promise requires a comprehensive rethinking of everything in the Department's capacity to improve job quality throughout the country. The Budget requests nearly \$4 million to support the Good Jobs Initiative, enabling the Department to provide additional training and technical assistance to agencies as they work to embed and promote good jobs principles in procurement, loans, and grants; engage employers on strategies and initiatives to improve job quality; and provide a centralized location of information and services on workers' rights under key workplace laws and on unions and collective bargaining for use by workers, unions, employers, researchers, other government agencies, and policymakers.

While UI provided a lifeline for millions of families throughout the pandemic, the pandemic has also shined a light on the inadequacies in the UI system after decades of underinvestment. Overburdened and outdated state UI systems kept millions of workers from getting benefits quickly and left many unable to access the program. These painful delays and barriers fell disproportionately hard on workers of color and low-income workers. To address these shortcomings, the Budget makes investments to ensure states can better handle higher volumes of claims and be better prepared for future crises. The Budget fully funds and updates the formula for determining the amount states receive to administer UI, which will allow states to serve claimants more quickly and effectively. In addition, the Budget includes a \$150 million investment to promote integrity in the UI system. This investment will provide funding to states for identity verification services while also supporting IT infrastructure updates to prevent fraud and improve the claimant experience.

While these critical investments will make meaningful improvements to the UI system and help ensure families across the country can access this vital assistance when workers need it most, we must also keep in mind that no amount of financial investment will be able to, on its own, fix all of the issues in the UI system. That is why the Budget puts forward principles for UI reform. As the pandemic has made clear, regular UI benefits in most states are far too low, leaving families without the resources they need to make ends meet in times of economic crisis. Additionally, millions of workers who lost income due to the pandemic and recession were ineligible for UI benefits. And despite its important relief and stimulative effects, UI's reach across jobless workers remains uneven, with Black and Hispanic workers facing lower success rates for receiving benefits than white workers. The Administration and I are eager to work with Congress on broad changes to modernize the program as well as advance racial, geographic, and gender equity in the UI system.

CONCLUSION

As Labor Secretary, I've made it my priority to travel across the Nation. It's a personal mission of mine to amplify the voices of working people and share their stories on what they need, successes they have had, and how the Biden-Harris administration can support them. I was able to see how lead pipes impact communities like Harambee in Wisconsin, where the health of the children and everyone else depends on the success of a stalled lead pipe replacement project. I visited a public library in Dallas, Texas, that provides broadband Internet for residents to help more people get access to online resources. And across the country I have seen first-hand how union-led job sites can boost local economies by hiring locally.

Despite all that we have been through, workers across the Nation are still showing up each and every day to help meet this moment. All of us have an opportunity to create an economy where everyone is respected, protected, and can thrive. The Department and the Biden-Harris Administration recommits its efforts to build an economy and a labor market that is more just and equitable and create opportunity for all.

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.

Let me begin with something I referenced in my opening remarks, and that is that workers deserve to be safe at work. I am concerned because right now we still do not have a COVID-19 workplace safety standard, and to me that is just really unacceptable, especially because last year, in a report by the Government Accountability Office on the Federal response to the pandemic, GAO (Government Accountability Office) made clear that OSHA in-

spectors were facing challenges with COVID-19 cases without a specific standard.

DEPARTMENT OF LABOR RULEMAKING TIMELINES

I have two questions for you. And let me start with the first. When will OSHA finalize a permanent COVID-19 standard for healthcare workers? And can you just give me a clear timeline here?

Secretary WALSH. I believe it will be done in the next 3 to 6 months. We are going through the process now, I do believe we are taking public comments, and we are moving through that final healthcare standard.

Senator MURRAY. Three to 6 months from now?

Secretary WALSH. Yes. Because it is a rule-making process, as you know the rule-making process, and I mean, I would love to speed it up, but unfortunately we have this, it is a process that is in place that we have to work on now.

Senator MURRAY. Well, when will OSHA take the next steps on a Permanent Infectious Disease Standard, a process that was actually initiated more than a decade ago?

Secretary WALSH. We are working on that as well right now. And I think that is in the same timeline. So OSHA made some priorities, and obviously we worked really hard on the rule-making process that was struck down by the Supreme Court on Vax-or-Test situation. And then at the same time that set us back a little bit in the infectious disease, and we got back on track with this infectious disease now we will focus on that.

And in my budget we are looking for a little more money on some of the rule-making processes, because we have lots of issues that we cannot get to because we can't unless we have the resources.

Senator MURRAY. Okay. Mr. Secretary, funding in this budget, together with investments through the American Rescue Plan and the Infrastructure Investment and Jobs Act, can really help us have an equitable recovery from the pandemic. But unfortunately, jobs that pay low wages and lack benefits have been, and actually continue to be, disproportionately filled by women, people of color, people living in poverty, people with disabilities, and the painful reality is our workforce development systems have long struggled to address these inequities, and too often leave out those same workers. And when we leave some people behind it actually holds us all back.

ENSURING AN EQUITABLE ECONOMIC RECOVERY

So tell me what specific steps you are taking to ensure our workforce development programs, including the registered apprenticeship program, are supporting all of our workers, including women, and people of color so we can build a stronger economy?

Secretary WALSH. Yes. Well, thank you for that. Let me just first say that one of the things, when we think about the infrastructure investments and the Bipartisan Infrastructure Law, we are thinking about making sure that it is an equitable investment across the board. When I look at the unemployment numbers in America, 3.6 percent unemployment rate right now in America, in the White community 3.4 percent, in the Black community it is 6.2 percent,

historically the Black unemployment number has always been historically double that of White—the White number all across the country.

So when we think about making these investments when we think about these investments, and we don't have—the Department of Labor isn't responsible for making a lot of investments in the Infrastructure Bill, because most of that is in transportation, and in commerce, and in energy. But what we have done is we have created the—we haven't created—the Good Jobs Initiative is an umbrella of making sure that as we make these investments we are making these investments to communities who are not leaving people behind. Who are not leaving opportunities for women, who are not leaving opportunities for people of color, who are not leaving opportunities for Native American, Alaskan Indian, all of the different communities in our community quite honestly, that have been underrepresented for so long.

So that is one of the—that is one of the ways that we are looking to the Good Jobs Initiative to make sure that this is an equitable investment in people's future.

EXPANDING APPRENTICESHIP PROGRAMS

We also, quite honestly, in the workforce development programs and grants, we are looking at expanding apprenticeships, and registered apprenticeship programs, we are doing more pre-apprenticeship programs to really create a pathway into different industries.

When you take the issue of nursing, we are headed towards a crisis in nursing in America in the next 5 to 10 years if we don't address it today. We have 60,000 people, young people, on waiting lists to get into nursing programs in the country, and we have a shortage coming. So when you look at that, we have certainly an ability to create a talent pool to go into nursing, what we want to do is make sure we are making the right investments, to make sure to see what the shortfalls are in those different industries.

We did it with the trucking—the trucking challenge, we had an issue at the ports with a lack of truck drivers. We sat down at the White House, myself, Secretary Buttigieg, we created a program, apprenticeship program, where any company in America could sign up with the Department of Labor for an apprenticeship and within 48 hours, we would turn that around and get that program running.

We had over 100 companies right now in America that are currently having apprenticeships in trucking in America. We are working on building the future. We are looking at the numbers and the ages of truck drivers in America. Do they need to be 21 to 25—it is okay.

[Interruption].

Senator MURRAY. Hold on. Just a minute, we apparently have a—

Mr. Secretary, I believe the outside feed has stopped. We will continue with our hearing.

You were talking about specific worker training skills, and I will just take a few seconds and just ask, worker training is critically important, but I am also concerned about those support services that allow somebody to go to work.

Secretary WALSH. Yes.

CHILD CARE INDUSTRY CHALLENGES

Senator MURRAY. I am talking about child care, transportation, those kinds of barriers. Can you just address that really quickly how the Department plans—

Secretary WALSH. Yes, real quick. I mean, I think in the child care space, and in the—that is one of the biggest challenges we have as a country. And when you think about, yesterday I testified in front of Ed and Labor, and child care was a big—great part of the conversation.

And quite honestly, you know, I think as a country we have to look and see, and realign what we do with child care. The pandemic has been devastating to child care industries in the very beginning days of the pandemic, March of 2020. We saw many child care facilities have to shut down because the kids weren't going there and there was no revenue coming in.

A lot of those agencies didn't recover. They had workers, particularly women of color, working in those areas that were making minimum wage, and very low wages, those workers left there and found other options for employment because they had to. And now as we think about the child care industry, rebuilding it, we have to really be really intentional about it.

And I feel that when we talk about child care and, you know, it has to be an all-of-government approach, meaning the Federal, the State, the local, but also the private sector. We really have to think about—outside the box when it comes to child care. And also universal pre-kindergarten is an opportunity for us as well to think about any additional child care.

So as we think about this, our office, the Women's Bureau is working very intently on this, and also through the Good Jobs Initiative we are looking at different ways of supporting communities across America.

Senator MURRAY. Okay. Thank you very much. Senator Blunt.

Senator BLUNT. Thank you, Chair.

CAREER PATHWAYS FUNDING LEVELS

Secretary, let us go back to my comment on Career Pathways. I think it is really important that people certainly, in high school, begin to get a sense of what jobs are out there: What the job satisfaction of those jobs is like, what the comparative salary level of those jobs is compared to other jobs, and let us be sure people have choices.

In the Career Pathways account, we started that in fiscal year 2020. In the most recent bill, we provided \$15 million, which was an increase of \$5 million. Your Department last June gave the first awards under this program, were made through the 2020 funding. As you start making—what are you going to do about this program? And how are you going to monitor the success of the awards you have already given?

Secretary WALSH. Thank you very much. Well, first of all, Senator, you know, I certainly agree with you in Career Pathways being an important aspect to make sure we continue to fund in this budget, because many young people in America, as was said in, ac-

tually both of your opening statements, not everyone is on a pathway to a college, and we have to make sure we are creating pathways into different careers.

This program was not dropped out of the budget, we didn't specifically call it out in the 2023 budget, we actually requested an increase of \$226 million for the National Dislocated Reserve which funds these grants. So it is part of the National Dislocated funds, which funds these grants. And one other thing, to be more clarifying this, I will absolutely work with you in your office afterwards to make sure that this is very clear, that we understand that these pathways monies are still in the budget when we actually look for an increase.

Senator BLUNT. Well, let us do that, because your staff told us just a couple of days ago, you specifically didn't request money in this category. So let us talk about, not today, but let us follow up and talk about what we intend to do there, how we are going to monitor the grants that are already out there.

INDUSTRY PARTICIPATION IN REGISTERED APPRENTICESHIPS

And I think what the Chair and I have tried to focus on in the committee, has been being sure people have the information they need, and then the opportunities they need to pursue as quickly as they can the jobs they would like to have, rather than spending years after high school searching for the information that they could have gotten while they were in high school, or just after they got out of high school. And so we are going to continue to talk about that.

On apprenticeships, generally, how do we ensure that all of the industries that want to participate in the registered apprenticeship program, have a chance to do that?

Secretary WALSH. Yes. We are reaching out right now, we are sitting down with stakeholders, and we are talking to industry about creating those pathways. I honestly feel in my heart that we are living in a unique moment in time, we are seeing people quit their jobs at high rates, we are seeing companies having a hard time finding people to go work for them. We are seeing young people that just can't connect to a good-paying job.

And I think the best way, in my opinion, is looking at apprenticeships in different industries, in the healthcare sector, in the IT sector. You see it in the building trades, and you see it in trucking now, how it is working. We take that model that is working in those industries.

BENEFITS OF PRE-APPRENTICESHIP PROGRAMS

I also want to add a component of pre-apprenticeship, so young people will have the opportunity. I was over in Germany a couple weeks ago, I was at Volkswagen, and I met with the leadership of the Volkswagen Company, and I saw the technology in there. But I met with about 20 young people between the ages of 16 and 18 years old that were apprentices, they were in an apprenticeship, pre-apprenticeship at Volkswagen.

And they were getting a stipend, but they were also learning on-the-job training, not necessarily how to use the machinery, but they were getting skills in coding, and how to use technology. And

I asked them. You know, they go to school a couple days a week, and they are in the company a couple days a week. We need to start thinking of those models that we are seeing in Europe that have been so successful in apprenticeships, in Switzerland. So we are working on those.

MONITORING H-2B VISAS

Senator BLUNT. Okay. Good. On H-2B visas, the temporary workers, and this is a big issue in a lot of sectors of our economy, particularly the tourist sector. And if you don't have those part-time workers the full-time jobs go away. We need to be sure that people understand that. That there are seasonal jobs, where, if you don't have the seasonal workers ready to come in and take the seasonal jobs then the jobs for other people that are full-time, year-round jobs, go away because the whole process just doesn't work.

That is particularly evident in tourism. In the last addition of workers, and I think the Department has expanded the program in a significant way to about 121,000 H-2B visas, but the last 35,000 of those were gone within five business days.

How are we monitoring that? And would you help me express the importance of being sure those kinds of jobs are filled for people who work alongside part-time workers, and have full-time jobs they wouldn't have if those part-time workers weren't there?

Secretary WALSH. Yes. Let me, first and foremost, I had a meeting with my office last week to talk about the H-2B program, about the distribution of the visas, because some of the Senators here at this table, and other members of the Congress and Senate, have called me, both Democrats and Republicans, about it.

And the increase in interest in this program, in the thousands of companies that are now applying for these visas, have exceeded—that we have never seen as much business, or as much interest in this program.

INCREASED TARGETING OF THE H-2B VISA PROGRAM

So we are having conversations. I think what we need to do with the H-2B visa program, and we are doing some internal conversations, I think we need to have a real honest conversation about what the future of the program should look like. We expanded this year, in the first round of the H-2B visas, I want to say, 22,000 visas. In the second round, we added another 35,000. That is the largest allotment, additionally, of H-2B visas since the program was revamped in 2000—I think—2013.

And the need or the desire to be getting these programs just getting bigger, and bigger, and bigger. And what is happening is, a lot of companies that are filling out applications for these programs they are doing it wrong because they have never done it before, and they get disqualified. So all of the people that know what they are doing are getting their applications in, and they get these grants. That is one problem.

The second problem is, and we had this conversation, as I said, the other day; we talked about the different industries in America. You have sugar down South. You have the crabbing industry on the coast. You have the fishing industry in Alaska. We are thinking about how do we make sure when we create these extra allotments,

is there a way for us to be able to put some allotments aside, because if it comes out in April then the farmers might get all the H-2B visas, but you need something in September or October for a different harvest, or something like that.

So we are looking at the program right now, on how to, how do we make this program, I wouldn't say more efficient, more successful. This program is needed. I am a supporter of the program, quite honestly, because in a lot of areas that it is really difficult to get workers in a short period of time. These companies, we asked these companies two things. One is to make sure there are strong labor protections for the workers that come from the southern border, number one—and Haiti, and some other places.

And number two, we want to make sure that they do their due diligence in trying to hire local American workers prior to them getting H-2B visas. So we are asking them those two things. Make sure you make an honest effort to look for workers, number one. And number two, we ask them as well to make sure they treat their workers fairly.

Senator BLUNT. Good. I would be more than happy to work with you and your staff on this. It is a problem. It is a problem we have dealt with for a long time. I think the numbers you have put out there this year, are as aggressive on this program as anybody has ever been, but the work environment is different than any environment we have ever been in. And that is why it makes some sense. But I would love to work with you on it.

Thank you, Chair.

Senator MURRAY. Thank you. Senator Schatz.

RESCINDING JOB CORPS EXEMPTION FROM THE SERVICE CONTRACT ACT

Senator SCHATZ. Thank you, Chair and Vice Chair.

Secretary, nice to see you again; and really enjoyed our conversation the other day. I know you are a big fan of the Job Corps. Hawaii Job Corps is one of the best in the Nation, regularly at capacity, and really delivering on the mission. I want to talk to you about the pay. DOL (Department of Labor) exempts Job Corps' contracts from the Service Contract Act, which means the Job Corps employees don't get prevailing wages and benefits.

My understanding is that is an administrative authority that you have. You could waive that but you don't have the money, and so the question is pretty simple. Would the Department consider rescinding the exemption if Congress provides the resources to do so?

Secretary WALSH. Yes.

Senator SCHATZ. Good enough for me. And if so, can you provide the committee with the amount of funding that would be required to do so?

Secretary WALSH. I will get that number for you. But I appreciate you asking that question. And I don't want to take too much of your time, but I think Job Corps is one of the most underutilized programs that we have in the Federal Government, that we could have 57,000 people a year that go to Job Corps, prepared for a job. And when a young person leaves Job Corps—and I look forward to visiting your district and seeing the Job Corps there—they should be guaranteed a job when they graduate Job Corps.

ONLINE PRESENCE OF DEPARTMENTAL TRAINING RESOURCES

Senator SCHATZ. Thank you very much. And speaking of job placement, this is a sort of broader question. I want you to imagine, say, 10 years from now, 5 or 10 years from now, what does the Department of Labor's online presence, online training resources look like?

You know, coming from State government, you know, more than a decade ago, the implementation of Federal workforce training programs is very siloed. We have got a Workforce Development Board that meets as a committee of the whole, with maybe more than 100 people, and they ratify their workforce development plan, mostly based on the fact that if they ratify it they get their revenue. And so there is not a lot of big-picture thinking.

And I am wondering whether there is a way to turn the Department of Labor's website, and other online presence into a real resource for workers, so they can, not just find jobs because there are plenty of private sector platforms for that, but figure out what the, you know, college and career readiness pathways are, what kind of technical training you need.

All of it is a labyrinth if you are new to the workforce, or if you are transitioning from one job to the other. And so this is a broader question. What does that website look like if you have all the resources in the world, in 10 years, so that it is really servicing people in a new economy?

Secretary WALSH. Yes. That is a great question. I think number one it is, in 10 years from now we get to expand our American job centers that do that work on the ground in cities and towns all across America, number one.

Number two, if there is a worker in America that is looking to make a change in their career, or put themselves in a better situation, they should be able to click a few buttons, get to a resource guide on the Department of Labor that directs them to their State or their city, that has the ability, that there is a partnership with the Federal Government in creating a pathway into a good-paying job.

So for example, if you live in, a small town in Hawaii and you are looking for a job, well the Department of Labor might not know who the employers are there, but we work collectively with the local government to make sure that that resource is there.

LINKING INDIVIDUALS TO EMPLOYMENT RESOURCES

It does two things: Number one, it would allow the person, the individual to be able to find the resources, but as important, it will allow employers to also find the people. So you would have to work with the employers as well, to make sure that they are part of the system, because the employers, if they feel that it is a good training opportunity, and the resources are being spent well in good workforce development, then we are helping employers grow.

We saw this year in this country 4.7 million people go into entrepreneurship on their own, 20 percent increase in the past. Some of those folks are going to become companies, some of those folks are going to become big companies, some of those folks are going to be looking for employees. The best way to do that is having the re-

sources. So I think it is about both sides tying the worker to the job, and the job to the worker.

WOMEN'S BUREAU ACCOMPLISHMENTS

Senator SCHATZ. Thank you. A final question: I have skepticism about bureaus, and so I pushed on my staff about the Women's Bureau. I said, what has the Women's Bureau actually done for women? And they have done an extraordinary amount for women.

Secretary WALSH. Yes.

Senator SCHATZ. Helping with the Equal Pay Act, the FMLA (Family and Medical Leave Act), and they can also be credited for helping to ensure women were included in laws providing minimum wage and overtime. Do I have your commitment to continue to support the Women's Bureau so that it can build on the successes from the last century?

Secretary WALSH. Yes. When I first became Secretary of Labor, the first thing I did was I asked for an increase in budget for the Women's Bureau. When I was Mayor of Boston we had a Women's Commission in Boston, and I changed it from a commission to an office in the Bureau. We need to give the Women's Bureau more power in the Department of Labor, as well as the Veterans' Office as well.

Senator SCHATZ. Final, just a comment. I want to thank you for your decision to include data on American Indians, Alaska Natives in the last monthly report. And look forward to working with you in this space. Thank you.

Secretary WALSH. Thank you, and thank you for bringing that up, because I think I misspoke in the very beginning in my comment about the numbers. So thank you.

Senator SCHATZ. Thank you.

Senator MURRAY. Thank you. Senator Hyde-Smith.

Senator HYDE-SMITH. Thank you, Madam Chairman and Ranking Member.

And thank you for being here today, Mr. Secretary, and I certainly appreciate your help with my labor issue with the catfish processing plant in Mississippi. And one of the things I want to talk about, is this administration continues to blame President Putin for this inflation, and despite the price increases going through the roof, but the administration, in my opinion, got it wrong when they kept insisting that this is transitory.

THE NATURE AND IMPACTS OF INFLATION ON EMPLOYMENT

And, you know, we have—it has been proven that it is anything but transitory. But the Biden administration has expressed that the United States is prepared for this, and positioned to meet the challenges of this stagflation, given the local—the strong labor market, but employment levels are still way below pre-pandemic levels.

So how can this possibly be true that we are positioned with the employment levels being so low, that we are positioned to overcome this?

Secretary WALSH. Thank you very much, Senator. Let me just begin by, there is no question that inflation, we all know this is causing pain for families in America, rising energy costs, food

prices, stretching budgets, all across the United States to very thin. But this is also an issue that Europe and U.K. are dealing with as well.

So there is no question, there are two things that we cannot deny. Number one is, the economic challenges we have had over the last two-and-a-half years due to the pandemic, shutting America down, and tens of millions of Americans not going to work and, not having really a strong plan for that, because we weren't prepared for a pandemic. The last time there was a pandemic was a hundred years ago.

IMPACTS OF RUSSIA'S WAR ON UKRAINE

And what Vladimir Putin is doing in Ukraine is an atrocity number one, and number two, absolutely is having stresses on the global economic crisis. I was with the President last week and we were talking about wheat. There is wheat in Ukraine that we can't get out of Ukraine, because Russia is blocking the exportation out of Ukraine. We have oil that we are taking from Russia, we have European countries that aren't taking oil. So we can't deny the fact that those challenges aren't adding to inflation.

The President has been very clear on lowering the costs that families have in front of them. He is also focused on reducing the deficit. I am working myself, 8.7 million Americans have gone back to work since the end of the pandemic, since the beginning—not since the end of the pandemic—since the pandemic kind of began and is moving forward.

IMPROVING EMPLOYMENT PROSPECTS

We have the lowest unemployment since 1970, and we have identified, and I have identified that we do have a problem in our country with making sure we are creating pathways for people to connect into jobs. And that is why I have asked for the increase in this budget in workforce development programs, in job training programs, in community college programs, and also in apprenticeship programs, and creating better pathways for people.

CHALLENGES FOR SMALL BUSINESSES

Senator HYDE-SMITH. How is the Labor Department adjusting or correcting its policies to address the issues of these small businesses that are having such a time trying to fill these positions, and related to the hardships placed on the American families?

Secretary WALSH. Yes. Well, I am willing to talk to any businesses and communities around America, to talk about ideas. I spent a lot of my time—you know, as Labor Secretary I spent a good amount of time reaching out and talking to businesses, as well, in America. Probably as much—more time than I talked to, quite honestly, unions in America.

Because I find it is really important to understand the challenges that businesses, particularly small businesses are having in our country. And small businesses, the biggest challenge is—well they have a lot of challenges right now, particularly with the pandemic, but their challenges now are trying to find workers that want to work in those different industries. So we absolutely will. If these

industries, that you, or companies, you want me to talk to, I would love to.

Senator HYDE-SMITH. And I agree obviously, that the Russian invasion has had a lot to do with this, but I also wholeheartedly believe that shutting down the Keystone Pipeline is what started it before the invasion. And employer retention, particularly in the manufacturing and the warehousing sectors, is a highly significant issue and quite a problem in the workforce today, obviously.

CREATING JOBS THROUGH MODERNIZING HIGH TURNOVER INDUSTRIES

But more and more companies find it hard to hire and retain workers for roles that normally have high turnovers, that are repetitive task jobs, and it seems that the opportunity to utilize technology could be a solution to fill these positions, while also creating a higher skilled position for the programming and operations of such things as collaborative robots.

And I believe this concept could be a game changer to reduce turnover while increasing higher wages and the workers for these positions, that so many people have difficulty dealing with. But it is just, you know, with the manufacturing that they are in, does the Department share this view? And will you provide any insight into the Department's focus in this area?

Secretary WALSH. Yes. Certainly the President is very supportive of creating more, and it is expanding manufacturing in America. And I know I can't lobby for legislation, but I would hope that we can get the Bipartisan Innovation Act through Congress, so that we can continue to make investments in American workers, in manufacturing. Some of that will be industrial manufacturing, and some of that will be technology in manufacturing.

And I think that we have such a great opportunity in front of us. I don't want to say. I said this yesterday and I probably shouldn't say it today, but I think that this Bipartisan Innovation Act is actually one of the biggest pieces of legislation for the future of our economy, and for the future of our workforce moving forward.

Senator HYDE-SMITH. Thank you. And my time is up.

Senator MURRAY. Thank you. Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair.

Welcome, Secretary Walsh. I know our Chair asked you earlier about the importance of child care in terms of getting people back to work, but I have a more specific question to ask you about.

INVESTING IN EDUCATIONAL AND CHILD CARE TRAINING PROGRAMS

Wisconsin is using a Department of Labor grant to test out an apprenticeship program that would train workers who enter the early childhood education and child care workforce.

Expanding this type of apprenticeship in my mind could have a real multiplier effect. So not only would it address severe shortages in the child care workforce and industry, but by increasing the supply of available providers, it would free up more parents to be able to look at full-time work. And by filling open positions we might even reduce inflation by helping businesses increase their production.

So how can the Department encourage investment in child care apprenticeship programs to reduce the workforce shortages, and increase the output of our economy?

Secretary WALSH. First of all, thank you for the question. And I am encouraged to see what is happening in Wisconsin, to see how that works. And I think that having programs like that around the country, to check is really important. This budget request that we are asking for is \$303 million for apprenticeships to further expand and modernize diversified, registered apprenticeships, by investing in high-quality youth and pre-apprenticeship models.

So you are doing it in Wisconsin, we are doing it here with the trucking challenge here in Washington, and around the country, quite honestly. We are looking at other areas, we are looking at healthcare, we are looking at IT. There is no question. When you think about the child care industry, number one, the challenges they have.

Number one, they have a challenge with funding, and the funding is not consistent in every State, sometimes the States fund it, sometimes the cities fund it, the Federal Government is funding it to some degree. That is one challenge.

The second challenge is recruiting and retaining talent, and having that pipeline, that young-person pipeline, or that pipeline into that industry where people can get paid while they are learning, on-the-job training, is going to be really important, number two.

Number three, the President filed the bill that really deals with the cost of child care. I think that the latest bill, if I am not mistaken, is a family earns \$150,000 collectively; they pay no more than 7 percent of their salary for child care. That is another important aspect of it, making it affordable for families at the kitchen table.

And the last thing, which is the first thing that you talked about, it really is not just about training people into this industry, but making sure we are paying them, and treating them fairly, because the long-term sustainability of the child care industry is key, the long-term sustainability of our economy is key, and they go hand in hand.

STATUS OF WORKPLACE VIOLENCE RULE

Senator BALDWIN. Thank you. Last month I introduced the Workplace Violence for Healthcare and Social Service Workers Act. It would require OSHA to set an enforceable standard to require healthcare employers to establish plans to prevent workplace violence.

Incidents of workplace violence have increased significantly during the pandemic, but were high for healthcare workers and social workers prior to the beginning of the pandemic. And frankly, our healthcare heroes have been put through hell, and certainly deserve better from all of us.

The need for action was made even more tragically clear by a deadly shooting at a hospital in Tulsa, Oklahoma, just a few weeks ago. So I know this item has been on OSHA's regulatory agenda. I wonder if you can update me and the committee on the status of the Workplace Violence Rule.

Secretary WALSH. Yes. Thank you. First of all, no one, as you know, should lose their life on the job for whatever reason, or even be concerned about losing their life on the job. And I know the administration strongly supports the passage of your bill, which is really important. In the meantime, OSHA has also worked extremely hard and has successfully prosecuted several important workplace violence cases under the Occupational Health and Safety Act. So we have done that. OSHA continues to issue citations in this space. So thank you for that.

And the last thing is, and I said earlier to the Chairwoman, I believe that we are on pace, hopefully, to get some final rule in the next 3 to 6 months.

RACIAL DISPARITIES IN STATE UNEMPLOYMENT PROGRAMS

Senator BALDWIN. Okay. Final question; this week a GAO report examining State's execution of the Pandemic Unemployment Assistance Program found significant racial disparities in the rate of approval. The report recommended that as a part of efforts to modernize the unemployment system that Department of Labor examine the potential causes of racial and ethnic disparities.

Will you commit to making that examination as recommended by GAO? And do you have any insights at this point?

Secretary WALSH. Yes, no. Absolutely, you know, the Department is focused right now on both fixing, and the short- and long-term issues with the unemployment system. You know, we have announced the availability of more than \$750 million in grants, funding for States. We have Tiger Teams that are out working—we are working on improving identity—improvement to the identity verification tools within the UI (Unemployment Insurance) program, we are working on equity grants, we are piloting programs.

I actually feel, I feel really good where we are right now in this process, because we have both States, Democrat and Republican Governor States that are very active with us in the UI reform. So I feel good where it is at. Eventually—I mean I asked for an increase in funding this year, but eventually States are going to have to really step up if they really want to make their systems equitable across the board. When I say “step up”, I mean making investments by stepping up.

Senator BALDWIN. Thank you.

Senator MURRAY. Thank you. I see Senator Braun has joined us. Are you ready to go? Or do you want 5 minutes? Senator Braun, if you want to go ahead.

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

MAINSTREET AND GIG ECONOMY WORKFORCE CHALLENGES

I just attended, earlier today, the National Federation of Independent Business Owners, and I and another Congresswoman, we were answering questions that they have. And many there are concerned, in general, about Main Street businesses. My wife has had one since 1978 and they are downtown. Some of the stuff that happened through COVID, a lot of those businesses got shut down, and many of them are grappling with all the issues we hear every day, a lot of pre-COVID, workforce, workforce, workforce.

There is a particular part of the economy though, the gig economy. And independent contractors, Main Street business owners that so many of them, to me, are so analogous to blue-collar workers, because they actually live out of these businesses, and I have always been a proponent in running my own business for 37 years: high wages, great benefits, safe workplace, no turnover. And I think that, generally, Main Street America, smaller businesses do all of that.

Let us focus on the gig economy, particularly independent contractors. It seems like, and they think that the current administration is trying to, you know, take their way of life away. You know, they looked at the PRO Act, they look at some of the things that are being done.

I would like your general comment on: Why we would look at them any differently from the good, blue-collar worker that most of us employ for those same reasons? Why would we want to do anything that would diminish their way of living because to me, they are that?

DEFINING INDEPENDENT CONTRACTORS

Secretary WALSH. No. Thank you, Senator. And you know, in a lot of cases independent contractors, people who are independently employed do great work, and they are part of our economy, and they are part of our—in some cases part of our main streets. We see it in trucking, and we see it in different industries.

The concern that I have always had when it comes to independent contracting, is folks that are under the understanding that they are hired as employees, and then they are paid with a 1099, and they are not—they are not technically—they are actually an employee of a company.

And I think that there are many different definitions of the concerns that people have in that, and that is kind of where, when I say this, I will speak for myself personally, that I have always gotten concerned. An example of that is a restaurant where somebody gets hired as a dishwasher, and then all of a sudden they are being paid with a 1099, and they have no repercussion at all.

They are really not an independent contractor, they are a dishwasher who works for a company. And we have been able—the Department of Labor, over the years, has gone back and claimed lost wages for people that have been characterized, or described in those different areas.

But when you talk about Main Street, I hear what you are saying. I mean, my formal role, obviously, you know, we had a lot of businesses, that people might have had a flower shop, or they had something that they were in themselves, their own worker, they were independent, they kind of did their own thing, or they were a planner, or things like that. I understand that.

BUSINESS OWNERS WITHIN THE GIG ECONOMY

Senator BRAUN. So let us focus more closely on gig economy then, because I don't think you should game the system by issuing 1099s when, technically, that individual is an employee. That to me is maybe skirting the rules.

But let us focus on gig economy. These are individual business owners. And they are worried too that they are going to be drawn into that independent contractor issue, and then lose their independence, their livelihood, because they would not be of that same category you are talking to. They are running their own businesses, and generally a business of one.

Secretary WALSH. Yes. In the gig economy, I mean, I have spent a lot—I don't want to say a lot of time—I have spent a fair amount of time in talking to the gig economy companies here in America, both the leadership of the companies, the advocacy groups that are pro-gig economy companies. And some of the other side that that isn't a pro-gig economy.

And I know that in a lot of States, California passed the Ballot Initiative, Washington State passed a law, and in Massachusetts, yesterday the Massachusetts Supreme Court just threw the ballot question for the gig economy for the Uber and Lyfts off the ballot. So basically saying, you have to come up with legislation.

So I know a lot of these conversations are happening in other places. I actually had a conversation last week—I will be real quick on this and actually provide another question—with Germany, talking about what they did with the gig economy in Germany. So just asking, what was the path forward there? So we have not taken any action as a Department, but I am still talking to all these groups.

Senator BRAUN. Well, very good, because I think that in our unique economy, you have got anywhere from huge corporations that, to me, shoulder the biggest responsibility, and where unions definitely come into play, because of the counterweight against that much financial power, make sure that we don't take Main Street America in all of its individualism, you know, kind of swept into a category that they are not part of.

Because you never know when that individual, that gig business, that small business on Main Street becomes a larger business. And to realize most of them make their living out of that. They are not growing it with return on equity in mind.

Secretary WALSH. And if you want to let the independent group that you spoke to today, they are more than welcome, I would love to sit and talk to them.

Senator BRAUN. Thank you.

Senator MURRAY. Thank you. Senator Capito.

Senator CAPITO. Thank you, Madam Chairman.

Thank you, Mr. Secretary, for being with us here today, and thank you also for the visit that we had in March. I enjoyed our conversation. And we talked about apprenticeships there. So I would like to ask a question.

DIVERSITY OF SUPPORTED APPRENTICESHIP PROGRAMS

We have some excellent apprenticeship programs in our State. And I recently visited one at Marshall University's, at the Manufacturing Tech Accelerator at the Robert C. Byrd Institute at Marshall. And it is providing participants with the skills they need to succeed in entry-level positions in manufacturing, you complete 2,000 hours of paid, on-the-job training from a participating em-

ployer, and the apprentices will qualify for a certificate to be a manufacturing technician.

I met a veteran there who had obtained this certification after retiring fully from his career in the military, and he is also now, excitingly, in the process of attaining a patent for an efficient manufacturing process that he created just months ago; a very impressive story.

So after visiting RCBI (Robert C. Byrd Institute), and after our conversation, I am wondering about your approach at Labor on apprenticeships, whether it is organized labors, or some such as the apprenticeships that are being offered through this program. And you know, would you say you support a wide range of these? And how are you approaching this at the Department?

Secretary WALSH. Yes. I absolutely—thank you first and foremost for having me in your district. I support a wide range of apprenticeships in different industries. I think the model of the building trades is the gold standard, \$2 billion a year investment, all by companies, and there is no Federal investment, or State investment. There are small grants around for different programs, but the majority of those programs get funded.

And you are talking about high quality training going on there. That is one model we could use. I think that there is an opportunity for us in this country to really have the ability to partner with community colleges, workforce development programs. I had the urban league in my office yesterday, we talked a little bit about diversity, and inclusion.

So you know, I have answered this question a couple times today about apprenticeships, but I hope by this—next year's hearing when I am here, we are able to point to several dozen apprenticeship programs that we are kicking off in the country, whether it is in healthcare, IT, early child's care, different industries that we can actually make a difference in.

Senator CAPITO. Great. We all look forward to that announcement. And certainly, as we see workforce shortages in just about everything; this is, I think, going to be extremely important because, not just the skill sets developed, but the time that it takes in certain instances, I think we can maybe short-cut some of the time to get a trained individual on the job.

IMPROVING SAFETY IN THE AMERICAN MINING INDUSTRY

I am very proud that I supported the nomination of Christopher Williamson to be the Assistant Secretary for the Mine Safety and Health Administration, or MSHA, as we call it at home. He is a proud son of Williamson, West Virginia, and we are happy that he is there. I don't know what initiatives he or you plan to take in the mine safety obviously.

Secretary WALSH. Yes.

Senator CAPITO. It is extremely important. I will tell you that our mines are operating at much higher capacity than they have in the past year or so, because of the increased demand, because of the geopolitical situation we see around the world, we are happy about that. We are not happy about the geopolitical situation, we are happy we got more miners to work.

So in the MSHA area, what are you guys looking at and how can we be helpful?

Secretary WALSH. Well, one thing we are looking at is we have seen an increase in fatalities this year, in mining. And a couple months ago we had the major miners on a call, we did a call with them, to talk about sharing best practices on safety, something I did when I was the Mayor of Boston whenever we had high shootings in Boston, we brought all the stakeholders to the table. We did the same thing with the mining industry.

We are asking for an increase in mine safety work in this budget. Chris is doing a great job, you know, his feet are wet. He didn't have—there wasn't much of a learning curve there, he knew the issue. And certainly they are working hard, and we do need to—we get some money from the American Rescue Plan, and we need some additional funding on the mine safety.

We are actually seeing an increase in mining, maybe not coal mining but we are seeing an increase in mining in America as well, metal mines, and things like that. So we need to make sure we stay on top of it.

Senator CAPITO. Right.

Secretary WALSH. And any time we acknowledge that these are tragedies happening, we are on top of it.

Senator CAPITO. Good. And I know a lot of those can occur in a lot of different—they may not be at the face of the mine, in the instance of the coal mining, a lot of them are vehicular accidents; and things like that, on the work site. So anything we can do to make them safer, and keep them healthy is important.

YOUTHBUILD GRANT PROGRAM DEPENDABILITY

The last thing, I am just going to kind of put this on your radar screen. I have always been interested in YouthBuild, I have visited—the Randolph County Housing Authority has a YouthBuild program that they have had for years. And then for some reason last year, no funding. And so it was kind of disruptive.

If you could help me, kind of figure out—they did get their funding for this year, so we are very pleased about that. But we wanted to have the continuity that you need in a program like that. So if we could work with your office to try to figure out how to make sure they have an iron-clad application that they can continue this program.

Secretary WALSH. Absolutely. I have been of supporter of YouthBuild for 25 years. When I was a legislator in Massachusetts we used to support it, and I know that YouthBuild got a—I think it was a \$24 million dollar grant this year on YouthBuild, but also clean energy; so some of the transition as well.

Senator CAPITO. Good. All right. Thank you.

Secretary WALSH. Thank you. Thank you, Senator.

Senator MURRAY. Thank you very much.

WORKER PROTECTION OVERSIGHT AND ENFORCEMENT

Mr. Secretary, I really hugely appreciate the President's strong investment in DOL's proposed budget for the Wage and Hour Division. As you know, the Federal minimum wage has been frozen since 2009, at the rate of \$7.25 cents per hour. Yet, even at that

low rate some employers are denying their workers that unacceptably low wage, or their overtime, or both. And it really is our job to protect those workers and make sure they are properly paid for their work.

But right now I know the agency does not have the resources to do their job when corporations flout the law. Can you talk a little bit about how the requested increase in Wage and Hour will allow you to improve the oversight on that?

Secretary WALSH. Yes. There is no question about it. You know, when I came in here a year ago, March, as the Secretary of Labor, one of the first things I did was looking at the different departments and agencies to see how we are doing with carrying out the work. At that time you, and Congress, and the Senate, had just passed the American Rescue Plan, and the money was being—hadn't quite been diverted yet to the different agencies. And we found that there was a real, real shortfall in enforcement and in the ability for these different departments, Wage and Hour, and OSHA, and other places, to do their job.

I don't view Wage and Hour, OSHA, and MSHA, I will use those three as example, as just an agency to go out and give corporations in America a hard time. I would love to get to the point where we can do education as well with companies, and what it means to pay people forward. But we were not there yet.

So what this additional revenue would do, would allow us the opportunity to protect more American workers, and making sure that workers that are owed money, who did the job, worked for companies, and were undercut by somebody, that they pay their workers fairly. That is all we are asking for here.

So that is, kind of, what would allow us the opportunity to do more, more enforcement of workers' rights, and making sure—and we are talking about workers who worked the work.

Senator MURRAY. Yes.

Secretary WALSH. We are not talking about people who didn't do the job. We are talking about people who actually worked the work, did the 30 hours, the 40 hours, the 8 hours, whatever it was, and didn't get paid, because their employer decided: I am not going to pay you.

STRENGTHENING YOUTH OUTREACH AND ENGAGEMENT

Senator MURRAY. Right. Okay. Thank you. And finally, I just want to talk to you because I am—about our young people who are disconnected from educational workforce opportunities right now. I know that more than a million fewer students are enrolled in college now, compared to before the pandemic, and the decline of community colleges, also really significant.

And high school graduation rates decreased in nearly half of all the States this past year, reversing really decades of progress. So work-based learning experiences are really integral to keeping young people connected to their school, and high quality workforce development programs can help successfully re-engage those young people who have, or are considering leaving school before graduation, and put them on pathways to success.

Talk to us about how you are working to strengthen the links between education and workforce development systems to re-engage these young people.

Secretary WALSH. I am going to just, for an observation, your relationship with Senator Blunt; we need more of that when we talk about how we are going to move our economy forward, how we are going to move our workforce forward. We need to be collectively working as Democrats and Republicans, to really make sure we are making investments in job training, workforce development apprenticeships.

We can look at one side of the aisle, and as you just said, people not going to college, and dropping out of high school, and not having opportunity, as a challenge, and a difficult and sad challenge for America, but you can also look at the other side of the coin, it is an opportunity. How do we get to those young people? How do we connect them to the workforce development apprenticeships, job training opportunities that are out there?

As I go around this country, I visited 36 States. I have visited probably 82 cities. I go to community colleges everywhere, and I am in different neighborhoods, I am talking to—I am talking to businesses, and leaders, and what is out there, whether it is electric boat in Connecticut, or it is Tinker Air Force Base in Oklahoma. These are public.

And then private industry, there are so many opportunities out there for people in America, we need to really make sure that we are connecting young people to jobs, and we need to make sure that, not just connect them to jobs, we need to go out and find the young people.

JOB CORPS OUTREACH POTENTIAL

We see it in Job Corps. Our Job Corps centers pre-pandemic had 57,000 young people in it, 57,000 people. Today we have—I think there is 20,000 online, 12,000 in person, we are getting there but we are not there. We have lost a lot. So we have to be more intentional, going out and recruiting, and finding young people, and finding people to let them know what is available. A lot of people, Senator Schatz talked about online presence.

Senator MURRAY. Mm-hmm.

Secretary WALSH. A lot of people, including myself, didn't know that we had American job Centers in America. I had two in the City of Boston, I had no idea they were there. We have to do a better job of explaining what those programs are.

Senator MURRAY. Okay. Thank you. Senator Blunt.

Senator BLUNT. Thank you, Chair. I have a couple more questions, Secretary. One is looking at the proposed budget, and back to the topic of inflation. Sometimes the budget reflects big increases in programs on all of the veterans' programs at the Department of Labor. The increase was less than 2 percent. There were a couple of programs where actually programs were reduced like State grants and transition assistance.

VETERANS' PROGRAMS STRUCTURE AND INVESTMENT LEVEL

What are you going to do about these veterans' programs that have a less than 2 percent increase in a more than 8 percent inflation world?

Secretary WALSH. Yes, no. One thing, that we are not cutting the veterans' budget, we are increasing the veterans' budget. The veterans, we work very closely—

Senator BLUNT. Well, I am not suggesting you are not increasing—

Secretary WALSH. No, no. I am not saying you did that. I am not saying you do that. Sorry.

Senator BLUNT. This is a question of how much you are increasing if these programs lose attraction, particularly the couple of programs you are cutting. But I am, overall, interested in all of these programs that don't increase, but increase by less than 2 percent. Other programs in the Department increase by a lot. I mean you are asking for a 13 percent increase in the overall budget, but the existing veterans' programs all grow by less than 2 percent. That is my question.

Secretary WALSH. Yes. Well, we are asking—yes, thank you. So I am just trying to get my notes here. We are asking for a 5.6 percent increase in our veterans' budget, the bottom line. And part of that is because the veterans' Department is when I talk about apprenticeship programs, we are including the veterans in the apprenticeship program.

When I talk about workforce development and job training investments, we are including the veterans in that program as well. So it is not a—

[SNEEZE].

Secretary WALSH. God bless you. It is not a directed line item in the Workforce Development for veterans, but we have veterans included in those conversations, and in that money. So when we think about like the trucking challenge, we have reached out—we did a trucking challenge, the Department of Labor made an investment because you gave us money, a little bit of discretionary funds to create this program. We did.

The first place we reached out to is the veterans, to get veterans into the program. So we are integrating our veterans' office into everything that we are doing. So the veterans' money is specifically for vets, for them to do the outreach, and do all the work that they do, and then all the other money that we have, whether it is workforce development, job training, all this, the veterans are part of that as well.

Senator BLUNT. I want to say to that, Secretary, there is a reason that we had the veterans set aside in some of these areas. And I think when we did that the idea that: Well, the veterans are included in everything else, would not have been a very satisfactory answer, as you are trying to focus on veterans specifically. But we can talk about that some more.

AMERICAN RESCUE PLAN FUNDING

And my other question is, the Department, in the American Rescue Plan, received \$2.2 billion in March as part of that, less than

5 percent of that has been spent, \$94 million has been spent, \$335 million has been obligated. So less than 5 percent has been spent, less than 20 percent, or so, has been obligated. What are you planning to do with that \$2.2 billion?

Secretary WALSH. I was just trying to—we are still spending it, and I was told behind me, we are still spending it.

[LAUGHTER].

Secretary WALSH. I will have to get that out——

Senator BLUNT. That is a better answer, than we are not going to spend it. What are you planning?

Secretary WALSH. Yes. Well, if you give me money I am going to spend it.

Let me get back to you, specifically, on what it is, where we are going, and the reasons for it. Some of the—we are having challenges with hiring, we are having challenges with different pieces. Let me look into that, and get back to you with a better answer.

Senator BLUNT. Well, I would think some of the overall—this big increase you asked for in the overall budget, maybe there are some ways to justify this \$2.2 billion to fill some of those gaps. But I look forward to talking to you about your plans on that money specifically.

Secretary WALSH. Absolutely, and we also don't want to spend the money just for the sake of spending the money.

Senator BLUNT. Well, I agree with that.

Secretary WALSH. You know, these are taxpayers' dollars, and we want to make sure we spend it correctly.

Senator BLUNT. Yes. Thank you, Secretary. Thank you, Chairman.

Senator MURRAY. Thank you. That will end our hearing today.

Secretary Walsh, thank you for a very thoughtful discussion about how we can support our working families, and build an economy that does work for everyone.

ADDITIONAL COMMITTEE QUESTIONS

For any Senators who wish to ask additional questions, questions for the record will be due June 24 at 5 p.m., the hearing record will 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

TRANSPARENCY OF EMPLOYERS' ANTI-UNION SPENDING

Question. I have been heartened by successful votes to unionize across the country, even despite corporations union busting and launching expensive disinformation campaigns. The Department plays an important role in providing transparency on this type of spending, which is chronically underreported.

What are your plans to boost transparency of employer spending on anti-union messaging in the workplace?

Answer. The resources included in the President's Budget would strengthen Office of Labor-Management Standards' (OLMS) review of reports that employers and consultants file with the Department under the Labor-Management Reporting and Disclosure Act (LMRDA). The resources would complement current efforts and ensure

that OLMS will continue to achieve its priority to adequately enforce the long-neglected employer and consultant reporting requirements. OLMS would enforce the LMRDA's reporting requirements on employers and their labor relations consultants in the same way it enforces reporting requirements governing labor organizations. The agency would review employer and consultant reports for completeness and accuracy and open investigations if compliance assistance efforts do not remedy any problems identified. The agency would also develop a methodology to identify employers and consultants who have engaged in reportable activity but failed to file a report, and open investigations as appropriate. As a result, whether the entity filing a given report is an employer, a labor consultant, or a labor organization, the agency will evaluate and investigate evidence that suggests they have not disclosed reportable activity. These undertakings will be standard investigations of anti-union expenditures and activities and, as with our Compliance Audit Program, will be conducted with the same level of scrutiny as audits of labor unions.

OLMS is taking other, more immediate steps to ensure meaningful enforcement of employer and consultant persuader reporting activities. OLMS is making employer and consultant reports more visible and easily accessible on the OLMS website. OLMS staff are educating the public and directing individuals with knowledge of unreported activity to contact an OLMS tip line.

The Department is also posting blogs, compliance assistance publications, and other materials to advance its efforts to obtain full compliance.

INFECTIOUS DISEASE NOTICE OF PROPOSED RULEMAKING

Question. During the hearing, we discussed the need for the Occupational Safety and Health Administration to move quickly to finalize the permanent COVID-19 standard for healthcare workers and a permanent standard for infectious diseases. Secretary Walsh indicated the healthcare standard would be done within three to 6 months, while the next steps for infectious diseases would be done on the same timeline. The Spring 2022 Unified Agenda of Regulatory and Deregulatory Actions released on June 21, 2022 identifies September 2022 for issuance of the final rule for the healthcare COVID-19 standard and May 2023 for the notice of proposed rulemaking (NPRM) for the infectious diseases standard.

Please describe your actions and plans for issuing the NPRM on infectious diseases closer to the timeline you identified during the hearing.

Answer. OSHA's current priority is issuing a final COVID-19 standard. Unfortunately, COVID is still a threat to working people and we are focused on keeping our healthcare workers safe. We expect to finalize the COVID-19 standard in September of 2022 and will then turn our full attention to the infectious disease NPRM.

COVID has shown us that we need a permanent infectious disease standard that will address all infectious disease hazards, including future pandemics. At this time, OSHA expects to publish an infectious disease NPRM in May of 2023. This is an aggressive timeline and somewhat dependent on our COVID work because the team of people working on the COVID standard also work on the infectious disease standard.

Question. How has the Department used available funding from the American Rescue plan for this important work?

Answer. Funding from the American Rescue Plan has been an extremely valuable resource for us to fund work on the COVID-19 and infectious disease standards in several ways. We are spending ARP money on staff time for economists, health scientists, industrial hygienists, and epidemiologists, as well as on legal assistance. We also utilize contracts to further the Agency's work. Contractors perform research, review literature, and engage in analysis.

Question. How will the Department use available balances of such funding to accelerate promulgation of the NPRM?

Answer. The Department will continue to use ARP funding to pay for staff such as economists, health scientists, industrial hygienists, and epidemiologists, as well as legal assistance. We will also use ARP funding for contracts to further our work so that we can move as quickly as possible on the NPRM.

PROTECTING AGRICULTURAL SECTOR WORKERS

Question. The number of Wage and Hour investigations in agriculture fell to 1,000 in fiscal year 2021.

This level is down by more than one-third from a decade ago. "Labor Exploitation and Trafficking of Agricultural Workers During the Pandemic" (https://polarisproject.org/wp-content/uploads/2021/06/Polaris_Labor_Exploitation_and_Trafficking_of_Agricultural-Workers_During_the_Pandemic.pdf) finds that labor trafficking victimization of H-2A Visa holders increased by 70 percent com-

paring a 6-month period prior to the COVID pandemic and during the pandemic. The report further noted that nearly two-thirds of such trafficking victims suffered threats of reporting to immigration and excessive hours, while one-third suffered the withholding of earnings.

Please describe the Department's actions and plans to protect workers in our agricultural sector.

Answer. Farmworkers are among the lowest paid and most vulnerable workers in the country.

Many of these workers are excluded from Federal collective bargaining protections under the National Labor Relations Act and from overtime protections under the Fair Labor Standards Act. As a result, farmworkers are uniquely susceptible to wage theft, unlawful retaliation, and human trafficking.

For farmworkers with H-2A visas, these vulnerabilities are compounded by the fact that they are reliant on the employer for housing, transportation, access to food, and their temporary status in the country. While the number of workers with H-2A visas has grown from 160,000 in fiscal year 2017 to more than 250,000 in fiscal year 2021, even without a corresponding increase in enforcement appropriations, the Department has continued to prioritize agricultural workers in its enforcement and outreach.

The Department is committed to ensuring that the rights of farmworkers are protected. In fiscal year 2021, the Wage and Hour Division (WHD) recovered over \$8.4 million for over 10,000 workers in the agricultural industry. To continue to achieve the greatest impact possible, WHD has launched a national initiative to focus enforcement and outreach efforts on the agricultural industry. When egregious violations are found, WHD uses every tool at its disposal, including program debarment, to protect workers and ensure that employers are held accountable.

Through its investigations, WHD is uniquely positioned to detect potential human trafficking indicators, to make referrals to criminal law enforcement agencies, and to calculate restitution for victims when requested by the Department of Justice. WHD continues to support the updated U.S. National Action Plan to Combat Human Trafficking by committing resources, collaborating with criminal enforcement agencies, and providing outreach to combat labor trafficking. Wage and Hour is also a U & T-visa certifying agency, and its efforts significantly assist qualifying victims of these crimes who are seeking immigration relief from the Department of Homeland Security (DHS).

WHD also plans to continue to strengthen its partnerships with employers, worker advocates, and community-based organizations. Since the beginning of this Administration, WHD has sponsored and participated in 787 outreach events focusing on H-2A compliance with agricultural workers and their advocates, as well as with employers, agents, recruiters, and partner agencies engaged in the H-2A program. Educating employers increases compliance while partnering with workers' trusted allies makes workers feel more comfortable filing complaints and participating in investigations.

Finally, the Department is currently engaged in rulemaking to modernize the administration of the H-2A program and to increase protections for workers and has announced that it will engage in further rulemaking to promote worker voices and worker protections.

Question. How will the budget proposal support implementation of these plans in fiscal year 2023?

Answer. Over the course of the past year, WHD has been working to rebuild its enforcement workforce and target its hiring in the geographic areas where its services are most needed. As a priority industry, employment in agriculture is taken into consideration when allocating personnel to be hired. The fiscal year 2023 budget will support hiring in district offices that focus on agricultural investigations, including district offices in Alabama, California, Florida, Georgia, Mississippi, North Carolina, and Texas. These hiring efforts will enable WHD to continue to focus on essential outreach and enforcement in agricultural areas.

Question. What steps will you take to ensure that unclaimed back wages collected, including for visa holders, are paid to those harmed workers?

Answer. WHD's efforts to put wages back in workers' pockets transforms lives. In fiscal year 2021, WHD assessed an average of \$1,211.70 for over 190,000 employees due wages, which can mean the difference in being able to meet the rent or pay a childcare bill. Returning these wages to workers is essential to the agency's mission, and WHD leverages partnerships with community-based organizations and foreign consulates while also engaging in innovative outreach strategies to ensure that back wages are paid to vulnerable workers.

WHD has been working with worker advocates, unions, and foreign consulates to build trust and increase workers' access to the agency. These partners have been

vital to the agency's efforts to locate workers and maintain relationships with workers over the length of the investigations. For example, WHD worked with community-based organizations in Pennsylvania to hold a back-wage clinic for unlocated mushroom farmworkers. The clinic resulted in the distribution of \$68,377 in back wages to 66 workers that WHD had previously been unable to contact.

Similarly, consulate partnerships amplify WHD's outreach and connect the agency with immigrant communities. As a trusted source of information and assistance, they help WHD reach more workers and deliver on the protections the law provides. They also play a vital role in locating workers due back wages after they have left their employment in the U.S.

Finally, WHD has developed an online search tool, Workers Owed Wages (WOW) that allows workers to enter information to find out if back wages are being held on their behalf.¹ The tool provides a quick and easy way for employees to find out if they are owed money and receive it. From January 2022 through June 2022, the WOW search tool facilitated the disbursement of over \$2 million to workers owed wages. The WOW system is currently available in English and Spanish.

Question. Please describe any barriers to back wage payments being made and plans to overcome them, including any needed legislative changes.

Answer. Immigrant and low-wage workers face several obstacles in recovering wages that are owed to them. These workers are often difficult to locate because they move frequently or may return to their home countries. This problem is exacerbated by the fact that investigations, particularly agricultural investigations, are often long and complex and may include litigation, making it more likely that workers have moved or changed contact information between the time that the investigation was initiated and the time that back wages are recovered. Further, low-wage and vulnerable workers may fear retaliation for coming forward and claiming the wages that are owed to them.

There are some statutory barriers as well, such as the current statutory requirement for any back wages to be sent to Treasury if they are not able to be delivered to the worker within 3 years. DOL believes that altering that requirement in some form could be beneficial to returning back wages to workers and is available to provide technical assistance and further briefing on the matter.

EVALUATION OF OFCCP CONTRACTOR SELECTION

Question. The President's budget proposes \$147 million, an increase of \$39 million, for the important work of the Office of Federal Contract Compliance Programs (OFCCP).

How does the OFCCP plan to evaluate and continue to improve its supply and service scheduling list for selection of contractors with the greatest risk factors for noncompliance with equal opportunity and affirmative action requirements?

Answer. OFCCP is deploying its resources more strategically by strengthening its process for scheduling Federal contractors for compliance reviews. The agency is incorporating broader sets of data and information to identify risk factors for non-compliance and better align its selection process with enforcement priorities. OFCCP schedules employers for evaluation using a "general administrative plan... derived from neutral sources," which includes various labor economic data and analytical procedures.² This can include, for example, a focus on industries or sectors with high prior labor and employment law violation rates or particular geographic regions.

In May 2022, OFCCP issued a new supply and service scheduling list of Federal contractors and subcontractors. Using neutral criteria, OFCCP developed and implemented a statistical methodology to conduct predictive modeling for the purpose of selecting Federal contractors and subcontractors. This model incorporated an analysis of EEO-1 Component 1 data to identify instances in which utilization of demographic groups differ from industry and local labor market averages. OFCCP focused on industries that have experienced employment growth during the pandemic and the industries expected to receive significant Federal investments for infrastructure and economic recovery, to ensure all workers have equal access to employment opportunities. The agency scheduled a larger proportion of establishments from those industries in which the average hiring rate increased after March 2020, the date of the onset of the economic impact of the pandemic, relative to a baseline established from hiring rates in the years before the pandemic (2014–2020).

¹ <https://www.dol.gov/agencies/whd/wow>.

² See *United Space Alliance, LLC v. Solis*, 824 F. Supp. 2d 68, 91 (D.D.C. 2011) (citing *Marshall v. Barlow's, Inc.*, 436 U.S. 307, 320, 321 (1978)).

OFCCP developed this methodology to strengthen its ability to identify risk factors for noncompliance in order to focus agency resources where workforce utilization patterns may indicate the existence of barriers to hire or advancement. OFCCP further anticipates these changes will help the agency reach a broader universe of Federal contractors, as well as subcontractors. Historically, OFCCP has not scheduled subcontractors for compliance evaluations when there is a lack of data concerning subcontract dates. For this scheduling list, OFCCP included the prime contract date as a proxy for the subcontract dates and will examine the utility of this approach.

In addition, where a parent company has three or four establishments on the May 2022 scheduling list, OFCCP has assigned these compliance reviews to the same region so that the agency and the contractor can engage in these reviews in a coordinated manner to increase efficiencies for all.

OFCCP is continuing to strengthen its supply and service scheduling list for selection of contractors with the greatest risk of noncompliance, including by promoting contractor compliance with the requirement to develop and maintain written Affirmative Action Programs (AAPs). OFCCP developed and launched in early 2022 an online portal, the “Contractor Portal,” for supply and service contractors to self-certify electronically that they have developed and maintained AAPs for each establishment and/or functional unit, as applicable. Compliance with OFCCP’s written affirmative action program requirements is essential because a complete AAP and the supporting personnel activity data provide the foundation for OFCCP’s compliance evaluation of a contractor’s employment practices. By June 30, 2022, existing contractors were required to certify whether they were in compliance. OFCCP has announced to contractors that those who fail to complete the certification through the Portal, or state that they have not developed or maintained an AAP, will be more likely to be on OFCCP’s scheduling list than contractors that have certified that they are in compliance.

Question. How would additional resources requested in the budget support this objective and increase contractor compliance with such requirements?

Answer. Given the Federal Government’s historic investments in the economy over the next decade, many more businesses will become Federal contractors and subcontractors. As a result, OFCCP will have substantially increased enforcement responsibility over this growing number of contractors. Additionally, contractors’ workforce structures and employment selection and pay systems are rapidly evolving, becoming more sophisticated and complex and the pandemic has accelerated changes to workplace structures, including the increased reliance on remote work.

The fiscal year 2023 funding request would allow OFCCP to increase its capacity to review a greater number of contractors and strengthen its investigation and resolution of systemic discrimination cases, which will increase contractor accountability and attention to proactive compliance. In particular, the fiscal year 2023 request would support 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. As the Agency rebuilds, OFCCP will continue robust engagement with a broad coalition of stakeholders, including contractors. The Agency will develop resources to highlight evidence-based research and promising practices to inform employers when developing actionable strategies to build inclusive workplace cultures and advance equity. The 2023 request would also provide the resources necessary to onboard new hires, develop and deliver in-depth employee training programs, and invest in the requisite workforce technological equipment and solutions. Investing in training and technology support along with hiring will help ensure long-lasting operational success and prevent attrition.

OFCCP also will work to align its traditional review of single contractor “establishments” with the evolving reality of the workplace, where contractors often take a more enterprise-wide approach to evaluating their employment practices, including compensation. With increased funding, OFCCP would also enhance its database production, software expertise and research capabilities to support stronger coordinated enforcement.

Where contractors refuse to provide access to data, witnesses, and other information that is necessary for OFCCP to conduct its compliance evaluations, OFCCP will use its fiscal year 2023 funding to prepare enforcement referrals for denial of access cases so that Federal contractors adhere to their responsibility to provide this information.

Question. How would access to data collected by the Equal Employment Opportunity Commission advance the OFCCP mission and minimize data collection burden on covered contractors?

Answer. OFCCP selects contractors for comprehensive compliance reviews by relying on a variety of data sources to focus the agency's enforcement resources. The EEO-1 report is a joint data collection to meet the enforcement needs of both the U.S. Equal Employment Opportunity Commission (EEOC) and OFCCP, while avoiding duplicative information collections and minimizing the burden on employers. EEO-1 Component 1 workforce demographic data has been shared between the two agencies for decades.

Collecting and analyzing pay data from private employers is important to OFCCP's efforts to ensure pay equity. In 2014, OFCCP published a rule proposing a pay data collection to enable the agency to more effectively focus its enforcement resources to better identify potential pay inequities warranting compliance evaluations. During the rulemaking, OFCCP considered public comments from contractors urging EEOC and OFCCP to coordinate compensation data collection by using the EEO-1 report, thereby decreasing employer burden. Ultimately, OFCCP determined that, rather than publishing a final rule, it would collaborate with the EEOC to collect compensation data as part of the EEO-1 filing.

In September 2016, the Office of Management and Budget (OMB) approved EEOC's final Paperwork Reduction Act notice to collect, from private employers and Federal contractors, workforce pay data by gender, race, ethnicity, job category and by pay bands via the EEO-1 report (Component 2). In August 2017, OMB issued a memorandum initiating a review and immediate stay of the revised data collection regulation. As a result of a lawsuit against OMB and EEOC challenging the stay, in 2019 a Federal district court reversed the stay and ordered the EEOC to collect 2 years of pay data from employers. EEOC complied, however, it subsequently announced that it would no longer collect pay data via the EEO-1.

OFCCP is interested in exploring opportunities to use the EEO-1 Component 2 pay data that has been collected to inform OFCCP's scheduling methodology and identify potential pay gaps or patterns of occupational segregation that merit further investigation. Pay data could be used to conduct analyses to identify employers that are outliers and depart substantially from comparable benchmarks that may warrant further inquiry. Such analyses could inform the methodology for selecting contractors for further review where OFCCP would have the opportunity to review the full set of pay data. When combined with an analysis of utilization outliers, the identification of pay outliers lends significant marginal utility to the Component 2 pay data for OFCCP and could enhance OFCCP's scheduling process. OFCCP's desk audit also includes a three-year trend analysis of EEO-1 Component 1 reports to identify utilization outliers. A similar analysis of trends in the Component 2 pay data—separate or in conjunction with the EEO-1 Component 1 data—may provide additional value in OFCCP investigations.

OLMS UNION PROTECTIONS

Question. The Office of Labor-Management Standards also protects union members through its work to identify fraud and embezzlement of union assets.

How would additional resources be used to target compliance audits on those at-risk of violating requirements without burdening unions that don't have any compliance issues?

Answer. Additional resources to fund the Office of Labor-Management Standards' (OLMS) initiative to enforce and review for accuracy employer and consultant reports required under the Labor-Management Reporting and Disclosure Act (LMRDA) dovetail with its efforts to reduce burden on labor unions that are free of compliance issues. The resources requested would permit OLMS to continue audits of labor unions both to detect embezzlements and to promote compliance with the LMRDA. Because it is not feasible for OLMS to audit every union, and doing so would unfairly burden compliant unions, OLMS developed and applies a methodology to focus its auditing resources on unions whose objective metrics suggest that they may have been victimized by criminal activity. This targeting strategy conserves resources—of both unions and OLMS—that would have been wasted on audits of problem-free organizations. The effectiveness of this methodology is measured by the percent of conducted audits that result in the opening of a "fallout" criminal case. If the fallout rate is high, it supports the conclusion that OLMS is successfully targeting its resources to labor unions that need it. Note: To be clear on a point that is sometimes misunderstood, we emphasize that the fallout rate measures only the "efficiency" of OLMS' targeting strategies. A high number does not suggest high criminal activity and a low number does not suggest low criminal activity. The fallout rate measures only the effectiveness with which the agency identifies and audits those unions that are vulnerable to fraud or embezzlement based on financial metrics that are often associated with fraud or embezzlement.

Question. Please describe how the Voluntary Compliance Partnership program is improving compliance with the LMRDA and allowing OLMS to cost-effectively fulfill its mission.

Answer. OLMS works with the nation's most prominent international and national unions through the Voluntary Compliance Partnership (VCP) initiative to assist their local and affiliate unions with LMRDA compliance, thus multiplying the effect of OLMS' efforts and allowing OLMS to more cost-effectively fulfill its mission. In 2021, the VCP program leveraged the resources of national/international labor unions to improve the compliance performance of over 16,000 of those international and national unions' affiliates. The same year, OLMS expanded the VCP program to 47 partner unions, an increase of two unions over the previous year. Over the years, VCP has solidified its platform as a national compliance assistance effort that measurably improves timely reporting, bonding coverage, accurate and complete reporting—including the submission of union constitutions and bylaws—and the implementation of financial safeguards to prevent unions from becoming victims of financial fraud. For example, the overall late-filing rate for unions under the VCP initiative is significantly lower than for non-VCP unions, and the late filing rate decreased significantly after increasing during fiscal year 2020, as the COVID-19 pandemic began. VCP continues to assist partner labor organizations with OLMS procedures regarding mergers and terminations, regional and national training conferences, and other organizational development activities. In every instance where a labor union partner addresses the compliance problems of its affiliates, it reduces the demand for OLMS enforcement resources, saving money and permitting OLMS to more cost-effectively fulfill its mission.

BLS YOUTH COHORT DEVELOPMENT

Question. The budget proposes \$14,500,000 for the Bureau of Labor Statistics to continue development of a new youth cohort for the National Longitudinal Surveys.

How would these funds be used to support a new youth cohort and generate additional information on and support research about the experience and education of youth during the COVID-19 pandemic, their future education and training and transition to the workforce?

Answer. The Bureau of Labor Statistics (BLS) began developing a new National Longitudinal Surveys (NLS) youth cohort in fiscal year 2021 and since then has conducted extensive outreach to Federal agencies, user groups, and scientists with relevant areas of expertise. Information about these activities, including agencies and subject areas around which they were organized and topics they targeted for feedback, are available at <https://www.bls.gov/nls/nlsy26.htm>. These outreach efforts allowed BLS to form a conceptual and practical foundation. Building upon these activities, beginning in fiscal year 2023, BLS would use the funding proposed in the President's Budget to build-out the new youth survey, which includes the following steps: (1) create management structures for coordinating the development of sampling procedures, questionnaire content, collection design, data processing systems, and dissemination tools; (2) design procedures for sampling and accessing the appropriate, high-quality sampling frame; (3) develop the collection instruments; and (4) initiate development of systems to manage, process, and disseminate the data that are collected or acquired from alternative sources. Also, outreach would continue throughout the development process. BLS would field its first round of collection in fiscal year 2026 and release the first set of data in fiscal year 2028.

It is anticipated the new cohort would comprise a nationally representative sample of youth between the ages 12 to 16 and living in the United States at the first interview, who would be interviewed periodically through their life up to and including through retirement age. The youth comprising the group will have been born during 2010–2014, and thus experienced the COVID-19 pandemic during their elementary schooling years. In the early years of the survey, BLS would collect retrospective information to capture information about respondents' elementary schooling years, including their experiences during the COVID-19 pandemic. This, along with the extensive information collected from them through their teenage years and into adulthood, would enable a wide range of research about how the experiences of this generation during the COVID-19 pandemic influence their future education and training and their transition to the workforce. Due to the survey's longitudinal design; its focus on education, training, skill development, and employment; and the breadth of additional domains for which it collects information, the new NLS cohort would be uniquely well-suited to support research on various topics, including the impacts of the COVID-19 pandemic on the cohort's educational and professional experiences, yielding valuable insights for governments, businesses, and other decision-makers. Previous NLSY cohorts have provided a lens for in-depth study of race-

, ethnicity-, gender-, and income-based differences, and a new cohort would advance these lines of research, allowing for comparisons across cohorts as well as incorporating potential adaptations to employment, education, and training resulting from economic and environmental changes over time.

OFFICE OF THE SOLICITOR OPERATIONS FUNDING

Question. The budget requests \$178 million, an increase of \$52 million, for the Office of the Solicitor which is necessary to support the day-to-day operations of the Department's agencies and programs as well as the regulatory agenda and priorities of the Department.

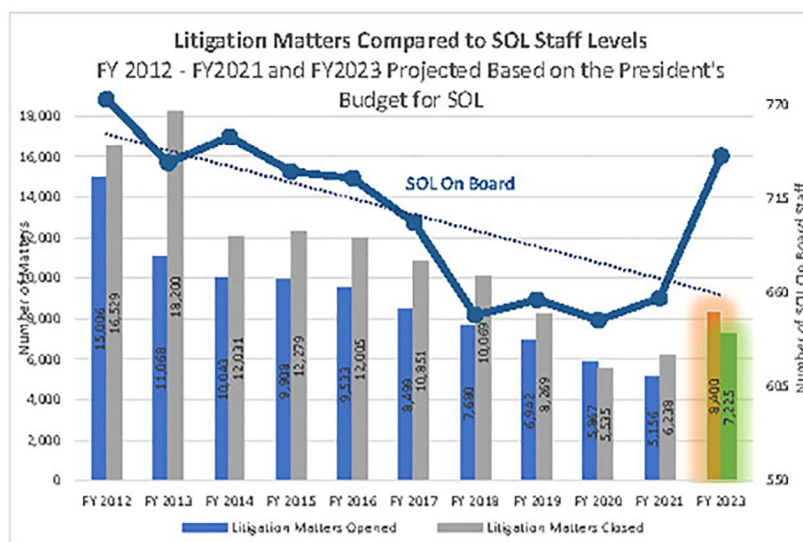
How would additional resources requested for the Office of the Solicitor reverse the trend over the past decade of the significant reduction in litigation opened and closed? What's the impact of this reduced litigation capacity on the ability of agencies to fulfill their statutory missions?

Answer. With the additional resources provided in the fiscal year 2023 President's Budget, the Office of the Solicitor (SOL) would greatly increase its enforcement litigation capacity, reversing the trend over the past decade of a steady and significant reduction in the number of litigation matters that SOL opens and closes. The decline in litigation correlates with the reduction in SOL FTE that has resulted from the combination of steadily increasing costs per FTE and insufficient direct appropriations, which for SOL have remained relatively flat. As reflected in the graph below, over the last 10 years, staffing decreases have forced SOL to significantly reduce the number of litigation matters SOL opens; in fiscal year 2021, SOL opened just 35 percent of the litigation matters it opened in fiscal year 2012.

At the fiscal year 2023 President's Budget funding level, SOL anticipates an overall 25 percent increase in its litigation workload, with opened litigation matters increasing by 63 percent in comparison to the full-year results from fiscal year 2021 and concluded litigation matters increasing by 16 percent compared to fiscal year 2021. The following data, focused on the litigation portion of SOL's workload, is included in the fiscal year 2023 President's Budget submission. This does not capture the critical pre-litigation work, legal advice, and regulatory work that SOL undertakes to assist DOL's agencies:

	FY 2021 Actual	FY 2022 Projected (Based on Flat Appropriation)	FY 2023 Projected (with President's Budget)	Projected Increase— FY 2022 to FY 2023	Projected Increase— FY 2021 to FY 2023
Litigation Opened	5,156	6,400	8,400	31%	63%
Litigation Concluded	6,238	5,500	7,225	31%	16%

The following graph illustrates the correlation between the decline in SOL's staffing levels and the decline in SOL's litigation matters over the past decade. This graph also illustrates the expected increase in litigation if the fiscal year 2023 President's Budget were enacted:



The decline in SOL staffing has diminished the ability of DOL (and its constituent agencies)

The decline in SOL staffing has diminished the ability of DOL (and its constituent agencies) to enforce the laws Congress has written, leaving workers unprotected and tilting the economic playing field against law-abiding employers. For example, SOL is presently forced to decline roughly 60 meritorious Wage and Hour matters each month, and about 70 meritorious, contested OSHA cases each month. This diminution in legal services not only hampers DOL's ability to provide relief for the most vulnerable workers but harms the majority of employers that are complying with the law. For instance, construction contractors that pay overtime to their workers are harmed if competing employers reduce their labor costs by failing to pay overtime. The fiscal year 2023 budget would enable SOL to litigate more cases generally, and in particular, more impactful, resource-intensive cases.

Finally, while this question is specifically about litigation, it is important to emphasize the effect that insufficient staffing has upon the full range of legal services SOL provides. Presently, SOL is underfunding critical general counsel programs and has a reduced ability to support client agencies with compliance assistance documents, guidance, and letters. Staffing shortages also hamper DOL's ability to carry out good government initiatives, such as clearing its FOIA backlog, and provide compliance assistance to the regulated community.

Question. Please share for the last five fiscal years and the fiscal year 2023 budget proposal amounts spent on or allocated for the Office of the Solicitor to:

- Work on Department regulatory activities;
- Support agency enforcement actions; and
- Provide other legal services.

Answer. The table below provides the requested information for the last 5 years and the fiscal year 2023 budget proposal. Because the vast majority of SOL's funding goes directly to salaries and expenses for the personnel that provide legal services,³ we have derived the allocations below from time spent on providing legal services. The dollar figures in the table were calculated by multiplying the percentage of total time spent by SOL personnel on a particular category of legal work (enforcement agencies, other worker protection agencies, departmental management and other agencies, and regulatory) by SOL's appropriated budget for a given year. The fiscal year 2023 data is a forecast of the distribution of SOL's work and expenditures based upon a two-year average (fiscal year 2021 to fiscal year 2022 Q3).

Following is further explanation of the table and data:

³ The remaining funding goes to non-personnel expenses that support SOL legal services, such as Working Capital Fund, rent, security, stenography, travel, and subscriptions.

- To demonstrate the expenditures or amounts allocated to “agency enforcement actions,” we provide data regarding SOL legal support to the DOL agencies that engage in significant enforcement work: EBSA, MSHA, OFCCP, OSHA and WHD. This represents about 66 percent of SOL’s workload on average over the period covered.
- Many other DOL agencies engage in worker protection activities, but their work is not primarily enforcement. We labeled these the “Other Worker Protection Agencies,” which include: ETA, ILAB, OLMS, OWCP, and VETS. This represents about 20 percent of SOL’s workload on average.
- The requested data for other legal services is reflected in the table as allocations for Departmental Management and Other Agencies, which covers legal work performed for the Department’s central management administrative agencies, and other agencies not included in the categories above. This represents about 11 percent of SOL’s workload on average.

The allocations in the table for regulatory work cover all DOL agencies and represent about 3 percent of SOL’s workload on average. The regulations allocation is not duplicative of the other agency-specific categories listed above and in the table below.

Department of Labor, Office of the Solicitor (SOL) Legal Services Workload and Expenditures													
by Agency Grouping													
FY 2018 - FY 2023													
SOL Activity - Work in Support of	FY 18 Work %	FY 18 Expenditure	FY 19 Work %	FY 19 Expenditure	FY 20 Work %	FY 20 Expenditure	FY 21 Work %	FY 21 Expenditure	FY 22 Q3 Work %	FY 22 Q3 Expenditure	FY 21 - FY 22 Q3 Avg Work %	FY 21 - FY 22 Q3 Average Expenditure	FY 23 Projected Work %
Enforcement Agencies	68.53%	\$91,069,517	67.03%	\$88,259,742	65.64%	\$86,445,911	63.56%	\$83,744,114	64.57%	\$64,853,624	64.07%	\$ 74,798,869	64.07%
Other Worker Protection Agencies	20.13%	\$26,750,757	19.89%	\$26,189,561	20.76%	\$27,340,297	21.27%	\$28,024,501	19.22%	\$19,304,424	20.25%	\$ 23,664,463	20.25%
Dept Management & Other Agencies	9.14%	\$12,146,146	10.82%	\$14,246,910	11.14%	\$14,671,046	11.76%	\$15,494,506	12.12%	\$12,173,237	11.94%	\$ 13,833,871	11.94%
Regulations	2.70%	\$2,923,580	2.26%	\$2,975,787	2.46%	\$3,239,746	3.41%	\$4,492,880	4.09%	\$4,107,965	3.75%	\$ 4,300,422	3.75%
FY 22 Q3 Portion of Budget										\$100,439,250			
Total FY Appropriated Funds Budget		\$132,890,000		\$131,672,000		\$131,697,000		\$131,756,000		\$133,919,000		\$ 132,837,500	

Amounts reflect all General, Unemployment Trust Funds and Black Lung Disability Trust Funds, and funds reprogrammed within the Departmental Management Appropriation. Amounts exclude reimbursable funds, funds transferred from other appropriations, and supplemental appropriations. The projection for FY 2023 is based upon the 2-year average from FY 21–FY 22Q3 as shown in the table.

INTERNATIONAL LABOR ENFORCEMENT

Question. The budget proposes \$129 million, an increase of \$23 million, for the Bureau of International Labor Affairs (ILAB) to enforce labor commitments of trading partner countries; combat child and forced labor and human trafficking; and effectively carry out its mission. This increase would build on the increased investment of \$10 million provided to ILAB in last year’s appropriations bill.

How would requested funds be used to build on increased resources provided in last year’s bill to include in the List of Goods Produced by Child Labor or Forced Labor those that are produced with inputs produced with forced labor or child labor? What actions have been taken and are planned to incorporate this information into the list?

Answer. The implementation of the List of Goods Produced by Child Labor or Forced Labor, including listing goods that are produced with inputs produced with forced labor or child labor, requires significant resources. ILAB is grateful for the interest from Congress in this vital tool and has utilized its appropriation to make important investments in this mandated work.

Recent Actions

ILAB has added a limited number of goods that we have reason to believe are produced with inputs produced with forced labor or child labor to the 2022 TVPRA List, which will be released in late September. The additions were based on ILAB’s improved knowledge base with respect to tracing supply chains, developed in part via two \$4 million grants in fiscal year 2021 to examine tracing methodologies for the supply chains of cotton, thread/yarn, and textiles from India, cobalt from the Democratic Republic of the Congo, and cotton from Pakistan. The grants contributed to a preliminary basis for a credible and multi-sectoral supply chain tracing methodology that ILAB then used to identify the goods and inputs that will be added to the 2022 List.

ILAB is currently fulfilling its required involvement in interagency efforts related to transparency and accountability in supply chains, such as those under the

Uyghur Forced Labor Prevention Act (UFLPA). As a statutory and critical member of the Forced Labor Enforcement Task Force (FLETF), ILAB reassigned staff to work closely with the Department of Homeland Security (DHS) and other inter-agency partners to meet the initial six-month timeline for developing the UFLPA enforcement strategy. ILAB plans to continue to prioritize staff resources to support the FLETF's ongoing work, as well as to support the increasing interagency and external demand for ILAB's technical expertise and guidance on implementing strong due diligence.

ILAB is uniquely placed to lead the U.S. Government's response on developing effective and worker-centered due diligence guidance and plans to continue leading and innovating in these priority areas using the requested funding. The requested funding would also allow ILAB to expand its preliminary supply chain tracing methodology by incorporating more complex trade data and developing and acquiring more specialized knowledge of supply chains—in particular, unique processing steps, which frequently act as a barrier to effecting supply chain tracing and transparency. ILAB would also incorporate private sector, multilateral and international organization, and other public sector efforts in this area. The requested funding would enable ILAB to expand its list of goods that include inputs made with forced or child labor, as well as to continue to strengthen and improve our list of goods made with forced or child labor in the direct production.

ILAB notes that expanded mandates for reporting and increased demand for ILAB expertise have outpaced appropriations for several years and appreciates Senators' leadership and commitment to supporting ILAB's work. ILAB's ability to examine additional supply chains beyond the supply chains explored in the two grants identified above (especially supply chains which may feature abusive and exploitative conditions) will require intensive and expanded resources.

Question. The USMCA Supplemental Appropriations Act, 2019 appropriates an additional \$180 million, available for obligation until December 31, 2023, for ILAB to support reforms of the labor justice system in Mexico, including grants to support worker-focused capacity building, efforts to reduce child labor and forced labor in Mexico, and other efforts related to implementation of the USMCA. These funds are supporting important progress in Mexico in the implementation of its labor law reforms and increase in the number of independent unions recognized in Mexico. How does the budget support further progress in this critical area? What future needs do you anticipate for this work particularly after the supplemental funds have been awarded?

Answer. The number of independent labor unions is still a small percentage of all unions in Mexico, but it is slowly growing with implementation of the labor reform, supported by ILAB project interventions, expert support from ILAB's labor attachés in Mexico, ILAB engagement with Mexican labor ministry staff and officials, and efficient deployment of the Rapid Response Mechanism. A recent ILAB monitoring trip identified the need for continued support of awareness-raising about the new labor justice model, including among small to medium-sized enterprises. As ILAB works to build the capacity of the new labor justice institutions in Mexico, particularly at the local level, ongoing funding will be needed to ensure the continuity of current efforts. Though all of ILAB's USMCA-related technical assistance projects in Mexico are designed to build sustainable capacity, the magnitude of Mexico's labor reform will necessitate ongoing ILAB engagement—including extended labor attaché presence as well as new and extended project investments, beyond December 31, 2023—to consolidate and institutionalize achievements and progress and ensure an enduring transformation of Mexico's labor landscape.

Question. Mathematica's "Synthesis Review of OCFT work in Cocoa and Fishing/Seafood" identified relationships between project features and effectiveness, recurring challenges and opportunities for improving future project success, including on sustainability of reductions of child and forced labor resulting from ILAB-funded projects. How will the conclusions and recommendations from this review be considered for fiscal year 2022 and fiscal year 2023 funding opportunity announcements? What steps are planned to strengthen project sustainability so that labor abuses don't re-emerge after projects conclude?

Answer. ILAB aims to disseminate all evaluations across the Bureau and our grantee community to maximize access and usership, including by hosting open presentations on evaluations and distributing ILAB's "Evaluation Roundup" to the larger stakeholder community. ILAB is in the process of launching a Knowledge Management Portal on the ILAB website to enable stakeholders to search past evaluations and other project resources by keyword to find specific lessons learned and good practices.

ILAB considers many conclusions and recommendations from the Mathematica Synthesis Review report on the cocoa and fishing/seafood sectors to be applicable to

ILAB's broader technical assistance portfolio and is applying these recommendations across funding decisions and Funding Opportunity Announcements. Some examples of ILAB responses are listed below:

- Mathematica Recommendation*: Consider funding projects for longer periods of time/larger budgets or to consider a two-phase funding approach.
- ILAB Response*: ILAB will pilot a two-phase project approach in fiscal year 2022. In Phase I, the project will work to improve regional and national coordination, and, if successful, these efforts will be scaled up within the region during Phase II.
- Mathematica Recommendation*: Engage families, community leaders, and unions/workers to support effectiveness.
- ILAB Response*: ILAB fiscal year 2022 programming and funding opportunities include an amplified focus on workers and their families. New projects will prioritize strengthening local civil society organizations and formal and informal worker organizations and engaging community leaders to build trust with marginalized and vulnerable workers, foster sustainable local capacity, and better support workers and their families with wholistic and locally led interventions.
- Mathematica Recommendation*: Design projects with more feasible outcomes.
- ILAB Response*: Fiscal year 2022 funding opportunities draw on ILAB staff expertise, complementary labor diplomacy efforts, trade leverage, and complementary sector- or country/region-specific initiatives to designate project sectors and countries or coordinate with grantees to jointly select countries and sectors. This comprehensive design approach supports the achievement of ambitious outcomes and ensures that project interventions will be supported and complemented by mutually reinforcing efforts. ILAB also works with grantees to assess expected project outcomes to ensure alignment with project timelines and available resources.
- Mathematica Recommendation*: Integrate tripartite approaches to support project effectiveness.
- ILAB Response*: ILAB is incorporating tripartite approaches as a best practice to increase worker voice and dialogue with government and employer stakeholders and improve labor conditions. Several ongoing ILAB projects include labor and employer organizations as co-implementers (e.g., the Solidarity Center and Center for International Private Enterprise are jointly implementing a project on labor law enforcement in Georgia), and ILAB is an active partner in the ongoing and successful Tripartite Commission in Honduras.
- Mathematica Recommendation*: Adopt gender-conscious project design.
- ILAB Response*: ILAB now requires applicants to describe an integrated gender approach from design through implementation to ensure representation of women, children, and youth (boys and girls) throughout the life of the project. ILAB is working with grantees to increase attention to gender in project design and monitoring and evaluation systems, including requiring gender-disaggregated data and, where appropriate, requiring targets for gender disaggregation.

ILAB is taking several steps to ensure the sustainability of project outcomes to prevent the re-occurrence of labor abuses once projects have concluded. ILAB encourages project designs that include robust engagement with existing host government and local community initiatives to tie project interventions and outcomes into ongoing, locally led initiatives. ILAB's Pílares project in Colombia, designed and driven by local civil society organizations, is a model approach that ILAB intends to scale-up using fiscal year 2022 funds.

ILAB's approach to building the capacity and motivation of local stakeholders, including government, private sector, and civil society groups, equips local actors with the tools and information to monitor and address labor abuses after projects end. All ILAB Funding Opportunity Announcements (FOAs) require applicants to outline a sustainability strategy for the proposed project and describe how they will promote the sustainability of key elements, beginning in the early stages of project implementation. Grantees update their sustainability strategy annually to ensure continued relevance of project outcomes and adjust to changes in capacity of individuals, communities, and country.

EVIDENCE CAPACITY INVESTMENT SURVEY

Question. The Department's Evidence Capacity Investment, January 2022, found that approximately half of survey respondents—which were restricted to occupations for which the use of evidence is relevant—reported they or their teams frequently

use statistics, research, and analyses. Just less than one-third of respondents reported using evidence for service improvements, or research agendas or questions. Please share your plans for implementing the opportunities for improvement identified in this report.

Answer. The Department's Chief Evaluation Office (CEO) has analyzed the findings of the Capacity Assessment for Research, Evaluation, Statistics and Analysis and identified fundamental gaps in skills and access to data that together prevent the Department from using evidence in their work. Based on that analysis, CEO has identified two priority areas of work:

- Conducting Department-wide trainings and capacity-building support for both supervisors and non-supervisors to prepare them to understand and use internal and external research and data resources. This includes support for staff with no formal education or training in mathematics and statistics, who nonetheless need to interpret evidence, as well as training tailored to those staff who already analyze, interpret, and report data analyses in their current positions.
- Launching a restricted use data (RUD) program and environment where DOL staff and trusted researchers can merge, analyze, and use DOL and other external data resources.

CEO has launched substantial planning and work on both the trainings and the RUD program within its existing resources, including:

- Establishing a Seminar Series for the Department's staff and Federal colleagues to learn about new and relevant research, data, and targeted evidence topics and resources, and to do so in an informal and accessible setting;
- Launching a monthly internal research roundup newsletter to draw attention to the Department's work;
- Creating an introductory webinar for all staff to be integrated into the Continuous Learning@Labor program;
- Leading the development of the Department's Evidence Institute in collaboration with the Department's Evidence Officials and as well as the DOL Training Officer and LearningLink staff, taking first steps toward offering professional, high-quality adult learning opportunities for DOL staff on evaluation, data analytics, and other evidence-related technical topics;
- Updating the Department's Scientific Integrity Policy—under the leadership of CEO and Scientific Integrity Official Dr. Christina Yancey—to ensure honesty, objectivity, transparency, and ethical behavior when it comes to science and scientific processes, in response to the Presidential Memorandum on Restoring Trust in Government through Scientific Integrity and Evidence-Based Policy-making; and
- Mapping the characteristics of the Department's existing restricted-use data files that could support a RUD Program and developing initial mock-ups of a website interface and application processes, forms, and other administrative materials.

CEO will continue to build upon these activities as possible within existing resources. With additional resources—both in staff and funding—the Department could expand and deepen the professional-quality trainings needed by staff as identified in the Capacity Assessment, as well as fully launch the RUD program, both of which are efforts that will make more meaningful capacity-building improvements across the Department's workforce.

Question. How would the budget request support implementation of these plans?

Answer. The Department proposed an increase to the Departmental Program Evaluation budget activity. In addition, robustly funding the Department's overall budget request could help support this work because CEO can access set-aside funds shared by DOL sub-agencies. Section 107 of the General Provisions in the President's Budget authorizes the reservation of not more than 0.75 percent from specific budget accounts for transfer to and use by the Office of the Chief Evaluation Officer for departmental program evaluation and related evidence-building activities. This authority offers an opportunity to repurpose a small portion of agency budgets for evidence-building.

QUESTIONS SUBMITTED BY SENATOR JOE MANCHIN, III

SPECIALIZATION OF JOB CORPS CENTER CURRICULUMS

Question. Job Corps is an educational and workforce training program administered by the Department of Labor. The Job Corps program helps youth build the skills they need to succeed, complete their high school education and help students find employment after they leave. West Virginia is proud to be home to two Job

Corps centers, one in Charleston and one in Harpers Ferry. The President's budget requests \$1.7 billion in funding for Job Corps in fiscal year 2023, which is an increase over the previous fiscal year. This funding will allow the continued operation of all 121 Job Corps Centers, facilitate updates and rehabilitation projects at existing Job Corps Centers and support the hiring of necessary staff. While this funding is put to good use in training the next generation of workers, the Department of Labor should consider creating a streamlined process that will allow Job Corps centers to more quickly submit and have approved requests to change curriculums or offer new, specialized courses to students. This would help ensure students have access to courses and trainings that will allow them to compete now and enter competitive industries. Creating more opportunities for students only stands to benefit our nation.

How can the Department streamline the process by which Job Corps centers create specialized curriculums, or offer new courses to students?

Answer. Job Corps recently evaluated the process governing its change request protocols for curriculums, identifying pain points and areas for improvements. As a result, in August 2022, the program implemented several changes to ensure efficiencies in the process. Noteworthy changes to the process include:

—*Streamlined Information Requests.*—Job Corps revised the process to provide clarity to all center operators, including additional information specific to establishing pre-apprenticeship curriculums.

—*Technical Assistance Enhancements.*—The program added a means for proactive technical assistance to the process (including office hours) to ensure the timely arrival, completion, and National Office approval of change requests.

These adjustments, in addition to process changes and ongoing guidance/training to center operators, were developed to continuously improve the quality of requests to the National Office and shorten the timeline for determinations. Job Corps' revised process and ongoing efforts to increase local and national partnerships will ensure that the program delivers high-quality curricula and training more efficiently and graduates are prepared for in-demand jobs with strong career paths and sustainable wages.

MENTAL HEALTH PARITY LAW COMPLIANCE

Question. Each year, the Secretary of Labor is required to submit a report regarding compliance with mental health parity laws. Mental health parity laws generally prohibit restrictions on mental health services that are more restrictive than those for all medical and surgical benefits. In January, the Department of Labor, along with the Department of Health and Human Services and the Department of the Treasury, released a report showing that health insurers for the most part are failing to deliver parity for mental health and substance use disorder benefits to beneficiaries. Senator Manchin has heard from several constituents who work in the mental health and substance use disorder workforce that mental health parity laws are simply not being followed. What's worse, mental health parity laws are not really being enforced. The bad actors aren't seeing any consequences for their actions, which are limiting patient access to mental health and substance use disorder services.

What is the Department doing to ensure employers are meeting their obligations to their employees, and that mental health parity laws are being enforced?

Answer. The Biden-Harris Administration has made enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) a top priority. MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA), specifies how group health plans and health insurance issuers to whom MHPAEA applies must perform and document comparative analyses of the non-quantitative treatment limitations (NQTLs) they impose on Mental Health and Substance Use Disorders (MH/SUD) coverage to demonstrate parity, and provide those analyses to the Secretaries of Labor, HHS, and Treasury or applicable state authorities upon request. This new enforcement authority continues to be the cornerstone of the Departments' heightened MHPAEA enforcement efforts. In light of the high priority placed on MHPAEA, the Employee Benefits Security Administration (EBSA) has redesigned its enforcement strategy and committed significant new resources to its MHPAEA enforcement efforts in order to best leverage the additional authority. The Department continues to devote greater resources to enforcement so as to take full advantage of these new and existing tools that Congress has provided to the Departments.

EBSA's ten Regional Offices across the United States are actively involved in investigating multiple health plan service providers and issuers, as well as health plans, to assess MHPAEA compliance. EBSA identifies NQTLs through a review of plan document language, analysis of claims data, follow-up on leads from provider/

participant complaints, and consideration of other sources. EBSA has developed specialized investigative tools to help identify potential NQTL red flags and analyze claims data for MHPAEA concerns. Additionally, EBSA works with consulting experts to develop approaches to evaluate comparative analyses.

Each of EBSA's ten regional offices has a team of investigators dedicated to MHPAEA NQTL investigations and these teams were recently expanded to provide more resources and subject matter expertise for these investigations at the regional level. EBSA's NQTL Task Force continues to provide oversight and coordination of these investigations, and additional support is provided from the Office of Enforcement, Office of Field Administration, and Office of Outreach, Education and Assistance in the EBSA national office.

As a result of the additional funding provided under the CAA, EBSA continues to hire additional investigators and other staff in support of EBSA's MHPAEA enforcement work. Since enactment of the CAA, EBSA onboarded new investigators and other staff using CAA- appropriated fundings. EBSA has held over 30 MHPAEA NQTL training programs for new and experienced investigators and other staff since April 2021. The funding provided under the CAA to support this critical work expires at the end of 2024.

EBSA has also retained or is in the process of retaining additional outside consultants and experts in the areas of autism, reimbursement rates, network adequacy, substance use disorder treatment, and eating disorder treatment to assist investigators in the review and evaluation comparative analyses and with medical and behavioral health issues in these investigations.

EBSA continues to conduct robust outreach initiatives and works extensively to improve the understanding of MHPAEA among plans, plan sponsors, issuers, consumer groups, participants and beneficiaries, healthcare providers, and state regulators. These initiatives include webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community. In fiscal year 2022 through June 30, 2022, EBSA conducted 49 compliance assistance outreach events nationwide that covered MH/SUD parity, and which were attended by employers, employee benefit plan administrators, attorneys, accountants, and other plan officials. Attendees received information about their responsibilities under Federal laws affecting group health plans, including MHPAEA. In addition to the compliance assistance events, EBSA also conducted 103 participant assistance and public awareness events that educated workers and other stakeholders about rights and benefits safeguarded under MHPAEA.

EBSA currently has 229 open MHPAEA investigations as of July 1, 2022, 124 of which involve one or more possible NQTLs. EBSA is increasingly focusing its investigative resources on service providers to multiple employer-sponsored health plans to obtain widespread corrections and relief impacting participants and beneficiaries of many plans across the service providers' books of business. These service provider investigations have focused on impermissible restrictions on medication assisted treatment (MAT) and exclusions of key services for autism and eating disorders, among other issues.

From February 10, 2021, through June 30, 2022, EBSA requested comparative analyses for over 260 unique NQTLs across 97 investigations. This far exceeded the 20 requests that the Secretary is required, by statute, to make each year (in addition to pursuing complaints received from the public).

The comparative analyses EBSA has reviewed in response to these requests continue to lack sufficient information upon initial receipt. As of June 30, 2022, EBSA has issued insufficiency letters relating to 182 NQTLs, identifying specific deficiencies in the comparative analyses and requesting additional information to remediate those deficiencies. In addition, EBSA has issued 54 initial determination letters citing plans/issuers for noncompliance related to 74 NQTLs (54 unique NQTLs). As of June 30, 2022, EBSA has issued 2 final determinations of noncompliance.

EBSA is prioritizing enforcement work on NQTLs impacting the adequacy of provider networks and impermissible exclusions of key MH/SUD treatments for conditions such as autism, eating disorders, and substance use disorder and addiction, while continuing to investigate NQTLs in the form of prior authorization and concurrent review requirements. EBSA will also continue to enforce MHPAEA's provisions related to annual and lifetime dollar limits, quantitative treatment limitations, financial requirements, disclosures, and coverage in all applicable classifications.

The Office of the Solicitor (SOL) provides legal support for all aspects of the Department of Labor's work in enforcing MHPAEA. SOL heavily supports EBSA's MHPAEA efforts, which will increase in fiscal year 2023 and beyond. In addition to litigating enforcement actions as necessary, SOL advises on a wide range of projects, including related to regulatory and sub-regulatory initiatives and investiga-

tion and enforcement approaches. SOL has a substantial number of attorneys across the country working to support these efforts.

This important and critical work advances the Department's commitment to serving the needs of the most vulnerable communities, as workers suffering from mental health and substance use disorder conditions are often economically and socially disadvantaged with limited resources to access and pay for care when benefits have been improperly denied or limited.

FECA EFFORTS TO COMBAT FRAUD

Question. Recent reports estimate that more than 105,000 Americans, including more than 1,500 West Virginians, died from drug-related overdoses in the last year. This is the highest number ever recorded. West Virginia continues to have the highest rate of overdose deaths in the country with 90 deaths per 100,000 people. This is almost triple the national average of 31.5 deaths per 100,000 people. Fighting the drug epidemic is one of my highest priorities. The Department of Labor's Budget Request for fiscal year 2023 asks for \$108.2 million to support the Office of the Inspector General. The Department notes this funding for the Office of the Inspector General will be used in part to continue oversight work on several "key areas of risk." Specifically, the Budget Request notes this funding will be used to fight fraud against the Federal Employees' Compensation Act, or FECA, program, as a way to address the oversight crisis.

How will fighting fraud in the FECA program help address the drug epidemic?

Answer. Reducing fraud is a high priority in the FECA program. Fighting fraud is critically important to address the drug epidemic and prevent future epidemics by actively seeking out patterns of overprescribing and areas of potentially harmful prescribing practices before they become large scale problems.

The FECA program utilizes a robust analytics platform to detect concerning trends from medical providers as well as anomalous billing patterns. The FECA program works closely with Inspectors General government-wide to support prosecution efforts. In order to keep pace with nefarious provider activity, the FECA program continues to detect new and emerging fraud schemes and to implement controls to curtail them. In fiscal year 2020, the FECA program's focus remained steadfast on fraudulent pharmaceutical practices by enforcing maximum quantities for certain prescriptions and drug kits. In fiscal year 2021, needed controls were placed on durable medical equipment rentals and platelet injection services. In fiscal year 2022, the program completed implementation of a pharmacy benefit manager (PBM) which provides additional tools to safeguard against opioid misuse and many other potentially harmful drug interactions.

The Federal Government has statutory penalties for those who commit fraud within FECA's workers' compensation system. Pursuant to 18 U.S.C. § 1347, it is a felony to engage in a scheme designed to defraud a Federal healthcare benefit program. Each violation can result in fines and up to 10 years imprisonment. The FECA program will continue to actively participate in ongoing auditing of medical billing, as well as work with the OIG and DOJ to fulfill its requirements to prosecute fraud and recoup illegal payments to stop fraudulent medical providers who contribute to the opioid drug epidemic.

These and other collective policy controls and investments, beginning with those addressing compounded drugs in 2016, have had tremendous success in decreasing the use of opioids, including duration and dosage. Reducing fraud in the FECA program and addressing the opioid epidemic will remain a high priority of the Office of Workers' Compensation Programs.

In addition, the following information was provided by the Office of Inspector General (OIG).

Fraud, either by FECA medical providers or claimants, facilitates the drug epidemic through the illegal distribution of drugs that can increase or further addictions.

The OIG currently has several Office of Workers' Compensation Programs (OWCP)-related reviews that focus on various fraud schemes involving opioids and other controlled substances including: the illegal prescription or distribution of controlled pain medications; illegal kickback schemes involving prescribers and pharmacies; and the unlawful distribution of controlled substances.

In order to more timely detect fraud activity, the OIG is seeking data from OWCP and their contractors that captures digital information for each billing from the OWCP and their contractors. Early identification of anomalies in the data, specifically related to opioids, will allow the OIG to save taxpayer dollars and protect claimants by stopping fraud while it is happening, and illegal practices that lead to opioid misuse. This OIG function is independent from OWCP's programmatic re-

sponsibility to detect fraud and protect claimants. We are also working with the OWCP to gain access to these reports and findings of their contractors' fraud and analytics programs. This will enable the OIG to build on its own data analytic models and to identify potential fraud for further investigation.

DOL's fiscal year 2023 budget request will allow the OIG to continue to focus investigative resources on OWCP fraud, particularly as it relates to provider fraud involving opioids and other controlled substances. Also, additional funding will enable us to thoroughly investigate those opioid matters referred to the OIG by the OWCP Program Integrity Unit.

Question. What other initiatives can the Department undertake to help end the drug epidemic?

Answer. The Department strongly supports the Office of the Inspector General's work in this area. In addition, the Department is addressing some of the root causes and is working to end the drug epidemic in various ways, both within the Department's authorities and by working with other agencies.

DOL is committed to working with the Departments of Health and Human Services and Treasury (together, the Departments) to use their full statutory authority to support the Administration's response to address the nation's mental health and substance use disorder epidemics through enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA facilitates access to treatment for substance use disorders by eliminating discriminatory restrictions in health coverage for substance use disorders (such as higher copayments, separate deductibles, lower annual visit limits) and other barriers placed on treatment (such as stricter preauthorization or medical necessity reviews). Under the Biden-Harris Administration, the Departments have committed to making mental health and substance use disorder parity a top enforcement priority. The Departments intend to issue additional rulemaking to further clarify MHPAEA's protections for individuals and the obligations it imposes on plans and issuers, to facilitate greater access to mental health and substance use disorder treatment.

In the Office of Workers' Compensation Programs (OWCP), in addition to fighting fraud, the Federal Employees' Compensation Program (FECA) program also implemented a pharmacy benefit manager (PBM) in fiscal year 2022, which provides additional tools to safeguard against opioid misuse and many other potentially harmful drug interactions.

Utilizing FECA's PBM, the FECA program has instituted thoughtful controls that allow up to a seven-day supply of an approved immediate release opioid prescription at a maximum of 90 MME (morphine milligram equivalents; the dosage strength) per day for claimants newly prescribed opioids, after which the provider must complete a prior authorization request to justify continued use. The prior authorization is reviewed by the PBM's pharmacists and other healthcare professionals, who will consider accepted conditions and surgeries, review medication profiles, assess drug-drug interactions and therapeutic duplications, assess the need for naloxone, and perform other clinical pharmacy checks to assist with optimizing prescribing based on nationally recognized guidelines as directed by the FECA program before approving continued opioid use.

The Department will continue to build on existing initiatives to address the opioid epidemic and substance use disorder. After awarding six initial demonstration grants in 2018 to test innovative approaches, the Department has since awarded over \$96 million to states, tribes, and local areas in response to the opioid crisis. These include 26 National Health Emergency (NHE) Disaster Recovery Dislocated Worker Grants (DWGs) to states and tribal entities, including a grant of \$10,000,000 to West Virginia, which was active July 1, 2019—June 30, 2022. Currently, 21 grants remain active. The NHE Disaster Recovery DWGs 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 can immediately mitigate the impact of the crisis.

In September 2020, the Department awarded \$20 million in grant awards to pilot the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT Act) grant. The SUPPORT Act grants were awarded to four States: Florida, Maryland, Ohio, and Wisconsin, and continue through 2024.

The Department's Chief Evaluation Office conducted an implementation evaluation of the initial demonstration grantees, which it has since made available on its website and, in partnership with the Employment and Training Administration

(ETA), shared broadly through webinars and conferences.⁴ The Department also continues to provide technical assistance, informed by its grants and the implementation evaluation, to share promising practices and information to assist States and local communities respond to the opioid epidemic and its impact on the workforce. This technical assistance includes an online community of practice, digital case studies from the evaluation, and a series of webinars from June–August 2022 on topics related to the role of the workforce system in serving individuals with substance use disorders, such as opioid use disorder in construction, recovery-friendly workplaces, peer recovery support careers, and training toolkits for serving individuals with substance use disorder.

Finally, the fiscal year 2023 President's Budget includes continued support for the areas listed above. It also includes resources within ETA for workforce training programs throughout the country, including a set-aside for workers in the Appalachian and the Lower Mississippi regions. Job Corps administers the Trainee Employment Assistance Program (TEAP) which includes counseling services and drug testing at Job Corps Centers. Additionally, the Department requests \$100,000,000 for economic revitalization and workforce training in communities impacted by changes in the energy industry through the POWER+ Initiative. Expanding economic opportunities in these regions and throughout the country is a key component of addressing the opioid epidemic.

INDEPENDENT CONTRACTOR RULEMAKING FEEDBACK

Question. Earlier this month, the Department's Wage and Hour Division announced it would engage in rulemaking on whether a worker may be considered an independent contractor, or an employee. The rule the Department previously put together on this rule was delayed, withdrawn, then ultimately reviewed and decided by the courts. As part of its announcement, the Wage and Hour Division announced it would hold two public forums to hear feedback directly from both employers and workers. The public will also have an opportunity to provide comments on the rule once it is published in the Federal Register. While it is good the Department will consult with both employers and workers as it considers a new rule, it is important ensure that the Department fully engages with the small business owners and other employers that will be directly impacted by this rule.

How does the Department plan to incorporate feedback from a wide array of stakeholders, from small businesses to workers?

Answer. The Department has been engaging with a wide array of stakeholders on this topic since the beginning of this Administration. The Department worked with stakeholders to identify business owners and their representatives, employers, workers, and advocates, among others, to share their input about determining employee or independent contractor status for purposes of minimum wage and overtime pay protections under the Fair Labor Standards Act. We continued that engagement in widely announced public forums to provide opportunities for gathering additional input. During those forums, we heard from employers, workers, business owners—including small business owners—advocates, freelance organizations, and others from across the country who provided valuable information. The Department appreciates the robust participation in these forums and took the views expressed during this outreach into consideration when drafting the proposal.

On July 5, 2022, the Department transmitted a draft proposed rule on Employee or Independent Contractor Classification Under the Fair Labor Standards Act to the Office of Management and Budget (OMB) for review. The public will have the opportunity to review and comment after publication of any proposed rule in the Federal Register.

TIMELINE FOR SILICA STANDARD RULEMAKING

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). As you are aware, in 2020 the U.S. Department of Labor's Office of Inspector General (OIG) produced a report that was critical of the Mine Safety and Health Administration's (MSHA) inadequate efforts to safeguard coal miners from crystalline silica exposure. That report found MSHA needed to update its regulations to: lower the legal exposure limit to silica, improve the ability of the agency to issue citations and fines for

⁴ <https://www.dol.gov/sites/dolgov/files/OASP/evaluation/pdf/NHE%20Opioid%20Final%20Report.pdf>.

excess exposure to silica, and increase sampling protocols where were found to be too infrequent to protect miners adequately. While it is good MSHA announced actions last week to ramp up enforcement on silica exposure, more needs to be done.

Last year your office informed my team that a Notice of Proposed Rulemaking on a Silica standard was scheduled for January 2022. It is now June and we have yet to see that proposal. When do you anticipate releasing the proposal?

Answer. We are working hard to publish a Notice of Proposed Rulemaking (NPRM) as soon as possible and hope to issue one by the end of the year.

Question. When do you anticipate finalizing that rule?

Answer. In order to issue a final rule to better protect miners from health hazards related to exposure to respirable crystalline silica, MSHA must first complete its work and publish the proposed rule. At the close of the comment period, MSHA will go through all the necessary steps in the regulatory process—including reviewing and responding to stakeholder comments and feedback and holding public hearings—and include a projected publication date for the final rule in an appropriate future Unified Agenda of Regulatory and Deregulatory Actions.

Assistant Secretary Williamson and MSHA are laser focused on the rise in cases of pneumoconiosis, including in parts of Appalachia where existing coal seams are thinner and layered in rock containing quartz. We know from investigative reporting by NPR and PBS, the National Institute for Occupational Safety and Health's (NIOSH) Coal Workers' Health Surveillance Program, and the works of other health experts that younger and less experienced miners are increasingly developing some form of pneumoconiosis, including the most severe forms of the disease. A growing number of experts and research point to respirable crystalline silica as the likely cause. Many metal and nonmetal miners also work in potentially dangerous mining environments where taking proper precautions to limit silica exposures are equally as important.

In addition to working on an improved health rule, MSHA is taking action now under our existing authorities to better protect coal and metal and nonmetal miners' health by limiting their exposure to respirable crystalline silica. MSHA recently announced a silica enforcement initiative that has four primary components: inspections, sampling, compliance assistance, and miners' rights. Working together with the mining industry, MSHA can take important steps to better protect miners from overexposures to toxic levels of respirable dust now while the Agency continues to develop a new mandatory health standard for respirable crystalline silica. This effort will result in more inspections and sampling at mines with repeated silica overexposures and for occupations at coal and metal and nonmetal mines known to have a high risk of potential silica overexposures.

Significant elements in the 2023 President's Budget request support for the silica enforcement initiative and the respirable crystalline silica rulemaking. The resources needed to support these efforts span multiple program areas and are presented relative to the 2022 Operating Plan:

- In recent years, MSHA has focused its compliance and technical assistance efforts on reducing accidents caused by powered haulage equipment, which continue to be a leading cause of mining fatalities and serious injuries, and MSHA has increased the agency's emphasis on reducing health hazards in mines, such as respirable coal dust in coal mines, silica/quartz in mines, diesel particulate matter, and noise. The President's Budget requests an additional \$34,046,000 in the Mine Safety and Enforcement program area for an additional 150 full time equivalents to continue the increase in health sampling and enforcement activities to ensure that miners' overexposure to respirable dust, quartz/silica, noise, and other health hazards are addressed by mine operators.
- Compliance assistance, particularly to small operators, is provided through MSHA's Educational Policy and Development (EPD) program area. The Educational Field and Small Mine Services in EPD assists in the development or improvement of the health and safety programs of mine operators and contractors in the mining community. MSHA anticipates compliance assistance will play a key role in aiding operators who reach out for assistance in reducing silica overexposures. The President's Budget requests an additional \$163,000 for training and compliance assistance.
- The President's Budget includes an increase of \$2,545,000 to the Office of Standards, Variances, and Regulations to support rulemaking activities, including publishing a proposed rule to protect miners' health from exposure to respirable crystalline silica. The proposal will address the control of respirable silica and the limit of permissible exposure. MSHA will consider the data and information gathered through working with NIOSH and mining stakeholders over the years and through a recent request for information, as well as any relevant information contained in the Occupational Safety and Health Administration's

fiscal year 2016 final rule on respirable crystalline silica. Once the proposed rule is published, MSHA will hold public hearings to ensure that it receives feedback from miners and mine stakeholders across the U.S. As it develops the final rule, MSHA will review all public comments received through the comment period.

—The Technical Support program area also plays a significant role in the silica initiative and the future implementation of the silica rule. The President's Budget requests a \$2,315,000 increase to the Technical Support budget activity to increase laboratory capacities to allow MSHA to handle an increase in sampling due to the silica enforcement initiative and the respirable crystalline silica health standard under development.

BLACK LUNG DISABILITY 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 continuing to see a growing number of 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. Unfortunately, the 2021 rates expired on December 31, 2021, putting an indebted Trust Fund in a precarious financial situation.

While Congress continues to work to find a path forward for Senator Manchin's bill that would extend the 2021 excise tax rate for 10 years, can we continue to count on the Department to protect and maintain these critical benefits?

Answer. Yes, you and all miners and survivors who receive benefits under the Black Lung Benefits Act (BLBA) can continue to count on the Department of Labor to protect and maintain these critical benefits. The Department of Labor does not want miners already burdened with black lung disease or their families to feel uncertain about the future. The Department has made it clear that miners and their survivors will continue to receive their Federal black lung benefits. The Department is working hard to make sure that mining communities understand that the U.S. Treasury is required by law to provide the Trust Fund with sufficient money to pay all benefits due regardless of tax revenues.

However, as you are aware, Congress intended that Federal black lung benefits primarily be paid by responsible coal mine operators, not the U.S. taxpayer. When coal excise tax shortfalls require the Federal black lung program to borrow from the U.S. Treasury to cover the cost of benefits, taxpayers are footing the bill, not the coal mining industry. Thus, the Department applauds Congress for permanently reinstating the coal excise tax rates of \$1.10 per ton of underground-mined coal and 55 cents for surface-mined coal in the Inflation Reduction Act of 2022. Mining communities can rest assured that their benefits are not in jeopardy.

QUESTIONS SUBMITTED BY SENATOR ROY BLUNT

WORKFORCE OPPORTUNITY FOR RURAL COMMUNITIES GRANTS

Question. The fiscal year 2018 LHHS bill began a \$30 million set-aside from the Dislocated Worker Assistance National Reserve to provide employment assistance and workforce training to workers in the Appalachian and Lower Mississippi Delta regions, which increased to \$45 million in fiscal year 2022 and now includes the Northern Border Regional Commission. The fiscal year 2023 budget request includes \$35 million, and does not include the Northern Border Regional Commission in the set-aside. There have been three rounds of WORC grants awarded thus far; Missouri received more than \$3.5 million in funding in the second grant round, but did not receive any funding in the first or third rounds.

What is the application process for these grants, and how important is geographic diversity when making final award determinations?

Answer. As in all competitive grants, the merit review and selection process for the Workforce Opportunity for Rural Communities (WORC) grant initiative is published within each year's Funding Opportunity Announcement (FOA). A technical merit review panel carefully evaluates applications against the selection criteria to determine the merit of applications. These criteria are based on the policy goals, priorities, and emphases set forth in the FOA. The final scores serve as the primary

basis for selection of applications for funding, and the Grant Officer reserves the right to take into consideration other relevant factors when applicable, such as the geographic distribution of funds. The Employment and Training Administration (ETA) notes that each year we receive many high-quality, high-scoring applications, making the WORC funding opportunity highly competitive. Available Federal funding determines the number of grants that can be awarded each year under the WORC competition. Complete information regarding the WORC grant initiative, including awards funded in Rounds 1—3, is available at <https://www.dol.gov/agencies/eta/dislocated-workers/grants/workforce-opportunity>.⁵

The FOA for WORC contains all the information and links to forms needed to apply for grant funding and is published at www.Grants.gov and https://www.doleta.gov/grants/find_grants.cfm.⁶ At each of the links below for WORC Rounds 1—3, see the “Related Documents” tab for the published FOA:

—WORC 1: FOA-ETA-19-08⁷

—WORC 2: FOA-ETA-20-04⁸

—WORC 3: FOA-ETA-21-08⁹

ETA also notes that the fiscal year 2023 Budget baseline and discretionary funding decisions were finalized before Congress completed its work on fiscal year 2022 appropriations in March, including the addition of the Northern Border Region as an eligible region for WORC grants. The Administration has committed to working with Congress going forward to adjust recommendations for fiscal year 2023 appropriations where relevant.

Question. Is the Department working with the Delta Regional Authority to provide technical assistance to ensure that entities applying have the necessary information and assistance to write the best grant application possible?

Answer. Yes. ETA supports the Delta Regional Authority (DRA) and potential applicants in several ways. First, ETA transfers funding each year to DRA in order to host direct technical assistance sessions for potential applicants, which includes help with understanding the requirements of the WORC program and how applicants can best develop applications that can be competitive for funding. While DRA plans and hosts these events, ETA provides support for specific issue areas including grant requirements and performance reporting. ETA regional offices regularly share potential grant opportunities with local networks and provide technical assistance to grantees during the period of performance.

Second, ETA—in partnership with both the Appalachian Regional Commission (ARC) and DRA—hosts an annual web-based technical assistance session that covers the requirements of the WORC program for that particular funding year and discusses the application requirements. For the 4th round of WORC this technical assistance webinar was held on May 23 for eligible applicants from both the Appalachian and Delta regions.

INDEPENDENT CONTRACTOR PROPOSED RULE

Question. The Department recently announced it is developing a new proposed independent contractor rule on determining employee or independent contractor status under the Fair Labor Standards Act. The Department held forums in June to hear from stakeholders from those who might be affected by employee or independent contractor classification. We need to ensure that our small businesses and relevant stakeholder industries have a seat at the table as the Department goes through the rulemaking process.

What are your plans to ensure that a new rulemaking won’t adversely impact small businesses or the broader economy?

Answer. The Department has been engaging with a wide array of stakeholders on this topic since the beginning of this Administration. The Department worked with stakeholders to identify business owners and their representatives, employers, workers, and advocates, among others, to share their input about determining employee or independent contractor status for purposes of minimum wage and overtime pay protections under the Fair Labor Standards Act. We continued that engagement in widely announced public forums to provide opportunities for gathering additional input. During those forums, we heard from employers, workers, business owners—including small business owners—advocates, freelance organizations, and others from across the country who provided valuable information. The Department appreciates

⁵ <https://www.dol.gov/agencies/eta/dislocated-workers/grants/workforce-opportunity>.

⁶ https://www.doleta.gov/grants/find_grants.cfm.

⁷ <https://www.grants.gov/web/grants/view-opportunity.html?oppId=315986>.

⁸ <https://www.grants.gov/web/grants/view-opportunity.html?oppId=326678>.

⁹ <https://www.grants.gov/web/grants/view-opportunity.html?oppId=333025>.

ciates the robust participation in these forums and took the views expressed during this outreach into consideration when drafting the proposal.

On July 5, 2022, the Department transmitted a draft proposed rule on Employee or Independent Contractor Classification Under the Fair Labor Standards Act to OMB for review. The public will have the opportunity to review and comment after publication of any proposed rule in the Federal Register.

Question. What is your timeframe with respect to this rulemaking?

Answer. On July 5, 2022, the Department transmitted a draft proposed rule on Employee or Independent Contractor Classification Under the Fair Labor Standards Act to OMB for review. The public will have the opportunity to review and comment after publication of any proposed rule in the Federal Register.

PROPOSED PROHIBITED TRANSACTION EXEMPTION CHANGES

Question. I am concerned about the proposed regulations to change the procedures governing prohibited transaction exemptions. The proposal includes eliminating the ability to discuss an exemption with the Department prior to officially requesting one, as well as redefining “independent fiduciary” as someone who has never previously received funds, and will not receive funds, for performing independent fiduciary services. As part of the creation of the exemption process, Congress explicitly required that any exemption granted must provide a benefit to all parties involved.

Will these proposed regulatory changes effectively eliminate the exemption process?

Answer. On March 15, 2022, the Department published a proposed rule that, if adopted, would supersede the existing procedure governing the filing and processing of applications for administrative exemptions from the prohibited transaction provisions of the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code of 1986, and the Federal Employees’ Retirement System Act of 1986 (FERSA). The rule proposes to update the Department’s prohibited transaction exemption procedures, which the Department updated most recently in 2011.

The proposed rule would create more clarity, certainty, and transparency around the exemption application process. In doing so, it would promote the Department’s prompt and efficient consideration of all exemption applications by, among other things: (1) clarifying the types of information and documentation required for a complete application; (2) revising the definitions of a qualified independent fiduciary and qualified independent appraiser in order to ensure their independence; (3) clarifying the content of specific reports and documents applicants must submit in order to ensure that the Department receives sufficient information to make the requisite findings under ERISA Section 408(a) to issue an exemption; (4) updating various timing requirements to ensure clarity in the application review process; (5) specifying items that are included in the administrative record for an application and when the administrative record is available for public inspection; and (6) expanding opportunities for applicants to submit information to the Department electronically.

The public comment period for the rule has closed, and the Department is carefully reviewing the 29 comments that it received. The Department will use these comments to inform any revisions it makes to the proposal at the final rulemaking stage.

QUESTIONS SUBMITTED BY SENATOR MIKE BRAUN

COASTWIDE LABOR CONTRACT NEGOTIATIONS

Question. Secretary Walsh, the International Longshore and Warehouse Union (ILWU) and the Pacific Maritime Association (PMA) are currently negotiating a new coastwide labor contract that will cover all 29 West Coast ports. The current contract is set to expire on July 1. As we have seen from previous negotiations, it is unlikely that the parties will reach a new agreement before July. Previous negotiations have witnessed significant disruption issues which have negatively impacted the economy.

What is the administration doing to ensure that the parties remain at the table, negotiate in good faith and don’t engage in any kind of disruptive activity?

Answer. We need to acknowledge that collective bargaining is a process in which the parties to the negotiation work out the terms and conditions of employment. In this case, the best role for government is to encourage the parties to commit themselves fully to collective bargaining that reaches an agreement. That’s what this Administration is doing.

As the Administration’s point person on the negotiation, I have been in touch with the parties for months and have met with and talked to the various players—the

ports, retailers, shippers, trucking companies, and unions—to get a sense of the issues relating to the supply chain.

As you note, the current collective bargaining agreement expired on July 1, but the parties are still at the table making progress and have expressed their commitment to the bargaining process. In fact, on July 26, the ILWU and PMA announced that they had reached a tentative agreement on terms for health benefits—a promising step. Meanwhile, cargo is still moving through the ports, and in fact, the Port of LA reached another record in June.

The fact that the parties are still bargaining past the expiration date of their contract is not unusual—in fact, it is typical for their negotiations. I am in regular touch with the parties to support them in this process, and we feel positive about the parties reaching an agreement.

Question. With all of the ongoing supply chain challenges we are facing, which is a significant cause of record inflation, how concerned is the administration about the potential for disruptions to cause further supply chain challenges? [Question background]

Answer. The administration is very attuned to the potential impact of these major negotiations on supply chains. The port negotiations are not going to solve our supply chain challenges, which pre-date and are far larger than these negotiations. That said, we are working to support the parties in this collective bargaining process to help them reach an agreement, and we feel positive about the parties reaching an agreement.

RULEMAKING FOR DETERMINING INDEPENDENT CONTRACTORS

Question. Independent Contractor Rules under the Fair Labor Standards Act (FLSA)—Recently, the Labor Department announced its intention to overturn workable, modernized rule that clarify whether certain workers are independent contractors or employees. Under the current rules, the Labor Department make the independent contractor vs. employee determination based on two main factors: the nature and degree of the worker's control over the work and the worker's opportunity for profit or loss based on initiative or investment. I've heard from many constituents that they like the flexibility of being an independent contractor.

How does the Department plan to address this issue? Will you impose the so-called “ABC Test” which failed so spectacularly in California?

Answer. On July 5, 2022, the Department transmitted a draft proposed rule on Employee or Independent Contractor Classification Under the Fair Labor Standards Act to the Office of Management and Budget (OMB) for review. The public will have the opportunity to review and comment after publication of any proposed rule.

Because the Department is currently engaged in rulemaking and the proposed rule has been submitted to OMB for review, the Department cannot discuss the contents of the proposed rule at this time.

Question. Do you believe the only way to implement an “ABC” style test would be through regulation?

Answer. The Administration is committed to ending the abusive practice of misclassifying employees as independent contractors, which deprives these workers of critical protections and benefits. In addition to including funding in the Budget for stronger enforcement, the Administration intends to work with the Congress to develop comprehensive legislation to strengthen and extend protections against misclassification across appropriate Federal statutes. The President strongly endorses a comprehensive approach to ending the unlawful practice of misclassification and holding violators accountable. He has called on Congress to develop legislation to adopt the ABC test and create substantive violations for misclassifying workers across appropriate statutes, including the Fair Labor Standards Act and the Family and Medical Leave Act.

THE JOINT EMPLOYER STANDARD

Question. Joint Employer Standard under the FLSA—I have many small business franchise owners in my state. They provide employment opportunities to my constituents and serve the public in their respective communities. These franchise owners need a clear and workable joint employer standard. Businesses simply should not be liable for other businesses out of their control. The Administration has already begun to regulate on the issue of joint employment.

Can you describe for the Committee the Administration plans for this area?

Answer. On July 30, 2021, the Wage and Hour Division (WHD) issued a final rule rescinding the prior administration's Joint Employer Under the Fair Labor Standards Act rule because it introduced an unduly narrow standard that had been in-

validated by a U.S. District Court for the Southern District of New York. That rescission took effect on October 5, 2021.

WHD continues to apply applicable caselaw for determining joint employment under the FLSA. WHD pursues joint employer liability in appropriate cases where an employment relationship exists between the worker and the employer in order to ensure that workers receive the wages that are owed to them.

WHITE COLLAR OVERTIME SALARY THRESHOLD

Question. White Collar Overtime Salary Threshold—The Department has begun taking comment on the minimum threshold at which an employee is exempt from overtime protections. The Obama Administration issued a rule on this threshold, but it was struck down by a Federal court. If the Labor Department sets that threshold too high, I fear it could hinder employers seeking to fill middle-management positions.

As you move forward with these new regulations, how will you determine where the threshold should be?

Answer. The Fair Labor Standards Act (FLSA) exempts from overtime and minimum wage pay protections bona fide executive, administrative, and professional employees who meet certain requirements, including a salary level test. These exemptions are often called the “white-collar” exemptions. The current salary threshold is \$684 per week, the equivalent of an annual salary of \$35,568.

The Department has committed to updating the salary level more frequently, and the Department of Labor’s Wage and Hour Division previously announced that it plans to update the regulations that implement the FLSA’s minimum wage and overtime exemptions for bona fide executive, administrative, and professional employees.

This spring, the Department held a series of listening sessions across the country to hear diverse views of participants on possible revisions to the regulations, as we did prior to issuing proposed updates to these regulations in the past two administrations. This series of listening sessions is important as we review the white-collar exemption regulations. At this time, no proposed rule has been issued. Once a proposed rule is published in the Federal Register, there will be a notice and comment period allowing all interested parties an opportunity to review the proposal and provide formal written comments.

EMPLOYER INJURY AND ILLNESS DATA

Question. The Occupational Safety & Health Administration has announced plans to force employers to submit injury and illness data to OSHA’s Washington headquarters. OSHA plans to then publicize the data. Obviously, this could result in breach of confidentiality of workers’ personal health information.

What procedures are you planning to ensure that this will not occur? Will you take measures to ensure employers’ confidential information will not be released?

Answer. OSHA has preliminarily determined that the proposed data collection would adequately protect information that reasonably identifies individuals directly. For example, OSHA would not require employers to submit information from the recordkeeping forms that directly identifies an employee, such as an employee’s name or Social Security Number. Further, OSHA plans to use the latest automated information technology to detect and remove information that reasonably identifies individuals directly before submitted information is posted online. This privacy scrubbing technology is capable of de-identifying certain information that reasonably identifies individuals directly (such as name, phone number, email address, etc.) that may be inadvertently submitted by employers to the system.

OSHA does not intend to release any confidential employer information. Similar to current electronic submission requirements, the proposed rule would not require employers to submit their confidential information to OSHA.

Question. Further, what usefulness will this information have to anyone? Is the Department’s real goal to give this information to labor unions who will use this data to access workers’ private information, foster support for their organizing efforts, and/or pressure employers in negotiations?

Answer. OSHA intends to use the injury/illness case-specific data:

—To support OSHA’s statutory directive to “assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources” (29 U.S.C. 651(b)) “by providing for appropriate reporting procedures with respect to occupational safety and health which procedures will help achieve the objectives of this Act and accurately describe the nature of the occupational safety and health problem” (29 U.S.C. 651(b)(12)).

- To help identify workplaces where workers are most at risk from specific hazards in order to assist OSHA in better targeting enforcement and compliance assistance resources.
- To provide information that supports evaluation of OSHA's existing programs and development of new programs.
- To make information available to all of the stakeholders in workplace health and safety, including employers, workers and prospective workers, customers and prospective customers, occupational safety and health professionals, and researchers so that they can better understand the nature of injuries and illnesses within industries, identify solutions for preventing these injuries, and make more informed decisions.

MENTAL HEALTH PARITY REQUIREMENT ENFORCEMENT

Question. DOL has championed civil monetary penalties to enforce mental health parity requirements. Unfortunately, employers are reporting that compliance guidance is lacking in this area.

Mr. Secretary, will you commit to providing adequate guidance before assessing penalties upon employers?

Answer. DOL, along with the Departments of Health and Human Services and the Treasury (together, the Departments), has issued multiple rounds of guidance for group health plans, health insurance issuers, and other stakeholders to facilitate the implementation and enforcement of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including 15 sets of FAQs with 96 questions, 7 enforcement fact sheets, 6 compliance assistance tools and templates, 6 reports to Congress, 6 press releases, and 7 publications. In addition, the Departments regularly conduct outreach initiatives to improve the understanding of MHPAEA among stakeholders, state regulators, and others, through annual webcasts, in-person seminars, and nationwide compliance assistance events. In addition to these initiatives, DOL provides informal compliance assistance to stakeholders on an ongoing basis, regularly assisting plans, issuers, and other stakeholders who contact DOL with compliance questions.

As part of the Departments' ongoing efforts regarding mental health and substance use disorder parity, DOL maintains a compliance program guidance document entitled the MHPAEA Self-Compliance Tool, which is intended to help plans and issuers, state regulators, and other parties comply with MHPAEA. Section 13001(a) of the 21st Century Cures Act added section 2726(a)(6) of the Public Health Service Act, which directs the Departments to provide a publicly available compliance program guidance document that is updated every 2 years, and the Department has used its MHPAEA Self-Compliance Tool as the mechanism to fulfill this requirement. The most recent MHPAEA Self-Compliance Tool, issued in 2020, includes a process for conducting non-quantitative treatment limitations (NQTL) comparative analyses, a list of the types of documents and information that a plan or issuer should have available to support its analyses, and illustrations of specific fact patterns to aid in compliance.

Moreover, the Departments issue subregulatory guidance on an ongoing basis to ensure that the regulated community has the guidance it needs to comply with MHPAEA. Most recently, on April 2, 2021, the Departments issued FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (FAQs Part 45) to provide guidance on the amendments to MHPAEA made by the Consolidated Appropriations Act, 2021 (CAA) and to promote compliance by plans and issuers. FAQs Part 45 describes the information that must be included in a sufficient NQTL comparative analysis, and notes that a comparative analysis that consists of conclusory or generalized statements, without specific supporting evidence and detailed explanations, or the production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis, is insufficient. The FAQs also provide guidance as to the types of documents that plans and issuers should be prepared to make available to support the analysis and conclusions reached in their comparative analyses.

In addition to FAQs Part 45, the Departments issued the 2022 MHPAEA Report to Congress in January 2022, highlighting notable compliance assistance efforts, including stakeholder outreach, webinars, and guidance for the regulated community. The Departments are working to issue another Report to Congress as required under Section 203 of Title II of Division BB of the CAA on enforcement efforts related to NQTL comparative analyses. Additionally, the Employee Benefits Security Administration expects to update its MHPAEA Self-Compliance Tool again in 2022.

As explained in the 2022 MHPAEA Report to Congress, the Departments' enforcement efforts are and will continue to be informed by stakeholder feedback. Accordingly, in the Spring 2022 Unified Regulatory Agenda, the Departments announced their intent to issue notice and comment rulemaking to consider what amendments to MHPAEA's implementing regulations are warranted, in light of their experience enforcing the law as well as the subsequent amendments made to MHPAEA. The Departments look forward to additional stakeholder feedback on MHPAEA through comments received in response to this future rulemaking.

TREE CARE INDUSTRY OSHA STANDARDS

Question. Many of my constituents in the Tree Care Industry are eager to see OSHA issue a standard that clarifies and codifies safe work practices for tree care operations. My understanding is the Federal Government currently regulates the tree care industry with a mishmash of standards intended for other industries and this has created confusion for enforcement officers, tree care companies and clients and workers. The industry has been pushing OSHA to address the problem for more than two decades. Some States have acted and issued tree care specific standards, but OSHA has been slow to do so as it pursues other priorities, most of which do not enjoy the same level of support. The Fall 2021 regulatory agenda listed June as the target date for a proposed standard.

Will OSHA meet this target date and if not, when do you anticipate OSHA will issue the proposed standard?

Answer. OSHA's standard-setting process is a long process that includes a multitude of procedural and legal requirements, as well as OSHA's evidentiary requirements and public participation. OSHA began working on a Tree Care Operations standard in 2008, with the publication of an Advanced Notice of Proposed Rulemaking (ANPRM). This document provided much background and gave stakeholders the opportunity to answer questions on work procedures, costs, and their experience with safety and health in the tree care industry. In 2016, OSHA continued with the rulemaking process and held a stakeholder meeting. In May 2020, OSHA completed the Small Business Advocacy Review (SBAR) Panel, a required step to obtain early input from small business representatives. These phases are crucial for OSHA to develop a complete and robust standard to protect all employees performing tree care. Transcripts and reports from the previous phases of rulemaking can be found on the OSHA website: Tree Care Operations Rulemaking.¹⁰

Due to pressing nature of the COVID-19 pandemic, since the beginning of this Administration, OSHA has focused its attention on COVID-19 Healthcare rulemaking—in addition to Heat Illness Prevention rulemaking. As a result, OSHA will not meet the target date of June 2022 for the development of a rule for Tree Care Operations. OSHA is reevaluating the timeframe for rulemaking and anticipates publishing a proposed rule for Tree Care Operations in fiscal year 2023. The rulemaking team participates in monthly American National Standards for Arboricultural Operations—Safety Requirements (ANSI Z133) meetings with the tree care industry and has held several meetings with the Tree Care Industry Association (TCIA) providing updates as appropriate. OSHA also provides robust guidance for the industry on its Tree Care Industry Safety and Health Topics Page.¹¹ Tree Care Operations rulemaking is a priority, and the Agency is consistently working towards a published proposed rule.

CONCLUSION OF HEARINGS

Senator MURRAY. This subcommittee is adjourned.

[Whereupon, at 10:54 a.m., Wednesday, June 15, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

¹⁰<https://www.osha.gov/tree-care/rulemaking>.

¹¹<https://www.osha.gov/tree-care>.

**DEPARTMENT OF LABOR, HEALTH AND
HUMAN SERVICES, AND EDUCATION, AND
RELATED AGENCIES APPROPRIATIONS FOR
FISCAL YEAR 2023**

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 160 public television licensees, collectively operating 336 public television stations serving nearly 97 percent of the American people, we appreciate the opportunity to submit testimony for the record on the importance of Federal funding for local public television stations and PBS. We urge the subcommittee to support \$565 million in 2-year advance funding for the Corporation for Public Broadcasting (CPB) in FY 2025, \$60 million for the Public Broadcasting Interconnection System in FY 2023 and \$30.5 million for the Ready To Learn program at the Department of Education in FY 2023.

**CORPORATION FOR PUBLIC BROADCASTING:
\$565 MILLION (FY 2025) 2-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 been critical during the COVID-19 pandemic, as local public television stations in all 50 States have provided enhanced educational services and content to help support students, families, teachers, and schools throughout this challenging time.

Federal funding for CPB, which enjoys the overwhelming support of the American people, is essential to making these services available to all Americans, including those in rural and underserved areas. 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 has increased the forward funded CPB appropriation in each of the last 3 years.

While public broadcasting is grateful for these increases, the FY 2024 enacted funding level of \$525 million still leaves the public broadcasting system about \$55 million, in inflation-adjusted dollars, behind where the system was 11 years ago. This shortfall continues to present a serious challenge at a time when the system 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.

In addition, local stations are facing a growing backlog of over \$300 million worth of infrastructure improvements we need but cannot afford to fund since the Public Telecommunications Facilities Program (PTFP) was defunded in FY 2011. The

longer these improvements are not addressed, the more they threaten local stations' reliable broadcast services and public service missions.

At the same time, public television stations are eager to make the transition to the new NEXT GEN TV broadcast standard, with its transformative potential for enhanced public service in telehealth, Smart Cities connections, precision agriculture, national security applications as well as remote learning and public safety communications. This transition will cost our system an additional \$400 million.

Public broadcasting respectfully requests that Congress take another substantial step toward securing our current and future public service goals in the FY 2023 appropriations process.

The \$565 million that public broadcasting is requesting in FY 2023 for FY 2025 will help restore lost purchasing power and help local stations begin to replace aging infrastructure, invest in new technology, and invent a 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 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.

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, Smithsonian Institution, NASA and other high-quality sources.

Additionally, local public television stations throughout the country have partnered with PBS to bring a first-of-its kind, free PBS KIDS 24/7 broadcast 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. During the COVID–19 pandemic, many stations have used 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, 13.5 million kids ages 2–8 watched PBS KIDS content. Parents also looked to public television for educational resources, with PBS Parents users increasing by 80 percent 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 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. Throughout the pandemic, public television has provided 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 19th year in a row, PBS was ranked the most trusted among national media institutions. That trust is more important than ever. Americans tune into their local public television station or view their online resources for trusted information that can 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 3 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 fiscal Year 2025 is 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 2-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 2-year budget cycles.

Finally, the 2-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, award-winning programs. Producers and directors like Ken Burns, Henry Louis Gates, Jr., Jamila Wignot, Stanley Nelson and others spend years developing programs like *The Vietnam War*, *Country Music*, *Ben Franklin*, *Rita Moreno: Just a Girl Who Decided to Go For It*, *Amy Tan: Unintended Memoir*, *Asian Americans*, *Reconstruction: America after the Civil War*, *African Americans: Many Rivers to Cross* and upcoming documentaries like *The U.S. and the Holocaust*, *Becoming Frederick Douglass* and *Harriet Tubman: Visions Of Freedom*. It would be impossible to produce this in-depth programming and the curriculum-aligned educational materials that accompany it without the 2-year advance funding.

PUBLIC BROADCASTING INTERCONNECTION: \$60 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 based on rapid advances in technology. In addition, to the interconnection system, this account also provides funding for other technologies and services that create infrastructure and efficiencies within the public media system.

Public television is requesting \$60 million for interconnection in fiscal Year 2023 to support continued investments in the public television and radio interconnection systems and new shared technologies and services including: cybersecurity; data analytics and business intelligence; single sign on service, a content management system and a content delivery network.

This funding request would help build out a suite of interoperable digital platforms and solutions which would effectively and efficiently help stations meet the growing and dynamic needs of digital audiences. This investment would help ensure that every public television and radio station, regardless of size or location, can provide its community with critical services and content on modern technology and platforms, meeting Americans where they are.

READY TO LEARN: \$30.5 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 the RTL grant, CPB and PBS have delivered evidence-based, innovative, high-quality content to improve the math, science, and literacy skills of high-need children. CPB, PBS, and local stations have ensured that the kids and families most in need have access to these groundbreaking and proven effective educational resources. In addition to children, this outreach helps empower caregivers to 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.

The current CPB and PBS RTL grant partnership is a 5-year comprehensive, learning and engagement initiative called "Learn Together: Connecting Children's Media and Learning Environments to Build Key Skills for Success." CPB and PBS are creating dynamic, new learning experiences produced by diverse media makers that will expose young children to career and workforce opportunities; helping them build vital functional literacy, critical and computational thinking, collaboration, and "World of Work" skills and knowledge.

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 3 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 5 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 5-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 \$30.5 million is requested in FY 2023 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 5 years and supported through annual appropriations. Funding in fiscal Year 2023 would provide the fourth year of funding in the latest grant round. Providing \$30.5 million for Ready to Learn in FY 2023 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.

¹Kennedy, 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.)

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 percent 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 2025 for CPB in addition to \$60 million in FY 2023 for public broadcasting's interconnection system and \$30.5 million in FY 2023 for the Ready To Learn Program.

NONDEPARTMENTAL WITNESSES

PREPARED STATEMENT OF THE ACADEMY FOR RADIOLOGY & BIOMEDICAL IMAGING RESEARCH

Chair Murray, Ranking Member Blunt, 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 comprised of more than 200 academic research departments, patient advocacy groups, industry partners, and imaging societies, representing thousands of radiologists and researchers in all 50 States. We are 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 at least \$49.048 billion for the National Institutes of Health's base appropriation. This figure represents an increase of \$3.5 billion over FY2022 plus the release of the 21st Century Cures funds. The Academy also supports a proportional increase to the National Institute of Biomedical Imaging and Bioengineering (NIBIB), resulting in at least \$458.5 million for FY2023—a \$33.6 million increase over the FY2022 enacted level. Further, should the Advanced Research Projects Agency for Health (ARPA-H) or pandemic preparedness efforts progress, funding should be designated separately from NIH's base and should supplement, not supplant, investment in basic research. While the Academy is supportive of ARPA-H and pandemic preparedness, and acknowledges they hold significant and exciting potential, investigator-initiated research is the foundation of basic science.

Moreover, Congress must work to ensure Federal appropriations are enacted on time to avoid disruptive interruptions to the research continuum. We must avoid relying on continuing resolutions, which are insufficient to meet evolving needs. At the end of FY2021 and beginning of FY2022, we received many examples of research left unpursued because funding was not available because of reliance on continuing resolutions. Delaying otherwise meritorious research only serves to further extend the time until we make lifesaving discoveries that help patients fighting deadly and debilitating diseases. Through consistent, robust funding for NIH and our National research infrastructure, we can continue to make advancements that will improve the lives of patients. The Academy is extremely grateful for the subcommittee's long-running support of NIH and encourages you to prioritize NIH for consistent and dependable funding levels for biomedical research, radiology, and imaging science.

IMAGING ADVANCEMENTS AND INNOVATIONS HELP PATIENTS

Imaging serves as a necessary diagnostic tool that researchers and clinicians of all types use to help advance our understanding of biology and to develop and deliver treatments. This is particularly evident in the research examples provided below and through discussions about ARPA-H. A review of the past ARPA-H listening sessions and discussions with Congressional offices shows the value of improved imaging and diagnostics in support of a spectrum of biomedical research advances—resulting in direct benefits to patients. By improving our imaging tools and techniques, we broaden the resources available to address many challenging medical 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 to improve the diagnosis and treatment of multiple cancer types, including breast, prostate, and pancreatic. Imaging research serves many purposes and can significantly improve patient outcomes.

Basic science advancements translate into a variety of clinical applications benefiting patients. Included below are examples of imaging applications to the Covid-19 pandemic, leveraging innovative, artificial intelligence technologies, and detecting and treating diverse types of cancer.

Detecting Covid-19 Quickly and Easily: From 0 to 1 billion +

Launched in April 2020 and led by the National Institute of Biomedical Imaging and Bioengineering, the Rapid Acceleration of Diagnostics (RADx)-Tech program has been instrumental in the Nation's Covid-19 testing strategy and response.² This Congressionally supported program utilizes a competitive system to funnel the best ideas quickly toward implementation. In short, RADx-Tech accelerated the development and availability of Covid-19 tests. In September 2020, there were limited test-

¹ <https://www.acadrad.org/about-the-academy/>.

² <https://www.nibib.nih.gov/covid-19/radx-tech-program>.

ing options, accounting for fewer than 700,000 Covid-19 tests per day for laboratory and point of care use. As of February 2022—less than 18 months later—there were 41 FDA-approved tests, including at-home, point of care, and laboratory options, resulting in over 1.8 billion tests produced cumulatively. That same month, over 5.6 million tests per day were manufactured—over 168 million in total for the month.³ These tests contributed directly to our understanding of a devastating pandemic and put tools directly into patient's hands. When coupled with strong support from policymakers, the funneling pipeline used by NIBIB can accelerate extraordinary advancements.

Machine Learning Technology Improves Diagnostic Imaging and Patient Outcomes

Applying artificial intelligence and machine learning tools to the imaging space continues to improve our diagnostic capabilities. In my testimony last year, I highlighted the efforts of the Medical Imaging and Data Resource Center. MIDRC continues to apply artificial intelligence and machine learning technology for screening, detection, staging, and follow-up for Covid-19 patients. Throughout 2021 and into 2022, MIDRC collected over 85,000 images and is progressing toward an artificial intelligence algorithm for automating image analysis to diagnose patients and provide a disease prognosis more quickly and efficiently.

In further examples of AI/ML applications, the University of Washington is pursuing multiple strategies to improve mammography. A 7-year MERIT award from the National Cancer Institute has enabled building AI algorithms for breast cancer analysis, building off a crowdsourced challenge. UW also recently launched a 5-year initiative funded by NIH to create an academia-industry collaboration to validate multiple, commercial AI algorithms for automated mammography screening interpretation. Like in the Covid-19 context, reliably automating the review and evaluation of screenings, especially as it adapts to new variables, could significantly improve the detection, treatment, and outcomes of breast cancer.

In a final example of AI-based applications, academic-industry partnerships are working to optimize imaging and diagnosis using AI-enabled Magnetic Resonance Imaging (MRI). This effort, which improves image quality and processes those images efficiently, is cutting exam times by over 30 percent. These advances are being disseminated broadly throughout the industry and are reshaping diagnostic capabilities and patient experience. Reducing the length of an examination accelerates the time to diagnosis and treatment, increases the efficiency of the imaging center to see more patients, and has a significant patient impact through reduced anxiety and increased satisfaction during a stressful time.

Better Images, Less Radiation, Faster Results

Finally, work conducted at the University of California-Irvine is improving a well-known and trusted tool, x-ray technology. The new imaging system, x-ray-induced acoustic computed tomography (XACT), is a promising alternative to traditional technology. Supported by an NIH grant, XACT can image the human body much faster while requiring a lower radiation dose for the patient. Moreover, a portable model is in development that can reach more patients, particularly in remote areas that may have difficulty accessing doctors' offices and care centers. XACT can be used for a wide range of image-guided procedures, such as biopsies, placement of drainage tubes, catheters, tumor ablation, and injections. The improved tool generates faster diagnosis and treatment, lowers radiation exposure, and reaches underserved communities, all leading to improved outcomes across a wide range of treatment or imaging interventions.

SUMMARY AND CONCLUSION

Sustained and robust NIH funding is crucial to advancing our efforts to understand and treat a myriad of diseases and disorders. NIH investments are also a key economic driver. In 2022, NIH funds generated \$2.60 in economic activity for every \$1 of research and flowed to every State in the Nation.⁴ Funding NIH's base program with at least \$49.048 billion will provide the robust support needed to sustain growth and secure advancements in 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.nibib.nih.gov/covid-19/radx-tech-program/radx-tech-dashboard>.

⁴ https://unitedformedicalresearch.org/wp-content/uploads/2022/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-FY21.pdf.

[This statement was submitted by Mitchell Schnall, M.D., Ph.D., President, Academy for Radiology & Biomedical Imaging Research.]

PREPARED STATEMENT OF ACCESSIA HEALTH

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

-
- Provide the National Institutes of Health (NIH) with at least \$49. billion and provide individual NIH Institutes and Centers with proportional discretionary increases.
 - Please provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
 - Provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion to facilitate timely public health efforts along with proportional discretionary increases for CDC Centers and Divisions.
 - Please provide \$6 million for the Chronic Disease Education and Awareness Program at CDC.
 - Provide the Health Resources and Services Administration (HRSA) with a funding level of at least \$9.8 billion.
 - Please support the development and advancement of innovative payment models and efforts to effectively enhance coverage and access, including through additional resources for the Centers for Medicare and Medicaid Services (CMS).
-

Thank you for the opportunity to submit testimony on behalf of Accessia Health and the community of patients we serve. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the significant ongoing investments in HHS, particularly medical research and public health programs that improve health for patients with debilitating and life-threatening conditions. Please maintain this commitment and further enhance support for medical research and public health programs as you work with your colleagues on appropriations for Fiscal Year (FY) 2023. Further, please continue to provide resources for the development and implementation of innovative models for payment and care delivery that prioritize patients while properly managing precious resources. Thank you again.

ABOUT ACCESSIA HEALTH

Accessia Health pioneered the patient assistance model for people living with chronic medical conditions. To date, over \$1.1 billion has been distributed to patients throughout the country, helping them navigate the complexities of the healthcare system.

We understand the patient journey and we are blazing new trails by leveraging our three decades of success to expand patient assistance support to serve today's patients and healthcare consumers.

Our patient assistance model includes healthcare education, financial assistance, specialized legal services, case management, and more. We are committed to serving diverse populations and seek partners who share our belief that all people deserve access to healthcare. Helping people is our mission and our passion.

ADVOCACY

We advocate for greater access to affordable healthcare and treatment for patients with rare and chronic diseases. Working on both the State and Federal level, we strive to ensure patient voices are heard and patient assistance is protected. Accessia Health also joins with partner coalitions to advocate for increases funding for healthcare programs and for patient-centered healthcare reforms.

We encourage you to adopt the aforementioned funding requests to better meet the unmet needs of patients with serious illness and to address gaps in care through systems innovation and scientific advancements. Our vision, is one where patients living with chronic illness, rare disease, or disability no longer struggle to access the treatment, and assistance they need to lead their best life.

SPECIALTY DRUG CARVE OUT: ONE EXAMPLE OF AN AREA WHERE PATIENT
PROTECTIONS ARE NEEDED

Third Party Administrators have reached out to employers advertising a new way to save healthcare resources for the company. The employer contracts with the administrator, then the entities work together to curtail the prescription drug formularies that the company will offer to their employees, specifically leading to cutting out specialty drugs from the formulary. Typically, the price point for the formulary cutoff are treatments greater than \$350. The employer is then told that the administrator will work with their employees to obtain any treatment if needed free of charge. The employee will then receive a concierge advocate who will work to obtain free treatments from the manufacturers. The self-insured plan saves massively on their healthcare spending less the contracted cost of the concierge workers. This is explained as a benefit to the employees that they will be receiving their treatments for free.

There are several problems with the sustainability of this new model. First and foremost, manufacturer patient assistance programs impose major limitations on these free product patient assistance programs. Historically manufacturer patient assistance programs were created to serve uninsured patients for a limited period time. However, many manufacturers will provide compassionate drugs to patients with commercial coverage if the product is not covered on the plan drug formulary. Due to the limited time, the concierge advocate will try additional strategies such as non-medical drug switching and/or claims they can import drugs from outside the United States. These programs also may have an income requirement to qualify. Manufacturer patient assistance programs are not a long-term solution for patients with rare and chronic conditions to obtain needed treatments and therapies. Since manufacturer patient assistance program are a benefit they offer, continuing this practice could encourage them to severely curtail access to these programs.

Congress needs to engage with the Biden-Harris Administration to end this practice that will clearly hurt patients with rare and chronic illnesses who need ongoing access to life sustaining treatments and therapies. In 2019, 44 percent of patient did not purchase a prescription due to cost. This practice, which is beginning to grow in the United States will further limit patient access to needed treatments and therapies. The Department of Labor, the agency with regulatory authority over ERISA plans, must work with Congress and also issue guidance restricting this practice.

PATIENT PERSPECTIVES

I was diagnosed with Fabry 6 years ago and my husband was diagnosed with Pompe 3 years ago. I don't know what we would do without Accessia Health's help—we would be bankrupt. With both of us having rare diseases, the bills would be astronomical. Everyone at Accessia Health is so helpful. I haven't met one person who isn't kind. —*Lupe and Duane Austin*

Accessia Health is a lifesaver. I was diagnosed with a rare genetic disease, Fabry disease, right after I purchased my new home. My treatments are over \$40,000 every two weeks. I wasn't sure how I was going to pay my mortgage, it's only with the help of Accessia Health that I'm able to stay in my home and afford my treatments, medical bills and nursing services." —*Lisa Wright*

Accessia Health's ACCESS program helped me receive Social Security Disability, which let me adopt my son Jacob. —*Randy Russell*

[This statement was submitted by Gwen Cooper, President & CEO, Accessia Health.]

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 \$49.1 billion for NIH's base program level budget in FY 2023.

As a result of the strong, bipartisan vision of the House and Senate Labor-HHS-Education subcommittees over the last 7 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 innovative prevention strategies, advanced diagnostics, pioneering treatments, and life-changing cures, , and in this time of unprecedented scientific opportunity, it is essential that Congress sustain long-term robust increases in the NIH budget.

In FY 2023, the Ad Hoc Group for Medical Research supports at least \$49.048 billion for the NIH base program level budget, which would represent an increase of \$4.1 billion over the comparable FY 2022 funding level (an increase of \$3.5 billion or 7.9 percent in the NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives). Importantly, the Ad Hoc Group strongly urges lawmakers to ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) supplement our \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH. This funding level, supported by nearly 400 stakeholder organizations, would provide real growth in the base budget above inflation, expanding NIH's capacity to support promising science in all disciplines. In addition, the coalition supports the president's proposal to supplement NIH's budget with additional mandatory funding to speed the pace of pandemic response and readiness.

Importantly, we also recommend a funding allocation for the Labor-HHS-Education subcommittee in FY 2023 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.

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, Washington, D.C., and U.S. territories. 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.
- In 2020, the gene editing tool CRISPR was successfully used to treat the inherited blood disorders sickle cell anemia and beta-thalassemia, only 8 years after the primordial bacterial immune system was harnessed for therapeutic use in the laboratory.
- 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. The cancer death rate for men and women combined fell 32 percent from its peak in 1991 to 2019, the most recent year for which data were available.

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 7 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 2021, NIH was able to fund more than 1,500 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, gender, and geographic 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 8 years. A \$1 increase in public clinical research stimulates an additional \$2.35 in private sector investments after 3 years. According to a United for Medical Research report, in FY 2021, NIH-funded research supported more than 552,000 jobs across the U.S. and generated more than \$94 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 2023, the Ad Hoc Group for Medical Research recommends that NIH receive at least \$49.048 billion in base funding to advance the foundational research NIH supports and continue the momentum in our Nation's investment in medical research, and that any funding for ARPA-H supplement our \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH.

PREPARED STATEMENT OF THE AFTERSCHOOL ALLIANCE

As you begin work on the Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill for fiscal year 2023, the Afterschool Alliance is joined by the organizations signing below in thanking you for increasing funding for the Nita M. Lowey 21st Century Community Learning Centers (21st CCLC) (Title IV Part B of the Every Student Succeeds Act) in fiscal year 2022, allowing an additional 30,000 students to access quality afterschool, before-school and summer learning programs. The pandemic has shown how important robust afterschool and summer learning programs are to working families and our most vulnerable students, and how vital resources are to support these programs to ensure they are available and effective for the children who need them. With this in mind, we request that you support a funding level of \$500 million for the 21st CCLC program in fiscal year 2023.

Through the 21st CCLC initiative, which serves about 1.8 million students in all 50 States and the American territories, local school and community-based organizations provide students in kindergarten through 12th grade with a safe and supportive environment where they participate in academic enrichment opportunities, get excited about learning new things, and connect with caring mentors before school, afterschool, and during the summer months. 21st CCLC programs serve students attending high-poverty, low-performing schools, and prior to the COVID-19 pandemic, these programs were a vital source of support for underserved communities. Now, with students back in-person at school after having spent significant amounts of time out of the classroom since March 2020, feeling isolated from their teachers and peers, and in need of additional enrichment and learning opportunities, 21st CCLC programs are more essential than ever.

We are grateful that the American Rescue Plan Act (ARPA) included set-aside language allowing comprehensive afterschool and summer learning and summer enrichment programs to be eligible to receive emergency Covid-19 relief funds to help student recover missed instructional time; however, increased staffing and program costs as well as unprecedented demand for local afterschool programs have pushed programs to the brink. The most recent America After 3PM report from the Afterschool Alliance found an all-time high of 24.6 million children were unable to access a program, with cost and program availability as the leading factors.¹ Additionally a fall 2021 survey of 1,000 afterschool program providers found that 54 percent had waiting lists, a significantly greater percentage than in the past.² While ARPA funds for out of school time programs are focused on the specific challenges related to the pandemic and are primarily directed to local school districts; community based providers including nonprofit, faith-based, park and recreation, library, and other non-school providers serving a wide range of vulnerable students continue to struggle to access the funding resources they need, with only 19 percent of providers surveyed reporting the ability to access Federal Covid-19 relief funds.³

Federal 21st CCLC formula grants to States enable rural, urban and suburban communities to leverage local resources by providing 3-5 years of funding to support local partnerships among community-based organizations, faith-based partners, private industry, and school partners (public, private, and charters). This funding infrastructure provided by 21st CCLC is foundation of afterschool and summer programming and enables communities to attract other partners and resources for students including access to mentors, new learning opportunities, nutritious snacks and meals, as well as helping address student mental health programs. Funds also are used for training, evaluation, and assistance to ensure quality programming is offered. While reflecting the needs of local communities, 21st CCLCs expand student access to activities and services designed to reinforce and complement the regular academic program, such as hands-on learning, physical activity, workforce development opportunities including gaining knowledge and skills in science, technology, engineering, and math (STEM), drug and violence prevention programs, counseling programs, the arts, and more.

In addition, the outcomes of 21st CCLC funded afterschool and summer learning programs are undeniable. Over a span of 20 years, researchers have built an evidence base for quality and effectiveness by studying afterschool programs across the Nation. An independent report published in March 2019 and supported by the Wallace Foundation, reviewed research from 2000 to 2017 and found programs improved a wide range of outcomes including student attendance, achievement in mathematics and English; grade promotion and graduation rates, and student health and fitness. This research spans the country, all age groups and a wide variety of indicators of well-rounded student success. Furthermore, the most recent Department of Education national annual performance report found that 70 percent of students increased their rates of homework completion and class participation while 63 percent of students improved their classroom behavior. Increasing funding for this proven program will continue to reap benefits in the communities where the 10,500 21st Century Community Learning Centers currently thrive.

We thank you for your continued support of afterschool and summer learning programs, and for your work on behalf of children and working families. We ask that the Labor, Health and Human Services, Education, and Related Agencies subcommittees ensure that the Nita M. Lowey 21st Century Community Learning Centers Program remains a vital resource to students and families moving forward. Contact Information: Erik Peterson, Afterschool Alliance
epeterson@afterschoolalliance.org.

¹ America After 3PM, 2020 <http://www.afterschoolalliance.org/AA3PM/>.

² Afterschool in the time of Covid-19 tinyurl.com/362ff68f.

³ Ibid.

Signed:

Afterschool Alliance
 After-School All-Stars
 AlphaBEST Education, Inc.
 America SCORES
 Boys & Girls Clubs of America
 Camp Fire National
 Children's Defense Fund
 City Year, Inc.
 Collaborative for Academic, Social and Emotional Learning (CASEL)
 Committee for Children
 Communities In Schools
 Council of Administrators of Special Education
 EDGE Consulting Partners
 Every Hour Counts
 Food Research & Action Center
 Forum for Youth Investment
 Foundations, Inc
 Girls Inc.
 Institute for Educational Leadership
 integrate opportunity, LLC
 KP Catalysts, LLC
 MENTOR
 National AfterSchool Association
 National Alliance for Public Charter Schools
 National Association of Elementary School Principals
 National Association of School Psychologists
 National Association of Secondary School Principals
 National Girls Collaborative
 National Summer Learning Association
 National Urban League
 National Recreation and Park Association
 Outward Bound USA
 Public Advocacy for Kids (PAK)
 Save the Children
 Search Institute
 UnidosUS
 YMCA of the USA

State and Local Organizations

Alaska Afterschool Network AK	Prime Time Palm Beach County FL
Alaska Children's Trust AK	Communities In Schools of Georgia GA
California School-Age Consortium CA	Georgia Statewide Afterschool Network GA
A WORLD FIT FOR KIDS! CA	Voices for Georgia's Children GA
EduCare Foundation CA	We Love Buford Highway GA
MENTOR California CA	Parents And Children Together HI
California Teaching Fellows Foundation CA	Iowa Afterschool Alliance IA
California AfterSchool Network CA	Girl Scouts of Silver Sage Council ID
EDMO (Edventure More) CA	After School Matters IL
Minga Education Group CO	ACT Now IL
Onward! CO	Brighton Park Neighborhood Council IL
MENTOR Colorado CO	Chinese American Service League IL
Scholars Unlimited CO	Fight Crime: Invest in Kids, Illinois IL
Sims-Fayola Foundation CO	ReadyNation, Illinois IL
YMCA of Metropolitan Denver CO	AYS—At Your School IN
Academy of Arts and Knowledge CO	Boys & Girls Clubs in Indiana, Inc. IN
Riverside Educational Center CO	Indiana Alliance of Boys & Girls Clubs IN
Brady High School CO	Kentucky Out of School Alliance KY
Project Dream with the Lake County School District CO	Covington Partners KY
School Community Youth Collaborative CO	Kentucky/West Virginia Alliance of YMCAs KY
WeldRE5J—Milliken Elementary CO	Maryland Out of School Time Network MD
Pagosa Arts Initiative CO	Maine Mathematics and Science Alliance ME
Boys & Girls Clubs of Pueblo County CO	
EdAdvance CT	

KYD Network MI	Nations Ministry Center TN
Youth Development Resource Center MI	YMCA of Middle Tennessee TN
Michigan Afterschool Association MI	YMCA Y-Quest TN
Michigan's Children MI	Dallas Afterschool TX
MENTOR Minnesota MN	BEACON Afterschool Program UT
YouthPrise MN	Utah Afterschool Network, Inc. UT
MENTOR North Carolina NC	Virginia Partnership for Out-of-School
Girls Inc. of Santa Fe NM	Time (VPOST) VA
New York State Network for Youth	MENTOR Virginia VA
Success NY	MENTOR Vermont VT
Ohio Afterschool Network C/O PAST	Vermont Afterschool VT
Foundation OH	Mentor Washington WA
The Opportunity Project OK	FuturesNW WA
Tula Public Schools OK	Empowering Youth Mentor Program WA
MENTOR Independence Region PA	Communities In Schools of Washington
North End Outreach RI	State WA
MENTOR Rhode Island RI	Joyce L. Sobel Family Resource Center
ALPHAS RI	WA
South Carolina Alliance of YMCAs SC	Change the Narrative WA
South Dakota Afterschool Network SD	Mentor Washington WA
United Way of West Tennessee TN	Lopez Island Family Resource Center
Girls Incorporated of Kingsport TN	WA
Greater Kingsport Family YMCA TN	Big Brothers Big Sisters of Southwest
United Way of Greater Kingsport TN	WA
United Way of Wilson County and the	Hey Mentor WA
Upper Cumberland TN	Youth Development Executives of King
Memphis Music Initiative TN	County WA
MENTOR Memphis Grizzlies TN	School's Out Washington WA
Tennessee Afterschool Network TN	Youth in Focus WA
United Ways of Tennessee TN	Circle Faith Future WA
Backfield in Motion TN	Youth Rise of Washington WA
Nashville After Zone Alliance/Nashville	
Public Library TN	

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 viral hepatitis programs in the FY 2023 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 programs combatting HIV and viral hepatitis. As you craft the FY 2023 L-HHS appropriations bill, we urge you to significantly increase funding for core public health programs that treat and prevent HIV and viral hepatitis in the United States, as well as fund newer programs that seek to end the HIV and viral hepatitis epidemics. These programs, many of which are a part of the safety net health system, are key to ending these epidemics and protecting our Nation from future infectious disease pandemics.

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. Today, HIV can be treated as a chronic health condition, and when that treatment is successful, it renders HIV untransmissible. People living with HIV who are able to get and stay in treatment can live a near normal life span, despite the impact of the virus. The toolbox for HIV prevention has grown substantially, with daily and now long-acting pre-exposure prophylactic (PrEP) medications in addition to traditional prevention techniques, such as condoms and syringe service programs. Despite these advances, progress toward ending the HIV epidemic has plateaued, with approximately 38,000 new infections each year since 2013.

The progress made to date has been inequitable, as demonstrated by the fact that three quarters of new HIV infections now occur among people of color. Federal programs to prevent and treat HIV must address the racial and ethnic disparities that contribute to this greater risk, and Congress must invest new resources in innova-

tive and effective prevention and treatment programs to end the HIV epidemic as a matter of racial justice.

Congress must invest new resources in innovative and effective prevention and treatment programs to end the HIV epidemic. These new resources must support programs in communities that bear the greatest risk and impact of HIV. Ending the HIV epidemic has become a matter of racial justice.

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 10 years. In the last 3 years, your Committee provided \$260 million, \$404 million, and \$473 million respectively for the EHE Initiative. Resources are 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 over 389,000 new PrEP prescriptions for people at risk for HIV. Through this funding the Ryan White Program engaged over 19,000 people in HIV care during 2020. 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 four of the EHE Initiative at the following levels: \$310 million for the CDC Division of HIV/AIDS Prevention to conduct targeted testing, connection to treatment, and robust surveillance; \$290 million for the Ryan White HIV/AIDS Program to increase access to high-quality HIV care and treatment; \$172 million for HRSA's Community Health Center program to provide prevention services emphasizing PrEP; \$26 million for NIH's Centers for AIDS Research to provide best practices to guide the plan; and \$52 million for the Indian Health Service to provide HIV prevention, treatment, education, and hepatitis C (HCV) elimination in Native American communities.

CDC HIV PREVENTION

CDC's Division of HIV Prevention focuses resources on those populations and communities most affected by investing in high-impact prevention. Through partnerships with State and local public health departments and community-based organizations, the CDC has expanded targeted prevention programs that work to address racial and geographic health disparities. 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 \$1.233 billion, including \$100 million for school-based HIV prevention efforts and \$310 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 nearly 90 percent of clients achieve viral suppression (which is critical for HIV prevention, because people who have achieved viral suppression cannot transmit HIV to others). The cost of medical care has consistently increased over the last decade, yet Ryan White programs have not received increased funding. Because of this, flat funding is essentially a cut to Ryan White programs.

The AIDS Institute requests that the subcommittee fund the Ryan White HIV/AIDS Program at a total of \$2.942 billion in FY 2023, distributed in the following manner: Part A at \$751.1 million; Part B (Care) at \$509.4 million; Part B (ADAP) at \$968.3 million; Part C at \$231 million; Part D at \$85 million; Part F/AETC at \$58 million; Part F/Dental at \$15.4 million; and Part F/SPNS at \$34 million; Ending the HIV Epidemic Plan at \$290 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.

PRE-EXPOSURE PROPHYLAXIS

This year will mark the ten-year anniversary of FDA approving the first medication for PrEP, potentially the greatest advent in the fight to prevent HIV. Despite the tremendous promise of PrEP, it is severely underutilized. Of the estimated 1.2 million people who could benefit from PrEP, only 23 percent have a prescription. Among racial and ethnic minorities, only 16 percent of Hispanic/Latino people and 9 percent of Black people who could benefit from PrEP have a prescription. This stark divide must be addressed if we are to end the HIV epidemic.

President Biden's FY 2023 Budget Request included a proposal for a 10-year, \$9.8 billion mandatory program to provide PrEP at no cost for un-and-underinsured people and develop a comprehensive provider network to ensure that we fill the large gaps in PrEP coverage. A national PrEP program is desperately needed, and it must start right away by increasing funding for Community Health Centers, CDC-funded health departments, and HHS grantees to establish and expand PrEP programs in places where PrEP uptake is low. But to overcome barriers to PrEP uptake, we also urge the Committee to task and fund HHS with creating a national PrEP program based on the President's proposal, with input from the HIV community. This program should ensure that cost is not a barrier to PrEP; that people have access to the suite of PrEP services required to maintain a prescription; that providers and people at risk for HIV know about PrEP and how to get it; and it should combat the misinformation and stigma that impede demand for PrEP.

VIRAL HEPATITIS IN THE U.S

Viral hepatitis continues to have a dramatic impact on the health of some of the Nation's most vulnerable communities and show no signs of abating as lack of sterile equipment among people who use drugs creates perfect conditions for the viruses to thrive. There are highly effective vaccines to prevent hepatitis A (HAV) and B (HBV), yet cases of HAV have increased 1,300 percent since 2015 and the number of new cases of HBV have stubbornly plateaued for the past decade. CDC estimates there were 57,800 new HCV cases in 2019, with 70 percent of those cases a result of drug use. Since 2010, the country has experienced a nearly 500 percent increase in new HCV cases.

Of the nearly 5 million people now living with HBV and/or HCV in the U.S., as many as 65 percent are not aware of their infection. 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. With so many Americans impacted by viral hepatitis, it is imperative the evidence-based prevention, testing, surveillance, and treatment programs have the resources they need to protect the country's health.

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 having 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 \$150 million for the CDC's infectious diseases and opioid epidemic efforts.

CDC VIRAL HEPATITIS PREVENTION

CDC's Viral Hepatitis program is the lead agency combating viral hepatitis at the National level by providing important technical assistance and funding to the States. The division is currently funded at only \$41 million and has received only minor increases over the past decade. Current funding is nowhere near what 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, laid out in the Viral Hepatitis National Strategic Plan for the United States:

A Roadmap to Elimination (2021–2025). However, only with a significant investment 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. This year, we request that the subcommittee appropriate \$140 million to the CDC to address the rise in viral hepatitis and combat the infectious diseases consequences of drug use.

SYRINGE SERVICE PROGRAMS

Syringe service programs (SSPs) are a critical tool in the fight to end the drug use epidemic and eliminate viral hepatitis. These important public safety programs reduce the spread of infectious disease, prevent overdose deaths, and connect clients to infectious disease and substance use 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.

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 Chairwoman Murray, and Ranking Member Blunt:

As the subcommittee continues its important deliberations on the Fiscal Year (FY) 2023 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 4 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 percent by 2030. Additionally, an updated National HIV/AIDS Strategy was recently released that expands upon and continues the bipartisan commitment to a whole-of-society approach addressing the HIV epidemic in the United States. We urge Congress to capitalize on the expertise developed by communities as part of the EHE Initiative so that we can improve and grow the Initiative. Ending HIV by 2030 is possible, but resources are needed to achieve this goal.

Over the past 2 years, the COVID–19 pandemic has shone 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. But, at the same time, it has shown what is possible when we come together to confront a significant public health crisis with the energy and resources that are required. Below are detailed domestic HIV funding requests that we join our coalition partners in the Federal AIDS Policy Partnership in urging the committee to include in the fiscal year 2023 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 3 years, on a bipartisan basis, Congress has appropriated additional funding for the Ending the HIV Epidemic Initiative, which looks to reduce new HIV infections by 50 percent by 2025, and 90 percent by 2030. We ask Congress to increase funding in FY 2023 for the Ending the HIV Epidemic Initiative by at least the amounts listed below in the following divisions:

- \$310 million for CDC Division of HIV/AIDS Prevention for testing, linkage to care, and prevention services, including pre-exposure prophylaxis (PrEP) (+\$115 million);
- \$290 million for HRSA Ryan White HIV/AIDS Program to expand comprehensive treatment for people living with HIV (+\$165 million);
- \$172 million for HRSA Community Health Centers to increase clinical access to prevention services, particularly PrEP (+\$50 million)

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 percent 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.

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 \$2.942 billion in FY 2023, an increase of \$447.5 million over FY 2022, distributed in the following manner: Part A: \$751.1 million, Part B (Care): \$509.4 million, Part B (ADAP): \$968.3 million, Part C: \$231 million, Part D: \$85 million, Part F/AETC: \$58 million, Part F/Dental: \$15.4 million, Part F/SPNS: \$34 million, EHE Initiative: \$290 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.

The CDC's Division of HIV Prevention is the Federal leader in creating 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 address racial and geographic health disparities. We urge you to fund the CDC Division of HIV Prevention at \$822.7 million in FY 2023, an increase of \$67.1 million over FY 2022. This is in addition to the \$310 million for EHE Initiative work within the Division.

CDC Infectious Diseases and Opioid Epidemic Funding

The United States is in the midst of an unprecedented and horrific overdose crisis. Last year, over 100,000 Americans lost their lives to overdose. At the same time, HIV transmissions among people who use drugs have risen over the past 5 years and viral hepatitis transmission among people who inject drugs continues to skyrocket. Combatting the overdose crisis requires significant and sustained support for evidence-based harm reduction interventions, particularly for Syringe Services Providers (SSPs), who are the first responders to the overdose and infectious disease crisis and effectively help prevent drug overdoses and new HIV and hepatitis infections. Harm reduction workers 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. And the CDC's Opioid Related Infectious Diseases program is best situated to support harm reduction programs and spearhead funding our syndemic approach to ending the overdose, HIV and viral hepatitis crises.

We urge you to fund the CDC's Infectious Diseases and Opioid Epidemic program in FY 2023 at the \$150 million, an increase of \$132 million over fiscal year 2022.

Syringe Services Programs

The Department of Health and Human Services, relying on the results of multiple studies, States 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 prevent overdose, connect people to substance use treatment, HIV and hepatitis testing, and other supportive services. SSPs have also been providing COVID-19 related services to vulnerable populations during the pandemic. The FY 2022 omnibus 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.

Pre-Exposure Prophylaxis

Pre-exposure prophylaxis, or PrEP, is a medication that effectively prevents HIV transmission when taken as prescribed. The first PrEP medication was approved by the FDA 10 years ago, and now there are multiple medications available, including generic medications and a new long-acting injectable version of PrEP. Increasing access to PrEP has been a key strategy in ending the HIV epidemic, yet more progress must be made.

It is estimated that only 23.4 percent of people who could benefit from PrEP have received a prescription. PrEP coverage is highest among white people, at 63.3 percent, yet only 8.2 percent of black people and 14 percent of Hispanic/Latino people who could benefit from PrEP in the United States are on a prescription. Additionally, PrEP coverage among women is only at 9.7 percent.

We are thankful that there has been an increased focus on PrEP both in Congress and from President Biden. In his FY 2023 Budget Request, President Biden called for a new mandatory funding program to expand PrEP across the United States through providing medication to un and under insured individuals, as well as supporting and expanding PrEP programs across a variety of agencies. Additionally, there is a bill in Congress seeking to increase insurance coverage of PrEP and ancillary services (S. 3295) and a bill which seeks to provide grants to HHS entities to expand PrEP programs throughout the U.S. (H.R. 5605).

As Congress moves through the regular appropriations cycle, we urge you to support funding for new and innovative programs to expand PrEP access, and ensure that those who want PrEP can easily access the medication without any costs or barriers.

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.

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 FY 2022, an increase of \$48.1 million and \$44 million over FY 2021 levels, respectively. We also urge you to fund Minority AIDS Initiative programs across HHS agencies at \$610 million in FY 2023.

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 Director of Advocacy Drew Gibson, at dgibson@aidsunited.org.

Sincerely,

[This statement was submitted by Carl Baloney, Jr., Vice President & Chief Advocacy Officer, AIDS United.]

PREPARED STATEMENT OF THE ALLIANCE TO END SLAVERY AND TRAFFICKING

The Alliance to End Slavery and Trafficking (ATEST) thanks you for your leadership in the fight to end child labor, forced labor and human trafficking. We appre-

ciate your efforts to pass legislation and provide resources to Federal agencies engaged in combating these horrific crimes. Due to underlying vulnerabilities, those most at risk of, and victim to, trafficking and exploitation will experience disproportionate impacts as a result of COVID-19 in the short, medium, and long-term. With this in mind, we seek your assistance in funding essential programs in the fiscal year 2023 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill. The number of trafficking victims significantly exceeds the availability of services at the Departments of Labor (DOL), Health and Human Services (HHS) and Education (ED). ATEST recommends robust funding and accountability for programs at these key departments to fulfill the highest priority mandates of the Trafficking Victims Protection Act of 2000 and subsequent reauthorizations (TVPA) and related legislation.

ATEST FY23 Appropriations Request Summary: LHHS				
Department	Program	FY22 Enacted	Authorized Funding	FY23 Appropriation Request
Labor	International Labor Affairs Bureau	\$96,125,000		\$168,000,000
	Employment & Training Administration			\$5,000,000 and Report Language (see below)
	Administration for Children and Families, Victim Services	\$28,755,000		\$50,000,000

Health and Human Services	Administration for Children and Families, National Human Trafficking Hotline	\$4,500,000		\$6,000,000
	Administration for Children and Families, Runaway and Homeless Youth Act	\$140,280,000		\$300,000,000 and Report Language (see below)
	Administration for Children and Families Office of Trafficking in Persons			Report Language (see below)
Education	Department of Education Grants to Local Education Agencies, Title I			\$2,000,000
	McKinney-Vento Act Education for Homeless Children and Youth Program	\$114,000,000	\$85,000,000	\$300,000,000

DEPARTMENT OF LABOR

International Labor Affairs Bureau: \$168,000,000.—We request \$168,000,000 for the Bureau of International Labor Affairs (ILAB) in the Department of Labor (DOL). Specifically, we request \$27,000,000 for the administration of ILAB,

\$70,000,000 for the Child Labor and Forced Labor program, \$48,000,000 for Workers' Rights Programs, and \$23,000,000 for program evaluation.

ILAB is an essential part of the U.S. government's international response to forced labor, human trafficking, and child labor. It is responsible for implementing Section 105(b)(2) of the TVPRA of 2005 (Public Law 109–164) and Section 110 of the TVPRA of 2008 (Public Law 110–457). In the past, these requirements have not been funded. Funding provided would allow ILAB to fulfill its Congressional mandates including: producing annual findings on worst forms of child labor in certain U.S. trade beneficiary countries; the development and maintenance of a list of goods produced by child or forced labor, including inputs to goods made with child or forced labor; and increased responsibilities in enforcing the U.S. Mexico Canada Agreement (USMCA). Adequate funding will ensure that staff is able to travel to the countries with which ILAB has partnered or where important research is needed to accurately maintain the list of goods made with forced labor or child labor. In addition, a robust and expertly staffed entity within the U.S. government's foreign policy establishment—that sits outside of the diplomatic constraints of the State Department and focuses particularly on worker rights—is tremendously important to the government's ability to tackle human trafficking and address the underlying factors that place individuals at risk of trafficking.

We request \$48,000,000 for Workers' Rights Programs because they are essential to maintaining coherence with the U.S. trade agenda. ILAB provides technical assistance to countries on a variety of worker rights issues, many of which correspond directly to labor rights commitments under trade agreements. Project goals include adopting or reforming labor laws or standards, improving labor inspectorates' enforcement capacity, increasing awareness of fundamental labor rights, and improving occupational safety and health conditions. ILAB also provides technical advice and other support to labor ministries through workshops and exchange programs and hones in on areas of particular concern including the cocoa and fishing sectors as well as other supply chains with heightened risks of child labor or forced labor.

Employment and Training Administration: \$5,000,000.—The Department of Labor Employment and Training Administration (ETA) should conduct a review of all employment readiness, training, and other discretionary programs, and revise program guidance as needed to explicitly include eligibility for trafficking victims where possible, per Sec. 107(b) of the Trafficking Victims Protection Act (Public Law 106–386). The requested funds should be used to develop and implement a pilot grant program to deliver trauma-informed employment and training services that address particular barriers to service, and challenges to finding employment, faced by survivors of human trafficking. The U.S. Advisory Council on Human Trafficking highlighted the need to provide access to employment and training programs to all survivors of human trafficking. In their inaugural report, released in 2016, the council noted that “...after leaving their trafficking situations, survivors [...] can find it difficult to live financially independent. Career development programs help survivors become self-sufficient and provide for their families. When survivors are employed, it positively affects their lives and prevents dependence on public benefits.” We also recommend that the DOL integrate training to identify potential signs of trafficking and referral options as a regular activity for State Farmworker Monitor Advocates, and during the provision of relevant services to particular at-risk populations, including through the Youth Build, Job Corps and Reentry Employment Opportunity programs.

Employment and Training Administration: Report Language.—Labor trafficking affects both U.S. citizens and foreign nationals working across many industries, most commonly domestic work, agriculture, manufacturing, janitorial services, hotel services, construction, health and elder care, hair and nail salons, and strip club dancing. DOL needs resources to protect and support victims, particularly with much needed skills training and job placement services, as well as providing referrals to shelter, medical care, mental health services, legal services, and case management. ATEST members have also worked with human trafficking survivors who were forced to engage in criminal acts of labor, including forced activities related to gangs, weapons and narcotics. Victims impacted by this form of labor trafficking also require additional legal services in the realms of criminal law and immigration.

Proposed Report Language: The Committee encourages the Employment and Training Administration to increase access and eligibility to employment and training services for survivors of all forms of human trafficking as required by Sec. 107(b) of the Trafficking Victims Protection Act (Public Law 106–386). The Committee also encourages the development and integration of training to identify potential signs of trafficking and referral options as a regular activity for State Farmworker Monitor Advocates, and during the provision of relevant services to particular at-risk populations, including through the Youth Build, Job Corps and Re-

entry Employment Opportunity programs. The Committee also encourages the Department to continue and expand its pilot initiative to develop and support networks of service providers in collaboration with HHS and DOJ.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families, Victim Services (ACF): \$50,000,000.—ACF fulfills mandates of the Trafficking Victims Protection Act to (1) Identify and serve victims who are foreign nationals; and (2) Create specialized case management programs to assist U.S. citizen victims. The number of trafficking victims certified as needing comprehensive, trauma-informed, gender-specific services has risen dramatically but funding for services has not kept pace. Additionally, funding increases for victim services programs under HHS have never matched the increases provided to programs under DOJ. Both programs are essential to effectively assist victims and survivors and we encourage parity in funding for both programs. While HHS departments have worked efficiently with limited resources to support service providers, further funding would allow HHS to fulfill legislated and related needs of victims more fully. We encourage ACF to use a portion of increased funding for legal services for victims. We request that increased funds be utilized equally for services for both foreign national victims and U.S. citizen and legal permanent resident victims, consistent with demonstrated need.

Service providers across the country have noted a significant increase in the services required by victims and survivors during the COVID-19 crisis. Data from one ATEST member organization providing services showed a 556 percent increase in emergency response cases to escaping survivors since 2019 at the start of the pandemic. Furthermore, this service provider has experienced a 455 percent increase in costs for basic necessities. A survey conducted by the OSCE Office for Democratic Institutions and Human Rights and the United Nations Entity for Gender Equality and the Empowerment of Women (the “OSCE ODIHR Survey”) confirms the increased needs of service providers to effectively assist victims during the pandemic. The crisis has heightened vulnerabilities to exploitation and required providers to work with limited resources to provide expanded services. We have seen unprecedented unemployment rates and significantly heightened client financial needs in all areas. Both trafficking victims currently receiving services and those newly seeking services have shown an increased need for direct assistance to pay for basic necessities like food and shelter. With the pandemic impacting employment opportunities in all industries where human trafficking survivors have formerly sought employment and stability, we expect a significant increase in the coming years in the need for sustained comprehensive services for all survivors for longer periods of time. Specifically, data from the National Human Trafficking Hotline showed that in April 2020, the number of crisis trafficking situations increased by more than 40 percent and the number of situations in which people needed immediate emergency shelter nearly doubled. We therefore request an increase in funds in fiscal year 2023 to \$50,000,000, which will help keep up with the expected needs of trafficking victims and their family members. Relatedly, we also request that any portion of these funds that currently operate under a match requirement are exempted from the 25 percent non-federal funding match requirement for fiscal year 2023.

Administration for Children and Families, the National Human Trafficking Hotline: \$6,000,000.—The National Human Trafficking Hotline (“Trafficking Hotline”) is a toll-free 24/7 center available to answer calls, text messages, online tips and email queries. The Trafficking Hotline connects victims with anti-trafficking services in their area (such as shelter, case management, and legal services), collects tips on human trafficking cases, and, where appropriate, reports actionable tips to law enforcement. The Trafficking Hotline serves both domestic and foreign victims inside the U.S. In fiscal year 2021, the National Human Trafficking Hotline received 13,450 signals from victims and survivors themselves, a 26 percent increase from fiscal year 2019. The significant increase in signals from victims and survivors underscores what an important and trusted resource the hotline has become for people experiencing trafficking.

As efforts to increase awareness, training, and education of the public and key industries on human trafficking generally and the National Human Trafficking Hotline specifically have succeeded, call volume on the hotline has increased thirty-fold since its inception in 2007. From fiscal year 2019 to fiscal year 2021 the hotline has experienced a whopping 60 percent increase in total signal volume. Given the disruptive impact of the COVID-19 pandemic on social, economic, and health outcomes, call volume will continue to steadily increase throughout fiscal year 2023 and beyond. We request \$6,000,000 in fiscal year 2023 to support the National Human

Trafficking Hotline to continue to meet the needs of victims and survivors of human trafficking.

Administration for Children and Families, Runaway and Homeless Youth Act: \$300,000,000.—We request a total of \$300,000,000 for ACF to implement the Runaway and Homeless Youth Act (RHYA) programs, Title III of the Juvenile Justice & Delinquency Prevention Act. This is the amount to be included in the most recently introduced bill to fully reauthorize RHYA, the Runaway and Homeless Youth and Trafficking Prevention Act of 2021. RHYA programs have been chronically underfunded since its inception, despite these programs costing less than other systems that many youth experiencing homelessness and survivors of trafficking encounter. Everyone should have the opportunity to succeed regardless of their start in life, but young people who are trafficked and youth experiencing homelessness are not plugged into the networks, resources, and supports they need for healthy development.

RHYA programs prevent trafficking, identify survivors, and provide housing and services to runaway, homeless, and disconnected youth. RHYA has been a necessary bridge for our youth, but more recently, it has supported us to meet the unprecedented need for safe and stable housing and supportive services for homeless youth. The COVID-19 pandemic significantly increased children and youth homelessness due to high unemployment, unstable living conditions, and job insecurity. Some of our sites, such as Covenant House Missouri, saw their waiting lists double.

In a typical year, 4.2 million young people (ages 13–25) experience homelessness annually, including 700,000 unaccompanied youth ages 13 to 17. Recent data from the National Human Trafficking Hotline also show that being a runaway homeless youth and living in unstable housing are two of the top risk factors for human trafficking. Numerous studies have found trafficking rates among youth experiencing homelessness ranging from 19 percent to 40 percent. Using the lower end estimate means that about 800,000 of the youth and young adults who experience homelessness in a year are also victims of sex trafficking or forced labor in cities, suburbs, rural communities, and American Indian Reservations across the country.

The cost of not investing in the lives of youth experiencing homelessness is an economic burden that affects the young person, taxpayers, and society. Researchers have found that taxpayers face an estimated lump sum 2011 fiscal cost per youth of \$248,182 and social cost of \$613,182.¹ Taking the modest taxpayer² cost of \$248,182 per youth and applying it to only half of the 4.2 million youth who experience homelessness every year in America, the taxpayer cost is over \$521 billion (2.1 million x \$248,182). Through increased investments, all youth in need of safe and stable housing and supportive services will be able to connect to the networks of support and resources needed to stabilize, heal, and thrive. These connected youth in turn become part of the solution to trafficking and homelessness and contribute to the community's well-being.

RHYA has provided base funding to communities across the country to develop community-based responses to youth and young adult homelessness and trafficking. These local systems of care are based on the unique needs of each region, their available resources, and local priorities. When we support young people experiencing homelessness, we prevent trafficking. RHYA programs are also trained in identifying and serving survivors of trafficking. Specifically, RHYA funds: emergency shelters, family reunification when safe, aftercare, street outreach, education, employment training, behavioral and mental health care, transitional housing, and independent housing options. This support achieves the following successful outcomes for youth: (1) safe exit from homelessness and hopelessness; (2) family reunification and/or establishment of permanent connections in their communities; (3) education, employment, and sustainable independence; and (4) prevention of human trafficking. Further, these programs are best positioned to prevent trafficking and commercial sexual exploitation and provide early identification of and services to youth victims of crimes.

Proposed Report Language: The Committee strongly encourages programs to have the ability to serve youth involved in other systems (such as child welfare and juvenile justice) that are not currently housed by that system.

¹ Foldes, Steven S. and Lubov, Andrea. (2015) The Economic Burden of Youth Experiencing Homelessness and the Financial Case for Investing in Interventions to Change Peoples' Lives: An Estimate of the Short-and Long-Term Costs to Taxpayers and Society in Hennepin County, Minnesota. <https://www.youthlinkmn.org/wp-content/uploads/2016/04/the-economic-burden-of-homeless-youth-in-hennepin-county.pdf>. Social cost is defined as the total costs to society including lost earnings, lost tax payments, public crime expenditures, victim costs, welfare support programs, education, excess tax burden and public housing support.

² Belfield, et. al., The Economic Value of Opportunity Youth. January 2012.

Administration for Children and Families, Office of Trafficking in Persons: Report Language.—In establishing the Office of Trafficking in Persons (OTIP), HHS underscored the importance of coordinating trafficking efforts across the Administration for Children and Families (ACF). ACF works directly with all victims of human trafficking—men, women, children, LGBTQ, foreign nationals and domestic clients—and the diverse needs and vulnerabilities of these populations can only be met by an effective coordinating body networked agency-wide. Additionally, the ongoing migration flows and refugee crises that swelled in scope around 2015 and have continued further highlight the need to develop responsible and robust parameters to ensure that unaccompanied minors working with ACF and the Office of Refugee Resettlement are not released to families or guardians who further exploit these vulnerable youth. Unaccompanied minors released to guardians after being identified as a victim of or at risk of human trafficking continue to report to service providers that they are exploited or labor/sex trafficked by those to whom they were entrusted. We also expect that the United States may well accept unaccompanied minors from Ukraine within the next year, and we strongly encourage ACF and ORR to implement and enforce strong protections for these youth to prevent re-trafficking or new forms of exploitation.

Proposed Report Language: Within the funds provided, the Committee encourages ACF to hire sufficient full-time employees to support the Office of Trafficking in Persons and coordinate trafficking efforts across ACF. Furthermore, these funds should be used to develop robust and effective protective mechanisms to ensure that unaccompanied minors processed through the Office of Refugee Resettlement are not further exploited or trafficked by the guardians or families to whom they are entrusted after their release.

Administration for Children and Families, Family Youth Services Bureau: Report Language.—The process of informing RHYA grantees has restricted the ways in which service providers are able to continue to provide services to vulnerable youth. For the past several years, RHYA grantees have been notified whether they will receive a grant or not within one day before a grant period is to begin. This lack of sufficient notice is extremely problematic for agencies and community-based organizations working to serve runaway and homeless youth who face higher risks of trafficking and violence. We recommend that the current bureaucratic process be streamlined, so that RHYA grant applicants are notified regarding whether they will receive a grant or not within at least 3 months in advance of the start date of a grant.

Proposed Report Language: When awarding funds under the Runaway and Homeless Youth Act program, the Secretary shall notify all applicants if they were successful or not at least 30 days before the grant is to begin as well as 30 days before an existing grant is set to end.

DEPARTMENT OF EDUCATION

Department of Education Grants to Local Education Agencies, Title I: \$2,000,000.—The Department of Education interfaces with approximately 50 million elementary and secondary school children each year, placing it in a unique position to identify victims of sex trafficking and forced labor and to prevent the victimization and exploitation of children who might be susceptible. While ED has been able to create some resources for educators without any dedicated Federal resources, dedicated funding for the prevention of child trafficking is essential. The funds should be used to develop materials regarding all forms of human trafficking, including sex trafficking and forced labor, to ensure that educators and students are aware of how to identify and address all types of trafficking. Further, we request that ED publish a white paper examining the appropriate role of educators and students, as well as the role of the education system, in preventing, identifying, and supporting child trafficking victims. The outcome of the white paper should inform the development of a model curriculum on the prevention of both sex trafficking and forced labor.

McKinney-Vento Act Education for Homeless Children and Youth Program (EHCY): \$300,000,000.—The EHCY removes barriers to the enrollment, attendance, and opportunity for success for homeless children and youth; all of whom are at high risk of human trafficking. The EHCY is effective in addressing youth homelessness. With the support of EHCY grants, local education agencies have provided identification, enrollment and transportation assistance, as well as academic support and referrals for basic services. Unfortunately, the resources directed to child and youth homelessness programs have not been sufficient in recent years. ED reported that during the 2017–2018 school year, public schools identified 1.5 million homeless children and youth, a 15 percent increase over the 3 previous school years.

However, only 22 percent of school districts receive support through the EHCY in any given year. As a result, homeless children and youth are under-identified and continue to face significant barriers to school enrollment and continuity.

Under the McKinney-Vento Act's EHCY, all school districts are required to designate a homeless liaison, who proactively identifies homeless children and youth and connects them with vital resources, including food, housing, and clothing. Because all school districts—even those in communities without youth shelters—must designate a liaison for homeless students, schools are uniquely positioned to identify youth who are being trafficked, or are at risk of being trafficked, and provide connections to services. Yet many liaisons are designated in name only and lack the time and the training to carry out their duties. This lack of capacity is particularly severe in light of the increase in student homelessness due to the COVID-19 crisis. Increasing funding for the EHCY will support a dedicated infrastructure within the Nation's public schools to identify and serve children and youth who are at very high risk of human trafficking, both during the current public health and economic crisis and as the economy is rebuilt.

As a champion for the victims of child labor, forced labor and sex trafficking, you understand the complexities of these issues and the resources needed to respond. We have carefully vetted our requests to focus on the most important and effective programs. We thank you for your consideration of these requests and your continued leadership. If you have any questions, please contact ATEST Director Terry FitzPatrick (terry.fitzpatrick@ATEST-US.org).

Sincerely,

Coalition to Abolish Slavery and Trafficking (CAST)
Coalition of Immokalee Workers (CIW)
Covenant House
Free the Slaves
HEAL Trafficking
Human Trafficking Institute
Human Trafficking Legal Center
Humanity United Action
McCain Institute for International Leadership
National Network for Youth (NN4Y)
Polaris
Safe Horizon
Solidarity Center
T'ruah: The Rabbinic Call for Human Rights
United Way Worldwide
Verité
Vital Voices Global Partnership

PREPARED STATEMENT OF THE ALPHA-1 FOUNDATION

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- Provide the National Institutes of Health (NIH) with at least \$49. Billion, a \$3.5 billion increase over Fiscal Year (FY) 2022.
 - Please provide proportional increases for individual NIH Institutes and Centers especially the National Heart Lung and Blood Institute (NHLBI) & the National Institute for Diabetes, Digestive and Kidney Diseases (NIDDK).
 - Provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion, a \$2.55 billion increase over FY 2022.
 - Please provide CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) with systematic and meaningful annual increases to bring total funding up to \$3.75 billion over the next 3 years.
-

Thank you for the opportunity to submit testimony on behalf of the Alpha-1 Foundation. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, the Alpha-1 community extends our thanks for the significant investments in HHS through the FY 2022 omnibus package, particularly the annual increases for the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). As you work with your colleagues on appropriations for FY 2023, please continue to invest in medical research programs that serve the rare disease community. Thank you again for your leadership on health funding

issues and for the opportunity to present the views of the rare chronic disease community.

ABOUT ALPHA-1 ANTITRYPSIN DEFICIENCY

Alpha-1 Antitrypsin Deficiency (Alpha-1) is a rare, genetic condition, passed from parents to their children through their genes. Alpha-1 may result in serious lung disease in adults and liver disease at any age. Alpha-1 occurs when there is a severe lack of a protein in the blood called Alpha-1 antitrypsin (AAT) which is mainly produced by the liver. The main function of AAT is to protect the lungs from inflammation caused by infection and inhaled irritants such as tobacco smoke. The low level of AAT in the blood occurs because the AAT is abnormal and cannot be released from the liver at a normal rate. This leads to a buildup of abnormal AAT in the liver that can cause liver disease.

Alpha-1 lung disease has been called “Genetic COPD”. Normal white blood cells in the lungs produce an enzyme called neutrophil elastase that destroys invading germs and digests damaged or aging cells. In most people, the alpha-1 protein neutralizes the enzyme after a short time. In Alpha-1 patients, there is not enough alpha-1 protein in the lungs; the enzyme then keeps working, attacking and destroying normal lung tissue. As the damage continues over years, lung diseases such as COPD can develop.

There is no cure yet for Alpha-1 Antitrypsin Deficiency. However, there are treatments available for Alpha-1 lung disease. Augmentation therapy consists of intravenous infusions, usually weekly, of alpha-1 antitrypsin protein purified from healthy plasma donors. The goal is to increase the level of alpha-1 protein in the blood and lungs to slow or stop the progression of Alpha-1 lung disease.

Alpha-1 Antitrypsin Deficiency can cause liver problems in infants, children, and adults. Large amounts of abnormal alpha-1 antitrypsin protein (AAT) are manufactured in the liver; nearly 85 percent of this protein gets stuck in the liver. If the liver cannot break down the abnormal protein, the liver gradually gets damaged and scarred. Currently, there is no way to prevent the abnormal AAT from getting stuck in the liver. This highlights the need for additional research at the National Institutes of Health.

The Alpha-1 Foundation supports the \$3.5 billion increase for the National Institutes of Health being advocated by the Ad Hoc Group for Medical Research. This additional funding would make possible research priorities for the Alpha-1 Foundation such as working with NIDDK to help develop treatments for Alpha-1 Liver Disease since there is no treatment currently.

HOME-INFUSION FOR ALPHA-1 PATIENTS

This year the Alpha-1 Foundation advocated to Congress regarding home infusion for the Alpha-1 patient community utilizing Medicare. Alpha patients with commercial health insurance coverage are allowed to receive their infusions of augmentation therapy at the home. Whereas Medicare beneficiaries are mandated to receive their infusions at infusion clinics, hospitals, and physician offices. With the onset of the COVID-19 pandemic, it is no longer safe for Alpha-1 Antitrypsin Deficiency patients to receive their infusions in the clinical setting.

Early in the COVID-19 pandemic, the Alpha-1 Foundation petitioned the Centers for Medicare and Medicaid Services (CMS) to grant a temporary home infusion benefit for Alpha-1 patients utilizing coverage through Medicare. CMS issued a temporary benefit however the specialty pharmacies would not implement it so the community had to choose between skipping treatments or potentially exposing themselves to a fatal respiratory virus.

The Alpha-1 Community is working to create a permeant home infusion benefit in Medicare Part B by supporting HR 7346, The John Walsh Alpha-1 Home Infusion Act. The legislation named for the legendary founder of The Alpha-1 Foundation would establish a permeant benefit in Medicare Part B. The pandemic has shown that precautions need to be taken to protect vulnerable populations such as the Alpha-1 Community from exposure to viruses such as COVID-19 and Influenza.

The Alpha-1 patient community serves as an inspiration to the leadership of the organization. This year we lost a wonderful Alpha-1 community member, Mr. Rich Lee. Rich Lee was a patient advocate, a social worker, and a congressional staffer but most importantly he was a husband and father. Rich passed away on February 13, 2022. Rich spent his career in service to our community, our state, and our country and all the lives he touched are better for that service.

Rich served on the staff of our former colleague, Representative John LaFalce; helping families here in New York through the casework Rich spearheaded in the district office. The work he did with the families of the Love Canal environmental

disaster was one of his most important contributions. During his tenure, Rich developed a respect and love for the House of Representatives as an institution that he carried and discussed for the rest of his life.

Rich Lee would eventually be diagnosed with Alpha-1 Antitrypsin Deficiency. Rich Lee was an advocate for increased medical research for improved treatments and increased access to care for those like himself who battle this disorder. True to form Rich was working to advocate for the Alpha-1 community to the end by helping the foundation with the home infusion legislation. I am honored to acknowledge this life well lived in service to others.

[This statement was submitted by Scott Santarella, President & CEO, Alpha-1 Foundation.]

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) 2023 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 \$226 million increase for Alzheimer's research at the National Institutes of Health (NIH) and \$30 million for implementation of the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act (Public Law 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. The Alzheimer's Impact Movement 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 which 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 \$321 billion for health care, long-term care, and hospice care in 2022. The U.S. taxpayer-funded Federal health care programs Medicare and Medicaid are expected to cover \$206 billion, or 64 percent, of the total health care and long-term care payments for people with Alzheimer's or other dementias this year. An estimated 6.5 million Americans aged 65 and older are living with Alzheimer's in 2022. By 2050, the number of people 65 and older with Alzheimer's may grow to a projected 12.7 million people. Unless a treatment to slow, stop, or prevent the disease is developed, in 2050, Alzheimer's is projected to cost nearly \$1 trillion dollars. Alzheimer's and other dementia threaten to bankrupt families, businesses, and our health care system.

INVESTING IN ALZHEIMER'S TREATMENTS

Last year, the Food and Drug Administration (FDA) 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, while not a cure, is a pivotal moment in addressing the disease. This is the first of a number of new treatments to come. We do recognize the drug may work differently for everyone who takes it, and may not work for some individuals. Importantly, aducanumab was studied in and is appropriate for people living with early Alzheimer's dementia and mild cognitive impairment 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.

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 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 \$226 million in Alzheimer's research at NIH in FY 2023 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 5 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 FY 2020, 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 FY 2021 helped fund additional public health departments and expand the impact of this crucial work into more communities across the country. In FY 2022, Congress appropriated \$25 million dollars for continuing its support for BOLD implementation, and will further enable the public health agencies to expand their activities.

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 works 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 currently leading a 5-year clinical trial to evaluate a 2-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 \$30 million authorized in the law for FY 2023 to ensure the meaningful impact that Congress intended. The Alzheimer's Association and AIM urge Congress to include the full \$30 million for the third year of BOLD's implementation at CDC in FY 2023. Activities supported by the requested \$30 million in FY 2023 would enable CDC to 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 \$226 million for Alzheimer's research activities at NIH and \$30 million for full implementation of the BOLD Infrastructure for Alzheimer's Act at CDC in FY 2023.

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 2023 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: \$30 million for Pediatric Subspecialty Loan Repayment (HRSA), \$60 million for Firearm Injury and Mortality Prevention Research (CDC/NIH), \$14 million for Pediatric Mental Health Care Access Grants (HRSA), \$28.134 million for Emergency Medical Services for Children (HRSA), \$205 million for the National Center for Birth Defects and Developmental Disabilities (CDC), \$356 million for Global Immunizations (CDC), \$12 million for implementation of Scarlett's Sunshine Act (CDC/HRSA), \$26.2 million for the administrative component of the National Vaccine Injury Compensation Program (HRSA), and \$15 million for provisions in the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act (CDC).

Pediatric Subspecialty Loan Repayment Program (HRSA):

FY 23 Request: \$30 million; FY 22 Level: \$5 million.—The AAP appreciates first-time funding of \$5 million in FY22 for the Pediatric Subspecialty Loan Repayment

Program, a Title VII health professions program designed to improve access to care for children with special health care needs by offering loan repayment to pediatric subspecialists and child mental health providers who agree to serve in an underserved area. To expand the number of beneficiaries of this program, the Academy respectfully requests \$30 million in FY23. The United States' current supply of pediatric subspecialists is inadequate to meet children's health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist, and approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in certain subspecialties such as developmental behavioral pediatrics. Spotlighting the needs of children with autism spectrum disorder (ASD), as an example, there are approximately 1.5 million children with ASD but there are only about 700 practicing board-certified developmental-behavioral pediatricians. The national wait time for a pediatric developmental evaluation is 5.4 months. In terms of equity, ASD prevalence among Hispanic children is about 16 percent 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 23 Request: \$60 million total; FY 22 Level: \$25 million total.—The AAP is tremendously appreciative of and applauds Congress for continuing to provide \$25 million total, split evenly between CDC and NIH, for firearm injury and mortality prevention research in fiscal Year22. Gun violence remains a public health problem, but the dearth of research on how best to prevent firearm-related morbidity and mortality makes it difficult to address it. Federally funded public health research has a proven track record of reducing public health-related deaths, whether from motor vehicle crashes or smoking. This same approach should be applied to increasing gun safety and reducing firearm-related injuries and deaths, including suicides, and continuing and expanding CDC and NIH research will be critical to that effort. As such, for FY23, the Academy urges Congress to allocate \$60 million for firearm injury and mortality prevention research, with \$35 million dedicated to CDC and \$25 million to NIH.

Pediatric Mental Health Care Access Grants (HRSA):

FY 23 Request: \$14 million; FY 22 Level: \$11 million.—The AAP appreciates the support Congress has shown for Pediatric Mental Health Care Access Grants, with \$11 million in funding for the program in FY22, as well as robust funding in the American Rescue Plan in recognition of the impact of COVID-19 on child and adolescent mental health. The 45 States, Tribal organizations, and territories who are receiving grants through this program are providing tele-consultation, training, technical assistance, and care coordination for pediatric primary care providers to diagnose, treat and refer children with behavioral health conditions. Research shows pervasive shortages of child and adolescent mental/behavioral health specialists throughout the United States. Integrating mental health and primary care has been shown to substantially expand access to mental health care, improve health and functional outcomes, increase satisfaction with care, and achieve costs savings. In fact, a recent RAND study found that 12.3 percent of children in States with programs such as the ones funded under this HRSA program had received behavioral health services while only 9.5 percent of children in States without such programs received these services. In FY23, the AAP urges Congress to provide \$14 million in funding for Pediatric Mental Health Care Access Grants so that this proven program can be extended to every State, Tribal organization, and territory.

Emergency Medical Services for Children (HRSA):

FY 2023 Request: \$28.134 million; FY 22 Level: \$22.334 million.—The AAP urges the committee to increase funding for the Emergency Medical Services for Children (EMSC) Program to \$28.134 million in fiscal Year23. EMSC is the only Federal program that focuses specifically on improving the pediatric components of the emergency medical services (EMS) system. EMSC aims to ensure state of the art emergency medical care is available for the ill and injured child or adolescent, pediatric services are well integrated into an EMS system backed by optimal resources, and that the entire spectrum of emergency services is provided to all children and adolescents no matter where they live. An additional \$5.8 million in funding in FY23 will allow the program to provide increased funding to States to address gaps in children's access to high quality emergency and trauma care as well to support States building mental health capacity for children in emergency departments.

National Center for Birth Defects and Developmental Disabilities (CDC):

FY 23 Request: \$205 million; FY 22 Level: \$177.06 million.—The AAP requests \$205 million for fiscal Year23 for the National Center for Birth Defects and Developmental Disabilities (NCBDDD). According to the CDC, birth defects affect 1 in 33 babies and are a leading cause of infant death in the United States. NCBDDD conducts important research on fetal alcohol syndrome, infant health, autism, attention deficit and hyperactivity disorders, congenital heart defects, and other conditions like Tourette Syndrome, Fragile X, Spina Bifida and Hemophilia. NCBDDD supports extramural research in every State and has played a crucial role in the country's response to the Zika virus, as well as COVID-19. Increased FY23 funding would be used to build upon and expand work within the Center's priorities such as uniform data collection for neonatal abstinence syndrome; supporting the act Early: Children's Mental Health program, data collection around sickle cell disease, and expansion of the Surveillance for Emerging Threats to Mothers and Babies (SET-NET) program to allow more States to participate and gather needed information to protect pregnant individuals and infants from emerging public health threats.

Global Immunization—Polio and Measles/Other (CDC):

FY 23 Request: \$356 million (\$276 million for Polio and \$80 million for Measles/Other); FY 22 Level: \$228 million (\$178 million for Polio and \$50 million for Measles/Other).—The CDC's global immunization program is one of the most cost-effective and successful public health solutions available and U.S. investments have driven remarkable results. The CDC was a founding member of the Measles and Rubella Initiative, which has vaccinated over 2 billion children and prevented 23.2 million deaths from measles since 2001. Since 1988, the CDC's global polio immunization work has reduced the number of polio cases globally by 99.9 percent, saving more than 10 million children from paralysis and bringing the disease close to eradication. Thanks to sustained funding by the U.S. government through the CDC and USAID and the coordinated efforts of the Global Polio Eradication Initiative (GPEI), the opportunity for a polio-free world is within reach. Unfortunately, the gains from global immunization are in jeopardy. Throughout the ongoing COVID-19 pandemic, many countries diverted resources set aside for polio and routine immunizations to fight the pandemic. While this was vital to many countries' ability to quickly respond to COVID-19, it has come at a terrible cost to polio eradication and routine child vaccination. In the first 2 months of 2022, measles cases were up 79 percent compared with the year prior. The World Health Organization and UNICEF warned of a "perfect storm" of conditions for measles outbreaks. Additionally, polio cases have increased, with Malawi experiencing its first wild polio case in three decades. To recover from pandemic-related disruptions, the Academy urges Congress to appropriate at least \$276 million for polio and \$80 million for measles vaccination programs.

Activities Authorized under Scarlett's Sunshine Act (CDC/HRSA):

FY 23 Request: \$12 million (\$8.5 million at CDC for the Safe Motherhood and Infant Health account and \$3.5 million at MCHB within the Special Projects of Regional and National Significance account); FY 22: Level: \$1 million at HRSA and \$2 million at CDC.—In passing the Scarlett's Sunshine Act in late 2020, Congress recognized the need for Federal investments in research and prevention of sudden unexpected infant death (SUID) and sudden unexplained death in childhood (SUDC). The law authorized \$12 million for HHS to award grants and improve data and monitoring. Full funding for this initiative will strengthen efforts to better understand SUID and SUDC, facilitate data collection and analysis to improve prevention efforts, and support children and families. Requested CDC funding would improve communities' responses to infant and child death cases, inform prevention and clinical care, and help standardize data collection and reporting, as well as procedures and protocols for death scene investigations and autopsies. The grants can also fund safe sleep outreach efforts, which can reduce the risk of SUID. The funds at MCHB would support the expansion and use of the Case Reporting System to provide data summaries and dashboards on all SUIDs and making datasets available to researchers. These MCHB funds can also support bereavement services for affected families, which MCHB cannot currently provide.

National Vaccine Injury Compensation Program Administration (HRSA):

FY 23 Request: \$26.2 million; FY 22 Level: \$13.2 million.—The Academy supports increased funding for the administrative component of the National Vaccine Injury Compensation Program (NVICP), which was established in 1988 to ensure an adequate supply of vaccines, stabilize vaccine costs, and establish and maintain an ac-

cessible and efficient forum for individuals found to be injured by certain vaccines. NVICP is an alternative to the traditional tort system for resolving vaccine injury claims and provides compensation to individuals found to be injured by certain vaccines. NVICP claims have increased more than fivefold from 402 claims filed in FY 2012 to 2,057 claims filed in FY 2021 while the administrative funding barely doubled from \$6.5 million to \$11.2 million during the same period. The steep increase in claims filed is due in large part to the flu vaccine being administered to adults. In fact, most of all petitions filed are now adult claims for alleged injuries from the flu vaccine. Though the number of petitions has risen, the number of staff to administer the claims has not risen at the same level. By hiring more staff and thereby expediting the processing of claims filed in the NVICP, the children and families who have been injured by a vaccine will be able to receive their due compensation in a timely manner. It will also help prepare HRSA to administer the NVICP program if the COVID-19 vaccine is eventually transferred from the Countermeasures Injury Compensation Program and included in NVICP program.

Activities Authorized under the VACCINES Act (CDC):

FY 23 Request: \$15 million; FY 22 Level: N/A.—The AAP is very appreciative that Congress specifically included the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act as part of Section 2302 of the American Rescue Plan that provided \$1 billion to improve vaccine confidence for both COVID-19 and routine immunizations. Much of this funding was distributed to State and local public health departments to help promote the uptake of COVID-19 vaccines and to provide Americans with accurate information about these vaccines. As we pass 2 years of living through the pandemic, it is more important than ever to bolster American's confidence in vaccines and debunk misinformation and disinformation about vaccines. The VACCINES Act authorizes the development of a national vaccination rate surveillance system at CDC and allows data collected to be used to identify communities with low vaccination utilization or where vaccine misinformation may be targeted. It also authorizes research grants to better understand vaccine hesitancy, attitudes towards vaccines, and develop strategies to address nonadherence to the recommended use of vaccines. Additionally, the VACCINES Act authorizes an evidence-based public awareness campaign on the importance of vaccinations to increase vaccination rates, including targeting communities that have particularly low vaccination levels. The AAP urges Congress to allocate the authorized \$15 million for CDC to ensure these activities take place to boost vaccine confidence in routine and COVID-19 immunizations and boost vaccination rates across the lifespan.

There are many ways Congress can help meet children's needs and protect their health and well-being. Adequate funding for children's health programs is one of them. The American Academy of Pediatrics looks forward to working with Members of Congress to prioritize the health of our Nation's children in FY 2023 and beyond. If we may be of further assistance, please contact the AAP Department of Federal Affairs at 202-347-8600 or pjohnson@aap.org. Thank you for your consideration.

[This statement was submitted by Moira A. Szilagyi, MD, FAAP, President, American Academy of Pediatrics.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION
FOR THE STUDY OF LIVER DISEASES

The American Association for the Study of Liver Diseases (AASLD) thanks this subcommittee for the opportunity to submit outside witness testimony on opportunities to support and improve the health of Americans living with various forms of liver disease, ranging from non-alcoholic fatty liver disease to liver cancer, in the Fiscal Year (FY)2023 Labor, Health and Human Services, Education and Related Agencies bill and report.

The liver, the largest solid organ in the body, is a master regulator of a diverse array of life sustaining chemical processes. In liver disease, these processes are disrupted. The result is ongoing organ injury, progressive scarring, and the development of cirrhosis and liver cancer. Over 40,000 Americans die each year from these complications. In 2019, liver disease was the fourth leading cause of death for those 45 to 64 years of age, and that figure continues to grow. AASLD is calling on this subcommittee to support biomedical research and public health programs to reverse the growing public health burden of liver disease. We respectfully request that you provide at least \$49.048 billion for the National Institutes of Health (NIH) and \$140 million for the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH).

FUNDING FOR NIH

Robust, sustained, and predictable funding is important to advance the entire biomedical research enterprise, not just work related to the full spectrum of liver diseases. AASLD is deeply appreciative of the investment Congress has made to provide NIH with the resources for meaningful growth above inflation, and our request of \$49.048 billion will ensure this trajectory can be maintained and meritorious research in liver disease will be supported.

To meaningfully advance our understanding of liver diseases, all NIH Institutes and Centers (I/Cs) must receive a proportional increase in funding in FY 2023. Many I/Cs support the research our members perform, reinforcing the importance of providing a proportional increase across the NIH: the National Cancer Institute supports research in liver cancer, one of the most lethal cancers; the National Institute of Allergy and Infectious Diseases-funded projects are advancing our understanding of viral hepatitis and helping us move closer to its elimination; and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) is funding projects to address the growing burden of alcohol-associated liver disease. AASLD would like to stress the importance of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the home for liver disease research, receiving at least a proportional increase to NIH. Unlike many other I/Cs, NIDDK did not receive any emergency COVID-19 funding, yet it supports many chronic conditions such as liver disease that increase a person's risk for severe COVID-19 and long COVID. The institute is already being forced to make difficult choices about funding COVID-19 related research and other research areas, which will only be exacerbated by receiving an increase that is not proportional to the broader NIH. Additionally, we are requesting this robust appropriation for NIH to provide for meaningful support of a diverse physician-scientist workforce. AASLD is concerned that the physician-scientist workforce is shrinking at a time when their expertise is needed to meet the needs of Americans living with liver diseases, especially as COVID-19 continues to pose an increased risk for these patients.

AASLD would also like to take this opportunity to address the Advanced Research Projects Agency for Health (ARPA-H). The \$49.048 billion we are requesting for NIH should be separate from any appropriation made to ARPA-H in FY 2023; any funds appropriated to ARPA-H should supplement, not supplant, those for NIH. AASLD strongly supports and believes in the potential for ARPA-H to meaningfully improve the health of Americans living with liver disease by developing new tools to treat and potentially prevent these conditions. However, this work cannot be done at the expense of the basic science and investigator-initiated research in which NIH invests; AASLD strongly believes the best way to support both lines of inquiry is for Congress to authorize ARPA-H so that is housed outside of NIH.

APPROPRIATE \$140 MILLION FOR CDC DVH TO SUPPORT THE
ELIMINATION OF VIRAL HEPATITIS

AASLD is committed to meeting the goal of eliminating viral hepatitis. We have vaccines to prevent Hepatitis A and Hepatitis B, and while we may not have a Hepatitis C vaccine, we now have the therapeutics to cure those infected. However, vaccines and effective therapeutics alone cannot move the country towards elimination; therefore, we urge Congress to provide the investment necessary to support this goal. The overall CDC budget has decreased in real dollars several times in the last decade. Despite recent pandemic-related investments across the agency, funding for DVH has remained relatively flat, leaving the Division unable to support the policies and programs necessary to bolster efforts towards the elimination of viral hepatitis. We therefore urge you to appropriate \$140 million for DVH as a down payment on progress towards elimination.

We recognize that this request represents a \$99 million increase in DVH's funding, yet it does not come close to providing the funding that the CDC estimated would be required to put the United States on the path to eliminating viral hepatitis. In its 2016 Professional Judgement Budget, the CDC estimated it would take at least \$316 million to do this. There is a critical need to enhance the capacity to detect and respond to outbreaks. Increased funding for DVH is also critically important to support adult vaccination programs for Hepatitis A and Hepatitis B and address the ongoing opioid epidemic, which has been exacerbated by the COVID-19 pandemic.

SUPPORT THE FORMATION OF A NATIONAL LIVER DISEASE STRATEGY

The burden of liver disease is growing rapidly, imposing significant costs to the country's public health and health care systems. For example, liver cancer has

emerged as one of the fastest rising causes of cancer deaths in the country, and with a forecasted 40,000 new liver cancer diagnoses and 30,000 liver cancer deaths in 2022, survival rates remain poor. Additionally, at least 5.3 million Americans are infected with viral hepatitis and the majority are undiagnosed while the disease destroys their liver.

Despite the growing toll the full spectrum of liver diseases is imposing, there is no strategy to address the breadth of the health and economic effects of this disease in the United States. For these reasons, AASLD calls on Congress to direct the Department of Health and Human Services (HHS) to develop a department-wide strategic plan to combat liver disease, including viral hepatitis, fatty liver disease, alcohol-associated liver disease, cirrhosis, and liver cancer. HHS should seek input from across the government, including from the CDC, the NIH, the Food and Drug Administration, and the Health Resources and Services Administration (HRSA), as well as researchers, providers, and patients to formulate this strategy.

Accordingly, the AASLD requests the inclusion of the following language in the report accompanying the FY 2023 LHHS Appropriations bill with regards to the HHS Office of the Secretary:

National Liver Disease Strategy.—The Committee recognizes the growing burden of liver disease, including viral hepatitis, non-alcoholic fatty liver disease, cirrhosis, and liver cancer, and its significant costs to the country's health care system. In 2019, liver disease was the fourth leading cause of death for those 45 to 64 years of age. Despite the growing toll the full spectrum of liver diseases is imposing, there is no strategy to address the breadth of the health and economic effects of this disease in the United States. For these reasons, the Committee directs the Secretary of HHS to develop a department-wide strategic plan to combat liver disease. This strategy should include a framework to guide the development of policies and initiatives to prevent, diagnose, and treat liver disease across Federal agencies. Specifically, the strategy should coordinate efforts to prevent future cases of liver disease through improved disease surveillance and improve liver disease outcomes for current patients by addressing health disparities and inequities. The Committee provides \$2 million to support this effort and requests an update on the department's plans to begin this work within 180-days of enactment.

SUPPORT UNIVERSAL HEPATITIS B VACCINATION

Hepatitis B is a highly infectious disease with an estimated 20,700 acute infections each year, and almost two million people are living with chronic hepatitis B in the US today. Today, some parts of the country, particularly those States most affected by the opioid epidemic, are experiencing sharp increases in infections. The hepatitis B virus can lead to serious complications, such as liver failure, cirrhosis, and liver cancer.

For these reasons, the AASLD was pleased to see the CDC Advisory Committee on Immunization Practices (ACIP) recommendation for universal hepatitis B vaccination for adults aged 19 to 59. CDC will be formally supporting this recommendation in a forthcoming edition of the Morbidity and Mortality Weekly Report. This is a key step towards eliminating this vaccine-preventable and treatable disease. As such, we respectfully request the inclusion of the following report language in the report that accompanies the FY 2023 LHHS appropriations bill under the HHS Office of the Secretary:

Universal Hepatitis B Vaccination.—The Committee believes the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) recommendation for universal hepatitis B vaccination for adults aged 19 to 59 is a crucial step towards the elimination of this vaccine-preventable virus. It comes as parts of the country, particularly those States most affected by the opioid epidemic, are experiencing sharp increases in hepatitis B infections. The Committee requests a report back on the specific steps being taken to implement this recommendation across the agency and departments, including but not limited to the CDC Division of Viral Hepatitis, the CDC Immunization Services Divisions, and the HRSA Health Center Program, and any barriers that have been encountered and assistance needed to overcome them within 120 days of enactment.

ADVANCE RESEARCH ON ALCOHOL-ASSOCIATED LIVER DISEASE

Alcohol-associated liver disease (ALD) represents a wide-range of liver injury resulting from alcohol use, including inflammation of the liver, cirrhosis, or permanent scarring of the liver, and other life-threatening complications. ALD is a major cause of liver disease and research advancements in this area are urgently needed, particularly due to the increased rates of alcohol consumption during the COVID-19 pandemic. Preliminary data indicate a significant increase in alcohol consumption

during the pandemic, and increased alcohol use has the potential to increase morbidity and mortality from ALD. Moreover, early data suggest that patients with ALD may experience worse COVID-19 outcomes and complications. For these reasons, AASLD believes this area of research could benefit from a more comprehensive approach to research on ALD and alcohol use disorders at the NIH. Therefore, the AASLD respectfully requests that you include the following report language in the report that accompanies the FY 2023 LHHS appropriations bill under the NIH NIAAA:

Alcohol-Associated Liver Disease.—The Committee is aware that alcohol use disorder and alcohol-associated liver disease are distinct diseases. However, it is rare for patients to have the latter without first having the former. Combining the research in this area in a holistic approach could lead to advancements for both, which are needed urgently given the increased rates of alcohol consumption during the pandemic. The Committee requests a report in next year's budget justification on the viability of this approach, including NIAAA's capacity to award related grants and the field's capacity to develop scientifically valid research projects.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2023 appropriations bills. We look forward to working with you to improve the health and well-being of all Americans living with liver disease.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH

Chair Murray, Ranking Member Blunt, and members of the subcommittee, thank you for the opportunity to submit testimony. I am Dr. Lisa Coussens, Associate Director for Basic Research at the Knight Cancer Institute, an NCI Comprehensive Cancer Center, and Chair of the Department of Cell, Developmental & Cancer Biology at Oregon Health & Science University. I am submitting testimony as President of the American Association for Cancer Research (AACR), the world's first and largest professional organization dedicated to advancing cancer research and its mission to prevent and cure all cancers. On behalf of the AACR's more than 50,000 members, who are scientists, physicians, other healthcare workers, and patient advocates, I ask for your support for at least \$49 billion in Fiscal Year (FY) 2023 funding for the National Institutes of Health (NIH) and \$7.766 billion for the National Cancer Institute (NCI).

The AACR is grateful for your commitment to cancer research and the increase of \$353 million Congress provided NCI in FY 2022. Today, as you begin work on FY 2023 appropriations, I humbly ask that you build on that support and address the urgent financial pressures at NCI.

History shows what can be achieved when Congress prioritizes medical research. After years of underinvestment, former President Clinton embarked on a path of doubling NIH funding, a goal which Congress far exceeded. In 1999, success rates, i.e., the percent of research grant applications that receive funding, reached 32 percent across NIH and 28 percent at NCI. The NCI Director at the time, Dr. Richard D. Klausner, referred to this era as "a golden age of discovery, one unique in human history." This funding fueled discoveries at an unprecedented rate.

Thanks to these investments, truly remarkable progress has been made. For example, treating late-stage lung cancer and melanoma has been revolutionized with the development of a new class of immunotherapies that activate a patient's own immune system to fight cancer. In the 1990s and early 2000s, fewer than 1 in 6 patients diagnosed with metastatic melanoma lived 5 years after diagnosis. But now more than half of patients with metastatic melanoma who receive immunotherapy combinations live longer than 5 years, many without any signs of disease. These remarkable new therapies emerged out of Federal investments in basic science.

And as a result, we see similar results playing out for the millions of Americans who otherwise might have lost their lives to cancer, as there are now nearly 17 million cancer survivors living in the United States. In the 50 years since the enactment of the National Cancer Act, cancer mortality rates have dropped by 27 percent. These drastic reductions are due to prevention efforts such as reduced smoking rates, more effective screening tools which detect cancer at an earlier, more treatable stage, and the success of better, more targeted drugs that allow patients with cancer to live longer after a diagnosis. These developments and therapies would not have been possible without decades of basic research funded by NCI and NIH to understand the causes and development of cancer, the immune system, and how cancer cells evade detection.

Researchers are building on these discoveries to find additional anti-cancer drug targets within the immune system and to understand why some tumors do not respond as well to treatment. We are so close to unlocking new discoveries that could fundamentally change cancer care and survivorship, but to do so, we need Federal investments to keep up with the growing demands on basic research for cancer.

The cancer research community's ability to understand, detect, and treat cancers is exploding with potential. Between 2013 and 2018, NCI witnessed a nearly 46 percent increase in grant applications, dwarfing the increase of other institutes at NIH which only increased by 4.9 percent. And yet, NCI funding has not kept up with application growth or inflation. Even with the significant funding provided by Congress, NCI's success rate in FY 2021 was only 13 percent, less than half the rate that spurred historic success two decades ago. NCI's success rate is also among the lowest of all institutes at NIH. Currently, less than one-in-seven grant applications are approved, leaving well-reviewed science unfunded and jeopardizing our ability to spur further innovative approaches to cancer science. This extremely low funding rate is not only limiting scientific discovery, but it is also having an adverse impact on the financial and career security of cancer scientists, in particular, early-stage researchers who may be forced to choose other, more secure career paths.

By meeting the NCI professional judgment budget level of \$7.766 billion in FY 2023, NCI can invest in more early-stage researchers, increase the availability of research grants, and accelerate the path to discoveries that will save lives. While financial constraints at NCI pre-date the emergence of COVID-19, the pandemic has exacerbated challenges within the cancer research community by closing laboratories, disrupting the implementation of clinical trials, and contributing to hiring freezes, forced staff turnovers, and delays and shortages of supplies. Many of these activities are yet to fully recover.

In addition, we do not yet know the full scope of what COVID-19 will mean for patients who delayed their cancer screenings, many of whom will be diagnosed with later stage disease that will be harder and costlier to treat. Former NCI Director, Dr. Norman "Ned" Sharpless, estimated that COVID-19 could result in 5,000 to 10,000 excess cancer deaths from breast cancer and colorectal cancer alone in the next decade due to delayed cancer screenings and medical appointments. The NCI's work will be crucial in rebuilding cancer science and ensuring that we emerge from this crisis with better tools to assist patients navigating a cancer diagnosis.

Throughout my career, some truths about cancer have become abundantly clear. Cancer does not care where you live, or whether you are rich or poor. It forces a tremendous economic and social impact regardless of whom it touches. But with investments in medical research, it is my goal that one day, even advanced cancers will be treated as a chronic condition that a person can control and live with, but one that will not ultimately take their life. We have the power to achieve this goal within our grasp. Now is the time to put our foot on the gas and accelerate discoveries. We do not have a moment to spare.

Thank you for the opportunity to submit testimony on behalf of the AACR and for your commitment to bringing us closer to our mutual goal of conquering cancer.

[This statement was submitted by Lisa M Coussens, MD (hc), PhD, FAACR, President, American Association for Cancer Research.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR DENTAL, ORAL, AND CRANIOFACIAL RESEARCH

Chair Murray, Ranking Member Blunt, and members of the subcommittee, thank you for the opportunity to submit this testimony on behalf of the American Association for Dental, Oral, and Craniofacial Research (AADOCR). I am pleased to submit this statement describing AADOCR's funding requests for FY 2023. I currently serve as President of the Association. I am also a professor and former dean at the University of North Carolina-Chapel Hill Adams School of Dentistry and an adjunct professor at UNC's Gillings School of Global Public Health.

For FY 2023, AADOCR—along with our colleagues in the oral health community—is seeking at least \$540 million for the National Institute of Dental and Craniofacial Research (NIDCR) and a total of \$49 billion for all of the Institutes and Centers at the National Institutes of Health (NIH). Funding at these levels is necessary for the entities' base budgets to keep pace with the biomedical research and development price index (BRDPI).

The NIH, through the biomedical research it conducts and supports, plays a critical role in improving Americans' health and well-being. When the COVID-19 pandemic hit our Nation and the world, the NIH helped safeguard the public health through its significant contributions to the development of testing, vaccines and

treatments. The NIH continues to develop and maintain the resources, both human and scientific, that provide our Nation with the tools it needs to address other diseases and disabilities.

The NIDCR, established by President Harry S. Truman in 1948, is the largest institution in the world exclusively dedicated to researching ways to improve dental, oral, and craniofacial health for all. Investments in NIDCR-funded research during the past half-century have led to improvements in oral health for millions of Americans and continue to show promise in areas encompassing the prevention of dental caries (cavities) and periodontal disease (gum disease), new diagnostic methods of oral and dental conditions, pain biology and management, regenerative medicine, oral cancer, and in assessing the efficacy of a human papillomavirus (HPV) vaccine for oral and pharyngeal cancers.

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. Poor oral health can affect activities that may be taken for granted—the ability to eat, drink, swallow, smile, speak, and maintain proper nutrition—and create economic burden that disproportionately harms older adults, low income, and underserved communities.

The oral cavity also serves as a window into many health issues, including but not limited to systemic diseases, such as diabetes, HIV/AIDS, and Sjögren's, an autoimmune disease that causes one's immune system to attack parts of its own body. Additionally, researchers are exploring the debilitating loss of salivary gland functioning and saliva production stemming from radiation treatment for head and neck cancers and even from common medications and aging itself.

The NIDCR played a critical role in responding to the COVID-19 public health crisis funding approximately \$3.9 million in high-impact coronavirus research. The Institute's research into minimizing infection risk in dental offices, the use of biosensors to detect SARS-CoV-2 in saliva, the role of periodontal disease in COVID-19 complications, and exploring mechanisms of viral entry into the tissues of the oral cavity played a critical role in combatting COVID-19. Continued investment in NIDCR will allow the Institute to pursue these research efforts and expand into new areas of research, such as the interplay between the oral microbiome and immune system, to improve Americans' oral and overall health.

In December 2021, NIDCR released "Oral Health in America: Advances and Challenges", a data-driven report with input from over 400 contributors documenting 20 years of progress in oral health since the 2020 Surgeon General's Report on Oral Health. The report provides insight into issues currently affecting oral health and serves as a call to action for a coordinated effort among oral health practitioners; researchers; and other stakeholders to improve oral health for all Americans.

AADOOR deeply appreciates Congress' longstanding and bipartisan support for the public health research enterprise. The funding increases NIDCR has received since 2015 have allowed the Institute to build its data repository and registry in several disease and research areas to meet the increasing need for open-source data sharing. These include clinical registries and repositories related to head and neck cancers, orofacial birth defects and craniofacial anomalies, and craniofacial microsomia cohorts to identify genetic risk factors. The Institute also participates in trans-NIH and NIH Common Fund initiatives for data analysis and sharing.

Despite NIDCR's impressive research agenda and scientific accomplishments, the Federal Government's annual investment in the Institute has not kept pace with the overall funding increases provided to NIH over the past several years. Funding of at least \$540 million in FY 2023 would help bring NIDCR funding into alignment with the overall NIH appropriation and allow NIDCR to build on its myriad successes in its mission to improve dental, oral and craniofacial health.

Recognizing that Federal research and public health efforts work in concert with one another and that success in one area can benefit another, we encourage Congress to support the full breadth of Federal agencies supporting oral health. Complementing our NIDCR and NIH requests, we urge you to provide \$35 million for the CDC's Division of Oral Health, \$46 million for the Title VII Health Resources and Services Administration (HRSA) programs that train the dental health workforce, \$500 million for the Agency for Healthcare Research and Quality (AHRQ), and \$210 million for the National Center for Health Statistics (NCHS) in FY 2023.

Finally, AADOOR strongly supports the establishment of the Advanced Research Projects Agency for Health (ARPA-H), which will help fill gaps in the biomedical research ecosystem by utilizing a bold new approach focused on the development of evidence-based, real-world-driven cures for a range of diseases. We urge you to support the Administration's request of \$5 billion for ARPA-H in FY 2023, but not at the expense of funding for the NIH's base budget. It's critical that funding for this

new agency complement—not supplant—the foundational investment in traditional NIH Institutes and Centers.

We appreciate the opportunity to submit this testimony and thank the subcommittee for its support of biomedical research, including dental, oral and craniofacial research, in FY 2023 so our Nation's citizens can continue to enjoy the benefits of state-of-the-art and world-leading health care. We stand ready to assist the members of this subcommittee in any way we can and are happy to answer any questions you may have.

Sincerely,

[This statement was submitted by Jane Weintraub, DDS, MPH, President (2022–2023), American Association for Dental, Oral, and Craniofacial Research.]

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES

The American Association for the Study of Liver Diseases (AASLD) thanks this subcommittee for the opportunity to submit outside witness testimony on opportunities to support and improve the health of Americans living with various forms of liver disease, ranging from non-alcoholic fatty liver disease to liver cancer, in the Fiscal Year (FY) 2023 Labor, Health and Human Services, Education and Related Agencies bill and report.

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FUNDING FOR NIH

Robust, sustained, and predictable funding is important to advance the entire biomedical research enterprise, not just work related to the full spectrum of liver diseases. AASLD is deeply appreciative of the investment Congress has made to provide NIH with the resources for meaningful growth above inflation, and our request of \$49.048 billion will ensure this trajectory can be maintained and meritorious research in liver disease will be supported.

To meaningfully advance our understanding of liver diseases, all NIH Institutes and Centers (I/Cs) must receive a proportional increase in funding in FY 2023. Many I/Cs support the research our members perform, reinforcing the importance of providing a proportional increase across the NIH: the National Cancer Institute supports research in liver cancer, one of the most lethal cancers; the National Institute of Allergy and Infectious Diseases-funded projects are advancing our understanding of viral hepatitis and helping us move closer to its elimination; and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) is funding projects to address the growing burden of alcohol-associated liver disease. AASLD would like to stress the importance of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the home for liver disease research, receiving at least a proportional increase to NIH. Unlike many other I/Cs, NIDDK did not receive any emergency COVID–19 funding, yet it supports many chronic conditions such as liver disease that increase a person's risk for severe COVID–19 and long COVID. The institute is already being forced to make difficult choices about funding COVID–19 related research and other research areas, which will only be exacerbated by receiving an increase that is not proportional to the broader NIH. Additionally, we are requesting this robust appropriation for NIH to provide for meaningful support of a diverse physician-scientist workforce. AASLD is concerned that the physician-scientist workforce is shrinking at a time when their expertise is needed to meet the needs of Americans living with liver diseases, especially as COVID–19 continues to pose an increased risk for these patients.

AASLD would also like to take this opportunity to address the Advanced Research Projects Agency for Health (ARPA–H). The \$49.048 billion we are requesting for NIH should be separate from any appropriation made to ARPA–H in FY 2023; any funds appropriated to ARPA–H should supplement, not supplant, those for NIH.

AASLD strongly supports and believes in the potential for ARPA-H to meaningfully improve the health of Americans living with liver disease by developing new tools to treat and potentially prevent these conditions. However, this work cannot be done at the expense of the basic science and investigator-initiated research in which NIH invests; AASLD strongly believes the best way to support both lines of inquiry is for Congress to authorize ARPA-H so that is housed outside of NIH.

APPROPRIATE \$140 MILLION FOR CDC DVH TO SUPPORT THE ELIMINATION OF VIRAL HEPATITIS

AASLD is committed to meeting the goal of eliminating viral hepatitis. We have vaccines to prevent Hepatitis A and Hepatitis B, and while we may not have a Hepatitis C vaccine, we now have the therapeutics to cure those infected. However, vaccines and effective therapeutics alone cannot move the country towards elimination; therefore, we urge Congress to provide the investment necessary to support this goal. The overall CDC budget has decreased in real dollars several times in the last decade. Despite recent pandemic-related investments across the agency, funding for DVH has remained relatively flat, leaving the Division unable to support the policies and programs necessary to bolster efforts towards the elimination of viral hepatitis. We therefore urge you to appropriate \$140 million for DVH as a down payment on progress towards elimination.

We recognize that this request represents a \$99 million increase in DVH's funding, yet it does not come close to providing the funding that the CDC estimated would be required to put the United States on the path to eliminating viral hepatitis. In its 2016 Professional Judgement Budget, the CDC estimated it would take at least \$316 million to do this. There is a critical need to enhance the capacity to detect and respond to outbreaks. Increased funding for DVH is also critically important to support adult vaccination programs for Hepatitis A and Hepatitis B and address the ongoing opioid epidemic, which has been exacerbated by the COVID-19 pandemic.

SUPPORT THE FORMATION OF A NATIONAL LIVER DISEASE STRATEGY

The burden of liver disease is growing rapidly, imposing significant costs to the country's public health and health care systems. For example, liver cancer has emerged as one of the fastest rising causes of cancer deaths in the country, and with a forecasted 40,000 new liver cancer diagnoses and 30,000 liver cancer deaths in 2022, survival rates remain poor. Additionally, at least 5.3 million Americans are infected with viral hepatitis and the majority are undiagnosed while the disease destroys their liver.

Despite the growing toll the full spectrum of liver diseases is imposing, there is no strategy to address the breadth of the health and economic effects of this disease in the United States. For these reasons, AASLD calls on Congress to direct the Department of Health and Human Services (HHS) to develop a department-wide strategic plan to combat liver disease, including viral hepatitis, fatty liver disease, alcohol-associated liver disease, cirrhosis, and liver cancer. HHS should seek input from across the government, including from the CDC, the NIH, the Food and Drug Administration, and the Health Resources and Services Administration (HRSA), as well as researchers, providers, and patients to formulate this strategy.

Accordingly, the AASLD requests the inclusion of the following language in the report accompanying the FY 2023 LHHS Appropriations bill with regards to the HHS Office of the Secretary:

National Liver Disease Strategy.—The Committee recognizes the growing burden of liver disease, including viral hepatitis, non-alcoholic fatty liver disease, cirrhosis, and liver cancer, and its significant costs to the country's health care system. In 2019, liver disease was the fourth leading cause of death for those 45 to 64 years of age. Despite the growing toll the full spectrum of liver diseases is imposing, there is no strategy to address the breadth of the health and economic effects of this disease in the United States. For these reasons, the Committee directs the Secretary of HHS to develop a department-wide strategic plan to combat liver disease. This strategy should include a framework to guide the development of policies and initiatives to prevent, diagnose, and treat liver disease across Federal agencies. Specifically, the strategy should coordinate efforts to prevent future cases of liver disease through improved disease surveillance and improve liver disease outcomes for current patients by addressing health disparities and inequities. The Committee provides \$2 million to support this effort and requests an update on the department's plans to begin this work within 180-days of enactment.

SUPPORT UNIVERSAL HEPATITIS B VACCINATION

Hepatitis B is a highly infectious disease with an estimated 20,700 acute infections each year, and almost two million people are living with chronic hepatitis B in the US today. Today, some parts of the country, particularly those States most affected by the opioid epidemic, are experiencing sharp increases in infections. The hepatitis B virus can lead to serious complications, such as liver failure, cirrhosis, and liver cancer.

For these reasons, the AASLD was pleased to see the CDC Advisory Committee on Immunization Practices (ACIP) recommendation for universal hepatitis B vaccination for adults aged 19 to 59. CDC will be formally supporting this recommendation in a forthcoming edition of the Morbidity and Mortality Weekly Report. This is a key step towards eliminating this vaccine-preventable and treatable disease. As such, we respectfully request the inclusion of the following report language in the report that accompanies the FY 2023 LHHS appropriations bill under the HHS Office of the Secretary:

Universal Hepatitis B Vaccination.—The Committee believes the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) recommendation for universal hepatitis B vaccination for adults aged 19 to 59 is a crucial step towards the elimination of this vaccine-preventable virus. It comes as parts of the country, particularly those States most affected by the opioid epidemic, are experiencing sharp increases in hepatitis B infections. The Committee requests a report back on the specific steps being taken to implement this recommendation across the agency and departments, including but not limited to the CDC Division of Viral Hepatitis, the CDC Immunization Services Divisions, and the HRSA Health Center Program, and any barriers that have been encountered and assistance needed to overcome them within 120 days of enactment.

ADVANCE RESEARCH ON ALCOHOL-ASSOCIATED LIVER DISEASE

Alcohol-associated liver disease (ALD) represents a wide-range of liver injury resulting from alcohol use, including inflammation of the liver, cirrhosis, or permanent scarring of the liver, and other life-threatening complications. ALD is a major cause of liver disease and research advancements in this area are urgently needed, particularly due to the increased rates of alcohol consumption during the COVID-19 pandemic. Preliminary data indicate a significant increase in alcohol consumption during the pandemic, and increased alcohol use has the potential to increase morbidity and mortality from ALD. Moreover, early data suggest that patients with ALD may experience worse COVID-19 outcomes and complications. For these reasons, AASLD believes this area of research could benefit from a more comprehensive approach to research on ALD and alcohol use disorders at the NIH. Therefore, the AASLD respectfully requests that you include the following report language in the report that accompanies the FY 2023 LHHS appropriations bill under the NIH NIAAA:

Alcohol-Associated Liver Disease.—The Committee is aware that alcohol use disorder and alcohol-associated liver disease are distinct diseases. However, it is rare for patients to have the latter without first having the former. Combining the research in this area in a holistic approach could lead to advancements for both, which are needed urgently given the increased rates of alcohol consumption during the pandemic. The Committee requests a report in next year's budget justification on the viability of this approach, including NIAAA's capacity to award related grants and the field's capacity to develop scientifically valid research projects.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2023 appropriations bills. We look forward to working with you to improve the health and well-being of all Americans living with liver disease.

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 would like to thank the subcommittee for its leadership and continued support of nursing education, the nursing profession, and nursing research, especially during this un-

precedented time. As the National voice for academic nursing, AACN represents more than 850 schools of nursing at private and public universities, who educate more than 565,000 students and employ more than 52,000 faculty.¹ Collectively, these institutions graduate our Nation's registered nurses (RN), advanced practice registered nurses (APRN), educators, researchers, and frontline providers.

As we work to combat current public health challenges, such as COVID-19, and prepare for the future, ensuring a robust nursing pathway requires a strong and sustained Federal investment. For Fiscal Year (FY) 2023, AACN respectfully requests that you provide support of at least \$530 million for the Nursing Workforce Development Programs (Title VIII of the Public Health Service Act [42 U.S.C. 296 et seq.] administered by HRSA and at least \$210 million for the National Institute of Nursing Research (NINR).

Landscapes Overview: 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 this public health emergency.

From the classroom to the frontline, we have witnessed how critical a well-educated nursing workforce is to the provision of high-quality health care. This need is only expected to grow, as the Bureau of Labor Statistics projects a 9 percent increase in RN workforce demand through 2030, representing the need for an additional 276,800 jobs.³ Demand for certain APRNs (NPs, CRNAs, and CNMs) is expected to grow even more, by 45 percent.⁴

While AACN saw student enrollment in entry-level baccalaureate nursing programs increase by 3.3 percent in 2021, the increase was 2.3 percent lower than 2020.⁵ Further, nursing schools saw enrollment decline in baccalaureate degree-completion programs and some graduate programs at the master's and PhD levels.⁶ For the first time since 2001, enrollment in master's programs decreased by 3.8 percent, which translates to 5,766 fewer students enrolled in 2021 than in the previous year.⁷ This is concerning because graduate programs prepare individuals for a variety of advanced roles in administration, teaching, research, informatics, and direct patient care.

There were bright spots in 2021, with enrollments in Doctor of Nursing Practice (DNP) programs up 4.0 percent.⁸ However, the fact remains that a total of 91,938 qualified applications (not applicants) were not accepted at schools of nursing nationwide in 2021 alone.⁹ As our annual survey found, "the primary barriers to accepting all qualified students at nursing schools continues to be insufficient clinical placement sites, faculty, preceptors, and classroom space, as well as budget cuts."¹⁰

Educational pathways are just one piece of the puzzle. Strong and historic investments in the current nursing workforce are imperative, especially as we contend with an aging nursing workforce and the lasting impact COVID-19 has had on the profession. In fact, registered nurses age 65 and older already make up 19 percent of the workforce, and "more than one-fifth of all nurses reported they plan to retire from nursing over the next 5 years."¹¹ Not to mention a recent study which found 52 percent of nurses considered leaving their position during the pandemic, up from

¹American Association of Colleges of Nursing. (2022) Who We Are. Retrieved from: <https://www.aacnnursing.org/About-AACN/Who-We-Are>.

²National 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>.

³U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Registered Nurses. Retrieved from: <https://www.bls.gov/ooh/healthcare/registered-nurses.htm>.

⁴U.S. Bureau of Labor Statistics. (2022). Occupational Outlook Handbook- Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners. Retrieved from: <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>.

⁵American Association of Colleges of Nursing. (2022) Nursing Schools See Enrollment Increases in Entry-Level Programs, Signaling Strong Interest in Nursing Careers. Retrieved from: <https://www.aacnnursing.org/News-Information/PressReleases/View/ArticleId/25183/Nursing-Schools-See-Enrollment-Increases-in-Entry-Level-Programs>.

⁶Ibid.

⁷Ibid.

⁸Ibid.

⁹Ibid.

¹⁰Ibid.

¹¹National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers (2021) The 2020 National Nursing Workforce Survey. Retrieved from: [https://www.journalofnursingregulation.com/article/S21558256\(21\)00027-2/fulltext](https://www.journalofnursingregulation.com/article/S21558256(21)00027-2/fulltext).

40 percent a year earlier.¹² We must minimize the loss of experienced nurses who may prematurely leave the profession, and at the same time support nursing education to meet the current and future demand for nurses.

With increasing demands, an aging population, nursing retirements, and an increase in workplace stress,¹³ bold investments in Title VIII Nursing Workforce Development Programs and NINR are imperative, not only as we confront existing health challenges, but as we provide tomorrow's equitable and innovative healthcare solutions.

Investments in Nursing Education Lead to a Strong Nursing Workforce

For over fifty years, Title VIII Nursing Workforce Development Programs have been a catalyst for strengthening nursing education at all levels, from entry-level preparation through graduate study. Through grants, scholarships, and loan repayment programs, Title VIII Federal investments positively impact the profession's ability to serve America's patients in all areas, bolster diversity within the workforce, and increase the number of nurses, including those at the forefront of public health emergencies and caring for our aging population.

Each Title VIII Nursing Workforce Development Program provides a unique and crucial mission to support nursing education and the profession. For example, the Advanced Nursing Education (ANE) programs help increase the number of APRNs in the primary care workforce and supported more than 8,800 students in Academic Year 2020–2021 alone.¹⁴ In addition, the Nurse Faculty Loan Program (NFLP) supported 2,763 graduate nursing students who intend to serve as nurse faculty.¹⁵ “By the end of the Academic Year, the programs graduated 779 trainees, 92 percent of whom intended to teach nursing.”¹⁶

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 into the nursing profession. Increasing diversity in the profession will not only create lifelong career pathways, but will also improve care quality and access to population-centered care. A recent HHS Assistant Secretary for Planning and Evaluation (ASPE) report makes the recommendation to “optimize existing workforce development programs to support diversity in the health professional workforce and further support the development of a diverse workforce through pipeline programs.”¹⁷ The Nursing Workforce Diversity (NWD) program serves as a glowing example of a successful Title VIII initiative that accomplishes this goal. In fact, in Academic Year 2020–2021, the NWD program awarded grants supporting 10,155 nursing students from disadvantaged backgrounds.¹⁸ To ensure the stability of our nursing workforce now and in the future, we request at least \$530 million for Title VIII Nursing Workforce Programs in FY 2023.

From Research to Reality: Nursing Science Protects Americans' Health

AACN recognizes that scientific research and discovery are the foundation on which nursing practice is built and is essential to advancing evidence-based interventions, informing policy, and sustaining the health of the Nation. In fact, a recent ASPE's report recommends to “support research that investigates long-term workforce trends arising from the pandemic and how they can be addressed including

¹² American Nurses Foundation. (2022). Pulse on the Nation's Nurses Survey Series: COVID–19 Two-Year Impact Assessment Survey. Retrieved from: <https://www.nursingworld.org/~492857/contentassets/872ebb13c63f44f6b11a1bd0c74907c9/covid-19-2-year-impact-assessment-written-report-final.pdf>.

¹³ American Association of Colleges of Nursing. (2020) Fact Sheet: Nursing Shortage. Retrieved from: <https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Fact-sheet.pdf>.

¹⁴ Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Pages 164–170. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>.

¹⁵ Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Page 181. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>.

¹⁶ Ibid.

¹⁷ Assistant Secretary for Planning and Evaluation, Office of Health Policy. Impact of the COVID–19 Pandemic on the Hospital and Outpatient Clinician Workforce Challenges and policy responses. (2022) Retrieved from: <https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf>.

¹⁸ Health Resources and Services Administration. Fiscal Year 2023 Budget Justification. Pages 171–174. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>.

entry and departure issues, impact on facility staffing, and factors associated with health worker morale.”¹⁹

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 percent of research-focused educational training grants at nursing schools are funded by NINR.²⁰ Through these grants and others, nurse scientists, often working collaboratively with other health professionals, are generating groundbreaking findings and leading translation research that works to address strategic imperatives, to include health equity, social determinants of health, population health, health promotion, and models of care. To further this vital work, we are requesting a total of at least \$210 million for the National Institute of Nursing Research.

CONCLUSION

Strong investments in Title VIII Nursing Workforce Development Programs and NINR have a direct impact on sustaining pathways into nursing and patient access to high-quality, evidence-based care in all communities across the Nation. During these unprecedented times, AACN respectfully requests support in FY 2023 of at least \$530 million for the Title VIII Nursing Workforce Development Programs and at least \$210 million for the National Institute of Nursing Research. Together, we can ensure that such investments promote innovation and improve health care in America.

[This statement was submitted by Cynthia McCurren, PhD, RN, 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) appreciates the opportunity to highlight priorities for the osteopathic medical education (OME) community in the LHHSE fiscal year (FY) 2023 budget.

AACOM 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 38 accredited colleges of osteopathic medicine (COMs)—educating nearly 34,000 future physicians, 25 percent of all U.S. medical students—at 60 teaching locations in 34 U.S. States, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

AACOM supports FY23 funding for the following priority programs:

- \$49 billion for the National Institutes of Health (NIH)
- \$11 billion for the Centers for Disease Control and Prevention
- \$9.8 billion for discretionary Health Resources and Services Administration
- \$1.51 billion for the PHSA Title VII and Title VIII health professions workforce programs
- \$500 million for Teaching Health Center Graduate Medical Education
- \$500 million for the Agency for Healthcare Research and Quality
- \$375 million for Children's Hospital Graduate Medical Education
- \$210 million for discretionary National Health Service Corps Scholarship and Loan Repayment programs
- \$75 million for the Medical Student Education Program
- \$67 million for the Area Health Education Center Program
- \$59 million for the Primary Care Training and Enhancement Program
- Permanent funding for the Rural Residency Planning and Development Program

Osteopathic medicine plays an essential role in our Nation's healthcare delivery system and is the fastest growing medical field in the country according to the U.S. Bureau of Health Professions. Osteopathic physicians are trained to see the body as a unit of interdependent systems which promotes healing through a dynamic

¹⁹ Assistant Secretary for Planning and Evaluation, Office of Health Policy. Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce Challenges and policy responses. (2022). Retrieved from: <https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf>.

²⁰ Journal of Professional Nursing (2019) National Institute of Health (NIH) funding patterns in Schools of Nursing: Who is funding nursing science research and who is conducting research at Schools of Nursing? Retrieved from <https://www.sciencedirect.com/science/article/abs/pii/S8755722319301164?via=ihub>.

interaction of body, mind, and spirit. DOs have expertise in the musculoskeletal system, receiving extensive training in osteopathic manipulative treatment, a hands-on technique and non-pharmacological solution to pain management.

AACOM is concerned that scientists at osteopathic medical schools are underutilized in NIH research and underrepresented on NIH Advisory Councils and study sections. The Joint Explanatory Statement accompanying the Consolidated Appropriations Act, 2022 (Public Law 117–103) highlighted this concern and requires NIH to report on the status of NIH funding to colleges of osteopathic medicine and the representation of DOs on NIH National Advisory Councils and study sections. We thank you for acknowledging this disparity and urge the subcommittee to ensure swift implementation.

If this disparity in funding and representation continues, NIH will miss a key opportunity to bolster its capacity to address some of the Nation's most pressing health threats. COMs have a commitment to serving rural and underserved communities: 58 percent are located in Health Professional Shortage Areas and almost all schools have a mission to address these populations. Moreover, nearly 40 percent of physicians practicing in medically-underserved areas are DOs. They serve as the backbone of the primary care system with more than half of DOs practicing in primary care specialties. Finally, COMs routinely train osteopathic medical students in community-based settings, which aligns with the U.S. Department of Health and Human Services Initiative to Strengthen Primary Health Care. Maintaining a focus on this issue will benefit the public by ensuring increased NIH research on these disadvantaged populations.

AACOM appreciates the opportunity to share our LHHSE FY23 funding priorities 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 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) 2023 appropriations for the National Institutes of Health (NIH). AAI recommends an appropriation of at least \$49 billion for NIH's base budget for FY 2023. In addition, AAI recommends providing substantial funding for the Advanced Research Projects Agency for Health (ARPA-H), though it is crucial that this funding supplements, and does not supplant, NIH's base budget. Robust investment in NIH will support needed research to prevent and treat dangerous infectious and debilitating chronic diseases, fund meritorious research proposals and scientists at all career stages, and ensure the continuity of our Nation's robust, preeminent biomedical research enterprise. Because the COVID-19 pandemic continues, AAI also strongly supports an infusion of supplemental funds to address ongoing COVID-19 needs, help scientists whose work was adversely impacted by pandemic-related interruptions, and prepare for future pandemics.

HOW INVESTMENT IN IMMUNOLOGICAL RESEARCH TRANSFORMED THE COVID-19 RESPONSE

Immunological research, including understanding how vaccine-induced immunity and memory are formed, has been vital to the development and use of safe and effective vaccines to protect against coronavirus disease 2019 (COVID-19). While the current vaccines against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, continue to provide strong protection against severe disease, hospitalization, and death, the emergence of variants like delta have resulted in surges of infections, leading to significant morbidity and mortality and placing great strain on our health care system. Although the latest variants (omicron and its subvariants) spread much more easily, they have generally caused less serious disease. Nevertheless, we must be vigilant and prepared for new variants and continue to invest significantly in research aimed at understanding the immune response to the virus and whether—and when—these new variants are able to evade vaccine-induced immunity.

As a result of three substantial coronavirus outbreaks across the globe [SARS, Middle East respiratory syndrome (MERS), and COVID-19] in the last two decades,

scientists are working to discover new approaches for vaccinating against coronaviruses. One such approach currently being explored by NIH is the development of universal coronavirus (“pan-coronavirus”) vaccines that could protect against these and other types of coronaviruses and viral variants.¹ Another approach that shows great promise is an intranasal vaccine, currently being tested against COVID-19. Delivering the vaccine intranasally could generate robust mucosal immunity at the site of infection, potentially resulting in long-term protection from infection. There are over a dozen intranasal vaccine candidates in various stages of clinical trials; preliminary data from one recent preclinical study showed the potential utility of using an intranasal vaccine as a booster dose to our current COVID-19 vaccines to induce long lasting, protective immune responses.²

Advances have also been made in the development of effective treatments for active COVID-19. Various therapeutics are now available to those who test positive for COVID-19, often preventing the development of serious disease. In other areas, treatment is lacking. There are few therapeutics available for those who experience post-acute sequelae of SARS-CoV-2 (PASC, or “long COVID”), a chronic condition that can affect almost every part of the body and incapacitate individuals who have recovered from initial infection. While research is ongoing, particularly through the NIH Researching COVID to Enhance Recovery (RECOVER) Initiative,³ there is currently limited understanding of what causes long COVID and why only some patients develop the condition. Some individuals, even those who had mild infections, experience lingering health problems that can severely limit their activity for months. More research is needed to investigate the cause and pathology of long COVID and discover treatments for this enigmatic and often debilitating condition.

OTHER IMPORTANT VACCINE ADVANCES

Malaria: Every year, malaria infects millions and kills hundreds of thousands of vulnerable people around the world, in particular young children living in poor countries with inadequate health systems. The development of the first World Health Organization (WHO)-recommended vaccine for malaria represents a major scientific advance with the potential to significantly improve health outcomes and was the result of decades of basic research funded in part by NIH.⁴ In addition, an NIH-funded phase 1 clinical trial found that a novel monoclonal antibody conferred unprecedentedly high levels of durable protection against malaria.⁵

Influenza: The Centers for Disease Control and Prevention (CDC) estimates that influenza has caused between 9 and 41 million infections, 140,000 and 710,000 hospitalizations, and 12,000 and 52,000 deaths each year in the United States over the last decade.⁶ Annual vaccination is currently the most effective way to prevent illness due to flu; however, these vaccines must be updated annually and their ability to protect against infection varies widely from year to year due to seasonal shifts in the type of influenza viruses that circulate. NIH is currently supporting research to develop new types of vaccines, including universal flu vaccines (currently in phase 1 clinical studies), that would protect more broadly and effectively against multiple strains of flu, including newly emerging strains that pose a pandemic risk.⁷

Tuberculosis (TB): In 2020, 10 million people were infected with, and 1.5 million people died from, TB.⁸ Although TB is the second leading infectious cause of death in the world, the only available vaccine against TB is the BCG (Bacillus Calmette-Guerin) vaccine, which has variable efficacy against pulmonary disease. NIH-supported research is seeking to understand how the TB bacterium interacts with its human host. Recently, NIH-funded researchers identified a method to dramatically improve the efficacy of the BCG vaccine in non-human primates by changing the route of administration.⁹

Opioid Use Disorder: The opioid epidemic has devastated families and communities across America, with 1.6 million people diagnosed with opioid use disorder

¹ <https://www.nih.gov/news-events/news-releases/niaid-issues-new-awards-fund-pan-coronavirus-vaccines>.

² <https://www.nytimes.com/2022/02/02/health/covid-vaccine-nasal.html>.

³ <https://recovercovid.org/>.

⁴ <https://www.nih.gov/news-events/news-releases/investigational-malaria-vaccine-gives-strong-lasting-protection>; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7227679/>.

⁵ <https://www.nih.gov/news-events/nih-research-matters/monoclonal-antibody-prevents-malaria-early-trial>.

⁶ <https://www.cdc.gov/flu/about/burden/index.html>.

⁷ <https://www.niaid.nih.gov/news-events/nih-launches-clinical-trial-universal-influenza-vaccine-candidate>.

⁸ <https://www.who.int/news-room/fact-sheets/detail/tuberculosis>.

⁹ <https://www.nih.gov/news-events/news-releases/changed-route-immunization-dramatically-improves-efficacy-tb-vaccine>.

and more than 70,000 people dying from opioid-related overdoses in the past year alone.¹⁰ NIH is currently funding cutting-edge research seeking to prevent addiction by generating antibodies to block opioid molecules from entering the brain and by developing a vaccine that could combat opioid use disorder.¹¹

Alzheimer's Disease: Alzheimer's disease, which afflicts more than six million Americans, is a devastating illness that deprives its victims of their lifelong memories and ultimately destroys their brain function.¹² NIH-funded basic research has revealed how the immune system can contribute to the formation of amyloid plaques in the brains of Alzheimer's patients, causing irreversible neuronal damage. Currently, there are multiple novel vaccine candidates, all currently in different stages of clinical studies, that aim to prevent Alzheimer's disease from ever developing.¹³

IMMUNOLOGY AND OTHER DISEASES, INCLUDING CANCER

While immunology has been in the news because of its extraordinary role in understanding and combatting COVID-19, critically important immunological research continues—and is advancing—in many other areas. Research on the immune system is improving our understanding of how to treat chronic conditions such as multiple sclerosis and cardiovascular disease; how to ensure successful organ or tissue transplantation; and how to protect against natural or man-made agents of bioterrorism.

Cancer research is also advancing, as immunologists have been able to effectively leverage the immune system's ability to recognize and eliminate tumor cells into treatments called immunotherapies. Scientists continue to unravel the complicated interaction between immune cells and cancer, with the hope that this will lead to the discovery of effective new cancer treatments. Recently, the Food and Drug Administration (FDA) approved the first KRAS inhibitor (sotorasib) to treat advanced KRAS G12C-mutant non-small cell lung cancer (NSCLC), which accounts for 82 percent of all lung cancer cases.¹⁴ With lung cancer one of the three most common cancers diagnosed in U.S. adults, and with mutations to the KRAS gene one of the most common genetic alterations observed in NSCLC, this approval marks a major breakthrough in oncology.¹⁵

THE ROLE OF A ROBUST NIH IN THE NATION'S BIOMEDICAL RESEARCH ENTERPRISE

The nation's major funding agency for biomedical research, NIH is also a key source of economic activity in every U.S. state and in countries around the world. More than 80 percent of its \$45 billion budget is distributed, following a competitive peer review process, to more than 300,000 researchers at more than 2,500 universities, medical schools, and other research institutions across the Nation,¹⁶ while approximately 10 percent of its budget supports ~6,000 researchers and clinicians who work at NIH facilities around the country.¹⁷ This funding supports both scientific research and local economies; in 2021, NIH funding supported more than 552,000 jobs and accounted for \$94 billion in economic activity across the U.S.¹⁸ The basic research that NIH funds is also critical to the biomedical research pipeline; it contributed to the discovery of all 210 new drugs that were approved by the FDA from 2010–2016.¹⁹

NIH is the indisputable leader of biomedical research in the world, and its scientists play an indispensable role in responding to both emerging and ongoing health threats. Together with scientists from the CDC and other Federal health and science agencies, NIH scientists have been essential to guiding the Nation through the coronavirus pandemic, in part by providing timely and candid scientific advice to the President, Congress, and the American public.

For many years, strong bipartisan support for biomedical research has led to substantial increases in the NIH budget. Although these increases have largely restored the purchasing power that NIH had lost to inflation and inadequate budgets since 2003, meaningful budget growth is needed to enable NIH to invest not just in im-

¹⁰ <https://www.hhs.gov/opioids/about-the-epidemic/index.html>.

¹¹ <https://heal.nih.gov/news/stories/COVID-vaccine>; <https://www.gao.gov/assets/gao-19-706sp.pdf>.

¹² <https://www.nia.nih.gov/health/alzheimers-disease-fact-sheet>.

¹³ <https://www.beingpatient.com/there-are-9-alzheimers-vaccines-in-trials-right-now/>.

¹⁴ <https://www.cancer.net/cancer-types/lung-cancer-non-small-cell/statistics>.

¹⁵ <https://www.cancer.gov/news-events/cancer-currents-blog/2021/fda-sotorasib-lung-cancer-kras>.

¹⁶ <https://www.nih.gov/about-nih/what-we-do/budget>.

¹⁷ <https://irp.nih.gov/about-us/research-campus-locations>.

¹⁸ https://www.unitedformedicalresearch.org/wp-content/uploads/2022/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-FY21.pdf.

¹⁹ <https://directorsblog.nih.gov/2018/02/27/basic-research-building-a-firm-foundation-for-bio-medicine/>.

portant research priorities across its Institutes and Centers, but also in its most valuable resource: the research workforce. While NIH should continue to support meritorious senior scientists, it is essential that it have the ability to support a sufficient cadre of trainees and early to mid-career scientists who are able to both address increasingly complex scientific challenges and eventually lead the research enterprise. Congress must, therefore, provide NIH with the resources needed for the training, development, and support of our next generation of researchers, doctors, professors, and inventors—and give them the dynamic research environment they need to pursue these careers.

CONCLUSION

AAI greatly appreciates the subcommittee's strong, continuous, and bipartisan support for NIH and urges an NIH base budget of at least \$49 billion for FY 2023 to help the agency invest in vital immunologic research, support meritorious biomedical scientists at all career stages, and help researchers and doctors discover new ways to prevent, treat, and cure disease. In addition, AAI recommends the appropriation of substantial funding for ARPA-H, which has the potential to greatly advance human immunology in an era of unprecedented scientific opportunity.

[This statement was submitted by Peter E. Jensen, M.D., Chair of the Committee on Public Affairs, American Association of Immunologists.]

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 House Committee on Appropriations, subcommittee on Labor, Health and Human Services, Education, and Related Agencies. We thank Chairman 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.

ACOG commends Congress for making great strides in advancing research and data collection to advance the health of women and families. Looking ahead, we urge you to make funding of the following programs and agencies a priority in FY23:

Title V Maternal and Child Health Block Grant at the Health Resources and Services Administration (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 Special Projects of Regional and National Significance (SPRANS) discretionary grant, the Block Grant supports the Alliance for Innovation on Maternal Health (AIM)—a program that works with States and hospital systems to implement evidence-based toolkits to improve maternal outcomes and reduce rates of maternal mortality and severe morbidity. For FY23, ACOG requests \$15.3 million for SPRANS to support continued implementation of AIM.

HRSA has also invested in the Women's Preventive Services Initiative (WPSI), supporting the WPSI multidisciplinary committee's development of guidelines for preventive services that are specific to women and improve women's health across the lifespan. More than 150 million people with private insurance—including 58 million women and 37 million children—currently can receive preventive services without cost-sharing. Additionally, 20 million Medicaid adult expansion enrollees and 61 million Medicare beneficiaries receive preventive services. ACOG recommends an investment of \$3,000,000 in FY23 to support the ongoing and expanding work of WPSI, to include data collection to gauge performance and progress in implementing preventive services guidelines and assessing utilization across clinical sites.

Safe Motherhood and Infant Health Program; Maternal Mortality Review Committees and Perinatal Quality Collaboratives at Centers for Disease Control and Prevention (CDC):

The United States has the highest rate of maternal mortality and severe morbidity of any developed country. The Safe Motherhood Initiative at CDC works with State health departments to collect information on pregnancy-related deaths, supports maternal mortality review committees, 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 maternal mortality review committee. We must continue to build on this progress and improve maternal health outcomes. ACOG requests that you fund the Safe Motherhood Initiative at \$164 million to help States expand or establish maternal mortality review committees and State-based perinatal quality collaboratives.

Women's Health Research at the National Institutes of Health (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 the Eunice Kennedy Shriver National Institute of Child Health and Human Development (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 its existing initiatives to produce new insights and solutions to benefit women and families. ACOG supports an appropriation of \$49 billion for the NIH in FY23, including \$1.816 billion for NICHD.

Advancing Maternal Therapeutics at the NIH:

Each year, more than 4 million women give birth in the United States 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 Public Law 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 2018, PRGLAC produced a report to the Secretary outlining 15 recommendations to facilitate the inclusion of this population in clinical research, and in 2020 an implementation plan was published. 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 within the Office of Population Affairs (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, particularly as we prepare for the likely event of the U.S. Supreme Court overturning the protections afforded by *Roe v. Wade*. ACOG requests \$512 million for Title X in FY23 to ensure individuals in need have access to evidence-based care. ACOG urges Congress to show its strong support for transparent, respectful, evidence-based, and comprehensive reproductive health care by funding this critical program.

Thank you again for the opportunity to submit our recommendations to the subcommittee, and for your commitment to improving women's health.

[This statement was submitted by Rebecca Lauer, Federal Affairs Manager.]

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) 2023. ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 161,000 internal medicine physicians, 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 FY2023, ACP is urging funding for the following proven programs to receive appropriations from the subcommittee:

—Health Resources Services Administration (HRSA), \$9.8 billion; Health Workforce, National Health Service Corps (NHSC), \$860 million in total program

funding; Primary Care Training and Enhancement (PCTE), \$71 million; Maternal and Child Health, Maternal and Child Health Block Grant, \$1 billion; Title X Family Planning Program, \$400 million;

- Agency for Healthcare Research and Quality (AHRQ), \$500 million;
- Centers for Medicare and Medicaid Services (CMS), Program Operations, Private Health Insurance, \$145.3 million;
- Centers for Disease Control and Prevention (CDC), \$11 billion; Injury Prevention and Control, Firearm Injury and Mortality Prevention Research, \$35 million; Chronic Disease Prevention and Health Promotion, Social Determinants of Health, \$153 million;
- National Institutes of Health (NIH), \$49 billion; Office of the Director, Firearms Research, \$25 million;
- Public Health and Social Services Emergency Fund (PHSSEF), \$3.8 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 17,800 to 48,000 primary care physicians by 2034. Without critical funding for vital workforce programs, this physician shortage will only grow worse. Therefore, we urge the subcommittee to provide \$9.8 billion for HRSA programs for FY2023 to improve the care of medically underserved Americans by strengthening the health workforce. The College urges at least \$860 million in total program funding for the NHSC in 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 FY 2021, with a field strength of almost 20,000 primary care clinicians, NHSC members are providing culturally competent care to a target of almost 20 million patients at over 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. 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 clinicians 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, to expand the pipeline for individuals training in primary care. 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.

Also, within HRSA, ACP supports \$1 billion for the Title V Maternal and Child Health (MCH) Services Block Grants within FY2023 Maternal and Child Health funding. ACP believes that policies—such as MCH Block Grants—must be implemented to address and eliminate disparities in maternal mortality rates among Black, Indigenous, and other women who are at greatest risk. MCH Block grants helped give access to health care and public health services for 60 million people in FY2020. ACP also supports the administration's request for \$400 million for Title X Family Planning in FY2023. The College has extensive policy supporting programs that provide access to essential family planning services, such as Title X. ACP believes that it is essential for women to have access to affordable, comprehensive, nondiscriminatory public or private health care coverage that includes evidence-based care over the course of their lifespans. Accordingly, women should have sufficient access to evidence-based family planning and sexual health information and the full range of medically accepted forms of contraception which can be accessed through Title X Family Planning programs.

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, to help restore the agency to its FY2010 enacted level adjusted for inflation. This amount will allow AHRQ to help clinicians 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 \$145.3 million in discretionary funding within CMS' Program Operations for private health insurance protections and programs. This funding would allow CMS to continue overseeing State-based Marketplaces (SBMs) and operating the Federally-facilitated Marketplaces (FFMs) if a State has declined to establish an exchange that meets Federal requirements. CMS now manages and op-

erates some or all marketplace activities in over 30 States. Specifically, ACP supports the administration's request for \$11.2 million for market oversight and \$134.1 million to operate and administer Federal marketplaces. Without these funds it will be much more difficult for the Federal Government to operate and manage a FFM, 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 \$11 billion overall for this mission, especially considering the ongoing COVID-19 public health emergency (PHE). The College also supports \$35 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 rebuild lost research capacity in this area. ACP greatly appreciates funding for this research in FY2020, FY2021, and FY2022 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 Social Determinants of Health within Chronic Disease Prevention and Health Promotion programs. 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.

The College strongly supports \$49 billion for the NIH in FY2023 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. ACP also supports the administration's request for \$25 million for research related to the prevention of firearms injury and mortality within the NIH Office of the Director.

Lastly, as the Federal Government continues to respond to COVID-19, ACP supports the administration's request of \$3.8 billion for the PHSSEF in FY2023 to fund programs such as the Strategic National Stockpile and the Biomedical Advanced Research and Development Authority. The PHSSEF must be funded adequately enough to maintain a robust pandemic response, especially when emergency supplemental funds are no longer available.

The College greatly appreciates the support of the subcommittee on these issues and looks forward to working with Congress during the FY2023 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 84,000 members of the American College of Surgeons (ACS), thank you for the opportunity to submit written testimony addressing fiscal year (FY) 2023 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 2023:

Fully Fund the 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). The MISSION ZERO Act acts upon 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.

ACS thanks Congress for providing \$2 million in funding for the program in FY 22. However, ACS strongly encourages Congress to fully fund the Military and Civilian Partnership for the Trauma Readiness Grant Program at the authorized amount of \$11.5 million for FY 2023. Building on previous funding will allow for implementation of military-civilian trauma partnerships, 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.

Cancer Prevention Research

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 2023.

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 \$49.048 billion including \$7.776 billion for the National Cancer Institute (NCI). The ACS also urges the inclusion of \$462.6 million for cancer programs at the Centers for Disease Control and Prevention (CDC), including \$30 million for the National Comprehensive Cancer Control Program, and \$61.4 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 45,000 firearm-related fatalities in 2020, a measured increase over previous years. ACS believes that the number of firearm-related fatalities can be reduced through federally funded public health research into firearm morbidity and mortality. 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. ACS supports a total of \$60 million-\$35 million for the U.S. Centers for Disease Control and Prevention (CDC) and \$25 million for the National Institutes of Health (NIH) to conduct public health research into firearm morbidity and mortality prevention.

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 Senior Congressional Lobbyist, at asuermann@facs.org, if you have any questions or would like additional information.

Sincerely,

[This statement was submitted by Patricia L. Turner, MD, MBA, FACS, Executive Director, American College of Surgeons.]

PREPARED STATEMENT OF THE AMERICAN DENTAL EDUCATION ASSOCIATION

The American Dental Education Association (ADEA) represents all 68 U.S. dental schools; more than 800 dental hygiene, dental therapy and other allied dental programs, as well as advanced dental education programs; over 50 corporate partners; and more than 18,000 individuals. ADEA submits this testimony on the Department of Health and Human Services and the Department of Education budgets for the record and for your consideration as you begin prioritizing fiscal year 2023 (FY23) appropriation requests.

ADEA's 68 U.S. member dental institutions' clinics and extramural dental school facilities provide dental care to more than 2.7 million patients annually. America's dental schools are one of the nation's largest dental care safety nets, providing more than \$74 million in uncompensated health care annually to the uninsured and underinsured.

According to the Health Resources and Services Administration (HRSA), 67 million Americans live in one of the 6,946 dental care Health Professional Shortage Areas (HPSAs). To close this gap, HRSA estimates that over 11,567 new practitioners are needed. When you consider there are slightly more than 201,000 practicing dentists in the United States and more than 72,500 of them are over age 50, and that U.S. dental schools graduate about 6,300 students per year, it is clear that additional work needs to be done to ensure all citizens have access to culturally competent, comprehensive and quality oral health care.

For dental students, the patient care experience begins in dental clinics, which are in all dental schools. These clinics must include most of the major service areas of a hospital and adhere to the rigorous guidelines that protect the health and safety of the public, much like hospitals do. Dental schools operate full clinical facilities with all the necessary treatment rooms and surgical suites, including areas for sterilization, diagnostic services such as radiology and pathology, and business operations. In contrast, medical schools conduct the majority of their clinical teaching and training in separate hospitals or affiliated academic medical centers and are not required to adhere to the stringent protective guidelines in their education buildings that are in place at dental school clinics.

Many dental schools are part of the same campuses as the medical schools, which are often in underserved communities. Dental schools also exist within minority-serving institutions. Dental schools are part of their local communities' health care safety net and have been a previously untapped health care resource, as demonstrated during the COVID-19 pandemic, and will be again in future pandemics. Dental school clinics serve the same geographic patient populations as their medical colleagues, providing care at reduced rates. A large number of the individuals who receive dental care in dental school clinics are members of underserved populations and do not have private insurance or the ability to pay private practice fees.

As you deliberate funding for FY23, ADEA respectfully urges your support for the following funding requests.

\$46 million: Oral Health Training Programs

The dental programs in Title VII provide critical education for predoctoral dental, dental hygiene and dental therapy students and training for post-doctoral advanced dental education residents in general, pediatric and public health dentistry. Support for these programs will help ensure an adequately prepared and culturally competent dental workforce. The program also expands access to care for underserved areas in community-based settings located in HPSAs.

HRSA programs address the dental school faculty shortage with Dental Faculty Development and Dental Faculty Loan Repayment Program grants to those who teach pediatric, general or public health dentistry and dental hygiene. Currently, more than 200 open, budgeted faculty positions exist in dental schools. The Primary Care Dental Faculty Development Program assists schools with recruiting and retaining both full-time and part-time faculty and community-based faculty to develop/enhance training focused on improving care for vulnerable and underserved populations.

Increased support is needed for the Oral Health Training Programs so the Federal Government can continue to assist in educating and training oral health professionals in areas where access to quality care is difficult. The positive impact of these programs is clear. In academic year 2020-21, 9,562 dental and dental hygiene students were educated in predoctoral degree programs, 736 dental residents and fellows in primary care dental residency and fellowship programs received post-doctoral training in advanced care, and 847 dental faculty members participated in faculty development activities and programs. Of the dental residents and fellows, 89 percent received training on COVID-19 and 79 percent received training on health

equity or the social determinants of health. Awardees were offered experience and training opportunities at 483 sites. Over 60 percent of these sites were in medically underserved communities and over 60 percent were in primary care settings. Almost 40 percent of the sites offered COVID-19-related services, demonstrating oral health professionals' ability to provide such care.

In addition to the Oral Health Training Programs, other Title VII programs play a key role in furthering the ability of the health professions workforce to respond to the changing makeup of those who need care. The Diversity and Student Aid programs play a critical role in ensuring the future health professions workforce reflects the Nation's changing demographics. These programs must receive adequate funding to sustain the progress necessary to meet the challenges of an increasingly diverse U.S. population.

The Health Careers Opportunity Program (HCOP) provides a vital source of support for dental professionals serving underserved and disadvantaged patients by providing a career pathway for individuals from these populations. This unique workforce program encourages young people from diverse and disadvantaged backgrounds to explore careers in health care generally, and dentistry specifically. One criticism often heard is that budget analysts do not know if the program is impactful. That is simply because the participants are not tracked to see what their future career path becomes. The success of the following career pathway program demonstrates that these programs can be effective.

ADEA and the Association of American Medical Colleges, through funding from the Robert Wood Johnson Foundation, operate a complimentary program, the Summer Health Professions Education Program (SHPEP). SHPEP is a six-week academic enrichment program for rising college sophomores and juniors from historically underrepresented racial and ethnic (HURE) populations who are interested in the health professions. A study of participants from 2006 to 2015 found that 65 percent of those who participated in the program's dental portion applied to dental school and, as of 2015, 589 graduated from dental school. These pathway programs are effective in attracting HURE individuals. ADEA requests that funding for HCOP be continued and we encourage the greatest possible support for the HCOP program.

The Area Health Education Centers (AHEC) program enhances high-quality, culturally competent care in community-based interprofessional clinical training settings. The infrastructure development grants, and point-of-service maintenance and expansion grants, ensure that patients from underserved populations receive quality care and health professionals receive experience working with diverse populations. ADEA strongly encourages the Committee to continue funding the vitally important AHEC program.

\$540 million: National Institute of Dental and Craniofacial Research

Dental research serves as the foundation of the dental professions. Discoveries stemming from dental research have reduced the burden of oral diseases, led to better dental health for millions of Americans, and uncovered important links between oral and systemic health. ADEA and dental school researchers are grateful for the increase NIDCR received in FY22; however, we note that NIDCR continues to have the smallest budget of all the Institutes, while evidence of the link between oral health and overall systemic health continues to grow.

The requested increase for FY23 will not bring us to parity, but it will bring us closer and provide the stable and consistent growth in research sought by former NIH Director Dr. Francis Collins, and shared by the NIH Acting Director, Dr. Lawrence Tabak, who is a dentist, dental educator and researcher, and former NIDCR Director. Through NIDCR grants, dental researchers in academic dental institutions have enhanced the quality of the Nation's dental and overall health. Dental researchers are poised to make dramatic breakthroughs, such as restoring natural form and function to the mouth and face as a result of disease, accident, or injury; and diagnosing systemic disease (such as HIV and certain types of cancer) from saliva instead of blood and urine samples. These breakthroughs, and countless others that bolster America's role as a global scientific leader, require adequate funding.

\$35 million: Centers for Disease Control and Prevention (CDC) Division of Oral Health

The CDC Division of Oral Health expands the coverage of effective prevention programs. The division increases the basic capacity of state oral health programs to accurately assess the needs of the state, organize and evaluate prevention programs, develop coalitions, address oral health in State health plans, and effectively allocate resources to the programs. This strong public health response is needed to meet the challenges of dental disease affecting children and vulnerable populations.

The current path of decreased funding will have a significant negative effect on the overall health and preparedness of the Nation's States and communities.

\$18 million: Ryan White HIV/AIDS Treatment and Modernization Act, Part F: Dental Reimbursement Program (DRP) and Community-Based Dental Partnerships Program

Patients with compromised immune systems are more prone to oral infections, such as periodontal (gum) disease and caries (tooth decay). The DRP is a federal/institutional partnership that provides partial reimbursement to academic dental institutions for costs incurred from providing dental care to people living with HIV/AIDS. Simultaneously, the program provides educational and training opportunities to dental students, residents and allied dental students. However, DRP reimbursement only averages 26 percent of the dental schools' unreimbursed costs. The current reimbursement rate is unsustainable long term. Adequate funding of the Ryan White Part F programs will help ensure that people living with HIV/AIDS receive necessary dental care.

ADEA thanks you for your consideration of these funding requests and looks forward to working with you to ensure the continuation of these critical programs and improve the oral and systemic health and well-being of the Nation. Please consider ADEA a resource on any matter under your purview pertaining to academic dentistry and education of the dental workforce.

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 at least \$815 million for fiscal year 2023, aligned with the request from the Friends of IES coalition, for which we are a leading member. In addition, AERA recommends \$49 billion in base funding for the National Institutes of Health (NIH) in fiscal year 2023. Within NIH, we recommend proportional increases for important research supported by 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.

INSTITUTE OF EDUCATION SCIENCES

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.

Our members, as well as State and Federal policymakers and practitioners, rely on IES to provide reliable education statistics, support research to improve academic and non-academic outcomes, and develop evidence-based practices to inform instruction and support student learning at all educational levels into the workforce. We appreciate the increases to IES appropriations over the past few fiscal years, which has helped support unanticipated costs for the National Assessment of Educational Progress (NAEP) in the delay in administering the 4th and 8th grade reading and math assessments due to the COVID-19 pandemic. We are also thankful for the inclusion of a specific line item within IES for program administration in the fiscal year 2022 omnibus appropriations legislation. This allocation is an important step in providing additional flexibility and resources for IES to hire staff. Program officers and statistical staff are critical to carrying out IES's mission, and particularly for the National Center for Education Statistics (NCES), which has seen the attrition of 23 staff positions since fiscal year 2015.

Since IES was created in 2002, it has made scientifically-based contributions to the progress of education that are used in classrooms across the country. For example, research findings supported by the National Center for Special Education Research (NCSE) have informed supports for implementing positive behavior interventions and supports, including Team-Initiated Problem Solving, used in over 1,000 schools. Recent work supported by the National Center for Education Research

(NCER) has led to the development of measurements of reading used in schools across the Nation, including the Lexia(r) RAPID(tm) Assessment program, Capti Assess with ETS(r) ReadBasix(tm), and the Phonological Awareness Literacy Screening in Spanish (PALS español). Innovations in NAEP have led to the examination of process data to better understand how students arrive at responding to assessment questions, with implications for future test item development.

Throughout the pandemic, IES has served as an important resource in providing information about distance learning; pursuing interventions to address socioemotional needs; and collecting data from schools on learning modes, school staffing, and COVID-19 mitigation strategies through the School Pulse Panel. The increased demand for evidence-based programs since the onset of COVID-19 and the need to address persistent and exacerbated learning gaps only further speak to the priority importance of supporting education research and statistics at IES to inform policy and practice.

We were pleased to see IES enlist the National Academies of Science, Engineering, and Medicine (NASEM) to conduct three studies to inform future directions for IES assessment, research, and statistical activities. The Future of Education Research at IES report included several recommendations to build on the current strengths of the research and training programs within NCER and NCSE. These recommendations called on IES to advance heterogeneity and knowledge mobilization as project types, fund additional mixed-methods and qualitative research, support research focusing on teacher- and system-level outcomes alongside student outcomes, and collect data on and measure impact of NCER and NCSE training programs.

As one overarching recommendation, the NASEM committee called upon Congress to reexamine the IES budget in light of comparative funding for other Federal research agencies with purposes no more salient than that of IES. We encourage the subcommittee to provide additional resources in the Research, Development, and Dissemination and Research in Special Education line items for IES to expand support for these emerging priorities and foundational research areas.

The Statistics line item supports NCES administrative data collections and longitudinal surveys, as well as participation by our Nation's students in important international assessments such as the Programme for International Student Assessment. Data from NCES, including from the Integrated Postsecondary Education Data System and the National Teacher and Principal Survey, are frequently cited and used to describe the condition of education in the United States. NCES also has an essential leadership role in implementing the Foundations of Evidence-based Policymaking Act, which directs Federal agencies to leverage data and evaluations to inform policy decisions.

Despite NCES' significant roles in producing, disseminating, and using these important education indicators, funding for NCES statistical activities remains below fiscal Year 2016 levels. In A Vision and Roadmap for Education Statistics, the NASEM committee that examined NCES statistical work referenced the limited capacity that NCES has in both funding and staff. Additional resources are essential to carry out several of the report's key recommendations, including developing a strategic plan, broadening outreach to data users to gather feedback on their needs, and establishing a joint statistical research program in partnership with IES. We strongly recommend providing sufficient funding for the Statistics line that would address the 15 percent loss of purchasing power for this account over the past decade and increase the capacity of NCES to conduct these activities.

Alongside the important survey work NCES supports, 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. The most recent SLDS grants are also providing States the opportunity to partner in the development of meaningful measures—in this case, to pilot an NCES-developed indicator to measure poverty using school geocoded addresses as an alternative to using free-and-reduced lunch eligibility. States participating in this pilot have provided feedback on this NCES initiative and have also noted strengthened data capacity and integrity within their data systems as a result.

To date, NCES has been unable to meet the State demand for SLDS grants. For the fiscal year 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 fiscal year 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. Inadequacies in funding reduce the vitality of this Federal-State partnership to support evidence-based policy work within and across States.

In A Vision and Roadmap for Education Statistics, the NASEM committee recommended that NCES strengthen State capacity to link data, adopt shared data standards, and provide actionable information to State and local education agencies to help improve student learning outcomes. Additional funding for SLDS would help enhance NCES technical assistance and ongoing efforts to promote best practices for State data governance structures and data interoperability, including through the voluntary Common Education Data Standards.

In sum, sustained, robust investment in the education research and statistical infrastructure at IES is necessary to support the success of our Nation's students, teachers, and education leaders.

NATIONAL INSTITUTES OF HEALTH

AERA recommends \$49 billion for the National Institutes of Health (NIH) in fiscal year 2023 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. Providing \$1.816 billion for NICHD in fiscal year 2023 will allow the institute to expand research to increase understanding of how best to support executive functioning, support additional research on early language and motor development, 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 in terms of prevention, intervention, and the health-risk consequences of a lack of or limited educational exposure. We recommend no less than the fiscal year 2022 funding level for OBSSR, including a proportionate increase in its fiscal Year 2023 budget as provided to the NIH.

Thank you for the opportunity to submit written testimony in support of at least \$815 million for IES and \$49 billion in base level funding for NIH in fiscal year 2023. 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 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. The AGS believes in a just society—one where we all are supported by and able to contribute to communities and where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. As the subcommittee works on its fiscal year (FY) 2023 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 2023:

—At least \$82 million to support the GWEP and GACA program (PHS Act Title VII, Sections 750 and 753(a))

—At least \$49 billion, an increase of no less than \$4.1 billion over the enacted FY 2022 level, in the FY 2023 budget for total spending at NIH for current institutes and operations; a minimum increase of \$60 million for the Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative; and a minimum increase of \$226 million for research on Alzheimer's disease and related dementias over the enacted FY 2022 level in the FY 2023 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 nearly double from 52.4 million today¹ to more than 94 million by 2060, while those 85 and older is projected to almost triple from 6.6 million today to 19 million by 2060.² 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.

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 \$82 million)

Our healthcare workforce receives little, if any, training in geriatric principles,³ which leaves us ill-prepared to care for older Americans as health needs evolve. 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 2022 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 the caregiving workforce and 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 3-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. Additional funding would allow 80 GWEPs at \$950,000 per program, enabling every State to have a GWEP and ensure that more rural and underserved areas of the country can have access to geriatrics training and expertise.

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 op-

¹U.S. Census Bureau. 2020 American Community Survey 5-Year Estimates Subject Tables. Published 2020. Accessed April 25, 2022. <https://data.census.gov/cedsci/table?t=Populations%20and%20People&tid=ACST5Y2020.S0101>.

²U.S. Census Bureau. An Aging Nation: Projected Number of Children and Older Adults. Updated October 8, 2019. Accessed April 25, 2022. <https://www.census.gov/library/visualizations/2018/comm/historic-first.html>.

³Only 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.

portunity indicating their intention to fund 26 GACAs for 4 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. Additional funding would allow 60 GACAs at \$100,000 per award, ensuring we have a larger and more geographically diverse pipeline of geriatrics research and training expertise with the incentives and resources needed to grow the field.

GWEPs and GACAs have been successfully leading and preparing the healthcare workforce, caregivers, and their communities, and most recently on the frontline throughout the COVID-19 pandemic, including working with health systems to participate in the outreach to vulnerable and hard-to-reach populations, preventing widening the health disparity gap exacerbated by the pandemic. These programs are 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 2023 appropriation of at least \$82 million for the GWEP and GACA program. This increase in funding over FY 2022 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. Given the increasing diversity among older people⁴ and rapid growth of the older population,⁵ the need for a diverse workforce as well as training in geriatrics and gerontology will continue to increase. The infrastructure of care 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 \$60 million for the Brain Research Through Advancing Innovative Neurotechnologies Initiative and a minimum increase of \$226 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 \$60 million in the FY 2023 budget for the BRAIN Initiative and a minimum increase of \$226 million for research on Alzheimer's disease and related dementias over the enacted FY 2022 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.⁶ Further, chronic diseases related to aging, such as diabetes, heart disease, and cancer continue to afflict 80 percent of people age 65 and older.⁷ Forty percent of Medicare beneficiaries have four or more chronic conditions and account for 78

⁴ Matthews KA, Xu W, Gaglioti AH, et al. Racial and Ethnic Estimates of Alzheimer's Disease and Related Dementias in the United States (2015–2060) in Adults Aged ≥65 Years. *Alzheimers Dement*. 2019;15(1):17–24. doi:10.1016/j.jalz.2018.06.3063.

⁵ U.S. Census Bureau. An Aging Nation: Projected Number of Children and Older Adults. Updated October 8, 2019. Accessed April 25, 2022. <https://www.census.gov/library/visualizations/2018/comm/historic-first.html>.

⁶ Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. *Alzheimers Dement*. 2021;17(3):327–406. doi:10.1002/alz.12328.

⁷ National Prevention Council. Healthy Aging in Action: Advancing the National Prevention Strategy. Published November 2016. Accessed April 25, 2022. <https://www.cdc.gov/aging/pdf/healthy-aging-in-action508.pdf>.

percent of Medicare expenditures.⁸ 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 at least \$49 billion, no less than a \$4.1 billion increase over the enacted FY 2022 level, in the FY 2023 budget for total spending at NIH for current institutes and operations. We also urge you to ensure that any funding for the Advanced Research Projects Agency for Health (ARPA-H) supplement, not supplant, the total \$49 billion base budget recommendation. 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, as President of the American Heart Association, I would like to submit my written testimony on behalf of our 40 million volunteers and supporters. My name is Dr. Donald Lloyd-Jones, and as the President of the American Heart Association, I serve as the chief volunteer scientific and medical officer, responsible for the oversight of all medical, scientific, and public health matters, and those related to public policy. I am also the Chair of the Department of Preventive Medicine, the Eileen M. Foell Professor of Heart Research, and Professor of Preventive Medicine, Medicine, and Pediatrics at Northwestern University's Feinberg School of Medicine in Chicago.

As an epidemiologist and board-certified practicing cardiologist for more than 23 years, I understand firsthand the burden of cardiovascular disease. I have a broad and deep understanding of what individuals and families need to promote health, prevent disease, cure illness, and manage chronic health conditions. As a volunteer with the American Heart Association for more than 24 years, I have been proud to advance the organization's mission to be a relentless force for a world of longer, healthier lives for all. I am also proud to represent the American Heart Association as a major advocate for population health at the Federal, State, and local levels, as a supporter of healthy communities, and as a champion for health equity.

The American Heart Association is the largest nonprofit funding source for cardiovascular and cerebrovascular disease research, next to the Federal Government. We have funded 14 Nobel Prize winners and several important medical breakthroughs, including techniques and standards for cardiopulmonary resuscitation (CPR), the first artificial heart valve, implantable pacemakers, cholesterol inhibitors, microsurgery, and drug-coated stents. Of note, the American Heart Association is also the largest and most experienced provider of CPR training-training millions of individuals, first-responders, and health care workers worldwide each year through a vast network of more than 3,500 Authorized Training Centers and more than 400,000 instructors.

As Congress works to draft the Labor, Health and Human Services, Education and Related Agencies (Labor-HHS-ED) appropriations legislation for fiscal year (FY) 2023, the American Heart Association respectfully requests that the subcommittee provide \$25 million over no more than the next five fiscal years to the Centers for Disease Control and Prevention (CDC) Division for Heart Disease and Stroke Prevention to expand an existing, national sudden cardiac registry to capture data from all States, nationwide. Annually, more than 350,000 people fall victim to sudden cardiac arrest outside of a hospital environment. It is the single leading mechanism of death in the US, and yet it is not well recognized as a major public health challenge. When a person experiences a sudden cardiac arrest, seconds count in the response of bystanders and the emergency system to restore a normal heart rhythm and blood pressure. Indeed, these seconds determine the difference between life and death, and the chance for a meaningful neurological recovery. Unfortunately, only about 1 in 10 victims survive a sudden cardiac arrest, and many survivors are left with permanent heart and brain damage.

⁸Centers for Medicare and Medicaid Services. Chronic Conditions Charts: 2018. Published 2018. Accessed April 26, 2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.

During an emergency response to an out-of-hospital cardiac arrest, the victim's chances depend entirely on a team of volunteers and professionals that span laypersons, emergency dispatch, law enforcement, medical first responders, EMS providers, and later hospital-based nurses and physicians. The team must work together to resuscitate the cardiac arrest patient by quickly recognizing the cardiac arrest event, providing early CPR and early defibrillation, delivering expert advanced care, and downstream post-resuscitation critical care and rehabilitation.

Traditionally, these efforts have been well-intentioned but have not leveraged quality improvement strategies that measure care and outcome. Consequently, there is marked disparity across emergency systems with survival varying as much as 10-fold across different communities.¹ The disparity is unacceptable and can be addressed with key programmatic implementation designed to impact local performance. The effective strategy for improvement was detailed in the National Academies of Science publication: *Cardiac Arrest Resuscitation: A Time to Act*.² Since its publication, there has been substantial effort to provide high-traction, accessible resources that can impact resuscitation quality improvement, and in turn, advance public health.

The cornerstone of quality improvement—as highlighted in the National Academies document—is the need for consistent, broadly-accessible, scientifically-informed registry data to measure the care and outcome of cardiac arrest and identify opportunities for programmatic improvement. The Cardiac Arrest Registry to Enhance Survival (CARES) was first established by the CDC in 2004 in collaboration with the Department of Emergency Medicine at the Emory University School of Medicine to meet this need and provide informative, high-fidelity surveillance that can direct quality improvement. CARES is the only national out-of-hospital cardiac arrest (OHCA) registry in the United States and currently includes 31 State-based registries covering 51 percent of the U.S. population and representing more than 2,500 EMS agencies and 2,000 hospitals. To date, CARES has published more than 100 articles in peer-reviewed journals and has supported countless quality improvement efforts in participating communities, resulting in an increase in cardiac arrest survival and a more thorough understanding of OHCA treatment and survival in the field of emergency medicine. CDC's funding for the CARES registry was eliminated in 2012 because of sequestration and other budget cuts. The CARES registry operations have continued in the absence of Federal funding for 10 years through an infusion of private funding each year. This is an unsustainable model for this critically important work. In addition, expansion of the registry to all remaining States and to cover the remaining half of the US population will require Federal support.

The CARES registry allows communities and public health organizations to monitor their quality of care, compare patient populations, measure interventions and outcomes, and ascertain whether resuscitation is provided according to evidence-based guidelines. Without uniform and reliable data collection in every State, communities cannot ascertain the effectiveness of their sudden cardiac arrest response systems, nor can they assess the impact of interventions designed to improve survival rates. In other words, one cannot improve what one does not measure, and every State across the Nation should be collecting these data in a unified, harmonized, and standardized central registry to best serve their communities.

Multiple systems—large and small—now use CARES as they move forward with program improvements. The emergence of CARES corresponds to dynamic programmatic opportunities to improve care for resuscitation. Implementation of these innovative programs to improve early CPR, defibrillation, and advanced treatment can accelerate with the use of CARES to evaluate how local implementation impacts prognosis. Early evaluation of this “measure and improve” quality approach has highlighted some remarkable success, ranging from outcome improvement in rural communities in North Carolina and Washington State to lives saved in urban centers such as Chicago and Detroit.

Now is the time to scale the registry to be an inclusive and truly national initiative that will leverage CARES measurement to achieve wide-ranging “best-practices” implementation that can improve care across emergency systems and in turn benefit community health and save many more lives from sudden cardiac arrest. We thank you for the consideration of our request to include \$25 million for the CDC Division for Heart Disease and Stroke Prevention to enable national access to

¹ Cardiac Arrest Registry to Enhance Survival (CARES), 2020 Annual Report, Page 38, https://mycares.net/sitepages/uploads/2021/2020_flipbook/index.html?page=1.

² Institute of Medicine. 2015. *Strategies to Improve Cardiac Arrest Survival: A Time to Act*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/21723>.

CARES and its consequent strategy to measure and improve resuscitation, address substantial system disparities, and in turn improve the Nation's health.

[This statement was submitted by Donald M. Lloyd-Jones, MD, ScM, FACC, FAHA, President, American Heart Association.]

PREPARED STATEMENT OF THE AMERICAN INDIAN HIGHER EDUCATION CONSORTIUM

On behalf of the Nation's 35 accredited Tribal Colleges and Universities (TCUs), which collectively are the American Indian Higher Education Consortium (AIHEC), we thank you for the opportunity to share our fiscal Year2023 funding requests. The following is a list of recommendations including Department, program, and funding requests.

Department of Education—Office of Postsecondary Education

- Strengthening Tribal Colleges and Universities (HEA Title III-Part A (Sec. 316): \$70,000,000 (discretionary)
- Perkins Career and Technical Education Programs (Sec. 117): \$16,000,000

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: \$10,000,000

Tribal Colleges and Universities: Serving Students Across Indian Country and Rural America

Currently, 35 accredited TCUs operate more than 75 campuses and sites in 15 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 fiscal Year2023 funding requests.

U.S. DEPARTMENT OF EDUCATION

Strengthening Tribal Colleges (HEA Title III—Part A—Section 316): TCUs urge the subcommittee to provide \$70,000,000 for the Strengthening Tribal Colleges and Universities 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 accredited TCUs through two funding sources Part A discretionary funding: FY 23 request \$70 million (FY 2022, \$43.895 million) and Part F mandatory funding (FY 2022, \$28.29 million).

In 2019, TCUs feared losing nearly half of Title III funding when Part F funding temporarily expired. Fortunately, the "Fostering Undergraduate Talent by Unlocking Resources to Education Act (Public Law 116-91) was signed into law on December 20, 2019, permanently authorizing Part F mandatory funding at \$30 million for TCUs. With increased Part A funding, TCUs will be able to expand critical student support programs, meet accreditation requirements, and address ongoing infrastructure needs, which are all essential in supporting institutional development.

Carl D. Perkins Career and Technical Education Programs

Tribally Controlled Postsecondary Career and Technical Institutions: AIHEC requests \$16,000,000 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 Development 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 fiscal Year2020, 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 fiscal year 2023.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families—Office of Head Start: Tribal Colleges and Universities Head Start Partnership Program: AIHEC requests \$10,000,000 for the TCU-Head Start Partnership program. The TCU-Head Start Partnership program was re-established in fiscal Year2020 with \$4,000,000, continued in fiscal Year2021 with \$4,000,000, and increased in fiscal year 2022 with \$6,000,000. TCUs have had demonstrated success in training early childhood educators and Head Start teachers who are urgently needed across Indian Country. In 2021, 71.7 percent of Head Start teachers nationwide held a bachelor’s degree or higher as required by Federal law; but only 42 percent of Head Start teachers met the requirement in Indian Country (Head Start Region 11); only 39 percent of assistant teachers in Region 11 met the associate-level requirements, compared to 76 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 Partnership Program (42 U.S.C. 9843g), which helped TCUs build capacity in Early Childhood Education (ECE) by providing scholarships and stipends for Head Start teachers and assistant teachers to enroll in TCU ECE 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 teachers and assistant teachers. However, recent reports revealed high turnover rates for Head Start workers. Many ECE teachers cited leaving their Head Start positions for higher paying jobs or retirement, due to pandemic-related stress, and other reasons.

In the 18 months since the program was re-established, six TCUs have accomplished incredible success in supporting the early childhood teacher pipeline. Recently, Stone Child College (Box Elder, MT) expanded its Early Childhood Education

program to offer a bachelor's degree, in addition to an associate degree, in response to student requests for in-person classes. Cankdeska Cikana Community College (Fort Totten, ND) offers an ECE associate degree and has an articulation agreement allowing students to transfer into the ECE bachelor's degree program at Mayville State University (Mayville, ND). Many of the current ECE students are full-time Head Start teachers while balancing part-time course work in addition to meeting family responsibilities. Through this program, TCUs are able to provide students with mental and emotional health resources to support and retain these resilient ECE students. Likewise, Navajo Technical University (Crownpoint, NM), Salish Kootenai College (Pablo, MT), Fond Du Lac Tribal and Community College (Cloquet, MN), and White Earth Tribal and Community College (Mahnomen, MN) have developed ECE student support programs to meet similar student needs. However, due to limited funding, only six of the 25 TCUs with ECE programs are funded to provide these transformative opportunities to advance early childhood education careers. With increased funding, TCUs can leverage resources to aid in building an early childhood education workforce to better serve the education needs of AI/AN children.

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 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 2023 appropriations requests. Thank you.

PREPARED STATEMENT OF THE AMERICAN LIBRARY ASSOCIATION

The American Library Association (ALA) urges the subcommittee to include in its Fiscal Year (FY) 2023 appropriations bill at least \$50 million for Innovative Approaches to Literacy (IAL) under the Department of Education (DOE).

As the Nation struggles with the lingering effects of COVID-19, we are beginning to see the troubling consequences on early literacy development. Librarians work heroically to continue needed services for all students and assist classroom teachers and administrators in new and innovative ways. During the pandemic, school librarians continued to support access to education and tutoring sites for homework help. School libraries lent books, eReaders, computers and hotspots to students, many of whom did not have access to these basic services at home. Some libraries are even streaming story times and author visits to encourage young children and their families to keep up reading in their homes.

School library services are in great demand yet face tightening budgets and reduced staff at many schools, which limits their ability to provide literacy training and support.

Innovative Approaches to Literacy is the only Federal program providing dedicated support to school libraries. Authorized in the Every Student Succeeds Act (ESSA), IAL provides competitive awards to school libraries as well as national not-for-profit organizations, including partnerships that reach families outside of local educational agencies (LEAs), to support children and families in high-need, underserved communities. By providing age-appropriate books, supporting parental engagement programs, and reinforcing professional development, the IAL program helps to support literacy skills to ensure that children enter school ready to learn and best positioned for success.

Since its inception in FY 2012, more than 200 IAL grants have been awarded to national non-profit organizations and school districts across every region of the U.S., delivering critical literacy resources in these communities. In light of interrupted learning this past year due to the pandemic, it is even more urgent to support children's literacy at home and in school. This is particularly acute for minority and low-income students. The IAL program is designed to provide the kind of support children and families need. Some examples of IAL grant activities include:

—In 2021, an IAL grant was awarded to Tuscaloosa (AL) City Schools, a midsize urban city school district serving 10,500 K-12 students in 20 locations. This collaborative grant with school libraries will provide a learning environment that is racially, ethnically, culturally, disability status and linguistically responsive. The grant will allow the district to implement the Alabama Literacy Act to improve reading proficiency of public-school kindergarten through grade 3 students. The district will be able to provide early literacy services and distribute

high-quality books on a regular basis to children from low-income communities. Tuscaloosa schools have set goals that include a minimum of 85 percent of librarians will receive literacy training; 100 percent of participating schools will develop, improve, or expand their K–12 literacy plan; a 4 percent increase over baseline; and 100 percent of students will receive personal books and/or access to online books.

—The Yakama Nation Tribal School in Washington state joined community partners to receive an IAL grant in 2021. Their Reading Through Mirrors & Windows IAL grant targets 14 schools with a large percentage of Native American and Hispanic students and will support literacy programs for educators, students, and parents designed to improve literacy skills. The grant will promote book distribution, mobile libraries, out-of-school time literacy activities, reader/writer theaters, and read-a-loud events. The 3-year grant has established laudable goals for the schools to achieve each year.

A strong learning environment begins with literacy skills in early childhood. However, only 35 percent of fourth grade students, 34 percent of eighth grade students, and 37 percent of twelfth grade students performed at or above the proficient level on the 2019 NAEP reading assessment (National Center for Education Statistics, 2019). This was exacerbated during the pandemic by school building closings and remote learning, which challenged students and educators alike. A study by McKinsey & Company found that students taking formative assessments in spring 2021 lost the equivalent of 4 months of learning in reading on average, but the unfinished learning was especially for students of color and those from low-income households. Without immediate and sustained interventions, researchers estimate that pandemic-related unfinished learning could reduce lifetime earnings for K–12 students by an average of \$49,000 to \$61,000.

The American Academy of Pediatrics reports that children introduced to early reading and literacy support tend to read earlier and excel in school compared to children who lack the same access to books and literacy activities. Early literacy mastery is a strong indicator of future success in school and in life. Unfortunately, more than one in three American children start kindergarten without foundational skills to learn to read.

Recent studies and articles demonstrate the challenges facing our youngest students. One article notes that early reading skills in Virginia are at a 20-year low while 60 percent of high-poverty students in Boston are high-risk for reading problems. Goldstein, Dana (2022, March 8) New York Times. Another article reports that more than one in three children who started school during the pandemic need “intensive” reading help. Sparks, Sarah (2022, February 16) Education Week.

Providing books and childhood literacy for such children is crucial to their learning to read, which is crucial to their—and our Nation’s—economic futures. IAL is an important literacy support program that is urgently needed to address reading decline. IAL grants have been awarded during the life of the program to almost every State in the Nation. Schools across the country have received grants, including Dillingham (AK) City School District; Savannah (GA) Chatham City Public School System, Ypsilanti (MI) Community Schools, Cottonwood (OK) School, and as well as many others.

For families living in poverty, access to reading materials is severely limited. Children in such households have fewer books in their homes than their peers, which hinders their ability to prepare for school and to stay on track. IAL helps bridge that gap. Accordingly, we urge the subcommittee to foster this work by continuing to invest at least \$50 million in IAL.

ALA asks for a modest, but critical, Federal investment of \$50 million in the FY 2022 Innovative Approaches to Literacy (IAL) program, authorized under the Every Student Succeeds Act. IAL provides competitive awards to high-need school libraries and national not-for-profit organizations (including partnerships that reach families outside of local educational agencies) to put books into the hands of children and their families.

ALA understands the tight fiscal constraints on the subcommittee, and we appreciate its continued dedicated support of IAL. Thank you for your commitment to sustaining and strengthening our communities and our Nation by supporting America’s school libraries.

- Provide the National Institutes of Health (NIH) with at least \$49. billion and provide individual NIH Institutes and Centers, such as NIDDK, NIMHD, and NCI with proportional discretionary increases.
- Please provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
- Provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion to facilitate timely public health efforts along with proportional increases for CDC Centers and Divisions, such as NCCDPHP and NCHHSTP.
- Please provide \$54.5 million for the Division of Viral Hepatitis at CDC.
- Please provide \$150 million for the Opioid and Infectious Diseases Program at CDC.
- Please provide \$6 million for the Chronic Disease Education and Awareness Program at CDC.
- Provide the Health Resources and Services Administration (HRSA) with a funding level of at least \$9.8 billion and ensure that the agency has sufficient resources to enhance organ donation through awareness activities and partnerships.
- Please support the communities Think Liver, Think Life awareness campaign and include timely committee recommendations prioritizing liver health efforts.

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 CDC and the emerging Chronic Disease Education and Awareness program, provided over recent years. Please maintain this commitment and further enhance support for public health programs as you work with your colleagues on appropriations for FY 2023. Thank you again.

ABOUT THE FOUNDATION

The American Liver Foundation is the Nation's largest non-profit organization focused solely on promoting liver health and disease prevention. The American Liver Foundation achieves its mission in the fight against liver disease by funding scientific research, education for medical professionals, advocacy, information and support programs for patients and their families as well as public awareness campaigns about liver wellness and disease prevention. The mission of the American Liver Foundation is to promote education, advocacy, support services and research for the prevention, treatment and cure of liver disease. Additional information and support can be found at www.liverfoundation.org or by calling 1 800 GO LIVER (800-465-4837)

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. Nearly 100 million people in the U.S. are affected by liver disease. Approximately 30 percent of adults and 3–10 percent 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 and then doubling that support for \$3 million for FY 2022. The first round of funding is now supporting four cooperative agreements in key areas, but 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 var-

ious liver conditions into liver cancer. This new program provides a competitive mechanism that allows CDC to award meritorious cooperative agreements on an annual basis and it is only growing more popular. Since there is tremendous demand in this area, and no shortage of quality opportunities for CDC, we ask that funding be systematically increased again with \$6 million provided for FY 2023.

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-documented 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 percent increase in rates of hepatitis C among 20–29 year olds and a 300 percent increase among 30–39 year olds. The elimination initiative has been well-supported since its establishment, but much more can be done. We ask that this allocation be systematically increased along with the annual funding for the Division of Viral Hepatitis (which saw its first modest funding increase in many years for FY 2022) 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 5 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 10 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 num-

ber of donors. Here, in New York, only 27 percent of people age 18 and over have enrolled in the New York State Donate Life Registry. But every 10 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 2023 APPROPRIATIONS RECOMMENDATIONS

\$11 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 \$6 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 \$40 million for CDC’s National Asthma Control Program (NACP)

\$49 billion for the National Institutes of Health (NIH)

—Provide \$4.015 billion for the National Heart, Lung, and Blood Institute (NHLBI)

—Provide \$932 million for the National Institute of Environmental Health Sciences (NIEHS)

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 Murray, Ranking Member Blunt, 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 FY 2023. The American Lung Association also asks for your leadership in opposing all policy riders that would weaken key lung health protections.

The ongoing COVID–19 pandemic continues to underscore 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, the consequences of the failure to adequately invest in both cross-cutting and individual programs at CDC has become evident. The pandemic has taken the lives of more than one million people in the U.S. and lung disease deaths this past year have increased 80 percent due to COVID–19. We ask that CDC funding be increased to at least \$11 billion for FY 2023. 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 suggests possible links between long-term exposure to air pollution and 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 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 FY23, 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 and biomedical research.

Provide \$11 billion for the Centers for Disease Control and Prevention (CDC): 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 \$11 billion for CDC for FY23 and sustained, robust and predictable funding moving forward annually for both cross-cutting initiatives such as workforce and data modernization, as well as individual lines as outlined below.

Provide \$3.75 billion for National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP): 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 percent 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 3 years (FY23–FY25) to \$3.75 billion. 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 those experiencing the long-term effects of COVID-19, or “long COVID.” 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 \$4 million increase in funding for OSH in FY22 and asks for an additional \$68.5 million for FY23. OSH works with State and local governments to prevent youth tobacco use and to promote evidence-based methods to help smokers quit; for example, OSH's “Tips from Former Smokers” campaign has successfully prompted one million Americans to quit smoking. 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 \$6 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 and unaware of the warning signs that would prompt earlier treatment. 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 fiscal year 2021 and the increase in FY22. In FY23, the Lung Association asks for this program to be increased to \$6 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 stand-alone 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 providing guidance to States in adaptation. The Climate and Health Program includes the Climate Ready States and Cities Initiative (CRSCI) that utilizes a five-step Building Resilience Against Climate Effects (BRACE) program to protect communities. The CRSCI program is a valuable tool for States, localities, Tribes and territories, but it has received insufficient funding. Just recently, funding for a number of States was actually cut. The President's budget requests \$110 million, which would allow CDC to implement a climate and health program across all States and territories.

Provide \$40 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. We thank Congress for the increase in funding of \$500,000 in FY22. Additional funding would allow increased surveillance in States, including where pediatric asthma surveillance is not available. At present, 24 States, Puerto Rico, and Houston, TX, receive funding, and additional entities are funded to collect detailed surveillance data so that public health interventions are more focused and effective. Additional funding of \$40 million in FY23 would also allow for the NACP to continue its efforts to develop public health interventions aimed at protecting people with asthma from wildfire smoke.

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. As the Nation waits to know if COVID-19 vaccines will be made available for children under 5, and if research shows that booster shots for non-immunocompromised adults are a viable way to reduce the effects of COVID-19, it is crucial that national vaccine programs remain prepared and well-funded as we enter the third year of the COVID-19 pandemic. The National Immunization Program must receive strong and sustained funding. The Lung Association asks for \$1.13 billion for NCIRD to enhance COVID-19 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 \$49 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. Although lung cancer remains the leading cause of cancer deaths in the United States, the lung cancer survival rate has increased 33 percent in the past 10 years due to improvements in treatment. It is important that funding for lung cancer research increase concurrently in order to continue to make life-saving advancements in research.

Provide \$4.015 billion for the National Heart, Lung, and Blood Institute (NHLBI): The Lung Association supports increased funding for the National Heart, Lung, and Blood Institute in FY23. NHLBI is a global leader in lung, heart and blood disease research, and invests in prevention programs and new treatments for chronic lung conditions. NHLBI currently conducts research on improving early identification and treatment of COPD, and on new asthma treatments for the half of all severe asthma patients who do not respond to conventional medication. As the COVID-19 pandemic continues, NHLBI research also addresses the uncertainty regarding the long-term impacts of COVID-19 on patients on the heart, lungs and blood. Additional funding of \$4 billion would allow NHLBI to bolster these crucial projects.

Provide \$932 million for the National Institute of Environmental Health Sciences (NIEHS): The Lung Association requests funding of \$932 million for NIEHS. Research at NIEHS studies and identifies links between chronic diseases and patients' environmental surroundings, which is fundamental to treating lung diseases such as asthma and COPD. Patients with asthma can be triggered by extreme weather events such as wildfires, underscoring the importance of research that prepares patients and providers for the health impacts of a changing climate. The Lung Association supports \$100 million for climate change and human health research within NIEHS.

Thank you for your consideration of our recommendations.

[This statement was submitted by Harold P. Wimmer, 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 a Statement to the Senate subcommittee on Labor, Health and Human Services, and Education, and Related Agencies in support of continued robust fund-

ing in the FY 2023 budget for the National Center for Complementary and Integrative Health (NCCIH) within the National Institutes of Health (NIH). We also encourage additional support for the Centers for Medicare and Medicaid Services (CMS) to implement and disseminate the recommendations of the 2019 HHS “Pain Management Task Force (PMTF)”, which include utilization of massage therapy for pain management.

Established in 1943 and numbering over 95,000 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.

The impact of COVID restrictions on patient access to health care for a variety of pain conditions is being felt now throughout the health care system. Opioid and substance abuse rates have increased. While there is no single solution to the opioid crisis, massage therapy demonstrably reduces reliance on opioids to address pain.

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.

As well, massage therapy is specifically supported in the May 2019 final report of the PMTF, and is part of the “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.

We would like to highlight that massage has been specifically noted in guidelines for non pharmacologic opioid alternatives issued by the Attorney General of West Virginia; and, it is among a list of four non-pharmacologic approaches to pain in a September 18, 2017 letter to American’s Health Insurance Plans, signed by 37 Attorneys General, which urges health insurance companies to encourage health care providers to prioritize non-opioid pain management options for chronic pain, as follows:

“When patients seek treatment for any of the myriad conditions that cause chronic pain, doctors should be encouraged to explore and prescribe effective non-opioid alternatives, ranging from non-opioid medications (such as NSAIDs) to physical therapy, acupuncture, massage, and chiropractic care.”

Despite the demonstrated value and efficacy of massage therapy through research, we know that more needs to be done. Research will continue to identify the optimal benefits of massage for particular demographic groups, including patients as young as infants up to Medicare beneficiaries. And, we need to better understand the underlying mechanisms of pain, and how and why pain manifests differently for different patients.

Maintaining a robust Federal research program at NCCIH dedicated to advancing massage therapy is vital, and health care providers need to be aware of the value of massage therapy in order for research findings to be put in action. For this reason, we believe it is critical that NCCIH continue to drive forward the most promising science surrounding massage and other integrative therapies to address both acute and chronic pain conditions. It is equally important that public and provider awareness of the known benefits of massage therapy be optimized, and we encourage additional support by this Committee for CMS to implement and disseminate the PMTF’s report and recommendations.

Thank you again for the opportunity to provide this statement.

PREPARED STATEMENT OF THE AMERICAN PHYSIOLOGICAL SOCIETY

The American Physiological Society (APS) thanks the subcommittee for its ongoing support of the National Institutes of Health (NIH). The sustained budget increases over the past several years have allowed the agency to support biomedical discoveries and innovations that drive the development of the next generation of

therapies. The existing Institutes and Centers at the NIH rely on consistent and steady funding growth to keep pace with the inflation of research costs and it is absolutely essential that the NIH continues to provide robust support for such investigator-driven research. Therefore, the APS urges you to sustain this vital effort by providing the NIH with a base budget of at least \$50 billion in fiscal year (FY) 2023.

While APS supports the goals of the new Advanced Research Project Agency for Health (ARPA-H) (ARPA-H), it is critical that any funding provided for this new program does not come at the expense of the NIH's fundamental research efforts. The ARPA-H budget should therefore be in addition to the \$50 billion base budget.

The NIH is the Nation's largest funder of biomedical research. More than 80 percent of the agency's funding supports extramural research, largely awarded through competitive grants. These grants fuel economic activity and job creation in every State. NIH funding in 2021 supported over 550,000 jobs and generated an estimated \$94 billion in economic activity.¹ The discoveries that emerge from NIH-supported basic and translational research provide the foundation for new drugs and therapies and prepare our Nation to confront challenging public health threats such as obesity and diseases associated with an aging population.

The historically robust support of the NIH and other Federal research agencies by Congress is a primary reason the US is the global leader in biomedical research. However, the rate of growth of Federal funding for research lags behind that of some other countries, including China.² Unless the US prioritizes investments in science, the Nation risks losing its edge in highly competitive technology driven industries.

While the private sector brings the majority of new treatments to the market, it relies on the breakthroughs from federally funded research to identify new targets and strategies to treat diseases. This partnership between industry and academic research has been key for decades of success of the American biomedical industry. A study published in the Proceedings of the National Academy of Sciences found that every single one of the 210 new pharmaceuticals approved by the FDA between 2010 and 2016 depended on research funded by the NIH.³

The NIH has proven its value as an institution over the past several decades. The rapid development of effective and safe COVID-19 vaccines was possible only because of many previous years of fundamental research supported by NIH. Other achievements include improvements in diagnostics, new cancer treatment options, and a better understanding of antibiotic resistance. The NIH also plays an important role in training the next generation of scientists by supporting trainees with individual fellowships and institutional grants as they complete their graduate degrees and seek the post-doctoral training necessary to pursue successful independent research careers.

Our public health system continues to face significant challenges. COVID-19 cases have decreased, but hospitals continue to see new infections. Millions of Americans potentially face long-term health effects due to COVID-19. In addition, our aging population will face increasing rates of conditions such as heart disease, diabetes, arthritis, kidney failure, and cancer. If we are to continue to advance new and innovative ways to address these and other challenges on the horizon—including developing the workforce necessary to do so—the NIH will need stable and predictable funding increases in future years.

The APS joins the Federation of American Societies for Experimental Biology (FASEB) in urging that NIH be provided with no less than \$50 billion in FY 2023, with additional funds for ARPA-H provided in addition to that amount.

Physiology is a broad area of scientific inquiry that focuses on how molecules, cells, tissues and organs function in health and disease. The American Physiological Society connects a global, multidisciplinary community of more than 10,000 biomedical scientists and educators as part of its mission to advance scientific discovery, understand life and improve health. The Society drives collaboration and spotlights scientific discoveries through its 16 scholarly journals and programming that support researchers and educators in their work.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES

The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the United States, with more than

¹ https://www.unitedformedicalresearch.org/wp-content/uploads/2022/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-FY21.pdf.

² <https://ncses.nsf.gov/pubs/nsb20221/executive-summary>.

³ <https://www.pnas.org/doi/10.1073/pnas.1715368115>.

133,000 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 primary 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 fiscal year 2023 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 \$40.048 billion for NIH in fiscal year 2023, an increase of \$4.1 billion (\$3.5 billion or 7.9 percent in NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives) above the fiscal year 2022 funding level. This is a critical year for NIH to expand its support of youth mental health research, including work on the potential harms and benefits of social media. 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. As an association with a longstanding history of devoting attention to and advancing diversity, equity, inclusion, and accessibility related issues, APA strongly believes these factors are critical to advancing biomedical, behavioral, and psychological research supported by the NIH.

APA recommends at least \$815 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. This sum is necessary to fully support the education research and statistical infrastructure essential to education policy and practice.

Finally, APA urges the Committee to provide \$60 million for gun violence research in fiscal year 2023, \$35 million to the CDC and \$25 million to the 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 populations 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) and 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. Recent funding cycles 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 \$30 million for the Graduate Psychology Education Program; \$225.8 million for the Behavioral Health Workforce Education and Training (BHWET) Programs; and \$38 million for the Mental and Substance Use Disorder Workforce Training Demonstration, including the Integrated Substance Use Disorder Program (ISTP). 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 \$25 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 \$1.7 billion for SAMHSA's Community Mental Health Block Grant (MHBG) and \$3 billion for the Substance Abuse Prevention and Treatment (SAPT) Block Grant in fiscal year 2023. APA is also asking the Committee to include a new 10 percent set aside for prevention and early intervention in the MHBG, similar to the SAPT set-aside. This would include growing school-based and community initiatives to address mental health before a person is deemed SED/SMI, which is the current statutory language for using block grant funding.

To address rising suicide rates and ensure proper implementation of 988 as the Nationwide number for the National Suicide Prevention Lifeline network, we urge the Committee to provide \$140 million for the National Suicide Prevention Lifeline, \$560 million for the 988/Lifeline Crisis Call Centers, \$10 million for the Behavioral Health Crisis and 988 Coordinating Office, \$200 million for the 988 Public Awareness Campaign, and \$100 million for the Mental Health Crisis Response Partnership Program. Additionally, we ask the Committee to include \$37 million for the State/Tribal Youth Suicide Prevention Program, \$12 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 and \$244 million for Project AWARE. Additionally, to increase the number of mental health providers working in school settings, APA requests \$1 billion 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 \$16.2 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.

To prevent maternal deaths, eliminate inequities in maternal health outcomes, and improve maternal health, APA urges the committee to prioritize the highest possible funding level for essential public health programs, including the Maternal and Child Health Services Block Grant and Healthy Start at CDC; Safe Motherhood and Infant Health at CDC; and research into pregnancy at NIH. In addition, APA requests \$100 million for maternal mental health equity grant programs.

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 \$27.5 million for MHPAEA enforcement, with 10 percent allocated to the Office of the Solicitor for parity litigation. To support MHPAEA enforcement within HHS, APA requests \$125 million for CMS' Center for Medicaid and CHIP Services (CMCS).

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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 \$12.2 billion for the Head Start Program, \$7.6 billion for the Child Care and Development Block Grant, \$450 million for Preschool Development Grants, and \$500 million for CAPTA Title I to support State child abuse prevention and treatment.

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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 co-morbid conditions.

*Health Resources and Services Administration**Graduate Psychology Education [GPE] Program*

U.S. Department of Health & Human Services Health Resources and Services Administration (HRSA) Interdisciplinary Community-Based Linkages

Mental and Behavioral Health

The Committee recommendation includes \$30 million for the interprofessional Graduate Psychology Education (GPE) Program to increase the number of health service psychologists trained to provide integrated services to high-need, underserved populations in rural and urban communities. The Committee recognizes the severe impact of COVID-19 on Americans' mental and behavioral health and urges HRSA to strengthen investments in the training of health service psychologists to help meet these demands.

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The Committee is encouraged by the work of NIMH to support research on issues related to youth mental health, including among youth of color and underserved LGBTQ+ and those with disabilities, and appreciates NIMH's work on a 10-year strategic plan to eliminate racial mental health disparities. From within the increase of \$—— that the Committee has provided NIMH, the Institute is directed to use \$50 million to lead a multi-institute research collaboration including NICHD and NIMHD to guide preventive measures, targeting of interventions, improved treatments, and long-term recovery. This collaboration should sponsor fundamental and applied research including social, behavioral, cognitive and developmental research, to build resilience, increase our communities' capacity to identify and care for young people at risk and those in crisis, and improve the targeting and delivery of clinical and community-based mental health interventions.

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The Committee is encouraged by the Administration's National COVID-19 Preparedness Plan strong emphasis on COVID-19 health equity and data collection. According to the plan, the Administration will continue to prioritize providing equitable access to COVID-19 health care and public health resources. Central to achieving this goal is continued progress in modernizing national disease surveillance and building the capacity at Centers for Disease Control and Prevention (CDC) and State and local health jurisdictions. The committee asks the Department of Health and Human Services (HHS) to provide a report detailing the CDC's progress toward disaggregating COVID-19 surveillance data by race, ethnicity, geography, disability status, sexual orientation, gender identity and other factors, including mental health conditions and substance use.

[This statement was submitted by Katherine B. McGuire, Chief Advocacy Officer, American Psychological Association Services, Inc.]

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the United States, with more than 133,000 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 primary 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 fiscal Year23 within the U.S. Department of Health and Human Services, U.S. Department of Education, and U.S. Department of Labor.

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FISCAL YEAR 2023 REQUESTED REPORT LANGUAGE

Health Resources and Services Administration

Graduate Psychology Education [GPE] Program

U.S. Department of Health & Human Services Health Resources and Services Administration (HRSA) Interdisciplinary Community-Based Linkages

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[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 \$11 billion for the Centers for Disease Control and Prevention and at least \$9.8 billion for the Health Resources and Services Administration in FY 2023. 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 2023.

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 percent 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 \$11 billion in FY 2023. We are grateful for the important increases provided for CDC programs in FY 2022 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 nearly 11 percent of CDC's budget.

CDC serves as the command center for the Nation's public health defense system against emerging and reemerging infectious diseases as well as man-made and natural disasters. From playing a leading role in aiding in the surveillance, detection and mitigation of the COVID-19 pandemic in the U.S. and globally, to monitoring and investigating other disease outbreaks, to pandemic flu preparedness, CDC is the Nation's—and a global—expert resource and response center, coordinating communications and action and serving as the laboratory reference center. States, communities and international partners rely on CDC for accurate information, direction

and resources to ensure they can prepare, respond and recover from a crisis or disease outbreak.

We strongly support the president's budget request for an additional \$400 million, for a total of \$600 million, in 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 2023 to \$35 million for CDC and \$25 million for NIH, as requested in President Biden's FY 2023 budget proposal. This will allow CDC to continue to support 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 \$401.85 million for NCEH in FY 2023, including \$110 million for CDC's Climate and Health program, as requested in President Biden's FY 2023 budget request. Climate change is threatening 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 2022 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 FY 2022 and provide at least \$9.8 billion for the Health Resources and Services Administration in FY 2023.

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 to build upon these successes and pave the way for new achievements by supporting critical HRSA programs, including:

- Primary Health Care that supports more than 13,500 health center sites which provide high quality primary care services to nearly 29 million people and reduce barriers such as cost, lack of insurance, distance and language for their patients.
- Health Workforce supports the health workforce across the 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 support patient-centered, evidence-based programs that optimize health, minimize disparities and improve health promotion and health care access for medically and economically vulnerable women, infants and children.
- Ryan White HIV/AIDS programs provides medical care and treatment services to over half a million people living with HIV. Ryan White programs effectively engage clients in comprehensive care and treatment, including increasing access to HIV medication, which has resulted in 89.4 percent of clients achieving viral suppression, compared to just 65.5 percent of all people living with HIV nationwide.
- Title X Family Planning program reduces unintended pregnancy rates, limits transmission of sexually transmitted infections and increases early detection of breast and cervical cancer by ensuring access to family planning and related preventive health services to millions of women, men and adolescents.
- 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 over \$18 billion for testing and treatment provided 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 RED CROSS AND THE UNITED NATIONS
FOUNDATION

Chair Patty Murray, Ranking Member Roy Blunt, and Members of the subcommittee, the American Red Cross and the United Nations Foundation appreciate the opportunity to submit testimony. We are grateful for the leadership that Congress has shown in funding CDC global health activities in prior years, and we urge Congress to protect and strengthen funding for the agency's global measles elimination activities for FY 2023 at \$80 million, which is part of CDC's overall Global Immunization Division line.

COVID-19 PANDEMIC AND GLOBAL HEALTH SECURITY

COVID-19 has had an unprecedented impact on global immunization programs. From 2019 to 2020 the number of children receiving a first dose of measles containing vaccine (MCV1) decreased in five out of the six world regions, resulting in an overall drop in the global vaccination coverage rate from 86 percent to 84 percent

over the period. It is estimated that more than 22 million children did not receive MCV1 through routine immunization, the highest increase in missed children since 2000. In addition, at least 93 million individuals did not receive MCV1 because of COVID-19-related postponements of 24 preventative measles vaccination campaigns scheduled during the year.

The pandemic also significantly disrupted measles surveillance and disease reporting. The number of lab specimens for suspected measles cases submitted for testing was the lowest in over a decade. Many countries did not provide reports to WHO and UNICEF on measles incidence, and of those that did report, only 32 percent achieved the measles surveillance sensitivity indicators needed to consistently detect cases and outbreaks. Thus, while available data indicates the number of reported measles cases did not increase over the past 2 years, this is likely due to underreporting that has led to significant surveillance gaps.

These factors paint an alarming picture of a growing immunity gap setting the stage for an increase in measles outbreaks and accompanying loss of life from an easily preventable disease. 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, as well as increasing the likelihood of the virus infecting U.S. communities. Global measles investments through the CDC Global Immunization Division will quickly close these global immunity gaps and strengthen surveillance systems. These investments will also help protect progress over the last decade in reducing maternal and child mortality and morbidity, as well as preserve and enhance the broader global immunization infrastructure. 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 played a pivotal role in saving the lives of 31.7 million children between 2000 and 2020, partnering with the Measles & Rubella Initiative to drive measles deaths down by 94 percent. Measles is a highly contagious disease that can cause blindness, swelling of the brain, and death. Nine out of 10 people who are not immune to measles will contract the disease if they come in contact with a contagious person, and the measles virus can cause long-term damage to the immune system. Every day, roughly 166 children still die of measles-related complications.

The rubella virus is a leading infectious cause of birth defects in the world despite availability of an affordable, effective vaccine since 1969. 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 vaccine 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 due to inadequate resources.

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 were linked to importation of the disease by unvaccinated U.S. residents returning from trips abroad from countries with active outbreaks. Controlling measles and rubella around the world reduces the likelihood of similar disease importations in the future.

Responding to measles outbreaks is resource intensive for health systems. In the U.S. outbreaks are costly for State and local health departments to detect and respond to and have economic productivity costs. In 2019, in response to the measles outbreak in New York City, the NYC Department of Health spent over \$6 million and dedicated more than 500 staff members to halt the spread of the disease which began with a single imported cases from outside the country.

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 over 3 billion individuals in 88 countries since 2001, saving the lives of more than 31.7 million children. In part due to M&RI, global measles mortality has dropped 94 percent, from an estimated 1,072,800 deaths in 2000 to an approximately 60,700 in 2020 (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 95 percent.

Thanks to M&RI leadership, the majority of measles vaccination campaigns have been able to reach more than 90 percent of their target populations with health equity at the forefront to ensure that the most vulnerable children are reached in communities that are underserved and difficult to access. 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 undernourished children; deworming 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, integrated 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, as in a low-income country it costs roughly \$2 to administer the combined measles and rubella vaccine to a child. 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 percent, the required level to establish herd immunity. 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

The CDC plays an essential role 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 is urgently needed to prevent needless childhood deaths around the globe.

In 2020, thanks in part to U.S. funding through CDC, M&RI supported the vaccination of approximately 129 million children in 32 countries. 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.

The CDC Global Immunization Division, through which the M&RI 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. As was seen during the response to COVID-19, resources like the Global Measles and Rubella Laboratory Network can be repurposed to quickly responded other critical health issues. By building the capacity for measles and rubella resources the U.S. is also building capacity for future response efforts.

CONCLUSION

Since fiscal Year2001, 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. U.S. government funding for global measles and rubella efforts, however, has remained level since FY 2010 at \$50 million, which due to inflation has significantly lost purchasing power. Furthermore, 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.

Because of these factors, for fiscal Year2023 the American Red Cross and United Nations Foundation respectfully request an increase of \$30 million to raise funding to \$80 million, as part of the overall funding for the entire Global Immunization Division account in FY 2023. This investment will allow the CDC to help countries to close the immunization gap created by COVID-19, strengthen global disease detection capacity, safeguard the progress made over the last decade to reduce maternal and child mortality, and protect Americans by preventing measles cases and deaths in the U.S. 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 the American National Red Cross and Peter Ye, Senior Vice President United Nations Foundation.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR ENGINEERING EDUCATION

SUMMARY

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) 2022 and asks you to robustly fund student aid, teacher preparation, and STEM programs in FY 2022. Additionally, ASEE requests continued 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 2022 was greatly appreciated and ASEE requests continued support of NIH. In addition, ASEE is excited about the establishment of ARPA-H and its potential to support transformative, high-reward technologies to transform health and medicine.

WRITTEN TESTIMONY

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 and support programs like Pell Grants, Federal Work-Study (FWS), Graduate Assistance in Areas of National Need (GAANN), 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 FY 2023 president's budget request, which proposed doubling the Pell Grant by 2029. ASEE joins the higher education community in requesting funding to support doubling the maximum Pell Grant award to \$13,000. 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 \$1.52 billion and \$1.09 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 also requests funding of \$35 million 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 to pursue graduate education in critical areas of need for the U.S. workforce such as engineering.

7Teacher 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 budget request proposal to invest \$132 million in the Teacher Quality Partnership grant program and \$20 million in the Augustus F. Hawkins Centers of Excellence grant program in fiscal Year2023. Having a well-prepared, diverse K–12 STEM educator workforce is absolutely essential to strengthening and growing the domestic STEM workforce. Furthermore, Congress should consider efforts to support teaching skills for STEM postsecondary faculty and 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 2022. 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 innovation and our economic development and needs to be grown and diversified in the United States. These and other programs targeted towards increasing the representation of historically underrepresented populations, including women, will ensure a healthy STEM workforce pipeline. Furthermore, ASEE supports the Administration's proposal from the fiscal Year2023 budget request to provide a \$282 million increase above fiscal Year2021 enacted levels to enhance institutional capacity at Minority-Serving Institutions and to create a new \$450 million grant program to expand the research capacity of institutions that are historically underrepresented in the research and development enterprise.

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. 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 and engineering technology 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 4-year institutions of higher education, ASEE urges Congress to robustly fund the Perkins Basic State Grant funding program in fiscal Year 2023 and encourage the program to build connections with NSF's ATE program.

National Institutes of Health

The National Institutes of Health are a strong supporter of engineering research through many institutes, especially the National Institute of Biomedical Imaging and Bioengineering (NIBIB), the National Cancer Institute (NCI), the National Institute of General Medical Sciences (NIGMS), and the National Heart, Lung, and Blood Institute (NHLBI). ASEE is grateful to the committee for its strong bipartisan support of the NIH over many years and most recently in FY 2022 appropriations. NIBIB is the major NIH Institute focused on engineering applications to human health and training the next generation of biomedical engineers. 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, diagnosis techniques, 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 \$49.048 billion in base funding FY 2023 so that NIBIB and other NIH institutes can continue to support critical biomedical engineering research and training.

ADVANCED RESEARCH PROJECT AGENCY FOR HEALTH

ASEE is excited about the establishment of the Advanced Research Project Agency for Health (ARPA-H) and believe it will enable new models for disruptive health innovation and enable development of transformative health technologies. ASEE is encouraged by initial planning at the Department of Health and Human Services (HHS) to give ARPA-H independence, ensure it has a unique culture, and focus its efforts on disease-agnostic platform technologies that have high potential across many disease and health areas. Congress should continue to encourage the development of a true risk-taking culture at ARPA-H to enable high reward outcomes. ASEE urges the subcommittee to ensure that any funding provided for ARPA-H supplements, and does not supplant, the NIH's base budget funding. As noted above NIBIB and other NIH institutes continue to support critical research and need robust funding.

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 Adrienne R. Minerick 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 \$49 billion for the National Institutes of Health (NIH) and \$11 billion for the Centers for Disease Control and Prevention (CDC) in fiscal year (FY) 2023. Within the CDC budget, we request \$175 million for the Advanced Molecular Detection (AMD) program in the National Center for Emerging and Zoonotic Infectious Diseases.

CONTINUING TO LEAD 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 Chair Murray, 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 several years, during which they and their House 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 percent 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 antimicrobial 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 had to be restarted, animal colonies repopulated, and fieldwork rescheduled. While our Nation's research capacity has demonstrated it can absorb shocks, the scale of this one was unprecedented in duration and impact. We must continue to nurture the research pipeline and workforce of tomorrow through sustained support for NIH and the training it provides to the next generation of scientists.

CDC'S INDISPENSABLE ROLE IN PREVENTING AND CONTROLLING INFECTIOUS DISEASE

The programs and activities supported by CDC are instrumental in protecting the health of the American people. ASM appreciates the extraordinary emergency funding provided to the agency in FY 2021 and FY 2022 to meet the needs presented by the pandemic. However, had Congress provided necessary support for CDC and public health infrastructure 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 2023, 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 SARS-CoV-2, to foodborne illness, 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, state/local public health agencies and commercial entities. ASM requests \$175 million for AMD in FY 2023.

—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 \$397 million, the National Healthcare Safety Network at \$100 million, and the Division of Global Health Protection at \$842.8 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, Chief Advocacy Officer, American Society for Microbiology.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

Dear Chairwoman Murray and Ranking Member Blunt:

Thank you for the opportunity to provide testimony regarding Fiscal Year (FY) 2023 appropriations. The American Society for Nutrition (ASN) respectfully requests at least \$49.048 billion dollars for the National Institutes of Health (NIH) and \$210 million dollars for the Centers for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS) in FY 2023. 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 in nutrition and obesity research in FY 2021. Although nutrition and obesity research make up only about 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. Nevertheless, healthcare costs and risk factors for diet-related diseases remain high. In fact, from 2019 to 2020, age-adjusted death rates rose 4.1 percent for heart disease, 4.9 percent for stroke, 8.7 percent for Alzheimer disease, and 14.8 percent for diabetes.¹ With additional support for NIH, additional breakthroughs and discoveries to improve the health of all Americans and reduce the economic burden of diet-related diseases 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 \$49.048 billion dollars for the NIH base budget in FY 2023 to support NIH nutrition-related research that will lead to important disease prevention and cures. This represents an increase of \$4.1 billion over the comparable FY 2022 funding level (an increase of \$3.5 billion or 7.9 percent in the NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives). ASN requests that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) supplement our \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH.

A budget of \$49 billion will allow NIH to provide adequate support for the 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. ASN strongly supports the President's budget proposal of \$97 million for the NIH Office of Nutrition Research to advance nutrition science. This is an increase of \$96 million above FY 2022 enacted to promote health and reduce the burden of diet-related diseases. By centrally coordinating implementation of the Strategic Plan for NIH Nutrition Research, the Office of Nutrition Research can support cross-cutting NIH nutrition research developed in collaboration with Institutes and Centers that already fund nutrition research. Increased support for nutrition research will provide solutions ensuring nutrition security and access to healthy food to prevent diet-related health disparities and promote health equity for a variety of diet-related diseases and conditions, such as cardiovascular disease, obesity, diabetes, and cancer. The complexity of human nutrition demands that cutting edge data science and system science methods be employed to move this field forward. Funds will support new training programs in Artificial Intelligence for Precision Nutrition that will focus on integration of related domains, including machine learning, systems biology, systems science, Big Data, and computational analytics to tackle complex biomedical challenges in nutrition science. 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 FY 2023 funding level of \$210 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 but more than a decade of flat funding has taken a significant toll on

¹ <https://www.cdc.gov/nchs/products/databriefs/db427.htm>.

NCHS's ability to keep pace. \$210 million reflects an increase to NCHS's base budget of \$30 million from its FY 2022 appropriation, reversing a decade of sequestration and restoring the program to its FY 2010 funding level, adjusted for inflation.

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. The U.S. Department of Agriculture uses this data to develop nutrition policies that guide multibillion dollar Federal food assistance programs, and nutrition researchers use this valuable data as well.

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 underrepresented 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 2023 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.

Sincerely,

[This statement was submitted by Paul M. Coates, Ph.D., 2021–2022 President, American Society for Nutrition.]

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF HEMATOLOGY

The American Society of Hematology (ASH) represents more than 18,000 clinicians and scientists committed to the study and treatment of blood and blood-related diseases, including malignant disorders such as leukemia, lymphoma, and myeloma, as well as non-malignant conditions such as sickle cell disease (SCD), thalassemia, bone marrow failure, venous thromboembolism, and hemophilia.

NATIONAL INSTITUTES OF HEALTH (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 field of hematology continues to make great strides in conquering blood diseases thanks to novel technologies, mechanistic insights, and cutting-edge therapeutic strategies. Groundbreaking scientific research highlighted at the December 2021 ASH Annual Meeting and Exposition, much of which was either funded by NIH or derived from NIH-funded research, presented information on advances in gene therapy, practice-changing discoveries in immunotherapies, and advances in patient care for a wide range of hematologic diseases and conditions. Moreover, the Society's regularly updated ASH Agenda for Hematology Research 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, extraordinary research that has occurred over the past 2 years to identify and develop 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 significant hematologic complications from COVID-19 infection, ASH developed the ASH 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. The questions outlined in the document identify significant questions about the biology, pathophysiology, and underlying clinical implications of COVID-19 as they relate to hematology science and clinical care and are meant to inspire research that leads to enhanced understanding of the disease process, decreased hematologic complications in COVID-19, and improved care of patients with hematologic disease. The original document outlined hematology-related basic science and clinical research questions that emerged in the first few months of the pandemic; the research agenda continues to be updated as our understanding of the natural history and treatment of COVID-19 improves.

ASH thanks Congress for the robust bipartisan support that has resulted in seven consecutive years of welcome and much needed funding increases for NIH. For fiscal year (FY) 2023, 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 \$49.048 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. ASH also joins the community in strongly urging lawmakers to ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) supplement the \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH. In addition, ASH supports the Administration's proposal to supplement NIH's budget with additional mandatory funding to speed the pace of pandemic response and readiness.

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 (Public Law 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 11 States participate in the data collection program, with data being collected from multiple sources (e.g., newborn screening programs and Medicaid) in order to create individual health care utilization profiles. Funding through the CDC Foundation has allowed Georgia and California to collect data since 2015; additional CDC Foundation funding, along with discretionary fund-

ing from CDC and the Department of Health and Human Services (HHS) and \$2 million in funding provided by Congress in fiscal Year2021 has allowed nine additional States (Alabama, Colorado, Indiana, Michigan, Minnesota, North Carolina, Tennessee, Virginia, and Wisconsin) to begin their data collection programs. These 11 States are estimated to include just over 35 percent of the U.S. SCD population.

ASH thanks Congress for the \$3 million provided for the data collection program in fiscal Year2022. This funding will allow CDC to continue to support data collection efforts in all of the States currently participating in the program. ASH also appreciates the Administration's request for \$4.5 million in funding for the program in fiscal Year2023. However, the Society strongly supports providing CDC with at least \$10 million in FY 2023 for the Sickle Cell Data Collection program. This additional funding is necessary to allow the program to continue in the States currently participating in the programs and to also expand the programs to include additional States with the goal of covering the majority of the U.S. SCD population over the next 5 years.

To further support CDC's sickle cell data collection efforts, ASH urges the inclusion of the following report language under CDC's National Center on Birth Defects and Developmental Disabilities (NCBDDD):

—Public Health Approach to Blood Disorders/Sickle Cell Disease

The Committee includes \$10,000,000 for the Sickle Cell Data Collection program to allow for data collection and analysis in States currently participating in the program and to allow for expansion to additional States. The Committee encourages CDC to provide technical assistance to additional States with a higher prevalence of SCD, so that they can successfully participate in this grant program to better identify affected individuals in their States and better meet their needs.

Additionally, ASH supports the public health community's request for at least \$11 billion in overall funding for the CDC in FY 2023. Strong funding for CDC is critical to supporting all of CDC's activities and programs, which are essential to protect the health of our communities. In addition to ensuring a strong public health infrastructure and protecting our communities from public health threats and emergencies, CDC programs are crucial to reducing health care costs and improving health. However, due to years of underfunding, many CDC programs have not received the resources that are needed to address the many health challenges we face as a nation. A funding level of at least \$11 billion would build upon the funding increase Congress provided CDC in FY 2022 and strengthen all of CDC's programs.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

ASH supports funding for the SCD programs within HRSA's Maternal and Child Health Bureau, including \$9,205 million for the SCD Treatment Demonstration Program (SCDTDP) and at least \$6 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 2023 appropriations bill recognizing the importance of the Sickle Cell Disease Treatment Demonstration Program in supporting the growth of comprehensive sickle cell disease centers:

—Sickle Cell Disease Treatment Demonstration Program

The Committee includes \$9,205,000 for this program, a \$2,000,000 increase above the FY 2022 enacted level. The Committee recognizes the importance of the program in supporting the comprehensive sickle cell disease (SCD) centers in the provision of coordinated, comprehensive, culturally competent, and family-centered care to people with SCD. The Committee affirms the goals of the program to improve care delivery and access to high quality care for people with SCD, with a focus on increasing access to SCD specialists; increase the number of providers with SCD expertise and knowledge of SCD treatment methods; and enable access to the latest treatment options following evidence-based guidelines

Finally, ASH joins many others in the physician community in supporting funding for HRSA's Preventing Burnout in the Health Workforce program. Health care professionals have long experienced high levels of stress and burnout, and our members have shared that COVID-19 has only exacerbated the problem. Burnout has been shown to reduce job performance, increase turnover, and, in its most extreme instances, lead to mental health issues. This important program, established by the American Rescue Plan Act and modeled after provisions in the Dr. Lorna Breen

Health Care Provider Protection Act, provides grants to health care organizations to support evidenced-based and evidence-informed programs, practices, and trainings with the goal of reducing burnout and promoting mental health and wellness among the health care workforce. As the U.S. continues to deal with the COVID-19 crisis, ASH respectfully urges Congress to provide robust funding for the Preventing Burnout in the Health Workforce program in order to expand access to vital programs to address the growing mental health challenges facing our health care workforce.

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 2023 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 \$2.03 billion increase provided for Fiscal Year (FY) 2022 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 more important than ever.

ASHG urges the subcommittee to appropriate \$49 billion for NIH's base budget in FY 2023, with any additional funding for the newly established Advanced Research Projects Agency for Health (ARPA-H) to supplement, not supplant, the core investments in the NIH base budget.

EXTRAORDINARY PROGRESS IN HUMAN GENETICS & GENOMICS RESEARCH

Federal funding for human genetics and genomics research is enabling new insights into the structure of, and variation in, the human genome, and leading to new discoveries in preventing, diagnosing, and treating disease.¹ Through the development of powerful DNA sequencing and computational tools, in the past year, an NIH-supported consortium generated the first complete assembly of a human genome, greatly expand our understanding of genomic variation and providing an essential tool for exploring the genetic underpinnings of disease.² Researchers are also developing new 'polygenic score' tools to assess one's risk for many of the leading causes of death in the United States, including cardiovascular diseases, immune disorders, and cancers.³ Such tools hold promise for enabling a personalized approach to preempting and preventing disease.

Genetic science is delivering major advances in the detection and treatment of chronic diseases, notably cancer. Through 'liquid biopsy' blood tests, clinicians can identify genetic changes in cancerous tumors in a non-invasive way to guide targeted treatments; this testing method is being further developed for the early screening and detection of multiple cancers. Because of federally funded research findings, we now have novel cancer treatment options such as CAR-T gene therapies. As of this year, the FDA currently lists 23 approved cellular and gene therapy products to treat cancers and other diseases.⁴

Human genetic and genomic research is also delivering hope for the millions of people in the United States living with rare diseases. For example, results from NIH-funded trials investigating gene therapies and gene editing technologies indicate that genetic approaches will allow patients afflicted with sickle cell disease to live pain-free and no longer in need of frequent blood transfusions. Effective gene therapy is now available for spinal muscular atrophy, a rare childhood disease characterized by progressive muscle weakness, and is being tested to treat other devastating diseases like Huntington's disease and familial amyotrophic lateral sclerosis (Lou Gehrig's disease).

¹American Society of Human Genetics. (2021). Success Stories in Human Genetics and Genomics Research (Chronic Diseases) [Fact sheet]. <https://www.ashg.org/wp-content/uploads/2022/01/The-Benefits-of-human-genetics-Noncommunicable-Diseases-factsheets-v3.pdf>.

²Nurk, S. et al. The Complete Sequence of a Human Genome. *Science* 376(6588): 44–53 (2022). <https://doi.org/10.1126/science.abj6987>.

³<https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

⁴<https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy-products>.

GENETICS & GENOMICS: STRIVING FOR EQUITY AND RESEARCH COHORT DIVERSITY

Genetic science can advance health equity through the deliberate, meaningful inclusion and participation of individuals from diverse groups in human genetics and genomics research. The inclusion of populations representing diverse ancestries helps us gain a fuller understanding of the genetics of health and disease, knowledge which can be used to develop more accurate diagnostic tests and more effective treatments that benefit all Americans.⁵ Diverse participation in research is essential if we are to realize the full promise of human genetics and genomics research and the equitable application of genetic discoveries in healthcare and society.

Genetics research studies illustrate the importance of research cohorts reflecting humanity's diversity.⁶ For example, because most individuals participating in genetics research are of European ancestry, polygenic risk score tests are more effective for assessing disease risk in people of European ancestry than for individuals with Hispanic, South Asian, East Asian or African ancestries.⁷ The Society commends NIH's efforts to advance diverse participation in research, particularly the All of Us Research Program.⁸ Significantly, in 2022, this program released a database of health information and whole-genome sequences from almost 100,000 individuals,⁹ half of whom are from historically underrepresented racial or ethnic backgrounds.¹⁰

RETURN ON INVESTMENT: GENETICS RESEARCH BENEFITS THE ECONOMY

As the United States moves towards recovery from the COVID-19 pandemic, economic activity across all sectors remains key for our return to normalcy. In addition to its importance for addressing health care needs in the United States, Federal investments in research and development have been shown to drive economic activity. A 2021 study commissioned by ASHG and conducted by TEconomy Partners highlights the growth of a dynamic ecosystem derived from human genetics and genomics 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."¹¹ The report estimates that the human genetics and genomics sector supports 850,000 jobs and generates \$265 billion in total economic activity annually,¹² demonstrating that this sector has grown around five-fold in the last decade.

BROAD DATA SHARING: ESSENTIAL FOR HUMAN GENETICS AND GENOMICS RESEARCH

Broad sharing of human genome data from NIH-funded research is essential for advancing science and maximizing the public's return on investment in biomedical research. Since the human genome houses sensitive information, the genetics and genomics research community is a leader in developing best practices for sharing data while protecting individuals' privacy. We strongly support policies including the Common Rule, the Genetic Information Nondiscrimination Act (GINA), the 21st Century Cures Act, the NIH Genomic Data Sharing Policy, and HIPAA, which together act to protect individuals from the inappropriate disclosure of data for non-research purposes.¹³ As Congress encourages NIH to explore the National security risks associated with the sharing of individuals' health information, we urge the Committee to recognize the privacy protections already established by Congress and NIH for genetic research data, and to ensure that broad data-sharing can continue to fuel scientific progress.

SUMMARY

ASHG joins the Ad Hoc Group for Medical Research in recommending at least a \$49 billion base budget for NIH for FY 2023. This funding level would allow NIH's base budget to keep pace with inflation, specifically the biomedical research and de-

⁵ 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* 384: 1–4 (2021).

⁶ Wojcik G., et al. Genetic Analysis of diverse populations improves discovery for complex traits. *Nature* 570(7762): 514–518 (2019). <https://doi.org/10.1038/s41586-019-1310-4>.

⁷ Ibid.

⁸ <https://allofus.nih.gov/>.

⁹ <https://www.researchallofus.org/>.

¹⁰ <https://www.nih.gov/news-events/news-releases/nih-s-all-us-research-program-releases-first-genomic-dataset-nearly-100000-whole-genome-sequences>.

¹¹ Tripp, S., and Grueber, M. (2021). The Economic Impact and Functional Applications of Human Genetics and Genomics.

¹² Ibid.

¹³ American Society for Human Genetics. (2021). Perspectives: Research and Privacy [Fact sheet]. <https://www.ashg.org/wp-content/uploads/2021/08/Factsheet-DataPrivacy.pdf>.

velopment price index, and support crucial research on human genetics and genomics across all of the NIH's 27 Institutes and Centers. ASHG also recognizes the important and catalytic role of ARPA-H for advancing science and biomedicine, building on the foundation of basic research supported by NIH. Funding to establish ARPA-H should complement NIH's current investments in basic research.

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 Brendan Lee, MD, PhD, President-Elect, 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) 2023 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. Dialysis, while an important tool to manage kidney failure, has outcomes worse than most cancers: 50 percent of people starting dialysis today will die within 5 years.

The COVID-19 pandemic is especially deadly for kidney patients. Americans with kidney diseases are the most at risk among Medicare beneficiaries for severe outcomes from COVID-19—including hospitalization and death—and COVID-19 damages the kidneys of 30 percent of all hospitalized COVID-19 patients, even those without a prior history of kidney diseases.

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 \$125 billion, or 25 percent of all traditional Medicare fee-for-service spending, to the care of all kidney diseases, including \$37 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 67 innovators across 5 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 and xenotransplantation. Further, KidneyX is delivering on its pledge to catalyze private markets to invest in the advancement of kidney care. For instance, investors contributed more than \$300,000,000 to multiple winners of KidneyX's first prize competition, Redesign Dialysis.

FY 23 funding will support Phase 2 of the Artificial Kidney Prize, which seeks to promote the integration and advancement of prototype bioartificial kidneys. With \$25,000,000 in funding, KidneyX can support additional innovators in the Artificial Kidney Prize competitions and run prizes in other priority areas, such as refining the diagnosis of kidney diseases—currently more than 90 percent of people with kidney diseases are unaware they have the condition—and developing tools to prevent kidney diseases altogether. Recent advances in regenerative medicine and xenotransplantation have demonstrated the promise innovation can bring to kidney health.

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 providing kidney health care 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
- Groundbreaking technologies that may lead to a fully implantable or bioartificial kidney, such as an implantable silicon filter cartridge paired with a bio-reactor with kidney cells that together provide continuous treatment without needing to be tethered to a dialysis machine, or a method to genetically engineer pig kidneys to make them perform life-sustaining functions when transplanted in humans, both seeded through the Artificial Kidney Prize competition

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 program total of \$250 million. KidneyX has received \$15 million since fiscal Year 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 2023 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 percent of Medicare spending (approximately \$37 billion) in CY 2019, yet therapeutics for kidney failure remain limited and 50 percent 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 2023 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 at the American Society of Nephrology, at zkribs@asn-online.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. ASN has more than 20,000 members representing 132 countries. For more information, visit www.asn-online.org and follow us on Facebook, Twitter, LinkedIn, and Instagram.

[This statement was submitted by Zach Kribs, Senior Government Affairs Specialist, American Society of Nephrology.]

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) 2023 and asks that the subcommittee encourage increased support for plant-related research with relevance to health within the agency, including within the newly established Advanced Research Projects Agency for Health (ARPA-H).

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, nutraceuticals, 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. 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.¹ Plants can be harnessed as biofactories to produce vaccines against infectious diseases such as Ebola, hepatitis B, cholera, and coronavirus. Indeed, in February 2022, a plant-derived vaccine developed by GlaxoSmithKline and Medicago, trademarked as Covifenz, was approved by regulatory authorities in Canada for the prevention of COVID-19.² Clinical trials showed that Covifenz was between 69–78 percent effective in preventing COVID-19 infection, demonstrating that this vaccine could be a valuable asset in ending the ongoing COVID-19 pandemic.³ 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” because they are, like humans, complex multi-cellular organisms yet afford ease of genetic manipulation, a lesser regulatory burden, and maintenance requirements that are less expensive and burdensome 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 immune

¹Page 19, Decadal Vision, <https://plantsummit.files.wordpress.com/2013/07/plantscience-decadalvision10-18-13.pdf>.

²<https://medicago.com/en/press-release/covifenz/>.

³<https://www.nejm.org/doi/full/10.1056/NEJMoa2201300>.

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 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 percent or more of the human genome. More recently, plants are among organisms that have been used to develop revolutionary technologies such as gene editing (such as the CRISPR-Cas9 system), capable of precisely editing genomes to potentially correct mutations that lead to disease. These technologies are being deployed to produce more nutritious food and to sustainably increase production. 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.

Use-Inspired Research.—In addition to their role in expanding our understanding of the basic mechanisms of biology, plants have been enormously beneficial in advancing use-inspired research aimed at developing breakthrough technologies, platforms, and solutions for health and medicine. The newly established Advanced Research Projects Agency for Health (ARPA-H) within NIH is a promising avenue for bringing new plant-based breakthroughs from idea to reality. The ARPA model for funding research has already proved to be an excellent fit for plant biology as shown by successful programs funded through the Defense Advanced Research Projects Agency (DARPA) and the Advanced Research Projects Agency—Energy (ARPA-E). As ARPA-H develops, ASPB supports the inclusion of plant-related research within the agency’s portfolio.

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 percent 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;⁴ 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 percent 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 striking tolls 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 percent 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 small-molecule pharmaceuticals. We appreciate NIH’s current investment into understanding the biosynthesis of natural products through transcriptomics and metabolomics of me-

⁴ [https://www.who.int/bulletin/archives/78\(10\)1207.pdf](https://www.who.int/bulletin/archives/78(10)1207.pdf).

dicinal plants and support more funding opportunities that, similar to the “Genomes to Natural Products” initiative, will enhance new plant-related medicinal research.

Plant biology is also contributing to the advancement of new agents for cancer immunotherapy, a newer treatment strategy that uses the body’s own immune system to fight disease. Research funded by NIH has shown that nanoparticles containing cowpea mosaic virus—which infects legumes but is harmless to humans—can be injected into tumors to bait the immune system into attacking and destroying cancerous cells. Ongoing support from NIH is enabling researchers to determine the mechanisms behind the efficacy of these nanoparticles in attacking tumors, research that will, in turn, pave the way for these and similar plant-derived treatments to enter clinical trials.⁵

CONCLUSION

Plants play unique and pivotal roles in nutrition and health, agriculture, and the 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 all components of the NIH and direct the agency to support additional plant research 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.]

PREPARED STATEMENT OF THE AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Chair 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) 2023 Labor, Health and Human Services, Education and Related Agencies appropriations bill. My name is Judy Rich, EdD, CCC–SLP, BCS–CL, ASHA’s President for 2022.

As the subcommittee begins its work on this critical legislation, I offer ASHA’s support for the following programmatic funding requests for the U.S. Department of Education (ED):

1. \$16.76 billion for the Individuals with Disabilities Education Act (IDEA) Part B State Grants, \$503 million for IDEA Part B Section 619 Preschool Grants, \$932 million for IDEA Part C Infants and Toddlers with Disabilities, and \$250 million for IDEA Part D section 662 personnel preparation grants within ED.
2. \$1 billion for the Administration’s proposed School-Based Health Professionals program to support efforts to address shortages of school-based health professionals. ASHA also urges the subcommittee to ensure that speech-language pathologists (SLPs) and audiologists are eligible for this program.

In addition, ASHA encourages the subcommittee to include report language to establish issue-specific technical assistance (TA) centers within ED to improve the ability of school-based SLPs and educational audiologists to meet the needs of students with communication disorders. Specifically, ASHA urges the subcommittee to create TA centers focused on Communications/Speech Disorders; Medicaid Services and Reimbursement; Workload Mitigation; and Telepractice 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 percent of the average per-pupil expenditure in public elementary and secondary schools. This critical program serves more than 6.5

⁵ <https://pubs.acs.org/doi/10.1021/acs.molpharmaceut.2c00058>.

million children in our Nation's schools, including students with communication disorders.¹ ASHA appreciates that the American Rescue Plan Act provided \$2.58 billion for IDEA Part B State Grants, \$200 million for IDEA Preschool Grants, and \$250 million for Part C Infants and Toddlers, and that the Consolidated Appropriations Act, 2022 (Public Law 117–103) increased IDEA funding above FY 2021 levels for the remainder of the current fiscal year. However, additional funding is necessary to build on this progress.

These additional resources are essential to support States and local education agencies in providing FAPE to all students with disabilities. 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 necessary services and supports for children with disabilities. ASHA supports the Administration's FY 2023 budget request for IDEA at the levels identified above to ensure students with disabilities can continue to access the services that they are legally entitled to.

TECHNICAL ASSISTANCE CENTERS

Speech-language pathology services are highly utilized by students served under IDEA. According to ED's 43rd Annual Report to Congress on the Implementation of IDEA, 2021, speech or language impairments represent the most prevalent disability category of services provided under IDEA Part B: 39.9 percent of children ages 3 through 5, and 16.3 percent of students ages 6 through 21.²

ASHA's 2020 Schools Survey found that school-based SLPs' top two challenges identified were excessive paperwork (81.7 percent) and high workload/caseload (56.5 percent), while educational audiologists rated those as their second (53 percent) and fifth greatest challenges (41.7 percent).^{3,4} Both SLPs and audiologists also identified challenges in Medicaid billing for eligible students.

Establishing TA centers focused on key issues impacting school-based SLPs and educational audiologists would provide them valuable support; thereby, helping to ensure a FAPE for students with challenges that SLPs and audiologists can help address. The TA centers would:

1. provide resources, guidance, and best practices pertaining to the assessment and treatment to habilitate the communication disorder(s);
2. identify and develop free or low-cost evidence-based tools, model programs, and best practices to address clinical and professional practice issues; and
3. offer support and guidance for utilizing Federal funding sources to support capacity to address staffing shortages of speech-language providers within the school, community, or home setting to ensure the delivery of effective services for all students and their families.

The specific mission for each TA center would include:

1. Communications/Speech Disorders Center: Provide resources, guidance, and best practices pertaining to the assessment and treatment to habilitate the communication disorders for clinicians and other members of the school community and provide support and guidance regarding the utilization of Federal funding sources to support capacity to ensure access to such services for all students.
2. Medicaid Services and Reimbursement Center: Provide resources to ensure that students who qualify for services under Medicaid receive such services, and to streamline the reimbursement process for providers, schools, and local and State education agencies.
3. Workload Mitigation Center: Provide resources to mitigate the workload burden for SLPs, audiologists, and other specialized instructional support personnel to best serve students, and support the State and local education agency's capacity building of providers.
4. Telepractice Services Center: Provide resources to support telepractice and the application of telecommunications technology to the deliver audiology and speech-language pathology professional services at a distance by linking

¹ U.S. Department of Education. (n.d.). About IDEA. <https://sites.ed.gov/idea/about-idea/>.

² U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. (2021). 43rd Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2021. <https://sites.ed.gov/idea/files/43rd-arc-for-idea.pdf>.

³ American Speech-Language-Hearing Association. (2020). 2020 Schools survey. Survey summary report: Numbers and types of responses, SLPs. www.asha.org.

⁴ American Speech-Language-Hearing Association. (2020). 2020 Schools survey. Survey summary report: Numbers and types of responses, educational audiologists. www.asha.org.

providers to students, and build capacity among State and local education agencies to appropriately access services through a range of venues.

The establishment of one or more of these centers would support SLPs and audiologists in ensuring that all students have access to FAPE; and ensure that State and local education agencies, school administrators, and other educators have access to resources to support students and providers. ASHA strongly encourages the subcommittee to establish TA centers to support the ability of school-based SLPs and educational audiologists to support students with disabilities, particularly a Communications/Speech Disorders TA center to help address the needs of the significant population of students receiving speech-language services, and a Medicaid TA center to ensure that schools, districts, and States are able to receive reimbursement for services provided to Medicaid-eligible students.

CONCLUSION

Thank you for the opportunity to provide this testimony for the record. ASHA appreciates the subcommittee's past investments in IDEA and other critical education programs and urges continued support at the recommended funding levels. These investments are crucial to ensuring SLPs and audiologists can meet the hearing, balance, speech, language, swallowing, and cognition-related needs of students who are receiving special education services in schools.

If you or your staff have any questions, please contact Eric Masten, ASHA's director of Federal affairs for education, at emasten@asha.org.

PREPARED STATEMENT OF THE AMERICAN THORACIC SOCIETY

SUMMARY: FUNDING RECOMMENDATIONS

(in millions \$)

National Institutes of Health	\$49,048
National Heart, Lung, and Blood Institute	\$4,05
National Institute of Allergy and Infectious Diseases	\$6,806
National Cancer Institute	\$7,766
National Institute of Environmental Health Sciences	\$909
National Institute on Minority Health and Health Disparities	\$660
National Institute of Nursing Research	\$199
Centers for Disease Control and Prevention	\$11,000
National Institute for Occupational Safety and Health	\$375
Asthma Programs	\$40
Division of Tuberculosis Elimination	\$225
Office on Smoking and Health	\$310
Global Climate Change Program	\$110
Chronic Disease Awareness Education Program	\$6
National Center for Environmental Health	\$401.85

AMERICAN THORACIC SOCIETY

The American Thoracic Society (ATS) is the world's leading medical society dedicated to accelerating the advancement of global respiratory health through multidisciplinary collaboration, education, and advocacy. Core activities of the Society's more than 16,000 members are focused on leading scientific discoveries, advancing professional development, impacting global health, and transforming patient care.

National Institutes of Health

The NIH is the world's leader in groundbreaking biomedical health research into the prevention, treatment, and cure of diseases such as lung cancer, chronic obstructive pulmonary disease (COPD), and asthma. The coronavirus pandemic has revealed the critical national public health security leadership role that the NIH holds in scientific expertise to guide the Nation and in critical biomedical research to develop new diagnostics, therapeutics, and prevention interventions, including vaccines.

To continue to accelerate the development of life-saving cures and treatments and innovative prevention interventions, it is essential for Congress to continue to provide robust, predictable funding increases across the full spectrum of NIH-supported research. We ask the subcommittee to provide at least \$49.048 billion in funding for the NIH in FY 2023.

In addition, while the American Thoracic Society supports the Advanced Research Projects Agency for Health (ARPA-H), we feel strongly that funding for this new agency should complement—not supplant—NIH funding.

National Heart, Lung, and Blood Institute

As the worldwide leader in research on heart, lung, blood, and blood vessel diseases as well as sleep disorders, the NHLBI effectively translates research results to the American public. To continue important advances in research, the NHLBI is investing in prevention programs and new treatments for cardiovascular disease including congenital heart disease, developing novel therapies for lung diseases such as COPD, asthma, cystic and pulmonary fibrosis, and driving precision medicine that is tailored to individual patient needs through data science.

National Institute of Allergy and Infectious Diseases

“Long COVID” or Post-Acute Sequelae of SARS-CoV-2 Infection (PASC) refers to the prolonged symptoms or new or returning symptoms that people may develop after recovery from initial SARS-CoV-2 infection. NIAID is conducting and supporting research, such as natural history studies, to understand what factors (e.g., age, sex, existing co-morbidities, and host genetic factors) may impact the development of post-acute symptoms, as well as the incidence and prevalence of long COVID. A better understanding of long COVID is essential to identifying and evaluating interventions to prevent and treat these long-term symptoms. The ATS supports the NIAID’s evaluation of promising therapeutic and prevention strategies.

National Cancer Institute

In 2022, lung and bronchus cancer were estimated to represent 12.3 percent of all new cancer cases in the U.S. The ATS looks forward to continuing collaboration with the NCI, the Federal Government’s lead agency for cancer research, on lung-cancer related research initiatives, including lung cancer screening, lung nodule management, lung cancer prevention, and the interaction between COPD and lung cancer.

National Institute of Environmental Health Sciences

NIEHS-funded scientists are poised to make major fundamental discoveries that will help us appreciate the impact of a warming climate on public health. Furthermore, additional NIEHS-funded research is necessary to design and tailor interventions that will reduce the impact of climate change on the incidence and severity of disease, for disadvantaged communities that may not have resources to mitigate the effects of climate change.

National Institute on Minority Health and Health Disparities

With the Administration’s commitment to addressing health disparities, the ATS is committed to ongoing collaboration on the implementation of evidence-based interventions to address health disparities, including, for example, pulmonary rehabilitation, lung cancer screening, access to curative procedures for early-stage lung cancer and asthma home visiting programs.

National Institute of Nursing Research

The American Thoracic Society’s Assembly on Nursing represents a wide variety of clinical areas including treatment of pulmonary disease, critical illness, and sleep disorders. The ATS will continue its long history of collaboration with the NINR to support a research focus on studies to understand and develop communication strategies and technological advances to help vulnerable populations that experience disparities of care in COVID related health outcomes.

NIH Sleep Research Plan

The NIH continues to lead global efforts to support research, innovation, education, and scientific advances related to sleep disorders and circadian biology through the National Center on Sleep Disorders Research (NCSDR). Last year, NCSDR released a five-goal Sleep Research Plan that aims to address sleep-related health disparities, facilitate clinical sleep and circadian research, and advance the scientific understanding and health impacts of sleep deficiency and circadian misalignment. The plan identifies nine Critical Opportunities (CO) related to the strategic goals, including working to develop tools for the early prediction, detection, and treatment of sleep deficiency, and identifying people-driven approaches to promote healthy sleep behaviors.

As the NCSDR begins its work to implement the 2021 Sleep Research Plan, Congress must ensure that NIH is provided with adequate resources to achieve each of the five strategic goals and comprehensively explore each Critical Opportunity.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Strong funding for CDC is critical to support essential public health programs that serve a wide range of U.S. communities. Due to years of underfunding, many CDC programs have not received the resources needed to address the myriad health challenges we face as a nation, resulting in many of CDC's most effective prevention programs not reaching all States.

National Institute for Occupational Safety and Health

NIOSH is a Federal leader in research on occupational health. NIOSH also provides support of respiratory masks and other occupational protective technologies, occupational health research training, and provides technical assistance in cases of workplace exposure outbreaks.

Asthma Program

Currently, twenty-three States, Houston, Texas, and Puerto Rico receive critical funding from the National Asthma Control Program to support State and local efforts to reduce the burden of asthma. Our request for \$40 million in funding for the National Asthma Control Program would enable CDC to continue to fund these programs to combat the terrible human and economic burden caused by asthma. This increase in funding would also allow CDC to expand the Asthma Call-Back Survey to more States, thereby facilitating the collection of critical asthma surveillance data necessary for effective policy planning and implementation.

Division of Tuberculosis Elimination

The COVID response has diverted staff and funds from TB control funding, resulting in missed opportunities to control TB in the U.S. Additional funding is needed to restore local TB control programs and to restore TB Trials Consortium (TBTC) trials sites that are conducting vital TB clinical drug trials critical to halting the TB pandemic.

Office on Smoking and Health

Tobacco use is the leading cause of preventable disease, disability, and death in the United States. In 2020, 12.5 percent of U.S. adults (an estimated 30.8 million people) currently smoked cigarettes: 14.1 percent of men, 11 percent of women. Every day, about 1,600 young people under age 18 smoke their first cigarette, and 235 begin smoking cigarettes daily. Over 16 million people live with at least one disease caused by smoking, and fifty-eight million nonsmoking Americans are exposed to secondhand smoke. The CDC is at the forefront of the Nation's efforts to reduce deaths and prevent chronic diseases that result from tobacco use.

Global Climate Change Program

Climate change continues to impact public health in a myriad of ways, including, smoke from wildland fires, droughts, intense heat, floods, and increased vector borne disease. Funding is needed to provide local communities the necessary funding to develop strategies for responding to health challenges posed by global climate change.

Chronic Disease Education Awareness Program

CDC continues to be challenged to respond appropriately to the growth of chronic diseases in the U.S. CDC does not have an established program for major chronic diseases such as COPD as well as less prevalent chronic diseases. CDC has created a competitive grants program to fund public education efforts on important chronic disease that CDC has not yet addressed. Funding is needed to expand grant opportunities to conditions like COPD and other chronic respiratory diseases.

National Center for Environmental Health

According to the CDC, over 25 million people, including over 5 million children, live with asthma in the United States. Asthma disproportionately impacts women and minority communities who bear the brunt of the disease. Individuals living in poverty, as measured by the Federal poverty line, are also more likely to suffer from asthma. In addition, asthma imposes significant economic burdens, costing the United States over \$80 billion in medical and indirect costs in the form of missed days of school and work. The ATS looks forward to further collaborations with the NCEH in highlighting asthma as a priority health condition with evidence-based interventions, which can prevent the need for costly emergency department visits.

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 2023 report language recommendations on two conditions that pose a significant personal burden for millions of women in this country and a significant financial burden on the U.S. healthcare system. 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.

1. *Overactive Bladder*

Overactive bladder is a sudden, intense urgency to urinate often followed by an involuntary loss of urine. It causes people to frequently go to the bathroom through the day and wake at night to urinate due to altered nerve signaling between the bladder and the brain. 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 percent higher health care utilization than matched counterparts without this condition. The Centers for Disease Control and Prevention estimated that the direct and indirect costs of overactive bladder in the U.S. was approximately \$76 billion in 2015, with a projected increase to \$82.6 billion by 2020.

Anticholinergic medications are commonly prescribed to treat overactive bladder. These therapies are the most studied, most frequently used, and the most widely covered by insurance companies. 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 Dementia (ADRD). 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 ARDR development and to determine if the risks substantially outweigh the benefits of these therapies. Such studies would have a vast public health impact, given the millions of people impacted by overactive bladder, the increasing number of people developing dementia, and the substantial social and economic impact that these conditions have on our country.

For these reasons, the American Urogynecologic Society urges the subcommittee to adopt the following report language in the report accompanying the Fiscal Year 2023 Labor-HHS-Education appropriations bill that directs the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK) and the National Institute on Aging (NIA) to coordinate further study of anticholinergic medications and alternative treatments to determine the safety and efficacy of these medication for overactive bladder and their potential risks related to ARDR.

NATIONAL INSTITUTES OF HEALTH

National Institute on Diabetes, Digestive and Kidney Diseases/National Institute on Aging

Overactive Bladder.—The Committee remains concerned about the safety of medications used to treat overactive bladder, which may be increasing risk of Alzheimer's Disease and Related Dementia (ADRD). Overactive bladder affects 38 million Americans, and one in three older adults in this country. Overactive bladder has a significant impact on quality of life and the healthcare system. The anticholinergic medications typically used first-line to treat overactive bladder have been shown to increase the risk of developing dementia. Dementia continues to grow as a prevalent and serious public health issue. The Committee urges the National Institute on Diabetes, Digestive and Kidney Diseases (NIDDK) and the National Institute on Aging (NIA) to coordinate further study of anticholinergic medications and alternative treatments to determine the safety and effectiveness of medications for overactive bladder, and their potential risks related to ARDR. The Committee requests an up-

date on the status of research activities focused on this issue in the fiscal year 2024 Congressional Budget Justification.

2. Pelvic Floor Disorders

AUGS recommends report language to address pelvic floor disorders in minority populations. Pelvic floor disorders, which include pelvic organ prolapse and urinary and bowel incontinence, impact more than 25 million women annually in the United States. Pelvic organ prolapse occurs when the pelvic floor muscles and connective tissue supporting the pelvic organs (the bladder, uterus and cervix, vagina, and rectum) weaken or tear and can no longer support these organs. The risk factors and causes of pelvic floor damage leading to pelvic organ prolapse include pregnancy and childbirth, aging and menopause, health conditions that involve repeated straining (such as obesity, chronic cough, and chronic constipation) and genetics.

Pelvic organ prolapse is a common problem, with 1 out of 8 women undergoing surgery for prolapse at some point in their life. Studies have shown a prevalence difference in racial and ethnic populations. Pelvic organ prolapse can occur in reproductive age women but becomes more common as women age and after menopause. Treatment of pelvic organ prolapse requires significant healthcare resources. Non-surgical treatments require frequent health care visits and surgical treatments are imperfect with approximately 20 percent of women experiencing recurrences within 10 years. Surgical repair of prolapse is the most common inpatient procedure performed in women older than 70 years.

Urinary incontinence and accidental bowel leakage are two additional pelvic floor disorders that impact over half of people aged 65 and older living at home. In fact, these conditions are leading causes for admission to nursing homes as families are challenged for caring for their loved ones. Patients who suffer from pelvic floor disorders such as these experience a significant adverse impact on quality of life, resulting in restrictions in activities, social isolation, depression, and physical discomfort.

Studies have shown that women from underrepresented backgrounds are much less likely to receive treatment for pelvic floor disorders. More research is needed to identify trends in clinical care and the efficacy associated with treatments for pelvic floor disorders. Furthermore, we need to better understand the role that medical literacy and barriers to care may play into the differences noted in outcomes amongst underrepresented populations who suffer from pelvic floor disorders. Families in this country with a loved one who suffers from a pelvic floor disorder will benefit from research that decreases barriers to effective identification and treatment of these impactful conditions.

For these reasons, the American Urogynecologic Society urges the subcommittee to adopt the following report language in the report accompanying the Fiscal Year 2023 Labor-HHS-Education appropriations bill that directs the Eunice Kennedy Shriver National Institute on Child Health and Human Development to prioritize research activities that study pelvic floor disorders in minority populations.

Eunice Kennedy Shriver National Institute on Child Health and Human Development

Pelvic Floor Disorders.—Pelvic floor disorders including urinary incontinence, accidental bowel leakage and pelvic organ prolapse, negatively impact the quality of life of more than 25 million US women each year. There are socioeconomic disparities amongst women suffering from pelvic floor disorders, with differences in symptoms, knowledge, access to care, availability of treatments, and treatment outcomes noted in patients from different backgrounds. Recent studies have shown that minority women are much less likely to receive treatment for pelvic floor disorders. A better understanding of disparities among women with pelvic floor disorders can help guide the development of initiatives for education, outreach, and treatment of women with pelvic floor disorders. Therefore, the Committee urges the National Institute on Child Health and Human Development (NICHD) to prioritize research activities into underrepresented patient populations and pelvic floor disorders. Such activities should include the development of educational programs for general practitioners, the evaluation of effectiveness of screening protocols for pelvic floor disorders in the primary care setting, investigating medical literacy amongst minority women as it pertains to pelvic floor disorders, as well as assessing socio-economic and socio-cultural disease perspectives by designing qualitative studies using focus groups of women with varying socio-economic, cultural and ethnic backgrounds, evaluating current educational resources, determining gaps in patient knowledge, and designing culture-specific educational materials and resources. The Committee requests an update on this issue and on research activities to advance pelvic floor

disorders prevention and treatment in the FY 2024 Congressional Budget Justification.

Thank you in advance for your favorable consideration of these report language requests. Your support will positively impact knowledge, access to care and treatment for overactive bladder and for pelvic floor disorders and improve the lives of the millions of American women affected by these devastating conditions.

PREPARED STATEMENT OF THE ANIMAL WELFARE INSTITUTE

Report Language Request

The National Child Abuse and Neglect Data System (NCANDS) was established in response to the Child Abuse Prevention and Treatment Act of 1988. It is a voluntary data collection system that gathers information from all 50 States, the District of Columbia, and Puerto Rico about reports of child abuse and neglect. The data are used to examine trends in child abuse and neglect across the country, and its key findings are published in its Child Welfare Outcome Reports, which are submitted to Congress, and in its annual Child Maltreatment Reports. In light of the acknowledged close relationship between child maltreatment and animal abuse, and with exposure to animal abuse considered an Adverse Childhood Event (ACE), the Committee encourages the Department of Health and Human Services to expand its NCANDS reports to add a category of “animal abuse” to the child and caregiver characteristics and environmental factors that may place the child at risk for maltreatment. Moreover, the Committee asks DHHS to provide a report to the Committee within 90 days on any steps it may have taken to make this change.

Justification

This language encourages DHHS to expand the data collected around child abuse cases to include animal abuse. To more accurately examine trends in child abuse and neglect, it is critical to pay attention to animal abuse as a risk factor in the family. Having such information will provide a better foundation for child abuse screening, prevention, and treatment programs and would benefit children, families, and pets.

Animal abuse is a serious crime in and of itself, and well-documented evidence has identified a strong link between it and many forms of interpersonal violence. For example, committing animal abuse is a better predictor of sexual assault conduct than previous convictions for homicide, arson, or weapons offenses. In a violent household, companion animals are often victims of the very same abuse that children, intimate partners, and vulnerable adults are suffering. A survey of families in New Jersey who had been referred for physical child abuse found that animal abuse was also present in 88 percent of those homes. As Dr. Lynn Loar wrote, “The behavior that harms the animal is the same behavior that harms the human.” Decades of research and practical experience have firmly established this link. In fact, the first person to suspect that a family may be in crisis could well be a law enforcement officer responding to an animal cruelty call.

There is growing understanding that being alert to the presence of abused animals will help to protect not only the animals themselves but also other members of the family.

Besides the direct abuse to which they may be subjected, children are particularly vulnerable to suffering long-term adverse effects from witnessing or even being forced to participate in the mistreatment of their pets.

There is substantial evidence linking child and animal well-being:

- Children form close bonds with their pets, often referring to them as their “best friends,” or reporting that they turn to them when troubled.
- Threatening or actually harming a pet by a caretaker traumatizes the child. Traumatized children are more likely to become victims or perpetrators of violence.
- The threat of animal abuse to silence child sex abuse victims has been a factor in a number of criminal convictions.
- Children who are cruel to animals are more likely to have been maltreated than other children. Cruelty to animals as an indicator of child maltreatment increases with the child’s age, persistence of behavior, and poorer social background.
- Children are exposed to a variety of traumatic experiences, referred to as “polyvictimization” or Adverse Childhood Experiences (ACE). To successfully intervene and treat children and families, all forms of polyvictimization need to be recognized. Animal abuse is one of them.

—Evidence of animal abuse has been introduced during child custody hearings and in many of those cases, it has been one of the factors leading to removal of children from one or both parents. In one such case involving sexual abuse and neglect of the children, the appellants motioned the court to sever the animal cruelty charges from the sexual abuse charges; however, the court declined, stating that the offenses were intertwined, and evidence of “animal cruelty was essential to establish the physical abuse offenses.” In reaching this conclusion, the court considered that the animal abuse led to discovering the child abuse, and that “mistreatment of the animals greatly reflected upon [the defendants’] state of mind when they committed the physical and sexual abuse.” *Schambon v. Commonwealth*, 821 S.W.2d 804 (Ky. 1991)

The National Council of Juvenile and Family Court Judges has gone all in in taking up this issue, working with the Animal Legal Defense Fund to bring a wide array of training opportunities to judges to expand their understanding of the relationship between animal cruelty and child abuse and how important this understanding is to the work they do with families. In a recent letter to her colleagues, Judge Katherine Tennyson (ret.) let them know that NCJFCJ “has developed a resource, Toolkit for Starting a LINK Coalition in Your Community for Guidance (<https://nationallinkcoalition.org/wp-content/uploads/2013/01/TOOLKIT.pdf>) for community leaders, including judges, to help with the skills and steps needed to form and sustain a coalition for addressing the pressing, but underacknowledged, issues relating to the link between animal abuse and interpersonal violence.”

NCJFCJ notes on its website that “[t]hrough their authority to issue protection and restraining orders, to remove children from abusive homes, and to order youthful offenders into treatment or secure placement, judges use the power of the courts to respond to cruelty and abuse, to protect victims and prevent future harm. Judges also have the opportunity to take measures to safeguard the wellbeing of an overlooked member of the household and the community—pets and animals. To do this effectively, they need to understand the links between behavior involving violence against animals and interpersonal violence.”

Thus, there is an urgent need for more complete information about these patterns so that child welfare agencies and the courts can understand how to intervene safely and effectively.

CURRENT DATA COLLECTED ON CHILD ABUSE

State child protection agencies voluntarily provide data to the Federal Government under the National Child Abuse and Neglect Data System (NCANDS), which tracks trends in child abuse and neglect across the country. Case reports on the nearly 700,000 children abused annually in the U.S. include a variety of details—such as the type of abuse a child suffered or whether the caregiver had a substance abuse disorder—that help researchers and service providers better understand the factors associated with child abuse. There can be no doubt that cruelty to animals, especially family pets, is such a factor. These data help to inform the need for screening and preventive services and to “allow analysis of victim, caretaker, and perpetrator characteristics, as well as responses to abused/neglected children in need of services.”

Information collected under NCANDS has been used to determine, for example, that children whose families face multiple stressors are at a higher risk of being repeatedly referred to Child Protective Services, and that some types of maltreatment are more likely to recur than others. Adding animal abuse to the range of stressors that are measured will give service providers and others a window into the lives of abused children that they currently do not have and may help identify children at risk who otherwise may have gone undetected.

[This statement was submitted by Submitted by Nancy Blaney, Director, Government Affairs.]

PREPARED STATEMENT OF THE ARTHRITIS FOUNDATION

On behalf of the more than 58 million adults and 300,000 children living with doctor-diagnosed arthritis in the United States, the Arthritis Foundation thanks Chairwoman Murray and Ranking Member Blunt for the opportunity to provide written testimony to the Appropriations subcommittee on Labor, Health and Human Services (HHS), and Education and Related Agencies for Fiscal Year 2023. We respectfully request: \$11 billion in funding for the Centers for Disease Control and Prevention (CDC)—and within that \$54 million for the CDC Arthritis Program—and \$30

million for the Pediatric Subspecialty Loan Repayment Program to be administered by the Health Resources and Services Administration (HRSA).

CDC ARTHRITIS PROGRAM

Arthritis affects 1 in 4 Americans and is the leading cause of disability in the United States, according to the CDC. It limits the daily activities of over 23 million Americans and causes work limitations for 40 percent of the people with the disease. This translates to over \$300 billion a year in direct and indirect costs. There is no cure for arthritis, and for some forms of arthritis like OA, there is no disease-modifying pharmaceutical therapy, making evidence-based self-management programs critical for managing the disease. The CDC is critical for the dissemination of evidence-based programs, data collection and disease surveillance, and public health research. The COVID-19 pandemic has exacerbated the challenges of disease management, making interventions like exercise programs more difficult to access and maintain. In FY 2023, Congress should increase CDC funding to \$11 billion to support key public health programs, bolster critical infrastructure, improve disease surveillance and data collection, and strengthen pandemic preparedness. Within that \$11 billion, Congress should allocate \$54 million for the Arthritis Program to expand the reach of its services and resources.

The CDC Arthritis Program is the only Federal program dedicated solely to arthritis. Today, the program provides grants to 13 States to support evidence-based disease management programs. The program aims to connect all Americans with arthritis to resources to help them manage their disease. Evidence-based programs like EnhanceFitness help keep older adults active, and have shown a 35 percent improvement in physical function, resulting in fewer hospitalizations and lower health costs compared to non-participants. In addition, Walk With Ease is an evidence-based group walking program that encourages people with arthritis to start walking and stay motivated to keep active. The program allows participants to meet a few times per week to receive health education on an arthritis or exercise-related topic followed by stretching activities, and a group walk. A recent CDC-funded randomized controlled trial found that the program can help reduce arthritis symptoms, reduce disability, and improve strength and balance.

Given the high prevalence and severity of this disease, the Arthritis Program is woefully under-funded compared to the investment in other chronic diseases. It is currently funded at \$11 million, and due to either reduced funding or flat funding in recent years, the program has lost millions of dollars in purchasing power over the last decade.

With full funding of \$54 million, the program would be able to:

- Provide funding to all 50 States to fully operationalize a National Arthritis Program. Today, the CDC Arthritis Program funds only 13 State programs around the country (AR, KS, MA, MN, MO, NH, NY, NC, OR, RI, UT, VA, and WA). These programs play a vital role in the dissemination of proven strategies and programs, and all States should receive funding to operate an arthritis program;
- Expand national partnerships that are critical to promoting awareness, increasing primary provider referrals for non-pharmacologic management of chronic pain, and providing access to arthritis self-management and physical activity programs; and
- Invest in robust data and intervention and prevention research to better understand arthritis.

PEDIATRIC SUBSPECIALTY LOAN REPAYMENT PROGRAM (PSLRP)

An estimated 300,000 children have arthritis, yet there are fewer than 450 board-certified practicing pediatric rheumatologists in the United States, mainly clustered in big cities and urban metro areas. Shockingly, seven States have no pediatric rheumatologists and five States have only one. Early diagnosis and treatment of arthritis is critical for disease management, and it can be difficult for providers untrained in pediatric rheumatology to diagnose arthritis.

The pediatric rheumatology workforce is stretched now more than ever due to the pandemic. Serious shortages are causing decreased access to care for young people, resulting in myriad complex challenges, including entire days of missed work and school for the child, siblings, and parents because of the length of time traveling to the nearest specialist; families deciding to move to a different state to be closer to a specialist, and having to travel by airplane to reach the closest specialist.

The Pediatric Subspecialty Loan Repayment Program (PSLRP) was funded for the first time in FY 2022 and will make loan repayment available for pediatric subspecialists like pediatric rheumatologists to practice in underserved areas. With initial funding of \$5 million, the number of applications HRSA can fund will be se-

verely limited, yet we anticipate demand will be high among pediatric subspecialists. We urge the inclusion of \$30 million in the FY 2023 appropriations bill to build upon this important investment and address the ever-growing and critical pediatric workforce shortage.

We thank the subcommittee for its commitment to the health and wellbeing of all Americans. As you write the FY 2023 Labor-HHS-Education appropriations bill, we urge the inclusion of \$11 billion for the CDC and \$54 million within that for the CDC Arthritis Program, and \$30 million for the Pediatric Subspecialty Loan Repayment Program in order to continue investments that improve the lives of people with chronic diseases like arthritis. Please contact Anna Hyde, Vice President of Advocacy and Access, at ahyde@arthritis.org, with any questions.

PREPARED STATEMENT OF THE ASPIRA WOMEN'S

Thank you for the opportunity to comment on the National Institutes of Health (NIH) budget priorities for fiscal year (FY) 2023. We commend the efforts of the NIH to identify gaps and barriers in women's health and modernize priorities for research on the complete health of women. We provide this testimony in support of increased funding within the FY 2023 Labor, Health and Human Services, and Education Appropriations bill for endometriosis and ovarian cancer, with an increased focus and attention on access and equity so all women can benefit from innovative and transformative healthcare advancement.

As a women-led transformative women's health company, Aspira Women's Health is focused on bringing innovative and proprietary technologies to women where the healthcare system overall has failed to address their unmet healthcare needs. Specifically, Aspira Women's Health is currently the sole provider of OVA1, an innovative and the only FDA-cleared blood test for ovarian cancer risk assessment when a woman presents with a pelvic mass. We are also focused on a non-invasive endometriosis blood-based detection test, as women suffering from this debilitating condition are also severely underserved. Current diagnostic and treatment options for endometriosis represent sub-optimal care for women with this chronically painful condition that often is mis-diagnosed or diagnosed years after the onset severe symptoms.

Women's health issues continue to be under-represented in terms of NIH resource allocation, with dire consequences. As it specifically relates to endometriosis, there are several specific important issues that need to be addressed. Foremost among them is that endometriosis is an irreversibly debilitating disease known to cause a wide spectrum of physical and psychological symptoms from chronic pain to infertility to increased risk of suicide, yet it is regularly mis-diagnosed or diagnosed up to 7-9 years after the onset of painful symptoms despite it impacting 10-20 percent of the overall female population and 5-50 percent among women with infertility. These symptoms are extremely painful and uncomfortable and range from pain during intercourse and bowel movements to excessive bleeding. If this chronic pelvic pain is detected and treated early, laparoscopy surgery may be avoided, saving patients from invasive surgery and our healthcare system from preventable expenditures. The total expenditures per patient are similar to a Type 2 Diabetic patient, yet this condition is a silent, pervasive, irreversible, and chronically painful and debilitating disease impacting millions of women.

Condition	Statistics*
Cancer	11% of women with endometriosis over age 40 had associated malignancy. ¹
Heart Disease	Women age 40 or younger with endometriosis were three times more likely to develop heart attack, chest pain, or need treatment for blocked arteries, compared to women without endometriosis in the same age group. ²
Mental Health Impact	Depression and anxiety are more severe in endometriosis patients. ^{3,4} 86% of endometriosis patients with chronic pelvic pain have depression. ⁵ Half of women with endometriosis have suicidal thoughts. ⁶
Sexual Dysfunction	Patients with endometriosis have more than twice the sexual dysfunctions as compared to women without the disease. ⁷
Irreversibility	20% of treated women will have symptoms return within 12 months, and a further 50% will have symptoms return within 5 years, regardless of treatment type. ⁸

A non-invasive biomarker-based blood test would be a significant improvement over surgery, and non-invasive methods for diagnosing endometriosis would reduce related costs. However, these advancements can't be realized unless funding for women's health issues is increased exponentially, particularly for debilitating and deadly conditions like endometriosis and ovarian cancer, respectively.

In addition to endometriosis, ovarian cancer also deserves increased attention and investment. Ovarian cancer is pervasive, often fatal and is frequently missed or misdiagnosed, especially among Black women. It is the only sex-specific cancer with greater than a 50 percent mortality rate. Comparatively, breast cancer and prostate cancer have mortality rates lower than 10 percent. Today, Ovarian Cancer accounts for more deaths than any other cancer of the female reproductive system. In terms of public funding for research, there are major disparities. An example is prostate cancer, which has a 2 percent mortality rate, yet receives 50 percent more funding than ovarian cancer from the NIH. Ovarian cancer disproportionately affects women of color. For example, the all-cause mortality of Black women with ovarian cancer is 1.3 times higher than white women, even when access to care is equal. Furthermore, studies have shown that the risk of not receiving surgical intervention remains high among Black women and Hispanic women when compared to white women, and Black, Asian Pacific Islander, and Hispanic women were all at significantly greater risk of dying within the first 12 months of cancer diagnosis when compared to white women. A way to address these key disparities is an increase in funding for ovarian cancer research, especially among women of color, as it is critical to improving patient outcomes in the populations that suffer the most.

A clear example as to why research dollars are key to expanding innovation is CA-125, the most widely used blood test for ovarian cancer detection, discovered in the early 1980s. This biomarker has low sensitivity for early-stage disease, approximately 50 percent, and may be even lower among women of color. Between CA125's poor sensitivity and the often asymptomatic nature of early-stage disease, as well as other factors, it is estimated that over three quarters of ovarian cancers are not discovered until they are in advanced stage. In addition to this, CA125 can be elevated in many benign conditions, resulting in false positives which can cause women to endure unnecessary exploratory, invasive, and costly surgery.

Fortunately, there are innovations that improve outcomes, such as the only multivariate index assay for assessing the risk of ovarian cancer on the market, OVA1®. OVA1 has an overall sensitivity of 92 percent and an early-stage sensitivity of 91 percent. In Black women, a group for whom CA125 often provides inadequate risk assessment, OVA1 detected 79 percent of malignancies, compared to 63 percent by CA125. When ovarian cancer is discovered and treated early, survival rates can be greater than 90 percent. In advanced stage disease, however, the 5-year survival can be under 20 percent. Furthermore, evidence suggests that detecting ovarian cancer early costs nearly 84 percent less than treating late-stage disease, based on the increased costs of unnecessary care, making innovations in early detection of ovarian cancer a cost-effective solution. Increased NIH funding would enable additional advancements in ovarian cancer diagnoses and care, while a focus on minority women would ensure improved patient outcomes for those most likely to die of this disease.

As you draft the Labor Health, and Human Services appropriations bill, I ask that you consider increased funding for endometriosis and ovarian cancer. With additional Federal research funding, innovators across the Nation can make significant improvements for women suffering from these debilitating and deadly diseases. We appreciate your consideration and your attention to endometriosis and ovarian cancer when making funding allocations and policy decisions, while providing increased focus and attention on access and equity so all women can benefit from innovative and transformative healthcare advancement.

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PREPARED STATEMENT OF THE ASSOCIATION FOR CAREER AND TECHNICAL EDUCATION AND ADVANCE CTE

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 are writing to respectfully request that the subcommittee increase funding for the Carl D. Perkins Career and Technical Education Act's (Perkins V) Basic State Grant program, administered by U.S. Department of Education's Office of Career, Technical, and Adult Education, by \$200 million- an overall amount of \$1.58 billion in the forthcoming Fiscal Year 2023 (FY23) Labor, Health and Human Services, Education, and Related Agencies appropriations bill. It is vital that Congress continues to build upon the recent investments made in Perkins V in order to fully support the implementation of the law and the over 11 million secondary, postsecondary, and adult learners it serves across the Nation.

As you are aware, the Biden Administration formulated its FY23 Congressional budget request before Congress had yet finished work on FY22 appropriations legislation. As a consequence, the Administration used fiscal year 2021 funding levels as the starting point for developing its FY23 request for Perkins V. For this reason, the Administration proposed an "artificial cut" to Perkins V's basic State grant program of \$25 million dollars. Officials from the U.S. Department of Education (ED) have since contended they support level-funding for this program. Yet, as Congress continues to debate economic competitiveness legislation and oversees the implementation of last year's bipartisan infrastructure law, the need for highly skilled workers has never been greater. Flat-funding for Perkins V's State grant program would therefore be inadequate given the growing employer need for skilled talent

and learner demand for CTE programs that provide on-ramps into these opportunities.

In addition, the Administration has also proposed the creation of a new \$200 million competitive grant program—roughly 15 percent of the total size of all Perkins V funding—which the Administration has dubbed the “Career Connected High Schools” initiative. This competitive funding proposal would serve limited students overall, and unfairly favor funding for eligible entities that already have the capacity to write grants while penalizing smaller and more rural districts and institutions. Distributing funding in this manner would likely further exacerbate many longstanding inequities in our Nation. Given that this proposal would fund activities that are largely duplicative of how Perkins V State grant funding is already used, this additional funding would be more efficiently and effectively deployed as part of the Perkins Basic State Grant allocation instead. Doing so would ensure far more learners are able to access high-quality CTE programs supported by Perkins V formula dollars—which go to every State and Congressional district—rather than this new competitive grant program which, by the Administration’s own estimates, would only support 32 grantees.

CTE at the secondary and postsecondary levels is an integral part of ensuring an equitable and efficient implementation of last year’s bipartisan infrastructure legislation. According to the Brookings Institution, at least 15 million new workers will be needed for United States infrastructure in the next decade. In order to make good on Congress’s promise to rebuild America’s infrastructure, CTE will require robust funding to reskill the workforce in critical areas such as construction, transportation, housing, utilities, and telecommunications. CTE serves a critical role in preparing learners to enter into in-demand sectors of the economy which have immediate and longer-term hiring needs. CTE also is central to efforts to reskill and upskill learners who have been displaced by economic forces outside of their control or who have been sitting outside of the labor market for one reason or another. Examining 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.

Just as all education programs have been hit hard by the pandemic, so have CTE programs. This has been exacerbated by the lack of dedicated CTE funding within any of the pandemic response 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 pandemic 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 of the 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. Each of these activities are resource-intensive and even more challenging as a consequence of the pandemic.

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. To achieve this, CTE programs need to be adequately resourced. Jobs that require more than a high school diploma but less than a baccalaureate degree were growing quickly before the pandemic and this trend is only expected to further accelerate. Further, the twin forces of automation and globalization require nimble, proactive, and responsive programs that provide specific technical skills as well as more transferable competencies. 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 these needs, no pandemic aid package passed by Congress in response to the public health emergency has included dedicated CTE funding. At a time of record-inflation, CTE programs are disproportionately impacted by pandemic-related financial challenges because of the need to purchase and maintain the industry-standard equipment required to adequately serve learners. Congress has an opportunity to provide much-needed resources to CTE programs as part of the FY23 appropriations process to begin to remedy some of these ongoing challenges.

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 graduation rate for students concentrating in CTE is 95 percent, compared to a national adjusted cohort graduation rate of 85 percent. 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. Furthermore, those students are more likely to continue their education—91 percent of high school graduates who earned two to three CTE credits enrolled in college.

The outcomes for adult learners are also significant: 84 percent of adults concentrating in CTE programs either continued their education or were employed within 6 months of completing their program. In fact, 90 percent of Americans agree that apprenticeships and skills training programs prepare individuals for a good standard of living.

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, while individuals who receive a certificate or degree from California Community Colleges almost double their earnings within 3 years. In Wisconsin, taxpayers receive \$12.20 in return for every dollar invested in the technical college system. Oklahoma's economy reaps a net benefit of \$3.5 billion annually from graduates of the CareerTech System. 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 \$1.58 billion in the Perkins V CTE State Grant program.

CTE programs are also preparing individuals with the skills that employers seek. A recent 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 as part of our shared economy.

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. Half of all STEM occupations, which offer students high-skilled, high-wage career opportunities, require less than a bachelor's degree. 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. Moreover, CTE programs can be leveraged as an important talent pipeline for occupational fields that are experiencing critical labor shortages due to the pandemic and other factors, such as nursing and teaching. CTE programs themselves can be harnessed to meet these needs directly, via “Grow Your Own” programs, that would help to alleviate labor shortages in these critical sectors of our economy.

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. 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. 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. Meanwhile, 89 percent of executives agree there is a talent shortage in the U.S. manufacturing sector, 5 percent higher than 2015 results. Other industries are also facing significant skilled labor shortages as they emerge from the pandemic.

Funding Perkins V at adequate levels will ensure that educators can equip students with the skills and related credentials they will need for in-demand fields. This will become increasingly pressing as the country continues to recover from the current public health and related economic crisis. Already, healthcare jobs are projected to have the largest increase of any occupational sector. Filling these and other positions created as a result of the pandemic, 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 most recent Job Openings and Labor Turnover (JOLTS) Survey from the Bureau of Labor Statistics, the ratio of unemployed workers to job openings is 0.6, meaning that there are nearly two open jobs for every unemployed person. This tight labor market underscores the immense demand for skilled workers, especially as we seek to implement last year's bipartisan infrastructure legislation. CTE remains a critical component of the workforce pipeline for key industries that are needed to sustain a long-term economic growth and recovery, such as health care, STEM, manufacturing, construction and transportation distribution and logistics.

However, 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. 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 of the programs. As our recent analysis demonstrates, funding for CTE State Grants remains \$403 million below fiscal Year 2004 enacted levels when using the Bureau of Economic Analysis' (BEA) Personal Consumption Expenditures (PCE) Price Index to adjust for inflation—the most conservative measure of inflation over time.

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. Congress recognized the need to begin to reverse this trend and from FY18 to FY22 provided an additional \$262 million for CTE State Grants, bringing the total investment to \$1.38 billion. While these budgets represented initial down payment 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 wider American economy. Congress should build on the momentum from recent years and continue to strengthen the investment in CTE State Grants in FY23. And, Americans agree: 93 percent of voters support increasing the investment in skills training.

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 forthcoming FY23 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 redouble our collective commitment to these valuable programs and ensure CTE opportunities are available for every learner.

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, Zach Curtis (zcurtis@acteonline.org) or Advance CTE's Policy Advisor, Steve Voytek (svoytek@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 \$2.25 billion increase for the NIH in fiscal year (FY) 2022. 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 FY 2023 funding to build on our Nation's investment in biomedical research:

- National Institutes of Health (NIH): \$49.048 billion
- National Cancer Institute (NCI): \$7.766 billion

- Beau Biden Cancer Moonshot Initiative: \$216 million
- Centers for Disease Control and Prevention’s (CDC) Division of Cancer Prevention and Control (DCPC): \$462.6 million
- Cancer Registries Program: \$61.4 million

THE NIH: A GREAT INVESTMENT

In FY 2020, 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 more than 536,000 jobs and generated over \$91 billion in economic activity in 2020.²

The importance of federally funded biomedical research has never been clearer than during the COVID-19 pandemic as scientists from all corners of the country worked to quickly develop effective COVID-19 vaccines. Researchers racing towards a vaccine were not starting from scratch; years of federally funded research 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—built on years of research and scientific discovery—is a testament to the need for continued investment.

Despite recent funding increases, the 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. While our research infrastructure is recovering, the funding levels we are requesting for FY 2023 would continue to aid the recovery from these setbacks and allow meaningful growth above biomedical inflation. The investment 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

Over the last 30 years the cancer death rate has fallen 31 percent. This includes a 2.4 percent decline from 2017 to 2018—a record for the largest 1-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. Almost 1.9 million new cancer cases will be diagnosed, and more than 609,000 people will die from cancer in 2022.³

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. ASCO is grateful to Congress for the FY 2022 funding provided to the NCI. The increase is an important step towards increasing the amount of R01 grants the NCI is able to fund. Despite the FY 2022 increase, however, the NCI’s funding has not kept up with the growth of research grant applications as compared to other NIH Institutes or Centers. In 2021, the NCI was only able to fund 11 percent of viable applications, compared to 28 percent 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 percent of grant applications by 2025. The NCI’s Professional Bypass Budget, released in December 2021, indicated the Institute needs \$7.766 billion in FY 2023 to stay on course to reach this goal.

The Beau Biden Cancer Moonshot Initiative has provided a much needed, albeit temporary, predictable increase in funding for the NCI. In its 7 years, the Cancer Moonshot has initiated many new clinical trial networks and established an infrastructure to conduct cancer research and share resources on a massive scale. Funding for the Moonshot will expire after this fiscal year, however. To leverage the infrastructure created by the Cancer Moonshot requires sustained investments beyond FY 2023.

President Biden has announced a reignited Moonshot, without requesting any additional funding for the NCI. In fact, the Administration’s FY 2023 Budget included

¹ National Institutes of Health; <https://www.nih.gov/about-nih/what-we-do/impact-nih-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, Cancer Facts and Figures 2022; <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf>.

a cut to the NCI's budget. These cuts would jeopardize our Nation's existing biomedical research infrastructure and undercut ongoing efforts to advance scientific knowledge for the treatment of cancers, and other important basic and translational research. ASCO supports the President's reignited Moonshot goals "to reduce the death rate from cancer by at least 50 percent over the next 25 years, and improve the experience of people and their families living with and surviving cancer—and, by doing this and more, end cancer as we know it today." The toll COVID-19 will have on cancer incidences in the future is not yet known. It is clear already that the disruption of health services resulted in millions of people who missed or postponed screenings or follow-ups as well as patients already diagnosed who experienced treatment delays due to the pandemic. The consequences of this interruption in care will become evident in our cancer statistics in the years to come. The Administration's ambitious goals simply cannot be met without significant funding increases for NCI in anticipation of the end of the authorized Cancer Moonshot funding and the threat of a cancer incidence increase as a result of COVID-19.

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 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 (TAPURTM) Study, which provides access to targeted therapies for patients aged 12 and older identified as candidates to benefit 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 2022, the TAPUR study has over 2,400 patients enrolled at 250 clinical sites in 28 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). These programs expand clinical research beyond the academic environment and allow access to clinical trials to a larger, more diverse patient population, by bringing trials to the community setting. Just last year, the NCI awarded 53 grants to researchers at 46 NCORP sites, 14 of which are designated as minority/underserved community 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.⁴ 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.

HARNESSING DATA & REDUCING DISPARITIES

A long-standing priority for ASCO is to ensure cancer treatments and care considers patient demographics and social determinants of health. While diverse, accessible clinical trials often offer the best clinical treatment option for cancer patients, trials are not always available, especially for smaller patient populations, such as pediatric or rare disease groups.

As a compliment to inclusive trials, cancer providers and researchers also need accessible data to understand cancer at a broader level. The Centers for Disease Control and Prevention's (CDC) cancer programs play an indispensable role in the prevention, detection, and treatment of cancer. Approximately 50 percent of cancer deaths can be prevented and the substantial cost of the treatment of advanced disease could be reduced through the use of existing evidence-based prevention and early detection strategies supported by CDC's Division of Cancer Prevention and Control (DCPC).

Unfortunately, Federal funding for DCPC has remained almost flat for many years. Between FY 2010 and FY 2022, DCPC funding increased by just \$19.5 million, or 5.3 percent, from \$370.3 million to \$389.8 million. Excluding funding for the WISEWOMAN heart disease program, which is housed within the DCPC, the FY10–FY22 increase is just \$8 million, or 2.9 percent. That's about \$100 million less than if DCPC funding had merely kept up with inflation.

To that end, ASCO joins the cancer community in requesting \$462.6 million for the DCPC, and \$61.4 million for the CDC's Cancer Registries Program. Cancer reg-

⁴National Cancer Institute; <https://ncorp.cancer.gov/about/>.

istries are a critical tool for providers and researchers, providing cancer surveillance, identifying trends among 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 toward 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 creation of the 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 of clinically impactful products is vital to helping patients. Additionally, efforts to establish ARPA-H or otherwise 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.

The 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 and 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. All patients should have access to 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 the agency should implement strategies to encourage decentralization of trials and ensure diversity and equity in research.

ASCO recognizes and appreciates the work of Congress and the Administration to establish ARPA-H and stands ready as a resource throughout its creation and growth. ASCO does not have a specific funding request for ARPA-H for FY 2023; we stand firmly by our principles that the agency's funding should not come at the expense of robust, predictable annual funding increases for the NIH, NCI, or other existing research agencies.

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 FY 2023 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 PROFESSIONALS IN INFECTION CONTROL AND EPIDEMIOLOGY

The Association for Professionals in Infection Control and Epidemiology (APIC) and the Society for Healthcare Epidemiology of America (SHEA) urge appropriators to prioritize investments in the following Federal programs:

LHHS Programs	Agency	FY 2023 Funding Request
National Healthcare Safety Network	CDC	\$100 million
Antibiotic Resistance Solutions Initiative	CDC	\$397 million
Advanced Molecular Detection	CDC	\$175 million

LHHS Programs	Agency	FY 2023 Funding Request
Center for Forecasting and Outbreak Analytics	CDC	\$50 million
Agency for Healthcare Research and Quality	AHRQ	\$500 million
BARDA Broad Spectrum Antimicrobials Program and CARB-X Search	ASPR	\$300 million

Although significant progress has been made to have fewer reported cases of COVID-19 in most States and hospitalizations decreasing, we must continue to take this pandemic seriously. Planning and investing for the next public health emergency must start today. While rapid advances were made in treatments and vaccines to combat the virus, severe gaps in healthcare were exposed and exploited by the virus. Further, during the pandemic, healthcare facilities saw significant increases in healthcare-associated infections (HAI) tracked by the National Healthcare Safety Network.¹ Additionally, CDC highlighted reports of sporadic antibiotic resistant outbreaks in COVID-19 units and higher rates of hospital-onset infections.² It is believed, nearly a decade worth of progress preventing these infections was lost during the pandemic.

As integral components of the Nation's public health infrastructure, these programs must be funded at levels demanded by the growing threat of existing and emerging infectious diseases. Moreover, these programs will be important to improve the quality of care delivered to Americans and crucial in preparing for the next public health emergency.

We urge you to invest \$100 million in the National Healthcare Safety Network (NHSN). As the CDC's domestic tracking and response system, NHSN equips healthcare facilities, public health departments, and Federal agencies with accurate and actionable data to identify emerging and persistent threats, such as COVID-19, HAIs, and antibiotic resistant infections (ARI), as well as to deploy targeted infection prevention interventions. NHSN is also the chosen platform for how hospitals and nursing homes submit their monthly healthcare personnel (HCP) COVID-19 vaccination data, to support CMS reporting requirements, as well as for Hospital Compare. NHSN has played a key role in the reduction in various HAIs over the 5 years prior to the pandemic (18 to 42 percent).³ Within 2 months of the National emergency declaration for COVID-19,⁴ CDC swiftly adapted NHSN to track COVID-19 in nursing homes where outbreaks have been the most severe.⁵ CMS relies on NHSN data for public reporting and incentive payments for healthcare quality performance, with NHSN data contributing to at least \$350 million in Federal savings.⁶ By leveraging electronic health records and commercial infection control surveillance systems, NHSN innovates our existing healthcare data infrastructure while bolstering our public health data infrastructure. The stagnation in Federal funding over the last 10 years cannot sustain the exponential expansion of NHSN from 300 in 2005 to more than 37,000 participating healthcare facilities in 2020—including hospitals, nursing homes, dialysis facilities, and ambulatory surgical centers (ASCs) across the country. An increased investment in NHSN would ensure CDC can provide adequate technical support to participants, modernize NHSN to produce faster data while reducing the administrative burden for healthcare facilities, and adapt NHSN to respond to the current and future pandemics. Through greater NHSN participation, CDC can leverage the data needed to establish reliable national benchmarks, allowing healthcare facilities to measure the progress of their HAI and ARI prevention efforts and ultimately optimize antibiotic prescribing practices and eliminate HAIs.

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⁴ <https://www.federalregister.gov/documents/2020/03/18/2020-05794/declaring-a-national-emergency-concerning-the-novel-coronavirus-disease-covid-19-outbreak>.

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We urge you to invest \$175 million in the Advanced Molecular Detection (AMD) Initiative. AMD supports the integration of genomic sequencing with bioinformatic and epidemiology to detect diseases faster, identify and respond to outbreaks sooner, and protect people from emerging and evolving disease threats. Through partnerships with State and local health departments, public health laboratories, and academic institutions, AMD increases access to the specialized technologies and expertise necessary to empower public health professionals at the frontlines to take action before disease-causing pathogens become more widespread. As the Nation responded to the COVID-19 pandemic, AMD was crucial to robustly tracking and combatting emerging variants of COVID-19 in real-time. An increased investment in AMD will better position the U.S. to respond more strategically and effectively to endemic COVID-19 and future pandemics.

We urge you to invest \$50 million in the CDC's new Center for Forecasting and Outbreak Analytics. The Center for Forecasting and Outbreak Analytics (CFA) is a new center established under the American Rescue Plan. The Center was created to improve the Nation's ability to prepare for and respond to infectious disease threats using data, modeling, and analytics. It will bring together next-generation public health data, disease experts, and public health emergency responders to meet the needs of policymakers. While a new program, CFA already had an impact during the COVID-19 pandemic by assembling models anticipating the omicron wave. Continuously investing in these types of innovative programs will allow policymakers to make better data-driven and timely decisions during the current and future public health emergencies.

We urge you to invest \$500 million for the Agency for Healthcare Research and Quality (AHRQ). As the lead agency for health services research and primary care research, AHRQ provide policymakers, health system leaders medical providers, and patients with evidence-based policies and practices to improve health care quality, safe, and value. AHRQ also funds research at academic medical centers and other research institutions, generating new knowledge and enhancing the effectiveness of interventions to promote patient safety, prevent HAIs, and improve patient outcomes. Greater investments in the evaluation of our healthcare delivery system are critical to closing the gaps in healthcare quality, spending, and outcomes.

We urge you to invest \$300 million for Broad Spectrum Antimicrobials and Combating Antibiotic-Resistant Bacteria Biopharmaceutical Accelerator (CARB-X) at the Biomedical Advanced Research and Development Authority (BARDA). Novel broad-spectrum antimicrobials are vital to ensure timely, appropriate treatment of infections, especially as antibiotics are becoming increasingly ineffective due to drug resistance. The BARDA Broad Spectrum Antimicrobials Program and CARB-X, programs within the office of the Assistant Secretary for Preparedness and Response (ASPR), have successfully supported the development of new FDA-approved anti-

⁷ <https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2022/04/20/mdhhs-announces-select-specialty-hospital>.

⁸ <https://www.cdc.gov/drugresistance/solutions-initiative/ar-lab-network.html>.

⁹ <https://www.cdc.gov/drugresistance/pdf/cdc-ar-lab-network-final-H.pdf>.

¹⁰ <https://www.cdc.gov/drugresistance/pdf/threats-report/Prevention-Works-More-Action-Needed-508.pdf>.

biotics. An investment in these programs will sustain the Nation's pipeline of robust medical countermeasures to antimicrobial resistance.

The ongoing COVID-19 pandemic has highlighted the importance of sustained investments in the Nation's infrastructure to protect combat emerging infectious disease threats. With the growing prevalence in AR, the challenges we face today will worsen without new investments. Preventing infections, improving antibiotic use, detecting threats, and implementing interventions are essential to ensuring public health. The societies thank you for this opportunity to submit testimony on behalf of clinicians and researchers who champion infection prevention and antibiotic resistance.

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PREPARED STATEMENT OF THE ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

APS RECOMMENDATIONS FOR FISCAL YEAR 2023 APPROPRIATIONS

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- The Association for Psychological Science (APS) supports a funding level of at least \$49 billion for the National Institutes of Health (NIH) in fiscal year (FY) 2023. Robust funding for this essential health-research agency is necessary to ensure that the country has the critical scientific research findings required to improve human health and well-being.
 - APS supports a funding level of at least \$11 billion for the Centers for Disease Control and Prevention (CDC) in FY 2023. As COVID-19 becomes endemic and current and future disease-based health threats loom, CDC must receive strong and reliable funding to effectively carry out its programs.
 - The behavioral and social sciences are essential to improving human health, which is why APS recommends Congress include report language urging continued funding of no less than \$38.9 million for the NIH Office of Behavioral and Social Sciences Research, which leads and coordinates behavioral and social sciences research supported by NIH. Likewise, APS asks that Congress fund and integrate behavioral science research at CDC as part of its ongoing efforts to ameliorate the negative impacts of social determinants of health.
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STATEMENT OF APS CHIEF EXECUTIVE OFFICER

Chair Murray, Ranking Member Blunt, and Members of the subcommittee, thank you for the opportunity to provide testimony as you consider funding priorities for FY 2023. I am Robert Gropp, Chief Executive Officer of APS. APS is a nonprofit scientific organization of 25,000 scientists and students dedicated to advancing research psychology for the benefit of science and society. APS recognizes and appreciates the subcommittee's efforts to strengthen public health and health research.

FUNDING FOR THE NATIONAL INSTITUTES OF HEALTH AND ITS BEHAVIORAL AND SOCIAL SCIENCES RESEARCH PROGRAMS

APS recommends a FY 2023 funding level of at least \$49 billion for NIH. This level of support is also recommended by the Ad Hoc Group for Medical Research, a coalition of patient and voluntary health groups, medical and scientific societies,

academic and research organizations, and industry that share a commitment to strengthening NIH. APS agrees with the hundreds of members of this coalition that NIH-funded research improves societal understanding of health science, prepares us to better combat health threats, and translates research into interventions and treatments that improve human health. In addition to funding priorities, APS is concerned about the following policy topic at NIH.

Support for behavioral and social sciences research at NIH: The COVID-19 pandemic has provided us with many tragic examples of the ways in which behavioral and social factors are linked with individual and public health. APS members' research demonstrates that understanding these behavioral and social influences is as essential to preventing and responding to the pandemic and other health issues as is understanding their biochemical, physiological, and general medical underpinnings.

Although all NIH institutes and centers support behavioral and social sciences research to some degree, NIH's Office of Behavioral and Social Sciences Research (OBSSR) plays a centrally important and unique role in coordinating these efforts across NIH, as well as leading important projects such as, most recently, accelerating COVID-19 related testing, therapeutics, and vaccine research; understanding the psychosocial outcomes of the pandemic; and testing approaches for more effective health communication, especially as related to health equity. OBSSR has also played a leading role in understanding how to prevent injury and mortality caused by firearms and the violence related to them. Given the importance of strong support for OBSSR, in partnership with other organizations in the behavioral, brain, and population sciences, APS urges that the following report language be included in the FY 2023 Labor-HHS Report:

Office of Behavioral and Social Sciences Research (OBSSR).—The Committee commends OBSSR for effectively coordinating and supporting essential basic, clinical, and translational research in the behavioral, social, and population sciences to advance the NIH mission. Recognizing the critical role of OBSSR to integrate these sciences throughout the NIH research enterprise via OBSSR's leadership and coordination, the Committee encourages NIH to continue to support OBSSR at no less than the FY 2022 funding level including a proportionate increase in its FY 2023 budget as provided to the NIH by the Committee. The Committee urges NIH to provide an update on OBSSR's activities and progress in the fiscal year 2024 congressional justification.

FUNDING FOR THE CENTERS FOR DISEASE CONTROL AND PREVENTION, AND POLICY ISSUES

In support of the CDC Coalition, comprising organizations committed to strengthening the country's public health infrastructure and prevention programs, APS recommends a FY 2023 funding level of at least \$11 billion for CDC programs in the Labor-HHS bill. The CDC is central to protecting the U.S. from the COVID-19 pandemic but also combatting chronic diseases; resolving the opioid, tobacco, e-cigarette, and obesity epidemics; and advancing other public health and prevention programs. Again, psychological science provides the understanding of human behavior that so often is the cause for these public health problems. Psychological science research also offers insights about how to support behavior changes that are the key to interventions that can contribute to improved behaviors and public health.

APS further encourages your consideration of the following issue.

Support for research on social determinants of health at CDC: APS is encouraged that Congress has made important investments in addressing social determinants of health (SDOH), which are defined by the Department of Health and Human Services as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality of life. APS supports ongoing investment in CDC's efforts to address SDOH and stresses that fundamental and applied research in psychological science and other fields is crucial for defining and understanding the factors that affect health and developing evidence-based methods for their remediation. In support of the basic and applied behavioral and social sciences that lead to opportunities to improve well-being for all, APS also urges that the following language be included in the FY 2023 Labor-HHS Report:

Behavioral Research and Social Determinants of Health.—The Committee continues to support investments to better understand the behavioral and social determinants of health and urges the CDC to fund and integrate knowledge from behavioral science research as a part of the effort to develop new evidence-based interventions to ameliorate social determinants' potential negative effects. The Committee believes that behavioral science research focused on under-

standing the social determinants of health can increase uptake of and adherence to healthy behaviors that help prevent chronic conditions such as cancer, heart diseases, and diabetes.

SUMMARY AND CONCLUSION

The thread shared by these two requests is that knowledge gained from psychological science is essential to improving human health and well-being. To illustrate, I respectfully direct you to the APS Global Collaboration on COVID-19, which has brought together psychological scientists and other experts to make recommendations on how our field can be applied for these purposes. This collaboration has identified that psychological and other behavioral science could have been better applied throughout the COVID-19 crisis, that these fields remain poised to contribute to COVID-19 and future health threats, and that new research and research funding are urgently needed to best prepare our country for future crises. I would be pleased to share further information on this effort with any interested Members of the subcommittee at your convenience.

Thank you for your ongoing commitment to supporting scientific research, education, and training that improve health and well-being and reduces disease in the United States and around the world. The one million deaths in the U.S as a result of the COVID-19 pandemic, among many other things, have been a heartbreaking reminder of the links between human behavior and health; strong support for the important Department of Health and Human Services programs referenced here will improve our chances of ensuring that such a crisis exacerbated by human behavior never occurs again.

[This statement was submitted by Robert Gropp, Chief Executive Officer, Association for Psychological Science.]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI), representing 104 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) 2023 funding. AACI requests a \$4.1 billion increase for the NIH for FY 2023, bringing the recommended funding level for the NIH to \$49 billion. This proposed level of NIH funding would ensure that academic cancer centers can continue to discover and deliver potentially lifesaving new therapies for patients with cancer. AACI also requests at least \$7.766 billion in FY 2023 for the National Cancer Institute (NCI).

As Congress moves into the FY 2023 budget planning process, 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 to patients—from prevention to survivorship. These centers are at the forefront of the National effort to eradicate cancer, yet progress in cancer research is complex. The pace of discovery and translation of novel basic research to new therapies can be accelerated by an appropriate and predictable investment in Federal cancer funding.

PAYLINE

Uncertainty surrounding research project grants (R01s) 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 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 in FY 2020 that R01 grants for established and new investigators were 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,¹ a slight increase. However, in FY 2022, R01 grants flatlined at the 11th percentile for another year.² We request that Congress build on past by making a strong investment in the NCI in FY 2023. Steady increases from the FY 2022 11th percentile rate are essential to achieving the goal set by former NCI Director Dr. Ned Sharpless, to reach the 15th percentile by FY 2025. To continue in this direction, we are hopeful that Congress will adopt the NCI Director's Professional Judgment Budget Proposal of \$7.766 billion for FY 2023.

CONCLUSION

Now is the time for Congress to invest in biomedical research in general—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 2022.³ 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 2023 spending package that includes \$49 billion for the NIH and \$7.766 billion for the NCI.

A robust Federal investment in NCI-Designated Cancer Centers and academic cancer centers will allow the cancer research community to continue accelerating progress against cancer. We must continue to build on this momentum or else we stand to lose an entire generation of potentially lifesaving research.

[This statement was submitted by Jennifer W. Pegher, Executive Director, Association of American Cancer Institutes.]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 155 accredited U.S. and 16 accredited Canadian medical schools; approximately 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 the millions of individuals employed across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. In 2022, the Association of Academic Health Centers and the Association of Academic Health Centers International merged into the AAMC, broadening the AAMC's U.S. membership and expanding its reach to international academic health centers.

The COVID-19 pandemic is only one illustration of 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 2023, 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 \$49.048 billion for the National Institutes of Health (NIH), in addition to any funding for the Advanced Research Projects Agency for Health (ARPA-H); \$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 \$718.8 million for the Children's Hospitals Graduate Medical Education (CHGME) program; and at least \$11 billion for the Centers for Disease Control and Prevention (CDC).

The AAMC appreciates the subcommittee's longstanding, bipartisan efforts to strengthen these programs. 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 out-

¹ <https://www.cancer.gov/grants-training/nci-bottom-line-blog/2021/funding-from-congress-allows-nci-to-raise-grants-payline>.

² <https://www.cancer.gov/grants-training/nci-bottom-line-blog/2022/budget-increase-funds-a-growing-nci-grants-portfolio>.

³ <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf>.

lined below. To this end, the AAMC joined nearly 400 organizations representing the diversity of Labor-HHS stakeholders in a May 10 letter reiterating the need for a robust funding allocation for the Labor-HHS-Education subcommittee. The AAMC also supports the president's proposal to supplement the annual HHS investments with mandatory funding to support ongoing pandemic preparedness.

National Institutes of Health. Congress's longstanding bipartisan support for medical research has contributed greatly to improving the health and well-being of all, highlighted, for example, by the central role medical research has played in combating COVID-19. As illustrated over the last 2 years, 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 a seventh straight year of bipartisan support that resulted in the inclusion of \$45 billion for medical research conducted and supported by the NIH in the fiscal Year 2022 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 fiscal year 2022.

In fiscal year 2023, the AAMC joins nearly 400 partners in supporting the Ad Hoc Group for Medical Research recommendation that Congress provide at least \$49.048 billion in program level funding for the NIH, which would represent an increase of \$4.1 billion over the comparable fiscal year 2022 funding level (an increase of \$3.5 billion or 7.9 percent in the NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives). Importantly, the Ad Hoc Group strongly urges lawmakers to ensure that any additional funding the subcommittee opts to provide for ARPA-H supplement our \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH. In addition, the coalition supports the president's proposal to supplement NIH's budget with additional mandatory funding to speed the pace of pandemic response and readiness.

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, gender, and geographic 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 ARPA-H as it gets underway. 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.

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 at least \$500 million in funding for AHRQ in FY 2023.

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 pivoted their curricula to educate our health workforce during this public health challenge. There were unexpected costs to provide personal protective equipment (PPE) for in-person clinical training or switching to a virtual learning experience.

Simultaneously, the pandemic underscored the need to increase and continuously reshape our health workforce. These programs have proven successful in recruiting, training, and supporting public health practitioners, nurses, geriatricians, mental health providers, and other frontline health care workers critical to addressing COVID-19. Additionally, HRSA has tasked grantees with utilizing innovative models of care, such as training providers in telehealth, to improve patients' access to care during the pandemic.

The COVID-19 pandemic pulled back the curtain on the pervasive health inequities facing disadvantaged and underserved 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 inequities, and attract health professionals who are more likely to treat underserved patients.

Further, the HRSA health professions and nursing workforce programs are structured to advance new delivery systems and models of care, such as those promoting interprofessional teams and integrating mental health services with primary care. Whether developing a new curriculum to address emerging and ongoing public health crises, such as substance use disorders, or collaborating with community leaders in educating providers to deliver culturally competent care, the Title VII and Title VIII programs help ensure our health workforce is at the forefront of meeting all patients' health needs. The AAMC joins the Health Professions and Nursing Education Coalition (HPNEC) in recommending \$1.51 billion for these critical workforce programs in fiscal year 2023. Additionally, the AAMC supports the president's proposal for at least \$50 million to fund the recently enacted Dr. Lorna Breen Health Care Provider Protection Act (Public Law 111–105). Funding from the American Rescue Plan allowed HRSA to support several programs to prevent burnout in the health care workforce and promote clinician well-being, but HRSA received far more high-quality applications than resources allowed the agency to support.

In addition to Title VII and Title VIII, HRSA's Bureau of Health Workforce also supports \$718.8 million in FY 2023 for 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 also encourage Congress to provide robust funding to HRSA's Rural Residency Programs to expand training opportunities in rural areas through funding to develop new rural residency programs or separately accredited rural training track programs.

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 \$11 billion for the CDC in FY 2023. 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 that total, the AAMC joins nearly 300 national, State, and local medical, public health, and research organizations in supporting the president's proposed \$35 million to increase funding for firearm safety research supported by CDC. The AAMC also supports the administration's proposal to double firearm morbidity and mortality prevention research funding at NIH to \$25 million in FY 2023 and to provide \$250 million to CDC for a new community violence intervention initiative.

Also within the CDC total, the AAMC supports increased or new funding for:

- Data Modernization Initiative (DMI): \$250 million
- Center for Forecasting and Outbreak Analysis (CFA): \$50 million
- Climate and Health Program: \$110 million
- Advanced Molecular Detection (AMD) program: \$175 million

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 emerging 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 fiscal year 2023 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 57-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 2023 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 (\$109,000,000); and Susan Harwood Training Grants, DOL Occupational Safety and Health Administration (\$13,787,000). Not only do these programs maximize the Federal Government's investment in them, but 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 farmworkers 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 available quality 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 the 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 each of DOL's performance goals. In 2020 alone, NFJP service organizations provided more than 20,000 agricultural workers with services, according to DOL. Extrapolating, these NFJP providers have served over 200,000 agricultural workers and their family members over the last 10 years. Funding program this year at \$109,000,000—the level set in the House Education and Labor Committee-approved WOIA reauthorization bill (H. R. 7309)—would

allow NFJP to train an even greater number of dependable, capable workers to take on the Nation's most challenging jobs. 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 236 trainers in 35 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 620,000 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 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 \$49 billion in base funding in fiscal year (FY) 2023. 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 newly established Advanced Research Project Agency for Health (ARPA-H) can support high-risk, high-reward research to accelerate the pace of biomedical innovation. AIRI urges the subcommittee to ensure that any funding provided for ARPA-H supplements, and does not supplant, the NIH's base budget funding. The promise of ARPA-H rests on the foundational research that NIH supports through its base budget.

AIRI is a national organization of more than 80 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 nearly 10 percent of NIH's peer-reviewed, competitively awarded extramural grants.

AIRI thanks the subcommittee for providing an increase of \$2.03 billion for NIH in the FY 2022 omnibus appropriations package. 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 research ecosystem. Continued budget certainty is needed for the agency to predict-

ably 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 \$49 billion for NIH in FY 2023.

AIRI looks forward to working with Congress and the Biden Administration to examine how the establishment of ARPA-H can push the research enterprise to take on high-risk, high-reward research efforts. If successful, ARPA-H has the potential to address 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 basic research discovery funded by the NIH can adequately inform the transformative, applied research that ARPA-H has the potential to carry out.

Not only is NIH research essential to advancing health, it also plays a key economic role in communities nationwide. In FY 2021, NIH invested \$35.73 billion, over 80 percent of its budget, in the biomedical research community. This investment supported more than 552,444 jobs nationwide and generated nearly \$94.18 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.

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.

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 \$49 billion for the NIH's base budget in FY 2023 and reaffirming that any funding for ARPA-H supplements the base budget funding 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 2023 RECOMMENDATIONS

¹NIH's funding information and economic impact data comes from United for Medical Research's 2022 Update on NIH's Role in Sustaining the U.S. Economy, <https://unitedformedicalresearch.org/annual-economic-report/>.

Health Resources and Services Administration:

- \$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
- \$47.42 million for HRSA's Minority Centers of Excellence
- \$47.95 million for HRSA's Health Careers Opportunity Program.
- \$2 million for HRSA's Minority Faculty Loan Repayment Program.
- \$67 million for HRSA's Scholarships for Disadvantaged Students (SDS).
- \$67 million for HRSA's Area Health Education Center (AHEC) Program

Centers for Disease Control and Prevention

- \$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

National Institutes of Health

- \$49 billion for the National Institutes of Health
- \$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
- \$300 million for the Research Centers at Minority Institutions (RCMI)
- \$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
- \$100 million for NIH's Extramural Research Facilities program
- \$50 million to reinvigorate the NIMHD's Research Endowment Program (REP)

Office of the Secretary

- \$72 million for the Office of Minority Health at the Department of Health and Human Services.
- \$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

Department of Education

- \$100 million for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

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 2 years, 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 minority health and disparities. To achieve this we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

AMHPS is comprised of the 12 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 its found-

ing 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 U.S. 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).

President Biden recently signed the John Lewis NIMHD Research Endowment Revitalization Act to revitalize this important initiative, and it is our expectation that NIMHD will act swiftly to reinvigorate the research endowment program so minority-serving institutions can participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Robust funding would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by communities of color, as well as other medically underserved populations. It would also help improve access to grants to

fund research projects, as well as hire staff and provide scholarships for students who come from underserved communities. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program.

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.]

PREPARED STATEMENT OF THE ASSOCIATION OF SCHOOLS AND PROGRAMS OF PUBLIC HEALTH

On behalf of the Association of Schools and Programs of Public Health (ASPPH), thank you for the opportunity to submit outside witness testimony concerning Fiscal Year (FY) 2023 appropriations for agencies and programs impacting the academic public health community. ASPPH is the leading voice of academic public health and we are focused on growing the high-quality public health workforce of the future. We represent 137 schools and programs of public health accredited by the Council on Education for Public Health (CEPH). Our membership includes over 10,800 faculty and over 72,000 students. ASPPH strives to strengthen the capacity of members by advancing leadership, excellence, and collaboration in public health education, research, and practice.

We want to thank the subcommittee for its steadfast support of public health programs that span the fiscal Year23 Labor, Health and Human Services, Education and Related Agencies (Labor-HHS-ED) appropriations bill. In addition to the ongoing demands of our public health system, the current pandemic has challenged the public health community's response to protect the American people and global populations. Your subcommittee has continued to provide the critical financial resources to advance those efforts. With our Nation reaching the 1 million death toll due to COVID-19, we underscore strong investments in public health initiatives at a time we need it the most. This pandemic is far from over.

As you draft the Labor-HHS-ED appropriations bill, please consider ASPPH's funding recommendations that support the mission of our 137 academic institutions. These agencies and programs provide the essential resources to advance evidence-based approaches to public health threats and prepare future generations of public health practitioners. These investments will lead to tangible public health outcomes that will benefit the Nation and the world.

Our FY 2023 funding recommendations for the leading HHS public health agencies are aligned with many other organizations in the public health community:

National Institutes of Health (NIH): We are grateful for bipartisan support for continuous increases to the NIH budget and join several organizations in supporting \$49.0 billion for ongoing work of Institutes and Centers, an increase of \$4.1 billion or 9 percent above the fiscal Year2022 enacted level. Public health research is a critical component of the NIH's research portfolio. In addition, we support \$1.0 billion for the second-year appropriation of the Advanced Research Projects Agency for Health (ARPA-H), which is the same as the FY 2022 appropriation that remains available into FY 2023. Within NIH, we support at least \$110.0 million for NIH Fogarty International Center, an increase of \$23 million or 26 percent above the FY 2022 enacted level. The investment in Fogarty is an investment in the health of all Americans by providing support for vital global research and training to both prevent newly emerging infectious agents from becoming domestic calamities and to help us reduce the rising rate of noncommunicable diseases and the health impact of chronic conditions around the world.

Health Resources and Services Administration (HRSA): Programs within HRSA are essential to ensuring an adequately trained public health workforce. We support \$9.8 billion, an increase of \$1.2 billion or 14 percent above the FY 2022 enacted level. Specifically, within HRSA we request:

HRSA Public Health Workforce Loan Repayment Program: \$200 million for a new program that provides up to \$150,000 in loan repayment in return for service in a State, local, Tribal or territorial health department. In 2010 Congress authorized this critical program, but it has not been funded at the necessary level to make an impact. Therefore, student loan debt is a major obstacle to students seeking careers in governmental public health due to low-paying, entry-level jobs that are available in health departments. Loan repayment will allow our Nation to strengthen the capacity of the public health workforce, at this critical moment, with the next generation of professionals who have the educational training in public health and related disciplines. This is a vital program will help public health graduates make significant contributions to advance the field of public health practice, particularly in preparation for the next public health crisis

HRSA Public Health Training Centers: at least \$15.0 million, an increase of \$5.3 million or 55 percent above the fiscal Year 2022 enacted level. The Public Health Training Center Program is the Nation's only comprehensive training system to ensure workers in healthcare, behavioral health, public health and other fields have the skills needed to respond to increasingly complex public health challenges and protect the Nation's health.

Centers for Disease Control and Prevention (CDC): As public health experts predict an increase in as many as 100 million COVID-19 cases in the coming months, we urge stronger investments in CDC to protect the health of our communities. Additionally, due to years of underfunding, many programs at the CDC have lacked necessary resources to address the various health challenges our Nation continuously grapples with. Robust support for the CDC budget is critical to enable proper tools for the agency to carry out its prevention mission and ensure translation of research on the community level. We support \$11.0 billion, an increase of \$2.6 billion or 31 percent above the FY 2022 enacted level. Specifically, within the CDC we support:

CDC Center for Forecasting and Outbreak Analytics: \$50 million to continue this new CDC center that was initially funded through the American Rescue Plan Act. The center supports the President's National Security Memorandum-1 which called for the establishment of a national capability that would support the U.S. Government and our partners with advanced analytics, disease modeling and outbreak analytics. The center will bring together next-generation public health data, expert disease modelers, public health emergency responders, and high-quality communications to meet the needs of decision makers. We strongly encourage the Committee to facilitate the center's continuous work with schools of public health and other academic institutions to engage the Nation's expertise in disease modelling, public health data analysis, research, and training to build workforce capacity in this emerging field.

CDC Climate and Health: \$110 million, an increase of \$100 million above the FY 2022 enacted level. CDC's Climate and Health Program supports state, Tribal, local, and territorial public health agencies as they prepare for the health impacts of a changing climate. Academic public health institutions are engaged in essential research and training to establish and support a workforce of public health professionals with competencies to understand and address the impacts of climate change on public health. ASPPH has developed a climate framework that will enable all of our member institutions to make an impact on public health climate issues in collaboration with local, State and the Federal Government. We urge the Committee to include funding to support academic public health partners to expand research, strengthen public health workforce education and training, and foster practice-based partnerships to design and implement mitigation and adaption strategies related to climate change.

CDC Prevention Research Centers: \$37.0 million, an increase of \$10.0 million or 37 percent above the FY 2022 enacted level. The PRCs are a national network of academic research centers committed to conducting prevention research. They are leaders in translating research results into policy and public health practice. PRCs work closely with community members to establish health priorities and develop applicable research projects that address local public health needs. These partners collaborate with health departments, educational boards, and the private sector to form long-term relationships that make PRCs the leaders in community based participatory research. In the past, for every \$1 the PRCs received from CDC, they were able to generate an average of \$4.85 in research funds from other sources. As a result, PRCs are able to conduct hundreds of public health research projects every year to address issues such as cancer, smoking, obesity, diabetes, cardiovascular and many other conditions.

CDC Academic Preparedness Centers: \$20 million, an increase \$11.8 million or 144 percent above the FY 2022 enacted level. ASPPH endorses supporting not fewer

than 10 centers at institutions of higher education, including schools of public health, and other nonprofit private entities, to establish a network of academic preparedness centers. The centers will coordinate preparedness and response activities with governmental health departments, healthcare providers, and coalitions to translate research findings into evidence-informed and evidence-based practices, support training needs, and provide technical assistance and expertise. This framework of a national network of centers will strengthen the connection between academic public health and public health departments and health care systems to proactively address future public health threats. In previous years, annual appropriations for this program exceeded \$30 million and supported 21 academic preparedness centers at schools of public health.

CDC Injury Control Research Centers: \$15.0 million, an increase of \$6.0 million or 67 percent above the FY 2022 enacted level. The CDC's Injury Control Research Centers (ICRCs) are on the scientific front line conducting cutting-edge, multidisciplinary research on the causes, outcomes, and prevention of injuries and violence. The ICRC Program forms a national network of nine comprehensive academic research centers, including some within schools of public health, that focus on three core functions—research, outreach, and training. ICRC research focuses on issues of local and national importance, including opioids, firearm safety, sexual violence, suicide prevention, adverse childhood experiences, and traumatic brain injury.

CDC NIOSH Education & Research Centers: \$34.0 million, an increase of \$3.0 million or 10 percent above the FY 2022 enacted level. These centers provide state-of-the-art interdisciplinary training for the next generation of occupational safety and health practitioners and researchers. To protect American workers, safety training must continually evolve to keep up with technological advances, globalization, new and emerging risks, and occupational health disparities associated with the changing demographics of the U.S. workforce.

CDC NIOSH Agriculture, Forestry & Fishing Centers: \$30.5 million, an increase of \$3.0 million above the 2022 enacted level. The Agriculture, Forestry, and Fishing sector has approximately 2.3 million workers, who experience the highest fatal occupational injury rate at 21.5 deaths per 100,000 full-time workers, almost twice the rate of the average workforce. These centers facilitate the most important research to develop the most effective intervention strategies, and translate those findings to achieve sustained safety improvements in workplace practice.

Agency for Healthcare Research and Quality (AHRQ): AHRQ is the only Federal agency that funds research at universities and other research institutions specifically on health systems. This includes research that takes into account the “real-life” patient who has complex comorbidities, as well as intersections with other aspects of the health care system. We support \$500 million for AHRQ, an increase of \$150 million or 43 percent above the FY 2022 enacted level.

Again, ASPPH appreciates the opportunity to submit this statement for the record and we stand ready to assist you and your staff with additional information and resources from across our institutions.

[This statement was submitted by Timothy E. Leshan, Chief External Relations & Advocacy Officer, Association of Schools and Programs of Public Health.]

PREPARED STATEMENT OF THE ASSOCIATION OF SCIENCE AND TECHNOLOGY CENTERS, THE ASSOCIATION OF CHILDREN'S MUSEUMS, AND THE ASSOCIATION OF SCIENCE MUSEUM DIRECTORS

Chair Murray, Ranking Member Blunt, and Members of the subcommittee:

Thank you for accepting this statement submitted by the Association of Science and Technology Centers (ASTC), the Association of Children's Museums (ACM), and the Association of Science Museum Directors (ASMD). We are the membership organizations for science and technology centers and museums, for children's museums, and for science and natural history museum leaders. Our networks of several hundred institutions in all 50 States and in nearly 50 countries around the world traditionally engage almost 100 million people annually in the United States. Our members and their institutions are increasingly serving as community hubs for increased understanding of—and engagement with—science and technology among all people and for serving the needs and interests of children by providing exhibits and programs that stimulate curiosity and motivate learning.

Our place-based organizations are leading institutions in the efforts to promote education in science, technology, engineering, and mathematics (STEM), developing rich, innovative, and effective science-learning experiences. We are helping to create the future STEM workforce and inspiring people of all ages about the wonders and the meaning of science in their lives. Our members are trusted and valued by their

communities: a recent national public opinion poll, showed that 95 percent of voters would approve of lawmakers who acted to support museums and 96 percent of voters want Federal funding for museums to be maintained or increased (Museums and Public Opinion, Wilkening, S. and AAM, 2018).

These past 2 years have been especially challenging for our community as all of our members, who traditionally receive about half of their operating income from revenue of people coming through their doors, experienced prolonged closure of their facilities. Even as they have reopened to the public, attendance and revenue may take several years to recover. At the same time, our member institutions continued to serve their communities and their missions, engaging their regions with STEM and youth engagement, supporting science learning and serving their communities in myriad other ways. Indeed, one of the most inspiring aspects of the past 2 years is how our member organizations have shown up for their communities and worked closely with local residents and organizations to advance conversation and action on the most urgent local priorities.

For example, a year ago ASTC and ACM joined with a coalition of other national organizations to launch Communities for Immunity (www.communitiesforimmunity.org), an initiative supported by the Centers for Disease Control and Prevention and the Institute of Museum and Library Services to activate museums, libraries, and Tribal organizations to boost vaccine confidence in their communities. Building upon the high degree of trust that the public has in these cultural institutions, Communities for Immunity has been able to effectively engage vaccine hesitant members of their communities.

As the Nation hopefully emerges from the immediacy of the pandemic, this example of action by the museum and library community demonstrates how these trusted institutions embedded in their communities offer an opportunity to advance community conversation and action on national and international challenges in locally resonant ways.

ASTC, ACM, AND ASMD REQUESTS FOR FISCAL YEAR 2023 APPROPRIATIONS

We appreciate the support that the subcommittee has provided for the Nation's science and education agencies, including support for programs of particular interest to ASTC, ACM, and ASMD.

In general, we stress the need for inclusive programs that include support for informal education as much STEM learning—including but not limited to school-aged youth—happens outside of formal schooling. Research has consistently shown that learning experiences outside of the formal classroom are vitally important to youth's future interest and capacity in STEM (National Research Council, 2006, 2009, 2015).

National Institutes of Health

The Science Education Partnership Awards (SEPA) program builds relationships between the biomedical research community and educational organizations—including science centers—that improve life science literacy. In addition, there is growing awareness of the importance of public engagement as a core aspect of several major initiatives that intersect with societal interests and public concerns, such as the BRAIN Initiative and the All of Us Research Program.

We strongly urge the subcommittee to appropriate at least \$21 million for the Science Education Partnership Awards (SEPA), based at the National Institute of General Medical Sciences (NIGMS).

In addition, we would welcome language that supports incorporating public engagement with science as an element of NIH funding programs more widely, including especially for initiatives that have significant public impact.

Institute of Museum and Library Services

As the primary Federal agency supporting all types of museums, the Institute of Museum and Library Services (IMLS) provides critical funding to museums through the Office of Museum Services (OMS)—as well as to libraries and to Tribal and other cultural institutions. This includes crucial resources for informal science activities at science centers and museums throughout the country.

Throughout the pandemic, OMS has provided critical leadership to the museum community through its CARES Act and American Rescue Plan grants, and 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.

The current appropriations level has allowed OMS to fund only a small fraction of the grant applications received that have been rated highly by peer reviewers. Increased funding for OMS would allow the office to increase its grant capacity for

museums, funds which museums will need to help recover from the pandemic and continue to serve their communities.

We urge you to provide at least \$54.5 million for the Office of Museum Services at the Institute of Museum and Library Services (IMLS).

We also ask for the subcommittee to include funding for the agency to explore establishing 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, 20 U.S.C. Section 9173(a)(4), in addition to the agency's current direct grants to museums. Unlike state library grants, IMLS does not have the ability to rapidly deploy resources for addressing state-defined needs and expand the reach of museums and enhance their ability to serve their communities.

Department of Education

The U.S. Department of Education has significant opportunity to complement its expanding support for schools and school systems—with concurrent support for out-of-school learning include summer, afterschool, and informal education.

The pandemic has shown how important robust afterschool and summer learning programs are to working families and our most vulnerable students, and how vital resources are to support these programs to ensure they are available and effective for the children and youth who need them.

Specifically, we request that you support an increase of \$500 million for the Nita M. Lowey 21st Century Community Learning Centers program in FY 2023, which would bring the budget to \$1.789 billion.

We continue to thank the subcommittee for all its support of a robust science and education budget. You have demonstrated your support for crucial programs that promote STEM education for our Nation's students. Like our organizations, you recognize these are vital investments in our future, and we thank you in advance for taking action accordingly.

Our two organizations—along with the broader museum community—stand ready to be of service to your work. We are always happy to provide examples of the ways that museums are contributing to their communities and helping to advance local, regional, and national priorities. With our networks of hundreds of community-based institutions, these examples can be in or near each Congressional district.

Founded in 1973, the Association of Science and Technology Centers (ASTC) is a network of nearly 700 science and technology centers and museums, and allied organizations, engaging more than 110 million people annually across North America and in almost 50 countries. With its members and partners, ASTC works towards a vision of increased understanding of—and engagement with—science and technology among all people. www.astc.org. Association of Science and Technology Centers, 818 Connecticut Avenue, NW, Seventh Floor, Washington, DC 20006, info@astc.org.

The Association of Children's Museums (ACM) champions children's museums worldwide. With more than 460 members in 50 States and 19 countries, ACM leverages the collective knowledge of children's museums through convening, sharing, and dissemination. www.childrensmuseums.org. Association of Children's Museums, 2550 South Clark Street, Suite 600, Arlington, VA 22202, ACM@childrensmuseums.org.

The Association of Science Museum Directors (ASMD) is a non-profit, professional association of natural history and science museum directors. Our community of science museum leaders gathers to share experiences and discuss issues related to the advancement of our respective organizations to benefit society and the planet. www.asmd-us.org. Association of Science Museum Directors, 2413 S. Whittier Avenue, Springfield, IL 62704-4655, asmd.styles@gmail.com.

[This statement was submitted by Christofer Nelson, President and CEO, Association of Science and Technology Centers, Arthur G. Affleck, III, Executive Director, Association of Children's Museums, and Bonnie Styles, Executive Director, Association of Science Museum Directors.]

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 FY23 appropriations for the U.S. Department of Health and Human Services (HHS). The Association of State and Territorial Health Officials (ASTHO) is a national nonprofit representing State and territorial public health agencies. ASTHO's members—the chief public health officials of these agencies—are dedicated to formulating and influencing sound public health policy

and assuring excellence in public health practice. ASTHO is requesting \$11 billion for the Centers for Disease Control and Prevention (CDC), \$824 million for the Public Health Emergency Preparedness Cooperative Agreement (PHEP), \$170 million for the Preventive Health and Health Services Block Grant (Prevent Block Grant), \$1 billion for Public Health Infrastructure and Capacity, \$153 million for Social Determinants of Health, and \$250 million data modernization efforts at CDC. Under the Assistant Secretary for Preparedness and Response (ASPR), ASTHO requests \$474 million for the Hospital Preparedness Program (HPP). Additionally, we ask for \$9.2 billion in discretionary funding for the Health Resources and Services Administration (HRSA).

Before I expand on the details of these program requests, ASTHO, and our members are grateful for the tireless work you and your staff do to support governmental public health. Despite heroic efforts to protect Americans' health, we have lost one million lives and 15 million lives globally to COVID-19. These deaths weigh on us all, and especially on those charged with protecting the health of all Americans. While we are grateful for emergency supplemental appropriations to address the COVID-19 pandemic, Congress must provide long-term, sustained, and increased discretionary funding to support the public health workforce, modernize our data systems, and build laboratory capacity, among other priorities. 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. Public health departments are anticipating that without a change, of course, there will be an enormous funding cliff in two to 3 years. Federal resources account for nearly half of all State and territorial health department funding. In addition to a global pandemic, our members face opportunities and challenges each day in their jurisdictions, including data modernization, public health technology, public health worker burnout, mental and behavioral health crises, and rare hepatitis cases in children. These issues may change in urgency over the next year, but the same health departments will be there to prepare, prevent, and protect all Americans. ASTHO remains concerned that emergency public health funding will not make up for decades of underfunding and the ongoing COVID-19 response.

America's State and territorial public health departments work in partnership with CDC toward this goal, and we respectfully request \$11 billion in overall funding for this agency. CDC plays a vital role in supporting communities to expand the capacity of our Nation's front line of public health defense: our country's state, Tribal, territorial, and local public health departments.

An essential program that remains vital support for public health preparedness and response is the Public Health Emergency Preparedness Cooperative Agreement (PHEP) at CDC. ASTHO requests \$824 million for the Public Health Emergency Preparedness Cooperative Agreement (PHEP) to sustain and improve governmental public health programs. This program was established after a dark day in American history: Sept. 11, 2001. Data show that PHEP has contributed to public health preparedness in the Nation's 62 State, local, and territorial public health departments. Also, as a result of recent increases in funding for this program, CDC was able to provide increased funds to some city-level grantees, allowing them to expand their public health preparedness capabilities. Grantees rigorously evaluate their capacity to prepare for public health emergencies.

In addition to the PHEP program, States bolster their infrastructure activities with the Preventive Health and Health Services Block Grant (Prevent Block Grant). ASTHO respectfully requests \$170 million for this program. For more than 30 years, the Prevent Block Grant has served as an essential funding source for State and territorial health agencies. In 1999, funding peaked at \$194.9 million. Since then, it has dropped by 17.9 percent, not including adjustments for inflation. Programs funded by the Prevent Block Grant cannot be supported or expanded through other funding mechanisms. States and territories use these flexible dollars to offset funding gaps in programs that address the leading causes of death and disability. In some cases, this funding serves as seed funding for innovative projects a State or territorial health department wishes to provide to meet community health goals not funded through other means.

State and territorial public health departments have traditionally operated under a boom-and-bust cycle regarding how they are funded. The "boom" occurs during a public health emergency, such as the COVID-19 pandemic, when policymakers increase public health funding to mobilize a response. ASTHO is grateful for the \$3 billion in emergency funding, however, this one-time funding must be met by sustained resources in order to make a lasting and real improvement to our Nation's public health system. It is then followed by the "bust," or return to chronic underfunding of agencies when the acute public health threat subsides and the crisis is

deemed to be “solved.” ASTHO respectfully requests \$1 billion for Public Health Infrastructure and Capacity at CDC. This funding will support efforts within agencies that build capacity to detect and respond to threats both domestically and globally while improving and supporting activities in core public health capabilities, including assessment, policy, preparedness and response, community partnership, communications, equity, accountability, and performance management. Moreover, funding will support agencies in their efforts to invest in a highly trained workforce that is ready to help emerging public health threats. It is also essential to ensure that funding is disease-agnostic, flexible, and sustainable to support the transition from sporadic influxes of funding that accompany the response to public health emergencies.

State and territorial health agencies are uniquely situated to lead, develop, and coordinate interventions seeking to bring economic and community sectors together to create conditions that foster vibrant health. Social and economic conditions—often referred to as the Social Determinants of Health (SDOH) (e.g., housing, employment, food security, education, and transportation)—significantly influence individual and community health. It is also understood that these factors are estimated to contribute significantly to a person’s health outcomes, while traditional healthcare only accounts for 10–20 percent. Therefore, knowing that investing in programs that address the root causes of negative health outcomes is a force multiplier; it not only improves Americans’ health but saves the healthcare system costs and burden. ASTHO, therefore, supports providing \$153 million in funding to support the implementation of a Social Determinants of Health program at CDC with goals to align and streamline SDOH programs across CDC, grow capacity to address SDOH in our communities, provide funding to address the SDOH of those who are most at risk and disproportionately affected by adverse social and economic conditions, and bolster the catalog and science base and disseminate these to communities. An increase in funding will support the expansion of activities that address social determinants of health in State, local, Tribal, and territorial jurisdictions that including expanding and implementing accelerator plans and building the evidence base to better understand health disparities.

Along with Partner Organizations, ASTHO Supports the Data: Elemental to Health Campaign. We called on Congress to provide the first-ever dedicated funding for public health data systems and build a 21st-century public health data super-highway. Thanks to the work of this subcommittee, Congress answered the call and has provided annual funding and necessary injections of supplemental funding through the CARES Act and the American Rescue Plan for CDC’s public health Data Modernization Initiative (DMI). For FY23, we request \$250 million for data modernization efforts at CDC. DMI is committed to building a world-class data workforce and data systems ready for the next public health emergency. We need robust, sustained, yearly funding to complete the foundational investment in DMI and ensure we are providing resources for public health systems and infrastructure, including at State and local health departments, to keep pace with evolving technology.

Under the Assistant Secretary for Preparedness and Response (ASPR), ASTHO is requesting \$474 million for the Hospital Preparedness Program (HPP) and the coalitions that serve their communities to operate and coordinate activities across the local, State, regional, and Federal levels to ready healthcare delivery systems for disasters and emergencies. These include developing mechanisms for effective patient movement, communicating situational awareness, and providing resource-sharing across disparate healthcare entities. HPP allows individual healthcare facilities and healthcare coalitions to access a truly national response network, enabling the system to save lives and protect Americans from 21st-century health security threats and is the only source of Federal funding for this work.

Additionally, we request \$9.2 billion in discretionary funding for the Health Resources and Services Administration (HRSA). We sincerely appreciate your support for HRSA and the significant increases provided in FY22. Robust funding for HRSA is critical to supporting all HRSA’s activities and programs, which are essential to protect the health of our communities. Additional funding will allow HRSA to fill preventive and primary health care gaps, support urgent and long-term public health workforce needs and build upon the achievements of HRSA’s more than 90 programs and more than 3,000 grantees.

Thank you for considering these funding requests. We stand ready to work with Congress to address the countless public health challenges and opportunities impacting our Nation’s health. If you have any questions or require additional information, please do not hesitate to contact a member of ASTHO’s government affairs team: Carolyn McCoy (cmccoy@astho.org) or Jeffrey Ekoma (jekoma@astho.org).

[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 CENTERS ON
DISABILITIES

THE ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES

The Association of University Centers on Disabilities (AUCD) is a membership organization that supports and promotes a national network of university-based interdisciplinary programs. Network members consist of 143 centers, including 67 University Centers for Excellence in Developmental Disabilities (UCEDD), 60 Leadership Education in Neurodevelopmental Disabilities (LEND) programs; and 16 Eunice Kennedy Shriver Intellectual and Developmental Disability Research Centers (IDDRC). AUCD's mission is to advance policies and practices that improve the health, education, social, and economic well-being of all people with developmental and other disabilities, their families, and their communities by supporting our members in research, education, health, and service activities that achieve our vision. AUCD's network of programs are located in every State and territory and are all part of universities or university medical centers. AUCD's programs excel in basic and applied research, training, information dissemination, creation of model demonstration programs, systemic reform, and policy analysis. Given that these programs work collaboratively, innovations from one program can be rapidly implemented in communities throughout the country. AUCD's programs serve as a bridge between the university and the community, bringing together the resources of both to achieve meaningful systemic change.

UNIVERSITY CENTERS FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

The University Centers for Excellence in Developmental Disabilities (UCEDD): UCEDDs are interdisciplinary centers authorized in the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) (Section 156 of Public Law 106-402, Subtitle D). The UCEDDs are located in every State and territory, with some States having multiple UCEDDs to serve the unique needs of the state. The funding supports the basic infrastructure costs of operation for each UCEDD. Each center leverages the investment to secure additional funding to carry out the purpose of the DD Act. The 67 UCEDDs provide training, technical assistance, service, research, and information sharing to people with disabilities, their families, State and local government agencies, and providers with a focus on building the capacity of communities and creating improvements in the service delivery system for people with Intellectual and Developmental Disabilities (I/DD) and other disabilities. The UCEDDs have directly improved services and supports in the States and territories in the areas of early intervention, healthcare, public health, community-based services, education, employment, housing, assistive technology, emergency response and transportation.

LEADERSHIP EDUCATION IN NEURODEVELOPMENTAL DISABILITIES (LEND) PROGRAMS

The Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Programs are authorized in The Autism Collaboration, Accountability, Research, Education and Support Act (Autism CARES Act) (Public Law 116-60). The LEND programs are located in 44 States, with an additional six States and three territories reached through program partnerships, (without additional Federal or State aid). LEND programs operate within universities and collaborate with university hospitals and/or academic health centers to provide advanced interdisciplinary training to enhance the clinical expertise and leadership skills of professionals in a broad array of professional disciplines in the identification, assessment, and intervention of children and youth with neurodevelopmental and other related disabilities. The training programs have an explicit focus on training professionals to provide culturally and linguistically relevant care and to recruit diverse students and professionals into the programs. In FY 2020, 24 percent of long-term trainees in the LEND programs were from underrepresented racial groups and 13 percent were Hispanic or Latino. LEND programs also include self-advocates and family members as trainees and faculty to ensure trainees interact with people with lived experiences and to increase the leadership skills of self-advocates and family members as part of an interdisciplinary care team. The LEND programs have pivoted in response to the COVID-19 emergency. Critical clinical services have transitioned to a mix of telehealth and in-person formats, providing access to assessment, support, and treatment. A real-time transition to the provision of training either remotely

or in a hybrid model proved an added benefit of building maternal and child health leaders with experience in telehealth to support the population of people with neurodevelopmental disabilities.

EUNICE KENNEDY SHRIVER INTELLECTUAL AND DEVELOPMENTAL DISABILITY RESEARCH CENTERS (IDDRC)

The Intellectual and Developmental Disabilities Research Centers (IDDRCs) were established in 1963. The IDDRCs represent the Nation's first and foremost sustained effort to prevent and treat disabilities through biomedical and behavioral research. The network of IDDRCs with AUCD membership consists of 16 Centers with current P30 core grant funding from the Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD). Each IDDRC supports 40–100 research projects on an annual basis that seek to advance the understanding of chromosomal conditions and biochemical processes as they relate to brain function and I/DD. IDDRCs contribute to the development and implementation of evidence-based practices by evaluating the effectiveness of biological, biochemical, and behavioral interventions; developing assistive technologies; and advancing prenatal diagnosis and newborn screening. They also provide invaluable research training, mentoring, and support to emerging leaders in clinical and research science.

FISCAL YEAR 2023 APPROPRIATIONS REQUESTS AND JUSTIFICATION

AUCD requests that Congress appropriate \$47,173 million for the UCEDDs for FY 2023 within the Administration for Community Living (ACL) in the Labor-HHS-Education appropriations bill. The increased funding will ensure the UCEDDs meet the requirements of the DD Act and that people with disabilities are fully included and accounted for as States and territories respond to the significantly increased demand for assistance due to the pandemic. In FY 2020, the UCEDDs reached 13 million people through community training and technical assistance activities and trained 6,242 professionals that work with people with disabilities. In FY 2021, the number of requests for technical assistance to UCEDDs increased by 44 percent and the number of technical assistance products developed for the UCEDDs increased by 83 percent. These increases are a direct result of the impact of the pandemic on the systems supporting people with disabilities and are not sustainable without additional assistance. As regulatory and service systems continue to evolve once the public health emergency expires, the support needs of people with I/DD and their families will not decline. In addition, the increased funding will enable the UCEDDs to fund a new round of competitive grants focused on increasing diversity, equity and inclusion by partnering with minority-serving institutions and will also support other UCEDD activities and programs to promote opportunities for people with I/DD to exercise self-determination, be independent, and be included in all aspects of community life.

AUCD requests that Congress appropriate \$57,344,000 for Autism and other Developmental Disabilities for FY 2023 and of this amount appropriate \$40,000,000 for LENDs (in report language) within Health Resources and Services Administration (HRSA) in the Labor-HHS-Education appropriations bill. The increased funding will ensure the LEND programs can address the significant unmet needs and disparities in evaluation, diagnosis, and treatment as well as supporting LENDs to recruit and support more autistic adults as faculty advocates and as trainees, with an emphasis on expanding LEND curriculum to include and address adult life needs and healthcare. Furthermore, while we are grateful the number of LEND programs were expanded from 52 to 60 in June of 2021, this was done with no increase in funding. All funded programs were subject to a 3.3 percent cut in their allocated funds to accommodate the expansion. We are hopeful the LEND programs will see their funding restored in FY 2023.

AUCD requests that Congress appropriate \$1.816 billion for the NICHD within the National Institutes of Health (NIH) (a 7.9 percent increase from FY 2021). AUCD additionally requests a proportional increase of 7.9 percent for IDDRCs within the NICHD in the Labor-HHS-Education appropriations bill.

The increased funding for NICHD is essential to building upon the cutting-edge research and collaboration of the IDDRC network to better understand the neural and biomolecular underpinnings of I/DD to better inform treatments and interventions. Previous increases in NICHD funding have not resulted in increases to the IDDRCs. This research is more important given the reality that people with I/DD are experiencing more severe symptoms of COVID-19 and die at disproportionately higher rates than people without disabilities.

OTHER PROGRAMS THAT SUPPORT AND SERVE CHILDREN AND ADULTS WITH DISABILITIES

AUCD supports the proposed increases in the President's budget for programs that support and serve people with disabilities, such as special education, post-secondary education, and vocational rehabilitation programs; programs that improve the health of children and adults with disabilities; and programs that generate new knowledge and promote its effective use to strengthen opportunities for an inclusive life in the community. We are specifically supportive of the President's proposed increases for the following programs:

- Transition Programs for Students with Intellectual Disabilities (TPSID) and related technical assistance centers (NCC and NDTAC) to promote college programs for students with intellectual disabilities;
- Projects of National Significance (PNS), innovative demonstration projects to monitor progress on key policy priorities for people with I/DD;
- The National Institute on Disability Independent Living and Rehabilitation Research (NIDILRR), the Federal Government's primary disability research organization, which funds programs that generate new knowledge and promote its effective use to strengthen individual and community capacity for inclusion; and
- The National Center on Birth Defects and Developmental Disabilities (NCBDDD) strives to advance the health and well-being of people with disabilities by preventing birth defects, promoting better understanding of developmental disabilities, and improving the health of people with disabilities.

AUCD and AUCD's member centers frequently secure grants from these programs. For example, the PNS fund three national long-term data collection projects that help policymakers, service providers, and people with I/DD and their families to make the most informed policy and individual decisions related to healthcare and employment. All three of the National longitudinal studies are conducted by AUCD's members. The studies include a study of the evolution of integration and inclusion of people ID/DD in society and more than 20 years of studies about community integration and employment for people with I/DD.

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 2023 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 \$3,000,000 increase over the FY22 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 2020, a worker died every 111 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 guarded roof edge; our farmers who may be engulfed in flowing grain, 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 they encounter at work, or heart disease from chronically stressful work environments. In addition to work-related deaths, we also have a high burden of nonfatal 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 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 im-

mense 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 these past few years, 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 wellbeing. 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 the pandemic, NIOSH 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 eighteen 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 leads the research and outreach efforts on the Nation's most dangerous worksites that often impact lives in rural parts of America. The NIOSH AgFF Program was established by Congress in 1990 (P.L. 101-517) in response to evidence that agricultural, forestry, and fishing workers suffer substantially higher rates of occupational injury and illness than other workers. Agricultural workers are more than six times more likely to die on the job than workers in other sectors combined, averaging 566 fatalities per year, and nearly 5 in 100 agricultural workers incur recordable nonfatal injuries each year. Our food security depends on a healthy agricultural workforce—an essential sector that has been hit particularly hard during the pandemic. Today, the NIOSH AgFF initiative includes 10 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 this vital production sector. 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, increased use of rollover protective structures (ROPS

or roll bars) and seatbelts on tractors has reduced overturn-related deaths. Partnering with fishing communities, the AgFF Centers developed comfortable life-jackets 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. As the majority of AgFF workers; self-employed farmers, ranchers, and fishermen; are exempt from State and Federal OSHA protections, NIOSH and the AgFF Centers fill a critical role in training and educating of AgFF workers.

NIOSH also supports 10 Total Worker Health (TWH) Centers of Excellence that conduct multidisciplinary research and test practical solutions to emerging challenges that impact the safety, health, wellbeing, 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.

While funding for the ERC, AgFF, and TWH Centers is crucially important to maintain resources, staff, and long-term capacity in occupational safety and health research at the State and regional level, we also emphasize that the overall NIOSH funding level is also critical. The requested increase in the NIOSH topline funding level supports NIOSH intramural research, including the NIOSH personal protective equipment program, which develops and monitors N95s and advanced respiratory protection systems; disaster response research; mental health research; Per- and Polyfluoroalkyl Substance (PFAS) research; and research on substance use disorders related to work. Increased NIOSH topline funding also enables reinstating reduced extramural funding levels for innovative investigator-initiated awards.

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 AUTISM SPEAKS

Thank you for the opportunity to submit testimony in support of autism funding within the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Department of Education (DOE), and other agencies under your jurisdiction. For Fiscal Year 2023 we request that the Committee increase its investment in autism-related activities. Specifically, we request that you fund autism activities at least at \$33.1 million at CDC and \$64.6 million for Autism and Developmental Disorders activities (which includes a \$7.5 million increase in research funding and a \$2.755 million increase for the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program) at HRSA. In addition, we request that the Committee strongly urge the NIH to invest in autism research consistent with the budget recommendation included in the Interagency Autism Coordinating Committee's (IACC) Strategic Plan and for all agencies to invest in research that addresses health equity challenges and disparities that persist in the autism community.

My name is Stuart Spielman, and I am the Senior Vice President for Advocacy at Autism Speaks. Autism Speaks is dedicated to promoting solutions, across the spectrum and throughout the life span, for the needs of individuals with autism and their families. We do this through advocacy and support; increasing understanding and acceptance of people with autism; and advancing research into causes and better interventions for autism spectrum disorder and related conditions.

We are grateful for the bipartisan leadership that both the Chairs and Ranking Members of the full committee and subcommittee have provided in supporting investments in autism research, training, and services over many years. As you consider this year's requests, we look again to your leadership to build on the significant progress that has been made and provide investments to meet the tremendous needs that continue to exist.

For Fiscal Year 2023 we request that the Committee invests in autism-related activities to align the Federal investment in autism-related activities with the budget recommendation of the 2016–2017 IACC Strategic Plan for Autism Spectrum Disorder. While the NIH, DOE, CDC, and HRSA are the largest funders of autism-related research, training, and services, multiple other agencies fund important autism-related efforts as well. We urge the subcommittee to use the recommendations and strategic objectives of the IACC, the congressionally created body responsible for advising the Federal Government on autism-related investments, to guide investment across all agencies.

Much of the progress in autism research that has been made is due to your work and support. The research you have supported has been remarkably important in better understanding the biology of autism, the numbers of individuals across the country with an autism spectrum disorder diagnosis, and the types of interventions and supports that can benefit the autism community. In many ways, it is because of this progress that we know that so much more needs to be done. Here are just a few examples of questions that research can answer:

- How can we develop personalized interventions and therapies to mitigate the co-morbid health conditions that occur in higher rates among autistic individuals?
- How can we promote evidence-based supports and services to assist the 70,000 autistic youth who every year transition out of school-age services?
- Even though autism can be diagnosed at 15 months, the average age of diagnosis remains at about 4 years old, and even later in low-income communities. What evidence-based practices can we use to help diagnose autism earlier across the board?
- Research indicates that autistic individuals, women in particular, are at greater risk for suicide. How can we adapt existing suicide screening and intervention models to better reach individuals at risk?
- Learning opportunities were lost during the pandemic. How can we ensure that educational loss during breaks in education are better understood and addressed for children, teenagers, and young adults with autism?
- There is a dearth of research on issues affecting autistic adults. What can be done to not only better understand service and support needs, but also why autistic adults have higher premature death rates and poorer health outcomes than the rest of the population?
- How does autism affect aging and related health conditions and how can we ensure that autistic adults are receiving appropriate mental health assessments as they age?

Recent research has shown that while we have made progress in identifying all children with autism earlier, timely access to needed services remains a major challenge. Children with autism spectrum disorder have nearly 4 times higher odds of unmet health care needs compared to children without disabilities, and Black autistic children are twice as likely to have unmet healthcare needs than their non-Hispanic white counterparts. Black and Latinx children experience delays in diagnosis that result in the loss of valuable treatment time. It is imperative that a greater investment in research is made to help bridge these gaps and ensure that culturally competent interventions and services are available in every community.

The scale of the challenges faced by our community require urgent, increased, and sustained investment. The IACC recommended in its most recent Strategic Plan a doubling by 2020 of 2015 levels of investment in autism research. Even with this investment, the IACC stated that the “increases recommended by the IACC would not be sufficient to accomplish all of the research goals identified by the plan.” The total annual cost of autism in the United States has been estimated to be at least \$236 billion. By contrast, it has been estimated that combined autism research funding among Federal and private sources is less than 1 percent of that amount—a tiny fraction of the estimated annual total cost of autism. Additional research investments can improve outcomes and help reduce those costs through early identification, improved interventions, and greater availability of supports and services.

Because of the Committee’s previous work and the decisions made by the agencies funded through this bill, there are opportunities to build on existing investments. For example:

- The National Institute on Deafness and Other Communication Disorders (NIDCD) FY 2022 Budget Justification highlighted research to help address communication challenges for autistic individuals. They note that 30 percent of autistic individuals over age 5 are functionally non-speaking yet are an under-represented group in research. Research the NIDCD is funding is intended to develop effective interventions and improve clinical practice for autistic individuals with communications challenges.

- The CDC receives only enough funding to monitor the prevalence of children with autism spectrum disorder in 11 States. Providing an overall funding level of at least \$33.1 million in fiscal Year 2023 would allow more States to participate in the ADDM Network, giving them invaluable information to drive efforts at the State and local levels and providing a better national dataset; allow for more study of the prevalence of autism across the lifespan; and continue support and enhancement of the “Learn the Signs. Act Early” program on child development.
- HRSA has been funding extraordinarily important research efforts to help address significant issues, like developing clinical medical standards and challenges related to the transition to adulthood. An overall funding level of \$64.6 million for Autism and Developmental Disorders in FY23 (to include an increase of \$7.5 million in research and a \$2.755 million increase for LEND) would greatly enhance HRSA’s ability to fund research to help bridge the gaps in these and myriad other areas.

We hear every day from individuals and families in the autism community about their successes, challenges, and everything in between. They have shared their experiences during the pandemic, telling us about their struggles to receive learning supports and meet basic needs like food and housing. An analysis of private health insurance claims data has shown that a greater percentage of people with autism, alone or with intellectual or developmental disability, died from COVID-19 than people with no chronic conditions. The damage done by the pandemic makes the need for a greater investment in the community even more compelling. The research that you have funded has brought a range of lasting changes and significant improvements. We are at a pivotal moment. Now is the time to address the significant gaps we know persist so that every person on the spectrum can achieve their full potential.

[This statement was submitted by Stuart Spielman, Senior Vice President, Advocacy, Autism Speaks.]

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 2023. Our key CDC programmatic priorities include those most critical to our members: immunization, epidemiology and laboratory capacity, public health data modernization, workforce, infrastructure and capacity, opioid overdose prevention, violence prevention, public health preparedness, and addressing the social determinants of health.

BCHC is comprised of health officials leading 35 of the Nation’s largest metropolitan health departments, who together serve more than 61 million—or about one in five—Americans. Our members work every day to protect and promote the public’s health. We thank you for your continued leadership and support for our Nation’s public health workforce and systems.

As the subcommittee members recognize, sustained annual funding is necessary to build public health capacity for the next pandemic, as well as the everyday work that helps keep communities as healthy and safe as possible.

NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

National Immunization Program

We respectfully request \$1.1 billion in FY 2023 for the National Immunization Program. The CDC Immunization Program funds 50 States, six large, BCHC member cities, and eight territories for vaccine purchase and immunization program operations. Increased and sustained investment is needed to modernize immunization information systems (IIS), establish State-to-state IIS data sharing, increase and sustain a network of adult immunization providers reporting data into IIS, and engage with communities to build vaccine confidence and minimize disparities among people of color and those at heightened risk for acute outcomes from vaccine-preventable diseases. BCHC also supports the creation of a Vaccines for Adults program that is essential to reduce vaccination coverage disparities, improve outbreak control, and enhance and maintain the infrastructure needed for responding to future pandemics, as well as routine, annual infectious disease.

NATIONAL CENTER FOR EMERGING AND ZOO NOTIC INFECTIOUS DISEASE

Epidemiology and Lab Capacity

We respectfully request \$800 million in FY 2023 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, Puerto Rico, and the Republic of Palau. ELC provides critical support to and for epidemiologists and laboratory scientists who are instrumental in discovering and responding to various food, water, and vector-borne outbreaks, as well as funding vital improvements in health informatics. Despite ELC's vital role in responding to the pandemic, annual funding levels are not adequate to maintain public health preparedness or address routine challenges, particularly at the city or county level. An increase to ELC would enable increased support to local health departments to provide for their jurisdiction-specific needs, which should be sent directly to large, urban jurisdictions directly, wherever and whenever possible. Further, ELC dollars sent to the States should be better tracked through CDC reporting structures and shared publicly to contribute to Agency transparency and ensure funds are in fact supporting big city epidemiology activities.

PUBLIC HEALTH SCIENTIFIC SERVICES

Public Health Data Modernization Initiative (DMI)

We respectfully request \$250 million in FY 2023 for the DMI that is working to create modern, interoperable, and real-time public health data and surveillance systems 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. Access to timely, accurate data at all jurisdictional levels is perhaps our most enduring public health challenge.

Public Health Workforce

We respectfully request \$106 million in FY 2023 for CDC's public health workforce and career development programs, the same as the President's budget request. 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 and develop the next generation of the public health workforce, as well as attract and retain diverse candidates with varied 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 \$1 billion in FY 2023 for a public health infrastructure and capacity investment. 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 prevention and response infrastructure, such as equity; policy development and support; communications; community partnership and engagement; organizational competencies; transparency and accountability; and emergency preparedness and response.

Governmental public health infrastructure requires sustained investments over time, and we believe this is an important start. Building a response in real time, such as during the COVID-19 pandemic, is not the way to best protect our Nation's health. BCHC is grateful for the inclusion of funding in the FY 2022 Omnibus package and urge an ongoing investment to ensure that our governmental public health system is prepared not just for the next pandemic, but also to strengthen the health of our communities every day.

Center for Forecasting Epidemics and Outbreak Analytics

We respectfully request \$50 million in FY 2023 for the Forecasting Center that was established with American Rescue Plan Act funding to facilitate the use of data,

modeling, and analytics to improve pandemic preparedness and response. This is the same as the President's budget request. Local health departments do not have sufficient capacity to do such activities on their own and would greatly benefit from the information and tools developed by the Forecasting Center. Therefore, sustained funding is required to maintain the center's functionality over time. Such resources could be critical to other public health crises such as the dueling community epidemics of violence and opioid overdose.

NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Opioid Overdose Prevention and Surveillance

We respectfully request \$713 million in FY 2022 for Opioid Overdose Prevention and Surveillance in line with the President's request. Overdoses are increasing in almost all of our Nation's communities, erasing gains of recent years. CDC's funding to health departments through the Overdose Data to Action (OD2A) program has been a critical resource for prevention of opioid and polysubstance use but must be expanded to include more big cities to ensure that substance use prevention continues to stem the tide of overdose and death. Funded prevention efforts include harm reduction and linkage to care initiatives with a focus on health equity and reducing stigma. Local health departments also need to be able to use these funds to purchase Naloxone; SAMHSA-funded purchasing is insufficient in supporting distribution. There is no one Federal funding stream that supports Naloxone purchase at the local level. Finally, we also encourage the committee to include directive language to ensure these dollars reach the local level in those communities that are not directly funded, as well as have CDC and HHS better track and report publicly state expenditures.

Gun Violence Prevention Research

We respectfully request \$35 million in FY 2023 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 and continues to be an acute issue in our Nation's largest cities. Significant gaps remain in our knowledge about the problem and ways to best 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 deadly 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 targeted programs. Additional funds in FY 2023 would be used to fund a new grant program to implement a menu of evidence-based, evidence-informed, and emerging strategies to prevent firearm-related injuries and deaths in high-risk urban and rural communities.

Community Based Violence Intervention Initiative

We respectfully request \$250 million in FY 2023 for a 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 and believes it is critically important to have both funds at, and engagement of, the CDC's National Center for Injury Prevention, to complement efforts funded through the Department of Justice. 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. 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 FY 2023 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 percent 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, predictable base funding for years to rebuild and improve. We also encourage the committee to include directive language to ensure these dollars reach the local level in those communities that are not directly funded, as well as have CDC 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 FY 2023 for the Social Determinants of Health (SDOH) program in line with the President's request. CDC's SDOH program was initially funded in FY 2021 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 and preventable inequities in health outcomes. Contact: Chrissie Juliano, MPP, Executive Director, Big Cities Health Coalition.

PREPARED STATEMENT OF THE BIPARTISAN POLICY CENTER

BPC is dedicated to finding bipartisan solutions to improve child care for children, families, educators, providers, and the broader economy. We know high-quality child care builds a strong foundation for young children and fundamentally supports the growth of their cognitive and social emotional development. There are more than 19 million children, or 27 percent of the U.S. population, under age 5 living in U.S. households and it is essential to both child development and a strong economic recovery that Congress ensure each of these children have access to high-quality child care.¹ In order to achieve this, we urge the subcommittee to address critical areas of need in the fiscal year (FY) 2023 Labor, Health and Human Service, Education and Related Agencies appropriations bill.

This testimony addresses two high-priority issues crucial to stable and thriving high-quality child care in our country. First is that the cost of care, which often exceeds what many parents can afford, freezing families out of the market without any high-quality care options to the most vulnerable populations. Second, the Nation is facing a shortage of safe and healthy child care facilities. While investments in facilities are critical, they are often not feasible for providers who are operating within a broken system and razor-thin profit margins. Consequently, providers do not have the capital to fund investments that prioritize the facility-related repairs, upgrades, renovations, and maintenance that meet modern safety and professional standards. Without the support of Congress, child care businesses will be unable to provide the necessary investment in facilities and parents, especially those in rural areas, will be denied access to the care they need. BPC believes it is essential to address both needs concurrently or the demand on child care will be overwhelmed by the lack of supply. For these reasons, BPC urges the subcommittee to double the discretionary funding for the Child Care Development Block Grant program (CCDBG), increase the Preschool Development Grant program (PDG) to \$450 million, and provide \$5 billion in dedicated funding to retrofit existing, and build new, child care facilities for FY 2023.

ECONOMIC IMPACT OF CHILD CARE

As this subcommittee considers the FY23 allocations for child care programming, BPC urges its members to weigh the impact lack of access to child care has on the Nation's post-pandemic economic recovery versus the costs of Federal support for increasing said access. While fundamental to the development of young children, access to child care as the Nation transitions away from remote work flexibilities can either serve as a barrier or present opportunities for employment. A BPC parent poll found 66 percent of parents said finding child care impacts the number of hours they can work, 50 percent said it affects whether they can search for a job, and 68 percent said it impacts whether they can stay in the workforce.² In BPC's 2021 report "Child Care in 35 States: What we know and don't know" found that over 3.4 million children (31.2 percent) with all available parents in the work force do not

¹ Child population by age group in the United States | KIDS COUNT Data Center.

² <https://bipartisanpolicy.org/blog/child-care-poll/>.

have access to a formal child care slot.³ The gap was higher in rural areas of the country and among women demonstrated by the fact that 1.3 million fewer mothers were employed in September 2021 compared to before the pandemic began.⁴ Our survey data shows the gap is highest among women with children under two. If the child care gap is not addressed, based on lost income to parents, businesses, and taxpayers, BPC estimates an economic loss across 35 States over the next 10-years to be between \$142.51 and \$217.02 billion.⁵ This estimation is not adjusted for inflation and could be more severe.

CCDBG AND PDG

Increases for both CCDBG and PDG would provide added stability and capacity to serve a greater number of qualifying families in need through high-quality care. Not adjusted for inflation, if Congress were to double the discretionary funding for CCDBG, BPC estimates that the U.S. Department of Health and Human Services (HHS) will likely be able to double the number of eligible children served. In addition to a greater investment for CCDBG, the increased funding for PDG will allow HHS to expand funding for the 28 States, Puerto Rico, and Guam which currently receive grants, as well as provide funding for almost all remaining States not currently funded.

BPC also urges Congress to authorize HHS and the Department of Education to allow Large Tribes to apply for PDG funding. Large Tribes, including the Muscogee Creek Nation of Oklahoma, are responsible for overseeing access to and delivery of early learning programming for as many as 53,354 children aged 0–4 years—a number greater than some States—yet are still not eligible for PDG support. Moreover, a 2018 report published by the Office of the Administration for Children and Families (ACF) found nearly one-third of American Indian and Alaska Native (AI/AN) young children live in households at or below the Federal poverty line.⁶ Additionally, only one-fifth of AI/AN young children were reported to have access to and attended an early care and learning program within a three-month period. BPC believes it is critical Congress address its systemic underfunding for AI/AN populations which begins with ensuring Large Tribes have equitable access to PDG funding.

CHILD CARE FACILITIES

Approximately 129,000 center-based child care programs serve nearly 7 million children in the United States, and 1 million in-home providers care for 2.7 million children.⁷ It is imperative that the physical spaces where kids learn, play, and grow contribute to their cognitive development and social, emotional, and physical well-being. However, many children might not have access to services that promote early learning. Instead, young children may be exposed to health and safety issues including lead, mold, dust, or other environmental pollutants that could cause long-term health developmental consequences.

As of 2018, the Environmental Protection Agency (EPA) reported that approximately 500,000 child care facilities are not regulated for lead in drinking water.⁸ Additionally, an investigation by HHS Office of the Inspector General found that across 10 States, 96 percent of child care centers inspected during unannounced visits had one or more potentially hazardous conditions and noncompliance with health and safety requirements.⁹ This is made worse because young children have frequent hand-to-mouth activity, meaning that potentially toxic or harmful substances within the facility have a high likelihood of being ingested. Other safety hazards include easily accessible electrical outlets, lead paint, unsafe play equipment, and open windows and gates.¹⁰

Due to razor-thin profit margins and a broken system where child care services have historically been undervalued, most providers do not have the ability to upgrade facilities and provide a competitive wage and increase access to meet the Na-

³ <https://bipartisanpolicy.org/report/child-care-gap/>.

⁴ <https://www.washingtonpost.com/politics/2021/11/08/why-havent-us-mothers-retained-work-child-care-infrastructure-they-need-is-still-missing/>.

⁵ https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/11/BPC-Economic-Impact-Report_R01-1.pdf.

⁶ https://www.acf.hhs.gov/sites/default/files/documents/opre/14005_acf_opre_aian_ec_needs_brochure_v7_072418_508b.pdf.

⁷ National Survey of Early Care and Education of 2012 (NSECE 2012) | The Administration for Children and Families (hhs.gov).

⁸ 3Ts for Reducing Lead in Drinking Water | US EPA.

⁹ <https://oig.hhs.gov/oei/reports/oei-03-16-00150.pdf>.

¹⁰ [CIFBldgInfrastructureReport.pdf](https://www.cedac.org/CIFBldgInfrastructureReport.pdf) (cedac.org).

tional need. Absent the necessary fiscal supports, providers will be unable to make facility-related repairs, upgrades, and renovations to meet safety standards. This lack of capital is compounded by the fact that more than 90 percent of child care businesses are women-owned and over half of the industry is minority-owned.¹¹ This lack of access to capital is further exacerbated by gender- and race-based discriminatory small business lending practices and results in parents left with no other options other than to place their children in a potentially dangerous setting.

BPC estimates a total of \$25 billion over a 5-year period is needed to address critical facilities needs. Beginning with \$5 billion for FY 2023, an estimated \$14 billion of the \$25 billion is needed to renovate existing facilities across the country to bring them up to professional standards with the remaining \$11 billion contributing to increasing the supply of new facilities. This will result in 12,600 new center- and home-based child care facilities, an additional 656,000 additional child care slots, and has the potential to reduce the number of children without access to care by 12 percent.

Increasing child care funding in FY 2023 is vital to the economic and social fabric of our Nation. After 2 years of living through endless challenges, unprecedented barriers to delivery of care, and exacerbated by the COVID-19 pandemic, the Nation recognizes the value of child care and the important role Congress plays in supporting families. Congress must provide a stable foundation for the child care system which is a pillar of a strong national recovery. We appreciate the subcommittee's bipartisan leadership and dedication to child care over the past 2 years and look forward to working together to improve our systems in order to better serve children and families.

PREPARED STATEMENT OF BLUE MOUNTAIN HEART TO HEART

Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee, my name is Everett Maroon and I serve as the Executive Director of Blue Mountain Heart to Heart (BMHTH), a nonprofit located in Walla Walla, Kennewick, and Clarkston, Washington, serving people living HIV/AIDS and people living with substance use disorder (SUD). I am pleased to submit testimony on behalf of the people I serve, my staff, my Board of Directors, and as a member of a large coalition of public health, HIV, viral hepatitis, and harm reduction organizations, to urge Congress to appropriate in fiscal year 2023 \$150 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) in the Department of Health and Human Services (HHS). This funding would help to save lives and address the urgent overdose crisis by providing support and expanding access to effective overdose prevention and harm reduction services provided by syringe services programs (SSPs).

No other public health intervention has been as thoroughly studied and examined in the last twenty-five years as SSPs. Notably, harm reduction work conducted at SSPs both satisfies classic public health objectives of primary, secondary, and tertiary health improvement (e.g., reduce the incidence of bloodborne pathogens, reduce the sequelae associated with needle use, and increase entry into treatment, respectively), and advances our understanding of real-time changes affecting our clients' front-line work that helps local and State public health jurisdictions ensure their work is relevant and useful. At BMHTH our strategic plan also includes reducing overdose and overdose death, and our hard work is showing success.

By every metric, the environment in which SSP clients find themselves is collapsing. They report to my staff and me that they have shifted from prescribed opiates to heroin, and now to fentanyl in the form of counterfeit oxycontin. Synthetic opioids appear to be driving much higher rates of overdose and contributing more often now to overdose death. In Washington State, an analysis of 2020 data on accidental overdose showed fentanyl was present in 70 percent of the toxicology results on autopsy. Meanwhile the median age of overdose death in Washington State has dropped to 29, indicating that many young people probably have died from their drug use before realizing how serious their substance use had become.

Earlier this month a young woman walked into a local SSP program and told me that she had overdosed on fentanyl the night before. I told her I was very glad to see her, since that was the case. She asked for naloxone. I gave her four kits of the reversal medication so she could bring some back to her friends who also use fentanyl and who live about 90 minutes away. She mentioned that when she "came to" in the emergency department at the Walla Walla hospital, the doctor left her

¹¹ <https://cdn.advocacy.sba.gov/wp-content/uploads/2016/09/07141514/Minority-Owned-Businesses-in-the-US.pdf>.

room quickly, crying. He returned shortly thereafter and explained that she was the first fentanyl overdose he'd been able to revive after losing six others—almost one person per day in his ER alone—in the preceding week.

It is incredibly important for your subcommittee to understand how urgent the overdose crisis is right now, not just in Washington State, but across our Nation. Naloxone distribution is essential, and getting it to the communities most at risk is paramount. A 5-year SAMHSA grant in Washington State that concluded in August 2021, in which BMHTH participated, showed that 1 in 7 naloxone kits given to clients at SSPs was used to attempt an overdose reversal. Robust naloxone distribution is part of Washington State's current national drug control strategy as well as part of the Washington State opioid crisis response plan. SSPs like mine have saved lives and made a significant difference in our regions and we need more support now. Comprehensive services to increase access to drug treatment and recovery are also necessary, but we must save people's lives first so that they have the chance to benefit from these interventions.

As a rural health provider who for the past 2 years has battled syndemic crises in HIV, hepatitis C, COVID-19, and the overdose crisis, I sincerely request that Congress provide the \$150 million requested for the health of our communities in central and southeast Washington State and nationwide. We are exhausted, but steadfast in our commitment to keeping our community members alive and helping them on the pathway to health. I have met and talked to grandmothers who became addicted after knee replacement surgery, veterans who became addicted after three tours of duty in Iraq and surviving a shrapnel injury, nurses who started stealing medications because they'd experienced too much stress in the emergency department, a middle-aged man whose parents had injected him with heroin as a child to make him quiet down ... my list of stories is harrowing, and sadly, it is growing. We need real relief and support now.

In Washington, our Attorney General has doggedly sued opioid distributors and manufacturers and won settlements. We hope that these gains will help fund life-saving services, but alone they won't restore our communities to their condition prior to the current crisis. Worse, COVID-19 has disrupted the ability of many community-based organizations to order naloxone while at the same time more fentanyl appeared in the drug market. There must be a robust Federal response to this unprecedented crisis both to save lives and build back our communities. Congress has the resources necessary to halt these dramatic losses and start needed healing.

In the meantime, as of April 30, 2022, we have reports of more than 230 overdose reversal attempts in southeast Washington with our naloxone distribution program, a trend that would bring us to 658 by the end of this year. In 2021 we saw 301 naloxone reversals. I cannot state clearly enough how quickly the environment is disintegrating with more than a doubling of overdoses expected based on current trends. The data are shown in the table below.

Table. Naloxone distribution at three SSP sites in southeast Washington State:

		January	February	March	April	May		Totals
Kennewick	overdose administrations	23	26	13	15	6		83
Distribution	Naloxone	72	93	79	74	6		324
	narcan	21	18	13	6			58
	unspecified refills*							0
								382
Walla Walla	overdose administrations	18	25	27	17	8		95
Distribution	naloxone	64	153	101	80	37		435
	narcan	35	23	41	0			99
	unspecified refills							0
								534
Clarkston	overdose administrations	16	19	14	16	1		66
Distribution	naloxone	58	57	71	56	4		246
	narcan	5	6	1				12
	unspecified refills							0
								258
Overdose Reversal Admins by Month		57	70	54	48	15	Total Administrations	244
							Total Distributed	1174

As a service provider who provides harm reduction, low-barrier treatment, intensive case management, field-based counseling, law enforcement-assisted diversion, and jail-based opioid treatment, I have attempted to fill many of the gaps I see in my rural region of Washington State. I am doing everything in my power to support people at risk of overdose and death, but I am faced with limited Federal funding for SSPs and overdose prevention; work restrictions on providers of treatment medications that make finding local providers difficult; a fractured health care sector in my region; and a skyrocketing overdose rate.

We know that people accessing SSPs are five times as likely to get into treatment and three times as likely to lower their drug use by frequency or quantity. A 2019 SSP survey conducted by the University of Washington showed that more than three quarters of SSP participants were somewhat or very interested in treatment. I urge you to please help me get them the life-saving care that they need now by fully funding the CDC's Infectious Diseases and Opioid Epidemic at \$150 million in FY 2023. Thank you so much for your time and consideration of my testimony.

[This statement was submitted by Everett Maroon, Executive Director, Blue Mountain Heart to Heart, Walla Walla, WA.]

PREPARED STATEMENT OF THE BRAIN INJURY ASSOCIATION OF AMERICA

As the Nation's oldest and largest brain injury advocacy organization, the Brain Injury Association of America (BIAA) is submitting written testimony in support of increased funding for fiscal year 2023 appropriations for Federal programs that impact approximately 2.87 million Americans who are treated annually in emergency departments and hospitals for a traumatic brain injury (TBI) and their families, who are generally the primary caregivers. While BIAA appreciates your support for additional funding for FY 2022 to the U.S. Department of Health and Human Services' (HHS) Administration for Community Living (ACL) TBI Programs, the total

program amount does not support funding for all States and territories to participate in that program designed to improve access to rehabilitation and community services as intended by the Traumatic Brain Injury (TBI) Program Reauthorization Act of 2018.

In addition, BIAA supports full funding for the National Concussion Surveillance System administered by the CDC's National Center for Injury Prevention and Control (NCIPC) in order to know the extent of concussions or mild TBI in this country so that we can better recognize and treat related symptoms. BIAA has also been a long supporter of 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, which funds research conducted by the TBI Model Systems. Specifically, BIAA urges:

- \$19 million additional funding for the ACL TBI State Partnership Program to provide funding to all States, territories and District of Columbia;
- \$5 million 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; and
- \$6.6 million to expand the NIDILRR TBI research capacity through the ACL TBI Model Systems (TBIMS) in order to increase the number of TBIMS from 16 to 18 (\$2.5 million each; and to expand TBIMS collaborative research projects for additional research on TBI as a chronic condition (\$1 million).

A TBI can happen to anyone at any time and can lead to physical, cognitive, and psychosocial or behavioral impairments ranging from balance and coordination problems to loss of hearing, vision or speech. Fatigue, memory loss, concentration difficulty, anxiety, depression, impulsivity and impaired judgment are also common after brain injury. Even "mild" injuries or concussions can have devastating consequences that require intensive treatment and long-term care. Often called the "silent epidemic," brain injury affects people in ways that are invisible. The injury can lower performance at school and at work, interfere with personal relationships and bring financial ruin.

The annual estimated cost to society exceeds \$60 billion, and consumers mistakenly believe employer health plans or the government will pay for needed services in a health crisis. In reality, insurance policies are geared to wellness and routine care, strictly limiting the type, amount, and length of rehabilitation and post-acute brain injury services available to most people. Therefore, families and individuals living with brain injury generally look to public programs to address these gaps in service delivery.

The following personal story explains all too well what can happen:

"I was in a really bad car accident on December 23rd, 2017. I still to this day have little to no memory of what happened, only from what I was told. It happened around 11pm, my ex-boyfriend was driving my car and somehow ran off the road, hit a tree, the car flipped the whole way around, I was immediately unconscious, he tried to drive away but the car was totaled. He took me out of the car and laid me on the side of the road while I was unconscious and bleeding internally, and he ran away, basically leaving me there for dead. A man in a nearby house heard what happened, came outside and saw me, called 911, my heart stopped beating 3 different times, I had to be airlifted to Hershey, I was immediately put into an induced coma which lasted 2 weeks.

I broke my spine, broke my neck, fractured my sternum and suffered a severe traumatic brain injury, I also had a minor stroke while I was in the coma which affected my whole right side. I lost my voice completely because I was on a ventilator for longer than your supposed to be, I had several skull fractures. I was then transferred to Hershey rehab hospital which I stayed for 3 months. Had to learn pretty much everything all over again. How to walk, write, spell, bath myself, dress myself, feed myself. I came home sometime in March of 2018, continued therapy. I'm still struggling with severe headaches, neck pain, everything that comes with a brain injury. That happened when I was 26, I'm 30 now. I was given very little hope of survival, but I'm still here, still alive, telling my story."

The causes vary from child abuse; motor vehicle crashes, falls, military-related injuries, violence, industrial injuries, and sports-related injuries. No one is immune from this disability. Yet, there are few resources to support families and caregivers with assistance in early recovery and through the rehabilitation process, let alone long-term care needs. 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, and Medicaid/Medicare) and payers (e.g., insurance, Workers' Comp, State and Federal programs). Twenty-eight States are currently funded by the ACL

TBI SPP for 5 years. 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.

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.

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.

The Brain Injury Association of America was founded in 1980 by individuals who wanted to improve the quality of life for individuals who had sustained brain injuries and their families. Today, the Association encompasses a nationwide network of more than 40 state affiliates sharing in the mission of creating a better future through brain injury prevention, research, education and advocacy. We urge you to consider increasing funding to the ACL TBI Program; the ACL NIDILRR program to expand TBI research; and to 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 me at: Susan H. Connors, President/CEO, Brain Injury Association of America, Email shconnors@biausa.org.

[This statement was submitted by Susan H. Connors, President/CEO, Brain Injury Association of America.]

PREPARED STATEMENT OF BRIDGERCARE

Dear Chairwoman Murray and Ranking Member Blunt:

As Executive Director of Bridgercare, I appreciate the opportunity to submit testimony in support of expanding the budget for the Title X family planning program (Office of Population Affairs, funded within the Health Resources and Services Administration account). We recognize and appreciate Chairwoman Murray's strong record of advocacy and leadership in fighting for family planning services and urge this subcommittee to take necessary action to move the program forward in this year's bill by appropriating the full \$400 million requested by the Biden administration.

Bridgercare is a nonprofit Title X clinic in Bozeman, Montana that has served our community for 50 years. Our mission is to provide excellent, affordable reproductive and sexual healthcare and education in a safe, supportive, empowering atmosphere. We serve over 5000 patients a year, around half of whom receive care on our sliding fee scale where patient fees are based on income. We provide a wide range of services from annual wellness exams, to STI testing and treatment, to cancer screenings, genetic cancer counseling, pregnancy testing, gender-affirming care, behavioral health counseling, and more. And as of April of this year, we will steward Montana's Title X program in place of the State health department through a new statewide nonprofit, Montana Family Planning.

Title X is the only Federal program solely dedicated to providing family planning services to people in the United States regardless of income. It was enacted with broad bipartisan support in 1970: sponsored by then-Representative George H.W. Bush and signed into law by President Nixon. Prior to Trump administration changes to the program in 2019, Title X served more than 4,000,000 patients across the country, and about 18,000 in Montana (a significant number in a State with a population of a little over a million). Title X clinics are invaluable resources in communities, serving a population of patients who often don't otherwise interact with the health care system. In 2016, 60 percent of women who received contraceptive services at a Title X-supported provider had no other interaction with the medical system that year.¹

¹ Ruth Dawson, "What Federal Policymakers Must Do to Restore and Strengthen a Title X Family Planning Program That Serves All," Guttmacher Institute (March 2021)

However, changes to the Title X program in 2019 decimated the National network—Montana was no exception. Between 2018 and 2020, the amount of patients served by Montana Title X clinics decreased by a staggering 53 percent.² We lost four clinics out of a network of 27. What this means in real terms is that thousands of Montanans were left without access to quality, affordable reproductive health care. Our desire to see the Title X program made whole again, and expanded, in Montana was a big factor in Bridgercare competing the state for stewardship of the program.

Since being awarded the Title X grant for Montana by HHS, we've already had five clinics reach out asking to join our network, and are well on our way to rebuilding Title X in Montana—we intend to grow the number of Montanans served by 10–15 percent each year for the next 5 years. Further, we'll develop a stronger administrative structure to respond to the diverse needs of providers across the State; we'll allocate dollars through clear, transparent means and ensure that Title X funds achieve their maximum possible return on investment in Montana. We'll focus on bolstering Title X services in rural, frontier, and Tribal communities and adolescent, Indigenous, and other underserved populations.

Expanding the Federal Title X program budget to \$400 million will likely coincide in a larger disbursement to Montana's Title X program, helping us to increase support for our subrecipients in every part of our state, and bolster investments in expanding reproductive health care access to historically underserved communities. We hope that this subcommittee will seize this opportunity to invest in quality, affordable reproductive health care for millions of people across the country. For more information, please contact: Stephanie McDowell, at smcdowell@bridgercare.org.

We thank you for your consideration of this request.

Sincerely,

[This statement was submitted by Stephanie McDowell, Executive Director, Bridgercare.]

PREPARED STATEMENT OF CAST

Since 1984, CAST (originally the Center for Applied Special Technology) has worked tirelessly to ensure that our Nation is one where learning has no limits for any individual. We pioneered Universal Design for Learning (UDL), a framework for inclusive design of learning and training environments that harnesses technology and instructional practices to remove barriers to learning in digital as well as physical settings. UDL is now incorporated in key Federal education, career training, and workforce laws.¹ UDL provides principles and guidelines to support innovation and success by expanding and strengthening preschool to post-secondary education as well as career training opportunities, including access to Science, Technology, Engineering and Math (STEM) for all individuals across the Nation.

Our aim is to create a level playing field where all learners have equitable opportunities to succeed by expanding access and opportunity to education and employment for all individuals, including those historically marginalized due to race, language, income, or disability. UDL encourages the design of flexible learning environments that anticipate learner variability and provide alternative routes or paths to success. UDL acknowledges that variability across all learners is the norm rather than the exception.

In support of its important portfolio of projects that include investments at the Federal level, in fiscal year 2023, CAST makes two recommendations for the U.S. Department of Education:

- (1) Include funding for a pilot to comprehensively develop and systemically embed the UDL framework across multi-State/multi-district/Tribal government [K–4 classrooms] as part of in-person, hybrid, or virtual learning environment(s) for a minimum of 3 years. The pilot will utilize the evidence-based principles, flexible scaffolds, and supports of UDL and will be awarded to States/districts/Tribal governments to support the full access of students with disabilities to the general curriculum, and to support all learners at-risk due to experiencing

<https://www.guttmacher.org/gpr/2021/03/what-federal-policy-makers-must-do-restore-and-strengthen-title-x-family-planning-program>.

²Brittini Frederiksen, Ivette Gomez, and Alina Salganicoff, "Rebuilding Title X: New Regulations for the Federal Family Planning Program," Kaiser Family Foundation (November 2021) <https://www.kff.org/womens-health-policy/issue-brief/rebuilding-title-x-new-regulations-for-the-federal-family-planning-program/>.

¹See: Public Law 110–315, Public Law 113–228, Public Law 114–95, Public Law 115–224, National Education Technology Plan 2021, U.S. Department of Education.

barriers to learning because of language, literacy, socioeconomic factors, or disability.

- (2) Fund education programs to sufficiently support States in their efforts to train personnel and educate all K–12 students. Key programs are:

(A) *Elementary and Secondary Education*

- Title I*: \$36.5 billion for students to access a quality education, and
- Title II*: \$2.5 billion to support teacher professional learning and student access to literacy, evidence-based instruction and practices including UDL.
- Results for the Nation (LEARN)*: \$192 million to improve English Language Arts.

Examples of UDL funded in K–12 schools (via ESSA’s Title I/II and/or combined Federal and State funding).

California:

- The California Coalition for Inclusive Literacy has trained more than 30 County Office of Education staff to become UDL coaches in five counties across the State.
- The Far North Literacy Consortium in Northern California works with five counties to implement UDL district-wide in rural areas of the state.
- With joint funding from the National Science Foundation Co-Organize Your Learning (CORGI) enhances engagement and learning through a Google application (app) designed for students and teachers to use and collaboratively answer questions requiring higher order reasoning.

New Hampshire:

- The NH UDL Innovation Network brings CAST together with 70 schools and 500 educators across the State. Participants engage with a small team from their school to learn what UDL is and how to apply it in their K–12 learning environments. Through collaborative school-based instructional rounds, online learning, statewide workshop days, and team-supported reflective practice, participants work to transform their classrooms for greater access and to support student agency.

(B) *Individuals with Disabilities Education Act (IDEA):*

- Part B Section 611*: \$16.2 billion to place the IDEA on a glide path to full funding (or 40 percent of the per pupil expenditure promised to districts when the IDEA was first passed in 1975).
- Part D-National Activities*: To provide the infrastructure to implement programs for students with disabilities through professional development, technical assistance, and more. Recommendations are:
 - State Personnel Development: \$39 million.
 - Technical Assistance and Development: \$49 million.
 - Personnel Preparation: \$300 million
 - Parent Training and Information Centers: \$45 million
 - Media and Technology: \$32 million

Examples of UDL funded under IDEA Part D:

- The National Center on Accessible Education Materials (AEM Center) provides technical assistance, coaching, and resources to increase the availability and use of accessible educational materials and technologies for learners with disabilities across the lifespan. The Center’s Quality Indicators provide practitioners, administrators, researchers, policymakers, and parents/caregivers with actionable steps toward increasing the availability and use of accessible materials and technologies from early learning through postsecondary education and workforce development.
- The Center on Inclusive Software for Learning has created and launched Clusive, a free, flexible, adaptive, and customizable digital learning environment. Students can use Clusive to read assigned or free-choice books and articles, build their own personal library, and take advantage of Clusive’s growing public library. Clusive helps learners build self-awareness through discovering, choosing, and using preferences that help build learning skills.

(C) *Career and Technical Education (CTE):*

- State Grants and National Programs: \$1.6 billion so States can develop career training pathways responsive to the needs of business and of learners that include a diverse population who may experience barriers such as poverty, low literacy, language and/or disability.

Examples of UDL in CTE: CAST's work with States, school districts and private partners increases access to well-designed curriculum and career training incorporating UDL that is especially focused on diverse youth and young adult learners. Two recent examples are:

- Outdoor Recreation Pathways (Tillotson Foundation): The project brings together outdoor recreation industry professionals, students, and educators to develop competencies and outline a CTE pathway into high-wage high-demand careers in this emerging field for youth in New Hampshire.
- BioFab Explorer: BioFab Explorer is a free educational resource developed in partnership with industry members from the Advanced Regenerative Manufacturing Institute (ARMI)/Biofab USA, as well as in collaboration with CTE educators and their students in New Hampshire. This free career exploration resource is meant to attract high school students into biomanufacturing. Biofab Explorer embeds UDL by providing learners with several pathways through the content and allowing everyone to build a customized user experience. Information is presented through multiple modalities to provide users with choices that best meet their needs.

(D) Vocational Rehabilitation:

- Demonstration and Training Programs: \$40.8 million for grants to spur innovative approaches and new partnerships that address long-term barriers as well as novel challenges that limits employment of individuals with disabilities.

CAST appreciates the subcommittee's consideration and urges a continuing investment in educational innovations that incorporate effective implementation of UDL while prioritizing the need to include UDL as part of the infrastructure of workforce and CTE faculty training makes sense.

As the subcommittee considers funding for career training and employment, CAST makes the following recommendation for the U.S. Department of Labor (DOL): Provide increased investments in research as well as career-exposure and training for eligible youth, young adults and adults who may experience barriers due to educational access/completion, literacy and/or disability. Key programs are:

(A) Office of Disability Employment Policy:

- Research and Demonstration: \$9 million to continue to develop, influence and expand employment-related policies and practices so that every youth, young adult, and adult with a disability gains access to career training and STEM career experiences.

(B) YouthBuild: \$145 million to support grants that provide work-based pre-apprenticeships, in support of unemployed youth and those who left high school prior to graduation.

(C) Job Corp: \$1.6 billion to ensure participants receive training that reflects the labor market's need for in-demand skills conveyed by up-to-date industry standards including creating proactive and innovative partnerships that further modernize its training and connect industry leaders to a diverse student body.

Examples of UDL funded by DOL:

- CEE-STEM: An Online STEM Career Exploration and Readiness Environment for Opportunity Youth is a web-based STEM Career Exploration and Readiness Environment to promote STEM understanding and knowledge as a part of classroom and career training for out of school youth. CAST, UMass Amherst College of Education, and YouthBuild USA developed the CEE-STEM project and utilized the UDL framework to create a personalized and portable digital tool for youth to explore STEM careers, demonstrate STEM learning, reflect on STEM career interests, and take actions to move ahead with STEM career pathways of interest. Going beyond the pilot, a customized version of the tool was also developed- to align with alternative careers, industries, or educational environments, and allows use of the e-portfolio for other purposes and populations. The e-portfolio was also piloted in two high school CTE settings and a registered pre-apprenticeship setting.
- The Wisconsin Regional Training Partnership supports the implementation of CAST's UDL e-portfolio in pre-apprenticeship programs in Wisconsin and Minnesota to help prepare and assess preparedness for the Industrial Maintenance Technician apprenticeship pathway. Partners are Jobs for the Future and SPR under the Apprenticeship Inclusion Models grant funded by the Office of Disability Employment within DOL.

CAST urges the subcommittee to further invest in programs that expand the use of the UDL framework. In doing so, Congress would increase the capacity of States, districts, schools and career training programs to provide more robust professional learning and other needed technical assistance so that teachers have the tools and

resources they need to teach and provide educational support to all learners. It is imperative that all youth and young adults, including first-time career seekers or those desiring new opportunities, have access to workforce development and career pathway strategies and programs that are designed from the beginning with their learning variability in mind.

CAST appreciates the opportunity to provide testimony to the subcommittee for the fiscal Year 2023 appropriations bill. We look forward to working with you as you develop a final appropriations bill that recognizes UDL as an integral component to K-16 education, and to increasing and sustaining a well-trained and vital workforce. Sherri Wilcauskas, swilcauskas@cast.org, www.cast.org

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 \$11 billion for CDC's programs in FY 2023 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 some CDC programs in FY 2022 and we urge Congress to continue efforts to build upon these investments and increase funding to strengthen all of CDC's programs.

CDC serves as the command center for the Nation's public health defense system against emerging and reemerging infectious diseases as well as man-made and natural disasters. From playing a leading role in aiding in the surveillance, detection and mitigation of the COVID-19 pandemic in the U.S. and globally, to monitoring and investigating other disease outbreaks, to pandemic flu preparedness, CDC is the Nation's—and a global—expert resource and response center, coordinating communications and action and serving as the laboratory reference center. 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.

We thank you for your support for important public health infrastructure programs including the Public Health Infrastructure and Capacity program which will provide flexible funding to strengthen core public health infrastructure and capacity needs at all levels of government, the Public Health Workforce and Career Development program to ensure the Nation has a strong and well-trained workforce and Public Health Data Modernization Initiative is helping to build a world-class and modern data infrastructure system to ensure all systems can communicate and share data seamlessly with one another to adequately respond to the next public health emergency.

Injuries are the leading causes of death for people ages 1-45. 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. CDC reports that in 2019, the total economic cost of both fatal and nonfatal injuries totaled \$4.2 trillion. In 2021, drug overdoses killed more than 100,000 individuals nationwide. CDC provides States with resources for opioid and other drug overdose prevention programs and to ensure that health providers to have information to improve opioid prescribing and prevent addiction and abuse. In 2022, there were 45,222 firearm-related fatalities in the U.S. We thank Congress for providing CDC with dedicated funding for firearm morbidity and mortality prevention research and strongly urge you to increase funding in FY 2023 to \$35 million at CDC. The National Center for Injury Prevention and Control must be adequately funded to conduct research, prevent injuries, address the Nation's drug overdose epidemic and help save lives.

In 2020, 696,962 people in the U.S. died from heart disease, the Nation's number one cause of death. More males than females died of heart disease in 2020, 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 2020, 160,264 people died of stroke, accounting for about one of every 19 deaths. Annually, heart disease and stroke cost the U.S. an estimated \$378 billion in health care and lost productivity. CDC's Heart

Disease and Stroke Prevention Program; WISEWOMAN; Division of Nutrition, Physical Activity, and Obesity; 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 609,000 deaths from cancer are expected in 2022. 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 percent. 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. The National Breast and Cervical Cancer Early Detection Program helps millions of low-income, uninsured and medically underserved women access lifesaving breast and cervical cancer screenings and provides a gateway to treatment and the Colorectal Cancer Control Program improves screening rates among targeted, low-income populations aged 50–75 years.

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 37 million Americans living with diabetes, more than 8.5 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.

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 more than 13 percent 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 investment in the Social Determinants of Health program and urge you to increase funding for the program to ensure that public health departments, academic institutions and nonprofit organizations are supported to address the SDOH that contribute to high health care costs and preventable inequities in health outcomes.

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 13 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 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 \$11 billion for CDC's programs in FY 2023.

[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

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 2023 (FY23). 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 increase funding to a \$2.5 million appropriation for the program in FY23 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 (Public Law 106-310 Title 23) and is the only such program that receives Federal funding for Tourette Syndrome (TS) public health education. The program has been flat funded since Fiscal Year 2015. The additional \$500,000 would fund: (1) a systemic literature review to determine prevalence of TS and tic disorders, (2) a systematic literature review to document cost and impact of TS and tic disorders, (3) small grants to pilot innovative approaches at Centers of Excellence (CoE) in 5-7 States to address priority needs including health equity, transition, and suicide prevention among families affected by TS and tic disorders through CoEs, and (4) two new Continuing Medical Education (CME) modules to serve U.S. providers to increase providers' ability to identify, diagnose and treat tics and tic disorders. With your support at the increased level of \$2.5 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 50 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 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 percent of parents struggle to cover the high costs of services for their child such as counseling, appointments and tutoring; 34 percent 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 percent 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 percent 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 percent 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 percent) 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 percent 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-Hyper-

activity 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 percent of children felt that dealing co-occurring conditions was one of the biggest challenges in managing TS. In addition, 32 percent of children and 51 percent 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 percent of children felt that TS negatively impacted their school experience and education and 69 percent 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 percent 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 2023 for the Tourette Syndrome Public Health Education and Research Program at CDC's National Center for Birth Defects and Developmental Disabilities at the increased level of \$2.5 million.

PREPARED STATEMENT OF CHOOSE HEALTHY LIFE
SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

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- Please provide the National Institutes of Health (NIH) with at least \$49 billion to facilitate continued growth in rare disease research activities.
 - Please provide proportional increases for the individual NIH institutes and centers, and \$660 million for the National Institute on Minority Health and Health Disparities (NIMHD) consistent with the administration's budget request.
 - Please provide a separate, meaningful increase to advance and adequately support the emerging Advanced Research Projects Agency for Health (ARPA-H).
 - Please provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion to support public health efforts.
 - Please provide proportional increases for the individual CDC centers, please continue to support the Ending the HIV Epidemic Initiative, and please provide the Social Determinants of Health program with \$150 million consistent with the administration's budget request.
 - Provide the Health Resources and Services Administration (HRSA) with a funding level of at least \$9.8 billion
 - Please continue to provide meaningful funding to support ongoing COVID-19 response activities.
 - Please establish a faith and community-based Health Equity Innovation Fund of at least \$100 million. The fund will provide resources to organizations that created a health workforce to address COVID-19 in underserved communities and now need resources to sustain that workforce as it addresses the underlying health inequities that led to the disproportionate morbidity and mortality the communities faced during the pandemic.
-

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to present the written testimony of Choose Healthy Life. On behalf of the communities we serve, we deeply appreciate the FY 2022 research and public health funding for COVID, for infectious diseases, for health equity, and for chronic conditions. As you work with your colleagues on FY 2023 appropriations, please continue to invest in public health and support organizations conducting innovative faith-based and community outreach.

About Choose Healthy Life

Choose Healthy Life (CHL) is a Black church initiative that ensures churches—the oldest and most trusted institutions in the Black community—receive the necessary resources, training, and support to address COVID-19 and other health inequities by making available health services to hard-to-reach communities.

With funding from the Quest Diagnostics Foundation, in January 2021, CHL established a full-time faith-based health workforce initially in fifty (50) Black churches in five major cities focused on administering COVID-19 testing and vaccination.

Based on the early success of the program, CHL churches were visited by both VPOTUS and FLOTUS, and in August 2021, CHL received funding from HRSA and grew its workforce to 120 churches across 13 States and the District of Columbia.

Since launch, CHL has conducted nearly 2,500 testing/vaccination events and administered over 90,000 COVID-19 tests and vaccinations through its churches.

Choose Healthy Life, founded by Debra Fraser-Howze, is guided by its 10-member National Black Clergy Health Leadership Council that is co-chaired by Rev. Al Sharpton (National Action Network) and Rev. Calvin O. Butts III (The Abyssinian Baptist Church, Harlem, NY).

Advising the clergy is an acclaimed Medical Advisory Board that includes former HHS Secretary Dr. Louis Sullivan, former CDC Director Dr. Tom Frieden, our Nation's first female medical doctor to serve in congress Dr. Donna Christensen, Co-founder of the Black Coalition Against COVID-19 Dr. Reed Tuckson and the Nation's top obesity medicine expert Harvard Medical School's Dr. Fatima Cody Stanford. Choose Healthy Life demonstrates the power that comes from the union of bringing faith and science together to address health disparities.

As the COVID-19 pandemic enters the endemic phase, CHL is pivoting its faith-based health workforce to focus on addressing key underlying health inequities—specifically obesity, diabetes, hypertension, maternal and mental health.

As stated by CDC Director Dr. Rochelle Walensky, "Your model of establishing in each church a full-time public health navigator ... trained and charged with pro-

viding access to COVID-19 testing and vaccinations in the immediate short-term while addressing other health disparities in the long term ... is a sustainable, scalable, and transferable approach to address public health disparities and inequities in the Black community ... it will serve us well far beyond the pandemic.”

About Health Disparities & CHL Support

- Healthcare outcomes in the Black community lag far behind healthcare outcomes in comparison to the White population:
- Adults are 30 percent more likely to be obese
- 60 percent more likely to be diagnosed with diabetes
- Men are 30 percent and women 60 percent more likely to have high blood pressure, with women twice as likely to have stroke
- Women are 40 percent more likely to die of breast cancer
- Twice as likely to die from COVID-19 and less likely to be vaccinated

About The Black Clergy Action Plan to Eliminate COVID-19 and Address Health Equity

- The Black church is the oldest and most trusted institution in the Black community and has the power to influence and drive change
- Establishes a health workforce in the Black Church to deliver vaccinations, testing, and to provide health services through local partners to those most in need
- Ensures that Churches are funded to sustain and build out its health services offering and effectively measure local impact
- Raises awareness and educate the Black clergy and community about COVID-19 and other health disparities
- Establish a network of trusted health navigators in the Black church to develop and execute a Community Solutions Action Plan (CSAP) to effectively measure local impact
- Proactively engages high-risk communities through COVID-19 testing/vaccination campaigns with the goal of stopping the spread of the virus and establishing pandemic preparedness
- Informs, educates and addresses health inequities that exist within the community (i.e. obesity, diabetes, and hypertension) through preventative health care and wellness outreach

About the Health Equity Innovation Fund

The Health Equity Innovation Fund will provide resources to organizations that created a health workforce to address COVID-19 in underserved communities and now need resources to sustain that workforce as it addresses the underlying health inequities that led to the disproportionate morbidity and mortality the communities faced during the pandemic. Many of these organizations sprung to life from within the community with private support to immediately address the pandemic. They have been results oriented, culturally competent, and directed by trusted leaders in the community. Too often the government provides resources to address challenges in underserved communities during a time of crisis and then abandons them after the crisis is over. The government needs to invest in those that are having an impact to ensure that they are sustainable into the future.

[This statement was submitted by Debra Fraser-Howze, Founder & President, Choose Healthy Life.]

PREPARED STATEMENT OF THE CHRONIC DISEASE ALLIANCE

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- Provide the National Institutes of Health (NIH) with at least \$49. Billion, a \$3.5 billion increase over FY 2022.
 - Please provide proportional increases for individual NIH Institutes and Centers.
 - Please provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
 - Provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion, a \$2.55 billion increase over FY 2022.

- Please provide CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) with systematic and meaningful annual increases to bring total funding up to \$3.75 billion over the next 3 years.
- Please provide \$6 million for the Chronic Disease Education and Awareness (CDEA) Program at CDC and NCCDPHP.

Thank you for the opportunity to submit testimony on behalf of the Chronic Disease Alliance and the National patient organization that support Chronic Disease Day. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, we extend our thanks for the significant investments in HHS through the FY 2022 omnibus package, particularly the annual increases for NIH and CDC. As you work with your colleagues on appropriations for FY 2023, please continue to invest in programs that serve the chronic disease community, most notably NCCDPHP at CDC. Thank you again for your leadership on health funding issues and for the opportunity to present the views of the chronic disease community.

ABOUT CHRONIC DISEASE DAY

Chronic diseases account for 7 of the top 10 causes of death in America and more than 90 percent of our annual healthcare spending. Hundreds of thousands of Americans who suffer from unpreventable chronic conditions need access to care. But the deadliest and costliest chronic diseases are also the most preventable. We promote actionable resources to lower the rate of preventable chronic diseases so that our healthcare system can better support individuals with unpreventable chronic conditions and invisible illnesses.

ABOUT CHRONIC DISEASE & INVISIBLE ILLNESS

Chronic Disease Day is an opportunity for legislators to pledge to address issues that impact across the entire chronic disease community. These issues include funding needed medical research and public health programs and advancing legislation that supports a patient's ability to access the care they need. While we reflect on recent progress and opportunities for further advancement around July 10th, our community of supporters work year-round to educate policymakers about contemporary issues and to use our stories and collective voice to advocate for issues that impact across the chronic disease community.

NIH and CDC both play key roles in preventing and addressing chronic illness. There is tremendous opportunity for the chronic disease community with increased funding, particularly innovative and impactful public health efforts led by CDC and NCCDPHP, such as the emerging CDEA program. There is also tremendous overlap between chronic conditions and health disparities, and we encourage robust resources for efforts to promote health equity, such as those led by NIH's National Institute on Minority Health and Health Disparities and CDC's Social Determinants of Health Program.

[This statement was submitted by Clorinda Walley, President, Good Days, Chronic Disease Alliance

PREPARED STATEMENT OF THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- CCTS joins the broader medical research community in asking Congress to provide the National Institutes of Health (NIH) with at least a \$3.5 billion funding increase for FY22, to bring total agency funding up to a minimum of \$49 billion annually.
 - Please provide the Clinical and Translational Science Awards (CTSA) program at the National Center for Advancing Translational Sciences (NCATS) with at least a \$35 million increase in dedicated line-item funding for FY23 to bring annual support for the program up to a minimum of \$641 million.
 - Please provide separate, additional funding to further support and implement the Advanced Research Projects Agency for Health (ARPA-H).
 - Please provide the Cures Acceleration Network (CAN) at NCATS with \$90 million in dedicated funding for FY23.

- 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 FY23.
- 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 \$11 billion for the Centers for Disease Control and Prevention (CDC).

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the strong support for the full spectrum of medical research demonstrated through the FY22 omnibus appropriations package. Particularly, thank you for maintaining line-item funding for the Clinical and Translational Science Awards (CTSA) program, for providing a meaningful annual funding increase for CTSA, and for the detailed instructions regarding utilization of CTSA funds and the central role of CTSA hubs. The value, importance, and impact of the CTSA program (as well as full-spectrum research at NIH) has been highlighted by our ability to quickly develop treatments, vaccines, diagnostic tools, and health information to quickly respond to the ongoing COVID-19 pandemic, and through ongoing work to promote health equity and enhance care delivery in rural and underserved communities. As you work with your colleagues on FY 2023 appropriations, CCTS and the broader stakeholder community encourage you to continue to support the full spectrum of medical research and provide increased funding for key clinical and translational research programs, including CTSA.

ABOUT THE COALITION FOR CLINICAL AND TRANSLATIONAL SCIENCE

The Association for Clinical and Translational Science, Clinical Research Forum, the CTSA Pls, 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. While we appreciate that the administration's FY 2023 budget request includes line-item funding for CTSA's, we are concerned that a cut is recommended and more concerned by supporting Statements that seem to indicate a change in focus for the CTSA program from core hub support to more traditional project-based activities.

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 2023.

A Few Recent Examples of CTSA Program Efforts

University of Wisconsin

Within two weeks of the pandemic (March 2020) the UW-M CTSA-collaborated with community partners and practice-based research networks (PBRNs), to make available anonymous statewide electronic health records data on 3.5 million residents to develop and disseminate reports of areas at high risk of severe COVID-19 complications. Over 150 reports were shared with State and local health departments and health systems throughout the state. Report requestors used information to gain enhanced awareness of the communities they serve and aid in COVID-19 response planning including preparing for potential surges, focusing outreach and collaborative efforts, assessing resource distribution, and identifying communication priorities and gaps. The CTSA made interactive maps and tools available at <https://nhp.wisc.edu/covid-19/>. Regional variations in vaccine acceptance and access were identified as an important barrier to control the pandemic. To address this problem, the UW-M CTSA developed an interactive COVID-19 Relative Mortality Risk and Barriers to Vaccination Tool. This tool aids vaccine intervention efforts that are appropriate for the community. The tool is available at the same URL: <https://nhp.wisc.edu/covid-19/>.

Stanford University

Our CTSA's Clinical and Translational Research Unit (CTRU) provided both clinic and laboratory services for the NIH RECOVER: A Multi-site Observational Study of Post-Acute Sequelae of SARS-CoV-2 Infection (PASC) in Adults. This study is a research initiative from the National Institutes of Health seeking to understand, prevent, and treat PASC, including Long COVID. Under PI Dr Upi Singh, Stanford in one of leading recruitment sites in this national consortium of USA research organizations, with 290 participants enrolled during the reporting period. The CTRU performs participant visits along side other clinics at Stanford and receives and processes all biospecimens collected at Stanford.

As a result of CTSA infrastructure, in under 48 hours of the March 16th, county-wide shelter-in-place, CTSA bioinformatics Faculty Lead, Dr. Shah, led a "data science response" in which data related to COVID-19 patients were made available for Stanford researchers. CTSA Faculty leaders also rapidly deployed protocols for the conduct of numerous, multi-center clinical trials for COVID-19. They formed the COVID-19 Clinical Research Review Program (Chair: Ken Mahaffey) to adjudicate the complexities of conducting multiple trials at the same time. They reviewed 630 study requests since March 16th, 2020. This committee is still in place.

CTSA Faculty leaders, rapidly deployed protocols for the conduct of numerous, clinical research protocols impacted by COVID-19. They formed the COVID-19 Clinical Human Subjects Research Committee (Chairs: Mary Chen and Pooneh Fouladi) to adjudicate over 250 request. This committee is still in place. Faculty Lead of CTSA BERD, Dr. Desai, developed an Adaptive Master Trial, able to add promising treatment arms in real-time and drop arms early for futility.

Tufts University

Since 2008, Tufts CTSI has provided outstanding resources and services to support full-spectrum translation to our community. We also have continually developed, demonstrated, and disseminated innovations to improve and accelerate clinical and translational research. Beyond supporting Hub research teams and incorporating these approaches into our internal operations and service delivery, we are a national leader in setting quality and efficiency standards and establishing clinical and translational science best practices.

Our mature resource and service infrastructure and proclivity for innovation allow us to respond rapidly and effectively to emerging public health needs. At the start of the COVID-19 pandemic, in days, we redeployed our resources and services, working closely with Tufts Medical Center leadership. Our Clinical and

Translational Research Center became the hospital's primary unit for COVID-19 research, with activation of two large Remdesivir inpatient studies in less than two weeks, other COVID treatment and vaccine studies, and a Tufts CTSI-initiated treatment trial for niclosamide, led by Dr. Selker and supported by a CTSA supplement. The Tufts CTSI MIT Center for Clinical and Translational Research helped design and produce novel personal protective equipment and facilitated dissemination around the world. We established a National COVID-19 Survivors Registry and a database enabling a COVID-19 biorepository. The Tufts CTSI Pilot program funded off-cycle COVID-19 research, and our Center for Research Process Improvement led a hospital-wide process to prioritize research studies and resource deployment. These represent a few of many examples of the breadth of our resources and services provided and the high degree of speed, flexibility, and collaboration of our teams when facing a public health emergency.

[This statement was submitted by Harry P. Selker, MD, MSPH, Chairman, Clinical Research Forum and Linda B. Cottler, PhD, MPH, FACE, President, Association for Clinical and Translational Science.]

PREPARED STATEMENT OF THE COALITION FOR HEALTH FUNDING

Centers for Disease Control & Prevention	At least \$11 billion
National Institutes of Health	No less than \$49 billion
Food & Drug Administration	\$3.653 billion
Indian Health Service	No less than \$49.8 billion
Health Resources & Services Administration	No less than \$9.8 billion in discretionary funds
Agency for Health Research Quality	No less than \$500 million

The Coalition for Health Funding—an alliance of over 80 health organizations representing more than 100 million patients and consumers, health providers, professionals and researchers—welcomes the opportunity to submit this statement for the record about the importance of health funding. Together, our member organizations speak with one voice before Congress and the administration in support of federally funded health programs with the shared goal of improved health and well-being for all. Each member organization has individual funding priorities within the Department of Health and Human Services (HHS), but we all believe that to truly improve public health, we need strong, sustained, predictable funding for all Federal agencies and programs across the continuum. The past 2 years have taught us many things about the state of our public health infrastructure, which is why it is so critical that investments are made to ensure we strengthen areas such as research, prevention, and treatment programs. While we work to end the current pandemic, annual sustained public health investment will help ensure we are not only better prepared for the next one, but importantly also protecting the overall health and security of our Nation.

HHS agencies play different yet interconnected roles in addressing our Nation's mounting health demands. COVID-19 has shown all Americans that our government works best when well-resourced agencies play complementary roles in defending and strengthening public health. Americans have seen first-hand the work that the National Institutes of Health did to fund certain vaccine technologies that Operation Warp Speed took through the development process and that the Food and Drug Administration (FDA) approved in record time to save American lives. With emergency funding, uninsured Americans have been able to access testing financed through the Health Resources and Services Administration (HRSA). The Centers for Disease Control and Prevention (CDC) routinely assessed available data to provide regular guidance to the public on COVID-19 safety protocols. And the Agency for Health Research Quality continues to deliver real world evidence on how we can better respond to the pandemic.

We know that our response to COVID-19 was not entirely a success. Our public health agencies were not as prepared for the pandemic as they could have been. But instead of seeing that as a reason to deny critical funding for these essential agencies, the Committee should see this as an opportunity to rebuild our public health agencies through robust funding and ensure that public health practitioners across the country have what they need to combat the next pandemic while managing the current one. We now know that pandemics are not science fiction. They are not the past. They are our present, and they will be our future. Shortchanging public health and health research programs—or cutting health programs at the expense of oth-

ers—leaves Americans vulnerable to health threats and does nothing to prevent these problems from arising in the first place.

Emergency funding to combat COVID-19 does not replace consistent, sustained year-over appropriations. Partially this is because we must stay vigilant in the face of the next pandemic. But we also must combat other serious health and economic threats from chronic and emerging diseases, environmental exposures, preventable conditions, workforce shortages, and health disparities. Pre-existing conditions contributed significantly to our COVID crisis, some of which are preventable, many of which are manageable. We saw firsthand the impact of workforce shortages and are continuing to deal with the fallout. Biomedical research, treatment, prevention, and health promotion programs are critical to success moving forward. Our public health infrastructure must be equipped to handle the myriad challenges that it faces beyond the extraordinary circumstances of the pandemic. In fiscal year (FY) 2022, discretionary health spending was only \$108 billion, or 7 percent of all discretionary Federal spending. Of this, a little less than half supported medical research at the NIH, and the remainder supported all other public health activities—disease prevention & response, health & safety security, workforce development, and access to primary and preventive care. Having learned from the past 2 years that these areas of spending cannot be afterthoughts; we urge you to fund them accordingly. To that end, we are calling for the following levels of investment for specific public health agencies in FY23.

- CDC: At least \$11 billion
- NIH: No less than \$49 billion
- FDA: \$3.653 billion
- IHS: No less than \$49.8 billion
- HRSA: No less than \$9.8 billion in discretionary funds
- AHRQ: No less than \$500 million

To achieve these necessary targets, appropriators must also raise the 302(b) allocation for the Labor-HHS-Education subcommittee to address its important needs. The era of budget sequestration hollowed out many of the very public health agencies we depended on to combat COVID-19. What the current pandemic would have looked like with appropriately funded agencies we will never know, but if we take our recent experience seriously, we will not face the same fate with the next pandemic. That's why the Coalition for Health Funding partnered with the Campaign to Invest in America's Workforce, Committee for Education Funding, and Coalition on Human in bringing together nearly 370 organizations to urge appropriators to raise the subcommittee's allocation in FY23 to at least \$239.59 billion.

We hope in your ongoing deliberations on FY 2023 and beyond you will recognize that emergency funding during the acute phase of a pandemic does not eliminate the need for sustained long-term funding to the very agencies we trust explicitly with American lives. They need the resources to develop the next generation of tools necessary to protect the public's health from other health threats and to ensure the solvency of Medicare's Trust Fund moving forward, which is of particular salience given the role Medicare plays in the health care of those who need it most. We look forward to working with the subcommittee in these endeavors and hope you will turn to the Coalition for Health Funding as a resource in the future.

[This statement was submitted by Erin Will Morton, Executive Director, Coalition for Health Funding.]

PREPARED STATEMENT OF THE COALITION ON ADULT BASIC EDUCATION

Chair Murray, Ranking Member Blunt, and members of the subcommittee:

My name is Sharon Bonney, and I am the CEO of the Coalition on Adult Basic Education (COABE). COABE is the leading professional association for adult education, and we represent the 79,000 adult educators and leaders around the country. Our teachers and leaders provide numeracy, literacy, digital literacy, work readiness, soft skills, high school equivalency and numerous wraparound services to more than 725,000 adult learners nationwide. With over 2,200 WIOA Title II programs around the country, adult education serves the Nation's most vulnerable adults.

COABE is appreciative of the \$15.5 million increase Congress provided to the Adult Basic Education State Grants program under Title II of the Workforce Innovation and Opportunity Act (WIOA) for fiscal year (FY) 2022. Because of this funding, adult educators across the country will be able to better serve adult learners and provide them with the skills needed for the workplace. Our programs provide these skills to 725,000 adult learners throughout the country, but there are millions

of Americans who need our services: 43 million adults are low-skilled in literacy and 62.7 million adults are low-skilled in numeracy in the United States.

Adult education programs provide an economic boost to participants. According to a recent Economic Mobility Corporation study, “unemployed residents with prior U.S. work experience who enrolled in an employment-focused English course boosted their earnings by an average of more than \$7,100 annually 2 years after starting the program, compared with unemployed non-English speakers who weren’t in the program.” Additionally, COABE estimates that for every dollar invested in adult education, the surrounding community receives \$60 back in increased income, property taxes and savings on legal system and welfare expenses.

Given this clear evidence of the economic boost adult education programs provide to participants and communities, demand for these programs is high. As a result, there are waiting lists in every State for these programs. The pandemic has further challenged programs as more adults have found that they need to enhance their literacy, numeracy and digital skills to compete for jobs in the workplace, and yet these very adults might not have access to technology and broadband to enable them to participate in these programs.

Adult education programs have been working hard to deliver high-quality education throughout the pandemic. These programs have turned to online and hybrid delivery services. But greater investment in technology, classroom space and professional development is critical. If funded at proper levels, adult education programs can play a significant role in the country’s recovery from the pandemic by providing millions of adult learners with necessary workforce and life skills.

Adult education provides learners with opportunities to which they may not otherwise have access. Learners often tell stories of how adult education changed their lives. I want to share the thoughts of two participants from Missouri and Washington that exemplify the power of adult education:

“I have been living in this beautiful country for 16 years. In 2015, my life changed. I made the decision to go back to school and try to get my HSE credential... I’m the first Spanish student finishing the course and getting the HSE diploma from the Spanish program, which was implemented in 2015, and I’m so proud of my achievement.”

—*Jose Viveros Barcenas, St. Charles Community College Adult Education and Literacy, Cottleville, Missouri*

“The program was a great experience, and I learned a lot. I was willing to expand what I learned in high school and the classes were smaller, so I got more one on one with the teachers. I was going for my GED and ended up with my diploma and now my associates. I encourage anyone that wants to get their high school diploma to go through HS21+. It is a great learning experience, with great instructors.”

—*Raymond Silva, Skagit Valley College, Mount Vernon, Washington*

We are encouraged by President Biden’s FY 2023 Budget proposal, which included an increase of \$10 million for the Adult Basic Education State Grants program. However, given the demand for these services and the opportunity they provide learners, we would urge Congress to exceed the President’s proposed increase and provide \$810 million for adult education in the final fiscal Year2023 appropriations bill.

Thank you for your consideration. Please let me know if COABE can be of any further assistance during the appropriations process.

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 continued support for a vital program addressing the health and safety of our Nation’s firefighters. As you consider the Fiscal Year (FY) 2023 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill, we urge you to provide \$5.5 million for the National Firefighter Registry.

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 scarcity 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.

During the 115th Congress, both the House and Senate unanimously approved the Firefighter Cancer Registry Act (Public Law 115–194). This 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.

Over the past several years, the registry has been able to make great strides, including developing an enrollment system to ensure information security and ease of access for users; obtaining the Office of Management and Budget's approval for the enrollment questionnaire; and compiling brochures, videos, and quarterly newsletters to maintain communication with the fire service regarding the status of the registry.

However, the registry has also faced new challenges due to evolving Federal requirements for data security and storage—in addition to the steps that remain to continue the launch of the registry and keep its vital work moving forward. To ensure that the National Firefighter Registry does not face delays with regard to the collection and analysis of data pertaining to cancer in the fire and emergency services, we are requesting \$5.5 million in FY 2023.

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
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 2023, COSSA urges the Committee to appropriate:

- \$49.048 billion for the National Institutes of Health;
- \$11 billion for the Centers for Disease Control and Prevention, including \$210 million for the National Center for Health Statistics;
- \$500 million for the Agency for Healthcare Research and Quality;
- \$814 million for the Bureau of Labor Statistics;
- At least \$815 million for the Institute of Education Sciences; and
- \$161 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 over the past 2 years in response to the COVID–19 pandemic.

NATIONAL INSTITUTES OF HEALTH

COSSA joins the more than 345 organizations in support of at least \$49.048 billion for the National Institutes of Health (NIH) base budget in fiscal year 2023. COSSA appreciates the subcommittee's leadership and its long-standing bipartisan support of NIH, especially during difficult budgetary times. We also appreciate the

Congress's interest in innovating and pushing the agency forward through support for high-risk, high-reward endeavors. It is critical that efforts to accelerate discovery in new, creative ways work in tandem with—not at the expense of—robust, sustainable support for fundamental and curiosity-driven research.

To that end, COSSA urges the subcommittee to ensure that funding for the new Advanced Research Projects Agency for Health (ARPA-H) supplement the \$49.048 billion recommendation for NIH's base budget, rather than supplant the investments NIH makes to biomedical and behavioral research across its institutes and center. To be truly transformative, increased investment is needed on all fronts.

In addition, as the COVID-19 pandemic has underscored, it is behavior change—not only medical intervention—that can help us gain control in the days and weeks immediately following an outbreak. From psychological research behind the merits of mass social distancing to understanding cultural variations in risk perception as we tailor communication about vaccine safety, the social and behavioral sciences have been an essential part of the response. We must learn from this experience and invest in our future preparedness by better committing to understanding the human behavior and social systems at play.

To that end, COSSA urges the subcommittee to “right-size” NIH's Office of Behavioral and Social Sciences Research (OBSSR), housed within the Office of the NIH Director. This critical office 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. We are appreciative of the \$10 million increase provided to OBSSR in the final fiscal year 2022 appropriations bill; however, behavioral and social science research at NIH remains grossly underfunded. For example, OBSSR's fiscal year 2022 budget of \$38.9 million represents only 1.5 percent of the total budget of the NIH Office of the Director; under the President's proposal, this would drop to 1.1 percent.

In addition, it is estimated that NIH funds roughly \$700 million in research related to behavioral and social science annually across its institutes and centers; however, about 62 percent of that is also classified as neuroscience research, leaving around \$430 million annually for non-neuroscience related social and behavioral studies. This amounts to only 1.1 percent of the entire NIH budget annually. Given all we have learned from the pandemic over the last few years, research on the social influences of 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 direct NIH to finally support the office at levels commensurate with the need for these critical insights.

CENTERS FOR DISEASE CONTROL AND PREVENTION

COSSA urges the subcommittee to appropriate \$11 billion for the Centers for Disease Control and Prevention (CDC), including \$210 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.

In addition, 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 of 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 \$814 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 \$815 million for the Institute of Education Sciences (IES) in fiscal year 2023. 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 \$161 million (\$141 million for Title VI and \$20 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, research scientists, and others involved in family medicine education. We urge the Committee to appropriate at least \$59

million for the Primary Care Training and Enhancement program, authorized under Title VII, Section 747 of the Public Health Service Act HRSA. In addition, we recommend the Committee fund the AHRQ at a level of at least \$500 million in discretionary spending and specifically fund \$5 million dedicated to AHRQ's Center for Primary Care Research.

More than 44,000 primary care physicians will be needed by 2035, and current primary care production rates will be unable to meet the demand, according to the authors of *Annals of Family Medicine* (Petterson, et al Mar/Apr 2015). The primary care training and enhancement programs and AHRQ research conduct research to enhance our Nation's workforce and health infrastructure, improving primary care to produce better health outcomes and reduce costs.

Primary Care Training and Enhancement—Title VII

The Primary Care Training and Enhancement 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. Moreover, new competencies are required for our developing health system. This program has not received an increase in funding since FY2020, just at the time that the COVID-19 pandemic has highlighted many of the failings of the current health care and public health infrastructure. The PCTE program can help address these flaws. For example, additional funding is needed for both residencies and medical school departments to help address faculty retention, public health competencies, recruit and retain students into primary care, develop new curriculum related to the pandemic, address health equity concerns and to increase full scope primary care physicians.

In this time of increasing primary care need, we urge you to recognize the importance of maintaining and expanding funding for programs that support the primary care workforce. Title VII funding for primary care training is an evidence-based investment in the future care of the Nation.

A 2021 report by The National Academy of Sciences, Engineering and Medicine 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 percent since the 1960s.¹ Primary care health professions training grants under Title VII are vital to the continued development of a workforce designed to care for the most vulnerable populations and meet the needs of the 21st century. We urge your continued down payment for this program and an increase in funding levels to \$59 million in FY 2023 to allow for a robust competitive funding cycle. This funding level will help continue important Title VII programs who use primary care training funding to develop innovative programs and curricula related to interdisciplinary training in rising new competencies.

We also ask for the following report language to accompany the increased funding level: The Committee includes \$59 million, an increase of \$10 million over the FY 2022 level, for Primary Care Training and Enhancement programs, which support training and direct financial assistance for future primary care clinicians, teachers, and researchers. This additional funding is to allow for a robust grant competition, to support programs within academic administrative units related to expanding the number of medical students choosing primary care careers. To stimulate this supply, it's important to reach as many allopathic and osteopathic primary care medical school departments as possible to explore innovations in training, more research into increasing primary care production, and dissemination of best practices.

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

¹National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

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.

We greatly appreciate the inclusion of increased funding in the FY 2022 omnibus package, and hope we can increase that further in FY 2023. With funding for FY 2022 of \$350,400,000 million, including \$2 million dedicated to the Center for Primary Care Research within it, 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 is needed to accomplish these goals. The President's FY 2023 budget request includes \$10 million in funding for primary care research in general. We ask that \$5 million be provided as a line item to the Center for Primary Care Research within AHRQ to help coordinate and direct primary care research funding at AHRQ. For this reason, we are supporting additional overall funding increases for FY 2023 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, and (6) how health extension systems serve as connectors of research institutions with practices and communities.

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, one of which was 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 the \$5 million in dedicated funds for PCR, AHRQ could prioritize and coordinate investments in PCR directly improving the health and wellbeing of Americans. The National Academy of Medicine's report on Primary Care concurs with RAND's assessment on the importance of targeted funding for PCR, demonstrating the variety of stakeholders which share common ground on the importance of prioritizing PCR.²

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 recruiting 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 in discretionary spending for FY 2023 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's Primary Care Training and Enhancement Program and AHRQ—both entities which enhance our Nation's primary care workforce and infrastructure.

[This statement was submitted by Winston Liaw, MD, MPH, Chair, Academic Family Medicine Advocacy Committee, Council of Academic Family Medicine.]

²National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

PREPARED STATEMENT OF THE COUNCIL OF STATE AND TERRITORIAL
EPIDEMIOLOGISTS

Chair Murray, Ranking Member Blunt, and members of the subcommittee, thank you for the opportunity to submit this testimony for the record in support of at least \$250 million in Fiscal Year 2023 funding for the Data Modernization Initiative and the Center for Forecasting and Outbreak Analytics at the Centers for Disease Control and Prevention (CDC). My name is Janet Hamilton, I am the Executive Director of the Council of State and Territorial Epidemiologists (CSTE). CSTE represents public health epidemiologists nationwide working on the front lines to respond to emerging public health threats—including, recognizing and identifying the very first introductions of COVID-19, and then responding daily during the COVID-19 pandemic.

As you know, COVID-19 exposed deadly gaps in our Nation's public health data infrastructure. After years of neglect, our antiquated public health data systems were not prepared to handle the onslaught of a pandemic caused by a highly infectious virus. Instead, paper-based systems, phone calls, spreadsheets, and faxes requiring data entry by hand remain in widespread use and left us ill-equipped to combat the spread of the virus as it emerged and surged. Delayed detection and response had dire consequences. And, while COVID-19 is the most recent—and ongoing-threat that requires a robust public health response, it is not the only threat we face nor last public health threat we will face. As we submit this, a new emerging threat leading to unexplained hepatitis in children is emerging—illnesses (potentially due to adenovirus) can be severe, associated with hospitalization and liver transplants in some children. Led by the CDC, State and local health departments across the country need a nationwide public health surveillance system to detect emerging threats and facilitate immediate response to keep our population safe.

Prior to the COVID-19 pandemic, CSTE initiated the call for improved public health surveillance systems. The pandemic only made it clearer that this goal cannot wait. With our partners at the Data: Elemental to Health Campaign we called on Congress to provide the first ever dedicated funding for public health data systems and to build a 21st century public health data superhighway. Thanks to the work of this subcommittee, Congress answered the call and has provided annual funding as well as critical injections of supplemental funding through the CARES Act and the American Rescue Plan for CDC's public health Data Modernization Initiative—or DMI.

The DMI is a commitment to building the world-class data workforce and data systems that support daily operations and are 'response-ready' for the next public health emergency with capacity to surge and scale. We are grateful to this subcommittee for providing more than \$1 billion to date for DMI through annual and supplemental appropriations. Unfortunately, it is not enough to meet our Nation's current or long-term public health surveillance needs, which Data: Elemental to Health estimates will cost at least \$7.84 billion over 5 years. In the immediate term, we need robust, sustained, annual funding for DMI to ensure we are providing resources for public health systems and infrastructure, including at State and local health departments, to keep pace with evolving technology.

DMI is an enterprise approach and there are five key interconnected pillars essential for public health data modernization. They are:

1. Electronic Case Reporting,
2. The National Notifiable Disease Surveillance System (NNDSS),
3. The Electronic Vital Records System,
4. Syndromic Surveillance, and
5. Laboratory Information Systems.

We need electronic Case Reporting (or eCR) to give health care providers a means to seamlessly communicate with public health. eCR will help guarantee that when providers see patients—in any setting—patient demographics, clinical information, and test results for reportable conditions (including, but by no means limited to COVID-19) are rapidly shared with State and local public health and then able to be seamlessly incorporated into CDC's National Notifiable Disease Surveillance System (NNDSS). eCR also assists with data completeness and rapidly understanding health inequities. DMI investments in eCR are already paying off. For example, race and ethnicity data received on case reports in pilot jurisdictions are over 90 percent complete which will support a more robust ability to appropriately address health disparities. More than 11,000 health care facilities were brought on board between January 2020 and February 2022. All 50 States, DC, and Puerto Rico, as well as 13 jurisdictions have received initial electronic case reports for COVID-19 and more than 18 million COVID-19 case reports have been sent electronically to public

health agencies—each representing a report that a health care provider did not have to enter manually!

Resources are needed to make improvements in NNDSS and rapid data submission from States to CDC. For example, state, territorial, local, and Tribal health department staff serve as disease detectives contacting and interviewing cases gathering detailed information to learn how and where they may have become infected—are they part of a cluster or outbreak, or what co-factors may have led to a more severe illness? For example, during the Zika response, case investigations conducted by the local health department identified persons working on elevators were at increased risk of infection as standing water often collected in the bottoms of open-air elevator shafts serving as breeding location for mosquitos. After case investigations and interviews are conducted, resources are needed to provide those details to the CDC through NNDSS. Numerous similar examples exist for COVID-19 where health department staff conduct outbreak investigations or identify clusters from genomic sequencing but are unable to electronically share those data with CDC's NNDSS due to agency infrastructure shortages. Additionally, right now, there are multiple jurisdictions who have the desire to provide more detailed COVID-19 case information to CDC, but don't have the data work force and resources to update file structures and data processes to submit those data.

We need an electronic lab test ordering and result process that supports the collection of information to launch a rapid public health response. Seamless electronic communication is critical—a health department forced to sort through mailed or faxed lab reports will not be able to respond promptly or adequately to an emerging threat. Investments here have also shown early success. Electronic laboratory reporting (ELR), which has now been implemented across the country, formed the backbone of our case surveillance for COVID-19, enabling States, localities, territories, Tribes and the Federal Government to have timely information to identify cases, where those cases lived, and basic information about their age. Without ELR we would never have been able to conduct control measures and know what was happening in virtually every jurisdiction. In many jurisdictions this information is automatically uploaded and ready for analysis within a day of the result.

We need improvements to our electronic vital records systems to ensure real-time transmission of birth and death data for statistical and—critically during a pandemic—surveillance purposes. We must make sure systems are interoperable so physicians, coroners, medical examiners, and funeral directors can seamlessly report deaths through their existing electronic records systems—eliminating delays and reducing errors.

Standards-based interoperability will also help identify threats as they emerge. As it stands, nearly one third of all emergency department visits are not reported to the National Syndromic Surveillance Program, which helps detect, monitor, control and prevent emerging diseases.

These five pillars are interwoven, and each plays a key role in moving the United States from an outdated and burdensome patchwork of systems to a 21st Century public health data infrastructure that provides complete, accurate, and instantaneous data. Again, DMI is an enterprise-wide approach, which will support widespread and rapid access to public health data for all public health programs at all levels of government for all diseases and conditions. Just like a rising tide lifts all boats, a public health data superhighway improves all public health programs. Public health needs a coordinated and integrated approach to using data to deliver on mission, serve the public, and steward resources while respecting privacy and confidentiality. Currently, CDC has many siloed public health surveillance systems, many of which are not interoperable, which results in duplicated and redundant data entry. DMI will help break down those siloes and ensure all systems are integrated and interoperable.

Equally important is a skilled workforce that includes epidemiologists, public health informaticists, data scientists, and other experts—all of whom work together so that the public health surveillance system is capable of detecting and monitoring current threats and ready for the next pandemic. The Administration has committed to strengthening our Nation's public health workforce, including epidemiologists and data scientists and we urge the committee to continue to provide resources towards this goal. This is an important step forward to grow and build the next-generation public health workforce and we hope to see the committee support continued funding to sustain this progress.

Working hand-in-hand with DMI, CDC's newly established Center for Forecasting and Outbreak Analytics (CFA) will facilitate the use of data, modeling, and analytics to improve pandemic preparedness and response. The CFA is already doing critical work, including helping to inform government response to the spread of the Omicron variant of COVID-19 in late 2021.

We do not have a science problem; we have a resource problem. The core data systems for a national infrastructure already exist they must be modernized and maintained so they can keep pace with new technology.

CSTE applauds President Biden for proposing an unprecedented investment in CDC through his discretionary budget request. The President requested \$10.675 billion for CDC. As part of this significant and well-warranted funding proposed increase, the President seeks to “prioritizes investments that will modernize public health data collection, increase capacity to forecast and analyze future outbreaks, and operationalize lessons learned from the COVID-19 response.” We also support the President’s proposal to invest \$81.7 billion in mandatory funding toward pandemic preparedness efforts, including \$28 billion for CDC to invest in critical efforts, including public health infrastructure and DMI. We encourage Congress to make this proposal a reality.

To make our public health systems work now, and in the future, we need regular, sustained annual funding for our public health surveillance. We respectfully request the subcommittee provide funding of at least \$250 million for DMI and \$50 million for CFA at CDC in Fiscal Year 2023.

Thank you.

[This statement was submitted by Janet Hamilton, MPH, Executive Director, Council of State and Territorial Epidemiologists.]

PREPARED STATEMENT OF THE COUNCIL ON SOCIAL WORK EDUCATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- \$25 million for the Minority Fellowship Program (MFP) at Substance Abuse and Mental Health Services Administration
- Heath Resources and Services Administration (HRSA):
 - \$225.8 million for HRSA’s Behavioral Health Workforce Education and Training (BHWET) grant program;
 - \$55.014 million for Scholarships for Disadvantaged Students;
 - \$82 million for the Geriatrics Workforce Enhancement Program (GWEP) and the Geriatrics Academic Career Award (GACA)
 - \$15 million for continued support of a demonstration program to strengthen the mental and substance disorders workforce;
- \$20 million for continued support of the Loan Repayment Program for Substance Use Disorder Treatment Workforce
- \$49.048 billion for National Institutes of Health (NIH)
 - NIH report language on Office of Behavioral and Social Sciences Research working groups

DEPARTMENT OF EDUCATION

- \$13,000 for the maximum individual Pell Grant;
- Experimental sites for paid internships for social work students

CSWE is a nonprofit national association representing over 900 accredited baccalaureate and master’s degree social work programs, as well as individual social work educators, practitioners, and agencies dedicated to advancing quality social work education. We appreciate your efforts and leadership on issues that impact social work, social work education, and the wellbeing of individuals, families, and communities and social and economic justice.

We encourage you to consider the following appropriations requests that will support social work programs and social work students in the fiscal year (FY) 2023 appropriations process. Pressing societal challenges and public health challenges like the twin pandemics of CoVID-19 and systemic racism, the opioid crisis and other substance-use issues, growing mental and behavioral health needs, workforce shortages, and rising higher education costs, are just some of the challenges facing social work students and practitioners. Your support of these appropriations requests will help meet these challenges.

Federal funding helps strengthen the pipeline of social workers, addresses the needs of vulnerable and at-risk populations, and supports students, including those from disadvantaged backgrounds. Social work students go on to work in a diversity of fields including child advocacy, geriatrics, school social work, healthcare and other fields. As policymakers continue to focus on the social determinants of health, support for social workers, who are the workforce at the center of addressing these social factors, will be critical. CSWE’s FY 2023 requests (as detailed below) illustrate support for important programs that address vital health workforce needs, provide invaluable student aid, address the social determinants of health, and promote

important health-care research. We respectfully ask for your support of these requests during the FY 2023 appropriations process.

Substance Abuse and Mental Health Services Administration: \$25 million for the Minority Fellowship Program (MFP). For more than 45 years, MFP has been increasing the number of professionals preparing for leadership roles in mental health and substance use fields and working to reduce health disparities and improve behavioral health-care outcomes for racial and ethnic populations. CSWE urges the committee to include \$25 million for the MFP in FY 2023.

CSWE requests the following report language be included in the FY 2023 Labor-H report: The Committee believes that among the many consequences of COVID-19, the increasing rates of burnout facing the mental and behavioral health workforce has negatively impacted the resilience of the Nation's public health infrastructure. The pandemic has laid bare the need to strengthen the public health workforce pipeline and the need to provide educational opportunities to all who wish to pursue a career in mental and behavioral health care. The Committee urges the Minority Fellowship Program in the Substance Abuse and Mental Health Services Agency to explore ways in which to expand program eligibility, particularly for students who fall under the Temporary Protected Status (TPS) and Deferred Action for Childhood Arrival (DACA) programs. These students, the majority of whom have lived most of their lives in the United States, are an invaluable resource to bolster our public health infrastructure and mental and behavioral health care workforce.

Health Resources and Services Administration: \$225.8 million for HRSA's Behavioral Health Workforce Education and Training (BHWET) program. CSWE was pleased to see continuous investments for the BHWET program in the fiscal Year 2022 Labor-HHS-ED appropriations bill. BHWET supports the recruitment and education of behavioral health-care providers, which is critical as the Nation continues to combat the pandemic, the opioid crisis, and substance use disorders. The number of training programs supported by BHWET has grown tremendously over the past several years, particularly amongst social workers. Social workers represent the most diverse health profession in the Nation and as efforts are taken to bolster the public health infrastructure, social workers represent a model for continued workforce growth and diversity. As the Nation's demand for well-equipped behavioral health-care providers continues to grow, we hope you will support \$225.8 million for BHWET in FY 2023.

- \$55.014 million for Scholarships for Disadvantaged Students. This program helps ensure that the United States has the pipeline of health professionals to meet health needs of underserved individuals and communities. Furthermore, this program provides much needed opportunities for students from disadvantaged backgrounds.

- \$51 million for the Geriatrics Workforce Enhancement Program (GWEP). GWEP supports training and educating health professionals, including social workers, as well as direct care workers, and family caregivers in the care of older adults. It is the only Federal program that focuses on developing a health-care workforce that maximizes patient and family engagement while improving health outcomes for older adults. GWEPs are successfully integrating and equipping a primary care workforce and family caregivers with the knowledge and skills to care for older adults and build community networks to address gaps in health care for seniors.

- \$15 million for continued support of a demonstration program to strengthen the mental and substance disorders workforce.

- \$20 million for continued support of the Loan Repayment Program for Substance Use Disorder Treatment Workforce.

National Institutes of Health (NIH): \$49 billion in FY 2023 for the National Institutes of Health. CSWE appreciates the continued support from Congress and the increased funding for NIH. To build on the advances in research, CSWE hopes you will support continued investments in biomedical and health-related research that incorporates the social and behavioral science research necessary to better understand and address the needs of high-risk populations including children, minority, and geriatric populations. Social and structural determinants of health play a large role in the health disparities that plague society. Social factors play a major role in people's health and as a result NIH needs to fund behavioral and social science research that tests innovations in the design of health care and integrate social care into health care and health care into social services. In addition, research must be funded that tests the effectiveness of these integrated services. NIH should expand research opportunities in this area to provide meaningful, comprehensive, and long-lasting improvements in health care delivery.

CSWE requests the following report language be included in the FY 2023 Labor-H report: The Committee believes that a more robust and focused NIH commitment

to behavioral and social science research and training would yield significant improvements to the Nation's health due to the important connections between social and physical conditions and health. Many of the leading causes of health disparities in our Nation are related social and structural determinants of health like race, income, access to care, housing, and employment. In the shadows of the COVID-19 pandemic, addressing these health disparities continues to be key challenge in our efforts to improve health across all populations. The 2019 Consensus Study Report from the National Academies of Science, Engineering, and Medicine entitled "Integrating Social Care into the Delivery of Health Care" highlighted the growing need to understand how social factors play a major role in people's health. The Committee provides \$10,000,000 for the Office of Behavioral and Social Sciences Research for grants, Notices of Special Interest (NOSI), and other funding mechanisms to support this work and urges NIH to consider how its programs in health services, translational, intervention, and implementation research are inclusive of social determinants of health research and researchers.

Department of Education: \$13,000 in FY 2022 for the maximum individual Pell Grant. Pell Grants are critical to ensuring access and affordability in higher education. CSWE also supports increasing the amount of Pell funding that is supported by mandatory spending. Student aid programs, particularly grant programs, represent important investments and help students avoid crushing debt burdens when they graduate.

- Support for the Public Service Loan Forgiveness (PSLF) Program. PSLF is an integral program to ensuring a pipeline of professionals in public service serving in high-needs areas. CSWE encourages Congress to continue support for this vital program and programs like the Temporary Expanded Public Service Loan Forgiveness (TEPSLF), which assists public service workers who were enrolled in ineligible loan repayment programs. In addition to continuing support for PSLF, CSWE asks Congress to continue oversight of how the Department of Education is implementing the program.

- Support for Paid Internships for Social Workers. Social work students are required to participate in at least 400 hours of field experience and at the graduate level masters students are required to complete at least 900 hours. These experiences are critical to ensuring the development of a professional social work workforce. Yet many times these experiences are unpaid. CSWE requests the following report language be included in the FY 2023 Labor-H report: The Committee directs the Department of Education to consider the feasibility of using its Experimental Sites authority for a pilot to use Federal Work Study and other financial aid funding to support social work students involved in internships and field experiences. The Department is directed to provide a report to the Committees on Education and Labor, and on Appropriations of the House of Representatives and on the Committees on Health, Education, Labor, and Pensions and on Appropriations of the Senate on its plan for an Experimental Sites Initiative. Point of Contact: Otto Katt, otto@lewis-burke.com.

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 (NPDPS). 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 percent 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 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 (NPDPS) 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 NPDPS 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 definitively diagnose human prion diseases, determine their origin, and determine whether the spread of CWD found in elk and deer in 30 States in the U.S. and in 4 Canadian provinces has become a human risk. A study in progress has reported 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 among its own species and the disease transmits by contact and through contaminated environment, including soil and plants, in free ranging and farmed 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 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 NPDPS, 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 7 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 NPDPS 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 NPDPS 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 NPDPS 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 NPDPS is funded entirely by the CDC from funds allocated by Congress. The CDC traditionally keeps approximately half of the appropriation for epidemiologic surveillance projects and funding prion disease surveillance at the state level.

Increasing the appropriation from \$6.5M to \$7.5M will allow the NPDPS 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 NPDPS 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, what risk 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 NPDPS 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 NPDPS 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 NPDPS has examined approximately 8,000 suspected cases of suspected prion disease and has definitely confirmed presence and type of prion disease in more than 4,800 cases.

The NPDPS 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 NPDPS 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 NPDPS provided assurances regarding rigorous human prion surveillance.

Since its inception in 1997, the NPDPS has collected and stored approximately 8,000 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, CJD Foundation.]

PREPARED STATEMENT OF 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 its ongoing commitment to, and support for, sustained and continued 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 \$226 million in Fiscal Year 2023 above the final enacted amount for Fiscal Year 2022 for Alzheimer's disease research at the NIH.

Additionally, Cure Alzheimer's Fund respectfully requests at least an additional \$60 million in total appropriations for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. Because of the past investments this subcommittee has made in the BRAIN Initiative, and with its interest in increasing early detection and diagnosis of Alzheimer's disease, the tools developed by the BRAIN Initiative are becoming ever more important to the search for a cure for 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 in 2004, Cure Alzheimer's Fund has invested more than \$145 million in research through 615 grants across the United States and internationally.

In my past testimony, I have highlighted several areas of novel research that Cure Alzheimer's Fund has supported. Many of these are of interest to Congress as well as shown through the Report Language accompanying the Appropriations bills. Things like Diabetes, Herpes, and the Exposome, and their impacts on the development of Alzheimer's disease are some of the areas of research that were highlighted in the Fiscal Year 2022 Appropriations Bill Report Language.

These are all areas in which Cure Alzheimer's Fund has long supported early-stage research.

As far back as 2010, Cure Alzheimer's Fund was investing in research into the relationship between Alzheimer's disease and Diabetes.

Research conducted by Sam Gandy at the Icahn School of Medicine at Mount Sinai was focused on the gene for a protein called SorSC1. SocSC1 has been independently linked to both Alzheimer's disease and Type II Diabetes. Cure Alzheimer's Fund research focused on better understanding the potential link between Alzheimer's disease and Diabetes.

<https://curealz.org/research/translational/studies-of-novel-ad-genes/brain-structure-abeta-metabolism-and-behavior-in-mice-deficient-in-diabetes-and-alzheimers-associated-sorcs1/>.

Cure Alzheimer's Fund is continuing this line of investigation by, among other efforts, supporting research in the lab of Dr. Miranda Orr at Wake Forest University exploring the impact of a high-fat diet and consequent metabolic syndrome on the onset of cellular senescence in neurons containing Alzheimer's tau pathology.

In 2015, Cure Alzheimer's Fund supported research into the hypothesis that beta amyloid plaques form as part of the brain's immune response to pathogens like Herpes Simplex Virus. This was the beginning of research into the theory that Beta Amyloid is part of the innate immune system; research that I have highlighted often in my submitted testimony.

<https://curealz.org/research/translational/studies-of-tau/abeta-expression-protects-the-brain-from-herpes-simplex-virus/>.

This early-stage, novel theory research supported by Cure Alzheimer's Fund led to two journal articles published in Neuron in 2018. These journal articles further established the link between pathogens like Herpes and Alzheimer's disease.

<https://curealz.org/news-and-events/evidence-of-the-link-between-alzheimers-and-herpes-continues-to-grow/>.

[https://www.cell.com/neuron/fulltext/S0896-6273\(18\)30526-9](https://www.cell.com/neuron/fulltext/S0896-6273(18)30526-9).

[https://www.cell.com/neuron/fulltext/S0896-6273\(18\)30421-5](https://www.cell.com/neuron/fulltext/S0896-6273(18)30421-5).

Dr. Rob Moir at Massachusetts General Hospital originally had the idea that Beta Amyloid was part of the innate immune system and is an antimicrobial.

Although Dr. Moir passed away in 2019, the research spurred by his idea continues today, and is an important area of research for Cure Alzheimer's Fund, this subcommittee, and Alzheimer's disease research in general.

In my submitted testimony last year, I highlighted the research supported by Cure Alzheimer's Fund that is focused on the role particulate matter and pollution play in the development of Alzheimer's disease. These exposome influences are important to not only better understanding Alzheimer's disease pathology, but also to understanding environmental justice and social determinants of health and how the air we breathe can influence our cognitive health.

<https://curealz.org/research/translational-research/air-pollution-and-app-processing/>.

The Fiscal Year 2022 Appropriations Bill Report Language also referenced increasing and improving diversity in clinical trials, improving diagnostic tools, and creating new tools for measurement of cognitive impairment.

Although the early-stage research supported by Cure Alzheimer's Fund is not focused specifically on these areas, the work by Cure Alzheimer's Fund to diversify research and brain banks samples will inform these efforts.

Knowing that having diversified samples available to researchers is vital to not only the work Cure Alzheimer's Fund is supporting, but also for other researchers working on other dementias and neurological conditions, Cure Alzheimer's Fund is working with the Brain Donor Project on a specific project to increase and improve outreach to underrepresented populations to increase brain donations. This project will help to create a more diversified brain bank with samples that will be available to all researchers working on all neurological conditions.

<https://curealz.org/research/foundational/biomarkers-diagnostics-studies-of-risk-resilience/targeted-recruitment-of-underrepresented-americans-for-brain-donation-registration/>.

The Fiscal Year 2022 Appropriations Bill Report Language also referenced the relationship between Alzheimer's disease and Down syndrome. These are also areas in which Cure Alzheimer's Fund has been supporting research. As this sub-

committee is aware, individuals with Down syndrome are virtually certain to have Alzheimer's disease pathology and clinical symptoms by the time they are 50 years old because their genetic trisomy leads to overproduction of the amyloid precursor protein.

In 2014, Cure Alzheimer's Fund hosted a webinar focused on the relationship between Down syndrome and Alzheimer's disease.

<https://curealz.org/news-and-events/alzstream-webinar-alzheimers-and-down-syndrome/>.

Recent public discussion of the anti-amyloid immunotherapy Aduhelm brought renewed attention to the importance of including the Down syndrome community in research on Alzheimer's disease. Cure Alzheimer's Fund recently funded work in the lab of Dr. William Mobley and the late Dr. Steven Wagner at the University of California San Diego testing an anti-amyloid oral therapeutic in a mouse model recapitulating both Down syndrome and amyloid pathology; this therapeutic has received significant funding from the NIH Blueprint program and will enter clinical trials in the next 9 months. It is of high potential to the Down syndrome community.

Cure Alzheimer's Fund has been supporting the research of Beth Stevens at Boston Children's Hospital. It may seem strange for an Alzheimer's disease organization to be supporting research at a pediatric hospital, but it is important work with insights into several neurological conditions including Alzheimer's disease and autism.

Dr. Stevens is researching Microglia and the role Microglia play in synapse development and elimination. Microglia plays an important role in pruning synapses in early life. During brain development, insufficient synapse pruning can lead to autism spectrum disorders. However, overaggressive synaptic pruning in older adults can lead to cognitive decline.

<https://curealz.org/researchers/beth-stevens/>.

<https://curealz.org/research/translational/studies-of-innate-immune-pathology/early-role-of-microglia-in-synapse-loss-in-alzheimers-disease/>.

This research shows how the drivers of neurological conditions are interrelated and that research into one condition could provide insight and answers to other conditions. This research also shows the value of the sustained and continuing investment in, and commitment to, Alzheimer's disease research made by this subcommittee. The commitment demonstrated by this subcommittee is providing NIH with the resources necessary for it to be able to invest in several novel targets simultaneously. And as I have described in this testimony, many of these novel targets are the result of early-stage research supported by private organizations like Cure Alzheimer's Fund.

Groups such as Cure Alzheimer's Fund can provide vital initial research funding allowing researchers to prove their concepts and compile initial data sets. With this information, researchers are then able to approach NIH for larger-scale and longer-term funding. It is a great example of public-private partnerships that are proving to be very important to advancing Alzheimer's disease research, as well as other neurological conditions.

This is only possible because of the commitment to Alzheimer's disease research shown by this subcommittee. Without adequate resources, NIH would not be able to pursue these different avenues of research; which are stated areas of interest to this subcommittee and Congress.

It would be disheartening, with all the advancements that have been made in the last 10 years, if NIH was not able to continue its broad-based research portfolio because of limited research funding. As progress is being made toward the goals of the National Alzheimer's Project Act, it is even more important for this subcommittee to continue to demonstrate its commitment to Alzheimer's disease research funding at NIH.

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 \$226 million above the final enacted level in Fiscal Year 2022 for Fiscal Year 2023 for Alzheimer's disease research at NIH, and at least an additional \$60 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 May 11, 2022.

[This statement was submitted by Timothy Armour, President and CEO, Cure Alzheimer's Fund.]

PREPARED STATEMENT OF DAVE PURCHASE PROJECT

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 \$150 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 2021, 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 \$20,000 to 16 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 continues to experience a public health emergency related to overdose, with over 106,000 overdose deaths counted between November 2020 and November 2021 and deaths increasing by an alarming 45 percent since January 2020. According to provisional CDC data, overdose deaths continue to accelerate in Washington, increasing by 28 percent in the latter half of 2021.

Overdose deaths have increased more dramatically among Black people and communities of color. In 2020, Black people had the largest percentage increase in overdose mortality—48.8 percent. The Hispanic or Latino community experienced a 40.1 percent increase in overdose deaths as compared to white people who experienced a 26.3 percent increase. American Indians and Alaska Natives experienced the highest rate of overdose mortality of all ethnic groups in 2020, a mortality rate 30.8 percent higher than that of white people.

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. In 2020 and 2021, in response to the housing crisis, we increased our outreach to individuals living houseless in encampments in Pierce County, WA. One of our outreach workers was able to connect to a disabled veteran who was experiencing active addiction and had been living houseless for several years. He was in rough shape as a result of an assault and had open, infected, wounds that required immediate attention. Our outreach worker cleaned and dressed the wounds and was subsequently able to get this individual a new tent in a safe location. He then referred the individual to our peer care navigator who was able to get the individual into medically assisted treatment for his opioid use disorder. The navigator was also able to secure a place to live for this individual in a tiny home village for veterans.

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 2020/2021, our team distributed approximately 19,000 doses of naloxone and 1,722 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 percent of the reported overdose reversals were performed by community members—other drug users, family members,

friends, bystanders—and not by first responders. With additional resources, SSPs could 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 percent. 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. NASEN's March 2020 survey of 173 SSPs—almost 40 percent of SSPs nationwide—showed a 43 percent decrease in SSP services as a result of COVID-19. A similar Drug Policy Alliance survey showed that 91 percent of respondents experienced an increase in clients in 2020. Funding shortfalls and increased need for services have persisted into 2022. As a result of increasing need coupled with decreased, limited resources, SSPs cannot reach the millions of people who could benefit from their life-saving services, including overdose prevention and access to critical health care.

Federal funding would expand access to critical and effective SSP programs. NASEN's own data show that there are only approximately 400–600 SSPs operating nationwide. The United States could easily use as many as 4000 programs—7–10 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 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 FY 2021, CDC provided technical assistance to help ensure high-quality, comprehensive services and best practices for SSPs.

If Congress were to provide \$150 million in FY23 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. It is urgent that Congress 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. My brother overdosed on fentanyl, but thankfully survived. Because he survived, in January 2022, after many months of transient homelessness and estrangement from my family, my brother entered a residential treatment facility for his substance use disorder. He stated he was tired of the isolation, the homelessness, and the constant feeling that he was vulnerable and worthless. Mostly, he said, “I miss the family.” This is not the first time he has been in treatment—and likely not the last. But with the support he receives from his treatment team, his recovery community, and

my family, we see improvements in his personality and his outlook on life and, in fleeting moments, we catch glimmers of the sweet, gullible, brother he is when he is not using meth.

Thank you for your time and consideration of my testimony. Please do not hesitate to contact me, Jenny Collier at jcollier@colliercollective.org, or Bill McColl at bmccoll@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, Tacoma Needle Exchange, and coalition partners.]

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, 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. 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. 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. In fiscal year (FY) 2023, Duke Health supports a program level of at least \$49.048 billion for the NIH base budget, which would represent an increase of \$4.1 billion over the comparable FY 2022 funding level (an increase of \$3.5 billion or 7.9 percent in the NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives). Duke Health strongly urges lawmakers to ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) supplement our \$49 billion recommendation for NIH's base budget, rather than supplant the essential foundational investment in the NIH.

Duke Health appreciates the inclusion of \$52 million in the FY 2022 Consolidated Appropriations Act (Public Law 117-103) for the National Institute of Allergy and Infectious Disease to support Regional Biocontainment Laboratories (RBLs) for research, operation support, and training new researchers in biosafety-level (BSL) 3 practices. Continued Federal investment in the RBLs will strengthen the Nation's research on biodefense and emerging infectious disease agents and improve our response to future public health emergencies. For FY 2023, Duke Health respectfully requests \$52 million to be shared among the 12 research institutions to conduct research on developing tests for new antiviral compounds, vaccines, and point of care tests; support operations costs and purchase of equipment to keep the laboratories up to date and safe; and support personnel trained in biosafety level 3 and 2 practices to ensure the highest level of expertise is brought to bear on these research needs that are critical for the security of the U.S.

Duke Health also appreciates the Committee's support for the National Center for Advancing Translational Sciences (NCATS) Clinical and Translational Science Awards (CTSA) Program. In FY 2023, Duke Health urges the Committee to consider urging NCATS to make supplemental funding available to Minority Serving Institutions that partners with CTSA's to incentivize these partnerships. We also ask the Committee to urge NCATS to increase the cap for CTSA Program Hubs.

Finally, Duke Health asks the subcommittee not to include language that would limit the use of nonhuman primates in research, which 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 \$11 billion for the CDC in FY 2023. Within the CDC, Duke Health also requests the Committee consider including \$10 million for the Sickle Cell Disease (SCD) surveillance program within the National Center for Birth Defects and Developmental Disabilities' Blood Disorder Division. Additional Federal funding for CDC's SCD Data Collection Program is also necessary to allow the program to be expanded to include additional States with the goal of covering the majority of the U.S. SCD population over the next 5 years.

NIH AND CDC FIREARM VIOLENCE RESEARCH

Duke Health is grateful for investments from Congress to support firearm violence research. As outlined in the FY 2023 NIH Budget Justification to Congress, violence is a widespread public health problem that has profound impacts on lifelong health, opportunity, and well-being. Duke Health asks the Committee to consider \$35 million for the CDC and \$25 million for the NIH to conduct public health research into firearm morbidity and mortality prevention. We also encourage Congress to explore opportunities for building out and further supporting this research at all other appropriate agencies, to ensure that federally funded research can explore the full scope of this public health issue.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Duke Health appreciates the subcommittee's continued investment in Title VII health professions training programs and Title VIII Nursing Workforce Development programs at HRSA. These programs help ensure a well-trained pipeline of health professionals to meet the increasing health needs facing the United States. These programs also increase the diversity and cultural competency of our Nation's health care workforce, which is increasingly important as the U.S. population grows and becomes more diverse. For FY 2023, Duke Health respectfully requests that the subcommittee provide \$980 million to Title VII health professions programs, and \$530 million to Title VIII Nursing Workforce Development 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 also supports the president's proposal to provide support for programs to address clinician burn-out and well-being, as authorized under Title VII and established in the recently enacted Dr. Lorna Breen Health Care Provider Protection Act.

Duke Health urges the subcommittee to provide \$23 million in FY 2023 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. Umbilical cord blood units have the advantage of use without full matching which specifically meets the needs of patients of non-Caucasian ancestry. These patients have the lowest chance of finding a complete match, but can still have access to transplantation therapy using a partially matched banked umbilical cord blood donor unit.

Duke Health respectfully requests the subcommittee provide \$37 million for the C.W. Bill Young Cell Transplantation Program through the NCBI at HRSA in FY

2023. 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 not less than \$500 million for the Agency for Healthcare Research and Quality in FY 2023. 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 and primary care research, AHRQ is the bridge between cures and care, and ensures that Americans get the best health care at the best value. For example, funding from AHRQ supports patients with sickle cell disease, 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, particularly through the development and use of evidence-based decision support tools.

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 2023, Duke Health urges the subcommittee to provide \$150 million for NCTSN, which matches the president's budget request.

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, fully authorized funding, for the Military and Civilian Partnership for the Trauma Readiness Grant Program for FY 2023 within ASPR. Originally known as MISSION ZERO,

this critical program provides 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. Building upon FY 2022's initial investment, 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 2023

- Provide \$49 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 \$11 billion to facilitate timely public health efforts.
 - Please provide \$6 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

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).

Most of the dystonia research at NIH is supported by NINDS. NINDS has utilized several 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 several 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 2022. 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 support of the 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 3 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, 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 automated 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 1 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 THE EDUCATION TRUST

On behalf of The Education Trust, a national nonprofit that works to close opportunity gaps that disproportionately affect students of color and students from low-income families, thank you for the opportunity to present testimony on the Fiscal Year 2023 (FY23) Labor, Health and Human Services, Education, and Related Agencies (L-HHS-ED) Appropriations bill. We request that the L-HHS-ED bill make substantial investments in excess of prior, cap-limited years to ensure that essential education programs have the resources they need to ensure the greatest impact for students of color and students from low-income communities.

While there are many programs under your jurisdiction that are critical to advancing equity, in FY23, The Education Trust is focused on the following:

- Strengthening the Pell Grant program by increasing the maximum award to keep pace with inflation, at a minimum, and ideally, doubling the maximum award.
- Supporting teachers and school leaders by including funding and language supporting the following:
 - ESSA (Every Student Succeeds Act) Title I-A (\$18.54 billion);
 - Incentives for States and localities to evaluate their education funding formulas and policies and implement equitable reforms (\$100 million);
 - ESSA Title II-A (\$3 billion);
 - the Teacher and School Leader Incentive Program (TSLIP) (\$200 million);
 - the Supporting Effective Educator Development Program (SEED) (\$140 million);
 - HEA (Higher Education Act) Title II's Teacher Quality Partnership (TQP) grants (\$300 million); and
 - restoring funding to the School Leader Recruitment and Support Program (SLRSP) (\$40 million).
- Maintain FY22 omnibus report language increasing equity in advanced coursework.
- Enabling enhanced preparation for teaching candidates at Historically Black Colleges and Universities (HBCUs) and Minority-Serving Institutions (MSIs) by allocating at least \$40 million in funding for the Augustus F. Hawkins Centers of Excellence Grant program.
- Developing and strengthening evidence-based student success programs by allocating \$110 million in funding for the Post Secondary Student Success Grant program.
- Supporting student parents by allocating \$500 million in funding for the Child Care Access Means Parents in School (CCAMPIS) program.

We urge increased support by the Committee for these critical programs to help meet the needs of students of color and students from low-income communities.

Strengthening the Pell Grant Program

The Pell Grant program is the cornerstone of Federal financial aid. The program benefits over 7 million students annually and continues to serve as the primary Federal investment designed to allow students from low-income backgrounds to access higher education. Over one-third of White students, two-thirds of Black students, and half of Latino students rely on Pell Grants every year.¹ Pell Grant dollars are well-targeted to those in need: 83 percent of Pell recipients come from families with annual incomes at or below \$40,000, including 44 percent with annual family incomes at or below \$15,000.²

Increase the Maximum Award

The maximum Pell Grant award has failed to keep pace with the rapidly rising cost of college over the past several decades. In 1980, the maximum Pell Grant award covered 77 percent of the cost of attendance at a public university. Today,

¹ Congressional Budget Office (CBO), January 2017 baseline projections for the Pell Grant program, <http://bit.ly/2mLy0nk>, Table 2; and Ed Trust calculation NPSAS:12 using PowerStats.

² Analysis of Federal Pell Grant Program Annual Data Report, available at <https://www2.ed.gov/finaid/prof/resources/data/pell-data.html>.

it covers just over 28 percent, the lowest portion in over 40 years. Bold action must be taken to halt and reverse this damaging trend.

We are appreciative of previous increases to the maximum award in prior appropriations bills, including the \$400 increase in the Fiscal Year 2022 (FY22) omnibus, and we respectfully request that you continue to annually increase the maximum award amount. It is also worth noting that nearly 1,200 organizations have gone on record supporting the doubling of the Pell Grant.

In FY23, Congress should, at minimum, increase the maximum award upward from \$6,895 to keep pace with inflation. It is also time for Congress to implement an ambitious plan to reverse the downward trend of Pell's purchasing power through doubling the maximum award, including expanding the mandatory funding stream, ensuring that the maximum Pell award covers at least half of the cost of attendance at a public 4-year institution.

SUPPORTING STUDENTS, TEACHERS, AND SCHOOL LEADERS

Increase funding for ESSA's Title I-A; ESSA's Title II-A (Supporting Effective Instruction); the Teacher and School Leader Incentive Program (TSLIP), the Supporting Effective Educator Development (SEED) program, HEA's Title II Teacher Quality Partnership (TQP) grants; incentivize States and localities to evaluate their education funding formulas and policies and implement equitable reforms; and maintain FY22 report language supporting increasing equity in advanced coursework.

The Education Trust, building on the prior \$1 billion funding increase for Title I in the FY22 omnibus, supports another \$1 billion funding increase in FY23 budget for ESSA's Title I-A program. However, it is important to note that most public education funding is distributed via State and local formulas. Therefore, any Federal funding increases of this size should be accompanied by levers that encourage States and districts to address the inequities inherent in those formulas. This is a tremendous opportunity to spark systemic reform of the status quo that sends \$23 billion more to predominantly White school districts than predominantly non-White school districts. We urge the committee to think boldly about how make the overall education funding system more equitable, including inserting report language to that effect, and to include the \$100 million designated for this purpose within the Biden-Harris administration's FY23 budget request in the L-HHS-ED Appropriations bill.

Furthermore, research and experience show the powerful impact that teachers and school leaders have on student learning. ESSA's Title II-A program provides grants to States and districts that can be used to invest in and develop educators. These funds can be used to, among other things, address inequities in access to effective teachers and school leaders, provide professional development, and improve teacher recruitment and retention. States and districts can also apply for additional competitive grant dollars for programs like TSLIP and SEED, which are targeted at specific, evidence-based strategies for improving teacher and school leader effectiveness and increasing educator diversity. Additionally, HEA's Title II TQP grants, awarded to partnerships between high-need districts and teacher preparation programs at institutions of higher education, can be used to recruit underrepresented populations to the teaching profession. As Ed Trust's work continues to demonstrate the positive impact that diverse teachers and school leaders of color can have on the academic achievement of both students of color and White students, we remain supportive of Federal dollars to increase and bolster the diversity of the educator pipeline.

Finally, research shows that Black, Latino and Native students, students with disabilities, and students from low-income families are underrepresented in advanced programs and courses (gifted and talented, advanced placement, international baccalaureate, honors courses, dual enrollment, etc.). We the inclusion of report language included in the FY22 omnibus that noted that funds under ESEA (Elementary and Secondary Education Act) may be used to implement open enrollment, automatic enrollment, and/or universal screening practices; to increase course access and success; to provide coaching and training for educators; to purchase materials; and/or cover exam fees for underrepresented students. The language also encouraged the Department to resume collecting data on passing rates for all Advanced Placement subject areas.

Considering the Nationwide attention to the need to invest in educators, especially as schools work to counteract the negative impacts of the COVID-19 pandemic, Congress appropriated increases for most of these programs in FY22: \$2.17B for the Title II-A grant, \$85M for the SEED program, and \$59.09M for HEA's Title II TQP grants, but unfortunately cut TSLIP by \$27M down from \$200M in FY21.

At a minimum, in FY23, Congress should: increase Title I–A; allocate \$100M to incentivize States and localities to evaluate their education funding formulas and policies and implement equitable reforms; increase Title II–A, TSLIP, SEED, and TQP beyond FY22 levels: \$18.54B, \$3B, \$200M, \$140M, and \$300M, respectively, and maintain report language supporting increasing equity in advanced coursework.

Restore Funding for the School Leader Recruitment and Support Program

Landmark research funded by the Wallace Foundation has found “virtually no documented instances of troubled schools being turned around without intervention by a powerful leader,” and the School Leader Recruitment and Support Program is the only Federal program specifically focused on investing in evidence-based, locally driven strategies to strengthen school leadership in high-need schools. A seven-year study, concluded in 2019, of school districts that created pipelines to develop school leaders saw increasing gains in student achievement over time, showing how a sustained initiative can demonstrate positive effects on student learning.

There is still a great deal of work to do, especially when it comes to identifying and efficiently preparing effective turnaround leaders, as well as sustainably supporting them to accelerate academic achievement, close gaps, and maintain improvement over time for all students and in every community. Developing strong leaders to build essential relationships with students and the communities they operate in is a fundamental necessity to help students finish the learning currently unfinished due to the COVID–19 pandemic. The SLRSP is a key lever for seeding the next generation of effective school leader development programs, promoting equity, advancing ongoing innovation, and sharing innovative lessons on transformational leadership with the broader field.

In FY23, Congress should restore funding for the School Leader Recruitment and Support Program to \$40M, the amount included in the FY23 President’s Budget and a moderate increase from what was included in FY22 Senate Labor-HHS–ED Appropriations bill.

Increase funding for the Augustus F. Hawkins Centers of Excellence Grant Program

Research has shown that students of color benefit tremendously from having teachers of color, particularly one of the same racial background: they are less likely to be chronically absent or suspended from school, more likely to be recommended for gifted and talented programs, and low-income Black students who have a Black teacher for at least 1 year in elementary school are less likely to drop out of high school and more likely to consider college. And while students of color make up the majority of students in public schools, the diversity gap for teachers of color still exists across every State. For example, Virginia has taken steps to address their diversity gap by using their ARPA (American Rescue Plan Act) funds to “provid[e] ongoing support to recruit, hire, and retain a diverse school staff” including programs to induct and mentor new teachers of color and targeted student loan assistance programs for pre-service and in-service teachers of color.

The nationwide impact of HBCUs, MSIs, Hispanic-Serving Institutions (HSIs), and Tribal Colleges and Universities (TCUs) on producing teachers of color cannot be overstated. HBCUs, TCUs, and MSIs, collectively, award only 11 percent of the Nation’s bachelor’s degrees in education, yet they produce more than 50 percent of the bachelor’s degrees earned in education by Hispanic, Native Hawaiian and Pacific Islander students.³ HBCUs graduate approximately 50 percent of the Nation’s African American teachers with bachelor’s degrees.⁴ HSIs prepare 90 percent of Hispanic teachers, and along with other MSIs, constitute a vital pipeline to maintain diversity among our Nation’s teachers.⁵

Considering the importance of these institutions, the increased needs they experience as result of graduating an outsized portion of the Nation’s teachers of color, and the exacerbated nature of the current shortage of teachers of color due to the COVID–19 pandemic, we request that Congress build on the highly appreciated \$8M investment made in the Augustus F. Hawkins Centers of Excellence grant program in the FY22 omnibus. Increasing Congress’ investment would provide critical

³Branch Alliance for Educator Diversity, “Homepage,” available at <https://www.educatordiversity.org/>.

⁴Jacqueline Jordan Irvine and Leslie T. Fenwick, “Teachers and Teaching for the New Millennium: The Role of HBCUs,” *The Journal of Negro Education* 80 (3) (2011): 197–208, available at <http://www.jstor.org/stable/41341128>; National Association for Equal Opportunity in Higher Education: Comments to the Department of Education proposed rule changes for teacher preparation programs available at: http://nafeonation.org/wp-content/uploads/2015/01/NADEC_Teacher_Prep_Regulations_Discussion_Document_2-2-15.pdf.

⁵Hispanic Association of Colleges and Universities, “Teacher Diversity,” <https://www.hacuadvocates.net/teacherdiversity?1>.

funding to these key institutions to provide increased and enhanced clinical experience and increased financial aid to prospective teachers of color, who face higher burdens in college access and affordability than their White peers. Finally, the FY23 President's Budget proposal recommended continued and additional funding for the program, and a recent House Dear Colleague letter in support of increasing funding to the program to \$40 million garnered 34 signatures and is circulating in the Senate.

In FY23, Congress should fund the Augustus F. Hawkins Centers of Excellence Grant Program at \$40M.

SUPPORTING COLLEGE STUDENTS

Fund the Post Secondary Student Success Grant Program

Despite the gains made in high school graduation rates over the past several decades, the fact remains that only six in 10 students earn a college degree after 6 years of undergraduate study, and Black and Hispanic individuals have a lower rate of degree attainment than their White and Asian-American peers. The COVID-19 pandemic has exacerbated this problem: college enrollment has declined by 5.1 percent across the board since spring of 2020. These challenges present the possibility of long-term negative effects on students, their families, state and national economies, and the country.

Congress, with the support of 14 organizations including Ed Trust, included a \$5 million dollar investment in Post Secondary Student Success Grants in the FY22 omnibus. That is a positive development that we look forward to helping the Department implement, but we will need much more to reverse these damaging trends. Prior proposals from the Biden administration and both chambers of Congress understood the size and scope of the problem of low college completion rates, and we hope the committee will revisit those when deciding how much to invest moving forward. The FY23 President's Budget proposal included a request for \$110M for this concept, as did a recent House Dear Colleague letter that garnered 26 signatures and is circulating in the Senate. We support that funding level for this appropriations cycle.

In FY23, Congress should fund the Post Secondary Student Success Grant Program at \$110M.

Fund the Child Care Access Means Parents in School (CCAMPIS) Program

Over 20 percent of undergraduate students are parents of dependent children, and within that cohort, 1.7 million are single mothers. As detailed further in this letter from 51 organizations in support of this funding ask, including Ed Trust, increasing the funding for CCAMPIS would provide child care support for approximately 100,000 more student parents, giving them access to the child care services they need to get to and through college. This population is increasing year after year, and in a recent survey of over 20,000 student parents, 70 percent indicated their current childcare provider was unaffordable. Furthermore, an upcoming report from Ed Trust will show that on average, a student parent would need to work anywhere from 30 to 90 hours a week to cover child care and tuition costs at a public college or university.

It is essential that Congress scale up the only program specifically designed to deliver on-campus child care to Pell-eligible student parents, which would dramatically enhance their chances of achieving educational success and financial stability.

In FY23, Congress should fund the Child Care Access Means Parents in School (CCAMPIS) Program at \$500M.

Thank you for the opportunity to submit testimony. The Education Trust looks forward to working with Congress to allocate Federal funds in a way that addresses the critical equity gaps that our Nation's students from low-income backgrounds and students of color continue to face. We are happy to respond to any questions or concerns that you may have on these topics.

Sincerely,

[This statement was submitted by Denise Forte, Interim CEO, The Education Trust.]

PREPARED STATEMENT OF THE ENDOCRINE SOCIETY

The Endocrine Society thanks the subcommittee for the opportunity to submit the following testimony regarding Fiscal Year (FY) 2023 Federal appropriations for biomedical research and public health programs. The Endocrine Society is the world's oldest and largest professional organization of endocrinologists representing approxi-

mately 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 the Centers for Disease Control and Prevention (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 \$50 billion for (FY) 2023; to facilitate the translation of these advances to improve public health, the Endocrine Society recommends the CDC receive funding of at least \$11 billion; and to ensure that women have access to appropriate health services, we recommend that the Title X program be funded at \$512 million. This request does not include additional emergency supplemental funds or new programs situated in NIH including the Advanced Research Projects Agency for Health (ARPA-H).

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.

EFFECTIVE PROGRESS REQUIRES CONSISTENT SUPPORT ACROSS NIH

Endocrinologists often study communication between different organs and how this influences disease, for example how hormones produced by adipose tissue influence the development of cancer or susceptibility to infections. Our members are therefore funded by many different Institutes and Centers (ICs) at NIH and appreciate the need to apply funding increases proportionally to all ICs and offices at NIH to effectively advance knowledge of complex biological systems and signaling pathways that impact multiple organs and diseases. We are concerned that when funding is applied disproportionately and at the expense of certain ICs, payline disparities increase and gaps in our understanding of important biological pathways emerge. Regular, sustainable, and proportional increases to all NIH ICs empower endocrinologists to develop novel interdisciplinary approaches that address public health priorities. For example:

- While the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is taking a leadership role in understanding the pathophysiology and clinical course of COVID-19 induced diabetes, NIDDK also partnered with the National Institute of Allergy and Infectious Diseases (NIAID) and others to develop community-engaged testing interventions among underserved and vulnerable populations.¹
- Endocrinologists funded by National Institute of Environmental Health Sciences (NIEHS) in partnership with the National Institute for Child Health and Human Development (NICHD) and others are aiming to improve our understanding of how climate change will impact public health, for instance via impacts on fertility.²

¹ <https://www.niddk.nih.gov/research-funding/current-opportunities/rfa-od-22-005>.

² Audrey J. Gaskins et al., 2021.

- Endocrine oncologists supported by the National Cancer Institute (NCI) and NIEHS are contributing to our knowledge of how drugs and consumer products can contribute to cancer risk in offspring.^{3,4}
- Endocrine researchers funded by the National Institute of Mental Health (NIMH) and Office of Research on Women's Health are helping us better address gaps in understanding of how sex differences contribute to mental illness in men and women.

REPORT LANGUAGE OPPORTUNITIES FOR FISCAL YEAR 2023

Research on Transgenerational Health Effects: Diethylstilbestrol (DES) is an endocrine-disrupting chemical that was prescribed to women between 1940–1971 to prevent miscarriage, premature labor, and other pregnancy complications. Unfortunately, not only was DES ineffective in preventing these complications, but it also was linked to a rare cancer in women and can cause a variety of cancers and other health effects in the daughters and sons of exposed women. Research now suggests that the effects of exposures may persist and cause health effects in the grandchildren of exposed women and future generations. Recognizing the critical need for knowledge about the health effects of DES exposure, the NIH established the DES follow-up study, creating a coordinated longitudinal cohort that has made important discoveries about the health effects of DES exposure. We are now at a critical point in time to learn more about the persistence of health effects beyond the children of exposed women so that future generations have valuable information about their own health risks.

We urge the subcommittee to therefore include report language asking NIH to report on plans for existing or new cohort studies that can address transgenerational effects of EDC exposures, including the continuance of the DES longitudinal cohort.

Supporting the Physician-Scientist Workforce: Recognizing the challenges facing the physician-scientist biomedical research workforce, the NIH convened and charged a Physician-Scientist Workforce Working Group with analyzing the current composition and size of the physician-scientist biomedical workforce and making recommendations for NIH to take to help sustain and strengthen a robust and diverse physician-scientist workforce. In 2014, the NIH released a report which made nine recommendations to sustain and strengthen a robust and diverse physician-scientist workforce. We know that several Institutes and Centers (I/Cs) have created initiatives for their own researchers; however, there is a need for the NIH to comprehensively look at and report on outcomes, best practices, and any gaps that may remain.

We urge the subcommittee to include report language asking NIH to provide an update on actions to bolster the physician-scientist workforce either by implementing the 2014 report's recommendations or otherwise, including outcomes data on the Medical Scientist Training Program (MSTP), and the Stimulating Access to Research in Residency (StARR) program.

Special Programs Must Not Erode Support for Investigator-Initiated Research

The Endocrine Society is enthusiastic about the potential for ARPA-H to advance transformative public health interventions and develop new research platforms that deliver improved care to patients quickly and efficiently. Likewise, we appreciate the importance of pandemic preparedness. However, these investments must not come at the expense of the important investigator-initiated research that have been chiefly responsible for the numerous NIH-supported success stories and public health achievements. We therefore urge the Committee to provide at least \$50 billion to the NIH base budget, with increases applied equally across all ICs and offices. Any additional funds for pandemic preparedness or ARPA-H should only complement, rather than supplant, these necessary investments in the future of biomedical research.

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

³ <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>.

⁴ <https://endocrinenews.endocrine.org/edc-exposure-during-pregnancy-may-reduce-breast-cancer-protection/>.

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 percent in those under 60 and by 71 percent in those 60 and older.⁵ 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 reproducible public health research. Adequate funding is critically important to ensure that CDC has the capacity to protect the public's health.

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.⁶ 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 2023 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 2023 Labor, Health and Human Services, Education, and Related Agencies appropriations bill:

- \$50 billion for the National Institutes of Health
- \$11 billion for the Centers for Disease Control and Prevention
- \$512 million for Title X

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 \$49 billion in fiscal year (FY) 2023 for the National Institutes of Health (NIH) base program funding, including increased support for vector-borne disease (VBD) research at the National Institute of Allergy and Infectious Diseases (NIAID); \$11 billion for the Centers for Disease Control and Prevention (CDC) base program funding, 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 \$52 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 and arthropod carriers of disease, like mosquitoes and ticks, 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

⁵The Diabetes Prevention Program (DPP) Research Group Diabetes Care. 2002 Dec;25(12):2165–71.

⁶Frost JJ, et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017.

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 resistance to pesticides. 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 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 on understanding how to increase protection after exposure to arthropod disease vectors and the pathogens they transmit that could cause Lyme disease and other tick-borne infections. Using grant funding from NIAID, researchers from the Yale School of Medicine developed and trialed the first messenger RNA (mRNA) vaccine targeting ticks.² Whereas previous efforts to develop vaccines against tick-borne disease in humans have targeted disease-related pathogens, this new mRNA vaccine technology induces immunity against a salivary protein produced by the vector ticks themselves. This study published in November 2021 in *Science Translational Medicine*,³ showed that the mRNA vaccine administered to guinea pigs caused blacklegged tick bites to become inflamed and ticks to fall off too quickly to transmit the pathogen that causes Lyme disease. This novel and important research demonstrates that the new mRNA vaccine technology holds the potential to protect individuals not only against the pathogen that causes Lyme disease but numerous other tick-borne pathogens that are carried by the blacklegged tick.

Within the NIH, the nascent Advanced Research Projects Agency for Health (ARPA-H), a signature priority for the Biden Administration, represents an opportunity to catalyze health breakthroughs that cannot readily be accomplished through traditional research or commercial activity, which could include understanding and preventing emerging infectious diseases. ESA supports at least \$4 billion for the ARPA-H to supplement, rather than supplant, the core investment of at least \$49 billion in NIH's base program level. Similarly, under NIH, the National Institute of Environmental Health Sciences (NIEHS) supports research and initiatives to address health concerns influenced by climate change or environmental agents, including VBD and zoonotic diseases. ESA supports at least \$110 million for NIEHS to continue efforts to identify potential health effects associated with climate change and environmental factors and implement health adaptation plans.

ESA requests robust support for CDC programs addressing VBD within the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) by supporting the Centers of Excellence on VBD, as authorized by the Kay Hagan Tick Act in 2019, and other work by the Division of VBD with at least \$75.103 million per year, as is aligned with the FY 2023 President's Budget Request, as well as the \$20 million authorized by the Kay Hagan Tick Act for the Epidemiology and Laboratory Capacity (ELC) program to address VBD. 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 percent 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).⁴ Disability and death from RMSF are preventable if the antibiotic doxycycline is administered within the first

¹ <https://www.gatesnotes.com/Health/Most-Lethal-Animal-Mosquito-Week>.

² <https://www.smithsonianmag.com/smart-news/first-ever-mrna-vaccine-for-lyme-disease-shows-promise-in-guinea-pigs-180979090/>.

³ <https://pubmed.ncbi.nlm.nih.gov/34788080/>.

⁴ <https://www.ncbi.nlm.nih.gov/pubmed/?term=30969821>.

five days of illness: without treatment, 1 in 5 RMSF cases lead to death.⁵ Importantly, spotted fevers have non-specific symptoms, and fewer than 1 percent 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.⁶ 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 for 5 years to establish regional Centers of Excellence (COE) to address existing and emerging VBD. The five centers, for which funding expired 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. Sustained funding for the COE is critical to continue essential efforts to help prevent and control VBD threats in the U.S.

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 for VBD.

ESA requests robust funding for IMLS, including no less than \$52 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.

ESA, headquartered in Annapolis, Maryland, is the largest organization in the world serving the professional and scientific needs of entomologists and individuals in related disciplines. Founded in 1889, ESA is a non-partisan professional organization over 7,000 members affiliated with educational institutions, health agencies, private industry, and government. Members are researchers, teachers, extension service personnel, administrators, marketing representatives, research technicians, consultants, students, pest management professionals, and hobbyists. For more information about ESA, please see <http://www.entsoc.org/>.

[This statement was submitted by Jessica Ware, PhD, President, Entomological Society of America.]

PREPARED STATEMENT OF THE EPILEPSY FOUNDATION

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- Please provide \$11 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 2022; and

⁵ <https://www.cdc.gov/media/releases/2019/p0513-rocky-mountain-spotted-fever-training.html>.

⁶ <https://www.cdc.gov/rmsf/resources/module.html>.

- \$164 million for the CDC's Safe Motherhood & Infant Health Program in order to support and help expand the Sudden Unexpected Infant Death (SUID) & Sudden Death in the Young (SDY) Case Registry; and
- \$5 million for the CDC's National Neurological Conditions Surveillance System (NNCSS).
- Please provide at least \$49 billion for the National Institutes of Health (NIH)'s base and ensure that any funding for the new ARPA-H, or for other targeted programs like pandemic preparedness, supplement the \$49 billion recommendation for NIH's base budget.
- 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 deeply appreciate the robust investments in public health and research 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 2023, please continue this commitment and provide timely investments public health and research programs at the CDC and in the NIH. 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 \$11 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:

- Training for School Staff: In FY21, 6,090 school nurses and 177,120 school personnel have been trained on seizure recognition and seizure first aid. On-demand training modules have been developed to scale up training of these key, frontline community members supporting students with seizures.
- Seizure First Aid Certification: 14,690 people were certified in seizure first aid in FY21, in partnership with multiple healthcare professional groups serving minority communities. Continued focus is needed on rural and ethnically and racially diverse communities as nearly 40 percent of persons diagnosed with epilepsy are Black or Hispanic and many people with epilepsy in those communities have poorer health outcomes.
- Professional Education in Epilepsy: To improve care in rural and underserved communities, Project ECHO has educated more than 1,155 primary healthcare providers about managing epilepsy over 3 years, though more focus is needed on management of severe, drug-resistant epilepsy and quality of care improvement methods. In addition, seven Behavioral Health Outreach webinars were

developed as tools for ensuring access to epilepsy knowledge and skills for behavioral and mental health providers.

- Reducing Barriers to Medication Adherence: By establishing a regular screening process for identifying and addressing barriers to medication adherence, an Epilepsy Learning Healthcare System (ELHS) is addressing a key health disparity in epilepsy. ELHS has produced 11 tools to help patients and families overcome common barriers to adherence.
- Supporting Mental Health Needs: Mental health screenings have been implemented on the 24/7 Epilepsy & Seizures Helpline since people with epilepsy are at increased risk for depression, anxiety, and suicide. Several suicide interventions have been successful. In addition, people with epilepsy are being connected to self-management programs that prevent and decrease depression.

Also as part of the \$11 billion for the CDC, please provide \$164 million for the CDC's Safe Motherhood & Infant Health Program in order to support and help expand the SUID & SDY Case Registry.

SUDEP is the sudden, unexpected death of someone with epilepsy, who was otherwise healthy. It is the leading cause of death in people with uncontrolled seizures. Each year, it is thought that more than 1 in 1,000 people with epilepsy die from SUDEP and this number increases drastically to 1 in 150 for people whose epilepsy is not controlled by treatment. But there are deficiencies and inconsistencies with how SUDEP-related deaths are tracked. While some strides are being made, the exact cause(s) of SUDEP are not known.

Building on child death review programs at the National Center for Fatality Review and Prevention Case's Reporting System, the SUID portion was initiated in 2009 and in 2015, the SDY Case Registry component was added to include children and adolescents. A joint collaboration of the CDC and NIH, the SDY Case Registry increases the understanding of the prevalence, causes, and risk factors for infants, children, and young adults up to age 20, who die suddenly and unexpectedly including from SUDEP-informing strategies to prevent future deaths. The registry is present in 22 States and jurisdictions but this is capturing less than half of these deaths nationwide. Increased investment in the CDC's Safe Motherhood/Infant Health Program where the Registry is housed would allow more States to participate and in turn, yield more data to improve understanding and prevention.

The Foundation urges the Committee to include the following report language:

Sudden Unexpected Infant Death [SUID] and Sudden Death in the Young [SDY] Case Registry.-The Committee is aware that SUID is the leading cause of death of infants 1 month to 1 year of age in the United States. While there is no known way to prevent SUID, there are ways to minimize risk by collecting and analyzing data, such as that available through the SUID and SDY Case Registry. The SDY component of the Case Registry has been critical in improving data gathered on sudden deaths of children and youth up to age 20. This includes the ability to study and better understand Sudden Unexpected Death in Epilepsy (SUDEP) and sudden cardiac death in the young. Each year, it is thought that more than 1 in 1,000 children and youth with epilepsy die from SUDEP. It the leading cause of death amongst people with uncontrolled seizures and the exact cause(s) of SUDEP are not known. Accordingly, the Committee includes an increase within CDC's Safe Motherhood and Infant Health program for the Registry to expand the number of States and jurisdictions participating in monitoring and surveillance. Furthermore, the Committee includes funding for CDC to award grants or cooperative agreements to States, Tribes, and Tribal organizations for purposes of improving data collection related to SUID and sudden unexpected death in childhood, including by identifying, developing, and implementing best practices to reduce or prevent infant death, including practices to improve safe sleep, as well as unexpected death in youth in coordination with appropriate nonprofits.

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 2023.

Please also provide at least \$49 billion for the National Institutes of Health (NIH)'s base and ensure that any funding for the new ARPA-H, or for other targeted programs like pandemic preparedness, supplement the \$49 billion recommendation for NIH's base budget 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 \$154 million in FY 2017 to \$198 million in FY 2020. Much more can be done though, particularly in the area of bold cross-cutting initiatives and multi-center efforts. For FY 2023, we ask that the subcommittee include key committee recommendations, like the language below, to encourage additional epilepsy research in emerging areas.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

Epilepsy Care.—The Committee congratulates NINDS and its sister institutes in the Inter-Agency Collaborative to Advance Research on Epilepsy (ICARE) for supporting fundamental brain research that has dramatically advanced the scientific understanding of the epilepsies over the last two decades. The Committee encourages NIH and other ICARE partners to increase their investments in health services and implementation science to ensure that the benefits of research are effectively translated to epilepsy care, and to work together to further coordinate their activities to improve systems of epilepsy care.

PREPARED STATEMENT OF ESSENTIAL ACCESS HEALTH

Dear Chairwoman Murray and Ranking Member Blunt:

As Chief External Affairs Officer of Essential Access Health (Essential Access), I thank you for this opportunity to provide testimony in support of increased funding for the Title X Federal family planning program in the fiscal year (FY) 2023 appropriations bill. The Title X family planning program has been level-funded by Congress for eight straight fiscal years, as the need for family planning and sexual health services has increased and become more critical than ever. With increased need and the rising costs of providing care, level-funding is equivalent to a cut.

Essential Access has been a Title X grantee since the program was established with strong bi-partisan support in 1970.

For over 50 years, Essential Access has administered the Title X Federal family planning program in California—the largest and most diverse Title X system in the Nation. This year, Essential Access was also awarded a grant to re-introduce the Title X program in the State of Hawaii and address the dire need for family planning services statewide. On March 30, Essential Access was notified that we were awarded a 5-year service grant to continue serving as the sole Title X grantee in both States. While we are proud to continue working with a robust network of qualified providers, the award amounts received were significantly less than the requested amount of funding necessary to meet the needs of Title X patients and health care providers throughout California and the Hawaiian islands.

The California Title X statewide program suffered a dramatic cut in funding. Our funding level for the next project period is \$13.2 million, a drastic reduction of \$8 million. This is the largest Title X funding cut Essential Access has received in our 50-year history administering the program. The \$2.1 million in funding support for the Title X program in Hawaii, does not meet the need for equitable, affordable, and high quality family planning services for the more than 66,000 people estimated to be in need of Title X-supported services statewide. Hawaii did not receive any Federal resources to support family planning care between the summer of 2019 and January of 2022. This gap in Federal funding greatly reduced the capacity of the family planning safety-net across the State of Hawaii.

Inadequate Title X funding is a direct consequence of the program receiving level-funding in the FY 2022 omnibus appropriations bill, despite strong support for significant increases from both chambers of Congress and the White House.

Failure to increase Title X funding has had an immediate and dire impact. In addition to not being able to meet the need for Title X resources in Hawaii, some health centers in California did not receive any Title X funding and all remaining Title X-funded health centers in California's Title X provider network received a reduction.

These unexpected cuts are compounded by increases in the cost of delivering care at a time when community health centers are already stretched thin by the pandemic and rising costs of providing care. Title X providers depend on these dollars

to support staffing, infrastructure, outreach and education activities, quality improvement activities, and other wrap-around services.

The impact of these cuts to Title X services will have a disproportionate effect on Californians and people of Hawaii with low-incomes, people living in rural regions and urban health care deserts, and communities of color.

Additional resources are urgently needed to meet the need for comprehensive family planning services in Hawaii and California, and across the country. I urge Congress to use the FY 2023 Labor, Health and Human Services, Education, and Related Agencies appropriations bill to make a strong statement in support of high-quality, equitable, and patient-centered family planning care and make it right for Title X by increasing program funding to \$737 million.

Thank you for the opportunity to submit this testimony. Contact Amy Moy at AMoy@essentialaccess.org if you have questions or need additional information.

Sincerely,

[This statement was submitted by Amy Moy, Chief External Affairs Officer, Essential Access Health.]

PREPARED STATEMENT OF EVERY HOUR COUNTS COALITION

As the Appropriations committee finalizes its fiscal year 2023 Labor, Health and Human Services, Education and Related Agencies (LHHS) appropriations bill budget request, the Every Hour Counts Coalition respectfully calls on Congress to preserve and strengthen Federal investments in education programs that help build and improve quality expanded learning systems across the country. The critical Federal investments that have been made to support students and communities recovering from the COVID-19 pandemic in previous years must be met by continued investment in annual spending to fully support the needs of students in all communities.

Every Hour Counts is a coalition of citywide intermediary organizations that are deeply engaged in building and improving expanded learning systems—coordinated groups of service providers, public agencies, funders, and schools. These systems provide critical support for local education programming by offering enrichment opportunities, raising funds to increase access, and promoting continuous improvement. Since its founding in 2005, Every Hour Counts has grown to 28 cities, representing longstanding partnerships with more than 3,500 schools, districts, and community-based organizations that provide quality after-school and summer programming. Every Hour Counts' partners and learning community members support initiatives that reach more than 500,000 students each year.

Strong Federal investments in education programs help to make these effective partnerships work. While emergency funding provided by the American Rescue Plan Act and previous COVID-19 relief packages were crucial in meeting the immediate needs of the COVID-19 pandemic (including summer and expanded learning), investments in the fiscal year 2023 budget are vital to ensure the success of continued recovery efforts in the years to come. Our coalition knows firsthand that out-of-school time instruction will continue to be a critical focus of long-term recovery and acceleration to address students' academic, social and emotional needs as the COVID-19 pandemic continues to affect students. Schools and districts cannot and should not be expected to meet every academic and non-academic need for their increasingly diverse student populations on their own. Therefore, we respectfully urge Congress to recognize the need to further invest in the following programs and initiatives:

NITA M. LOWEY 21ST CENTURY COMMUNITY LEARNING CENTERS PROGRAM

The Nita M. Lowey 21st Century Community Learning Centers (21st CCLC) program is the only Federal funding stream dedicated to supporting local summer learning and after-school programs in every State. Today, more and more youth participate in after-school and summer programs across the country,¹ and experts believe the quality of these programs is continually improving. These programs have been especially critical resources during the COVID-19 pandemic for working families and vulnerable student populations. Despite significant increases in the number of students enrolling in quality expanded learning programs, there continues to be substantial unmet demand for enrichment opportunities throughout the country, particularly for low-income communities. For every child in an after-school program, two are waiting to get in, a discrepancy further amplified in rural and low-income communities.²

The much-needed increases to this program over recent years are helping serve nearly 2 million children and families in high-need communities across the country by increasing access to high-quality expanded learning programs and will continue to play a critical role in communities as students recover from the COVID-19 pandemic. Congress should push to maintain this positive momentum and continue increasing investments in these programs. Therefore, we respectfully ask that Congress support the 21st CCLC program by increasing its funding level to \$1.39 billion, a \$100 million compared to fiscal year 2022 funding levels.

FULL-SERVICE COMMUNITY SCHOOLS

Full-Service Community Schools address academic, social and health services for students, their families and community members in high-poverty areas throughout the United States. These integral services help students overcome barriers to learning and have become even more crucial to the well-being of communities in the wake of the COVID-19 pandemic.

Every Hour Counts urges Congress to continue its commitment to these services by supporting President Biden's proposal of \$468 million for the Full-Service Community Schools program. This support will ensure that vulnerable communities, including high-poverty rural areas, receive academic, social and health services to strengthen their recovery from the COVID-19 pandemic.

IMPROVING ACADEMIC ACHIEVEMENT OF THE DISADVANTAGED- TITLE I, PART A

More than 90 percent of the Nation's school districts and nearly 60 percent of all public schools across the country rely on Title I funds in order to ensure that high-need students meet challenging State academic standards. As schools and districts work towards implementing school improvement strategies, particularly in partnership with intermediaries and other community-based organizations, it is critical to provide robust investments in the Title I program to ensure that schools have the resources needed to serve all students, including their most high-need students. The COVID-19 pandemic has highlighted the disparities among schools that were properly equipped to support students during times of crisis and those that were not. Our nation needs to make the investments necessary to provide equitable resources to schools so that all students may receive proper opportunities to learn and grow.

The Every Hour Counts coalition asks that Congress support President Biden's proposal for Title I. Making strong investments in communities with fewer resources is critical in ensuring that the needs of students are addressed in the years to come.

SUPPORTING EFFECTIVE INSTRUCTION STATE GRANTS- TITLE II, PART A

The Title II, Part A program provides flexible funding to States and districts to support high-quality professional development for educators, including the after-school workforce and other school personnel, that positively affect teacher, school leader and educator effectiveness. , High-quality staff are necessary for after-school, summer and other expanded learning programs to be successful. Despite the fact that the after-school workforce is one of the fastest growing education sectors in many cities, most citywide systems do not have comprehensive strategies in place to recruit, train and support a qualified and diverse workforce. Every Hour Counts' community partners have been working together with schools and districts to provide joint professional development with in- and out-of-school personnel to help increase supports for these educators and in turn increase educational quality. Educators must receive high-quality training and supports to properly address the academic, social and emotional needs of students during the COVID-19 pandemic recovery. Comprehensive out-of-school time (OST) organizations have demonstrated that they are willing and able to rise to post-pandemic challenges—and they are already strategizing how to do so, but they need consistent, reliable funding and partnerships to help strengthen programming, solve challenges, and fill gaps.

We encourage Congress to continue its support for this program in fiscal year 2023 by requesting that it be funded at \$2.295 billion, the authorized funding level stipulated in the Every Student Succeeds Act (ESSA).

STUDENT SUPPORT AND ACADEMIC ENRICHMENT GRANT PROGRAM- TITLE IV, PART A

The Student Support and Academic Enrichment (SSAE) Grant program provides formula grant funds to States and districts to support a host of activities that provide well-rounded educational opportunities, including those that increase student interest and engagement in science, technology, engineering and math (STEM) subjects, as well as activities to support safe and healthy students and activities to support the effective use of technology.

Over the past 7 years, Every Hour Counts has been involved in multi-city demonstration projects that have aimed to advance and strengthen the connections between STEM learning in the classroom and expanded learning programs in order to increase access to these opportunities for all students, particularly those from traditionally underrepresented groups. Through a focus on joint professional development and collaborative instruction between teachers and expanded learning educators, we have been able to create a culture shift in communities to make STEM learning an expectation in quality expanded learning programs. Providing enrichment opportunities has been especially important as the Nation attempts to re-engage students returning from remote learning during the COVID-19 pandemic and as the country plans to strengthen its STEM pipeline to continue being a global leader in innovation and technology.

We believe that this program will provide much needed funding to schools and districts to support the unique needs of their students and communities and therefore hope that Congress will demonstrate more support for it in fiscal year 2023. The Every Hour Counts coalition urges Congress to support this program by funding it at \$1.6 billion, the authorized funding level stipulated by ESSA.

THE CORPORATION OF NATIONAL AND COMMUNITY SERVICE—AMERICORPS PROGRAM

AmeriCorps volunteers play a critical role in helping to increase student outcomes, build capacity and drive quality both in the classroom and in expanded learning settings. As tutors, mentors and role models volunteering in classrooms, after-school and summer learning programs across the country, AmeriCorps volunteers' days extend beyond the last bell. In many Every Hour Counts communities, AmeriCorps volunteers help us raise the bar on quality expanded learning programs and provide hands-on learning experiences to more students. During the COVID-19 pandemic, AmeriCorps volunteers have provided crucial supports to students and communities that will continue during the pandemic recovery period. For example, the Minnesota AmeriCorps Emergency Response Initiative, launched at the start of the pandemic, focused on providing tutoring support to K-12 students during the summer of 2021 and continued funding will ensure such programming exists.

We respectfully urge Congress to further support these programs by requesting that the Corporation for National and Community Service be funded at \$1.767 billion and the AmeriCorps State and National program be funded at \$970 million in fiscal year 2023.

THE EDUCATION INNOVATION AND RESEARCH PROGRAM

The Education Innovation and Research (EIR) grant program provides funding to develop, implement and scale field-initiated innovations to improve achievement for underserved students. Crucially, the program places an emphasis on evidence-based practices and requires diligent evaluation of the innovations. The mission of the EIR program aligns closely to the mission of Every Hour Counts, and currently, Every Hour Counts works across sectors to build expanded learning systems across the country that engage students and improve academic and social-emotional learning outcomes. At our Expanded-Learning Systems-Building Institute, for example, we used cross-sector collaboration to share best practices, resources and lessons learned to consider how to scale high-quality practices, develop program quality improvement and keep racial equity at the center of our work. The COVID-19 pandemic has demonstrated the importance of social emotional learning and the needs of the whole child. Addressing these needs is a crucial element of the U.S. Department of Education's pandemic recovery efforts and requires robust Federal investment.

Every Hour Counts asks that Congress support President Biden's \$514 million proposal for EIR with respective set-asides of \$73.3 million for STEM and SEL education activities. Building upon this investment will expand educational opportunities that support the "whole child" across a number of key programs.

The Every Hour Counts coalition stands in strong support of the programs mentioned above which provide critical resources to schools and districts working in partnerships with us to improve educational outcomes for students across all communities. We urge Congress to support our Nation's youth through robust investments that will strengthen their recovery from the COVID-19 pandemic and guide them towards success.

Please do not hesitate to contact me if you have any questions or if we can be of any further assistance.

Sincerely,

[This statement was submitted by Jessica Donner, Executive Director, Every Hour Counts.]

PREPARED STATEMENT OF FASD UNITED

Madam Chair and subcommittee members, FASD United strongly supports an increase of at least \$2 million for FY 2023 for this line item in CDC's budget, together with report language to strengthen federally supported initiatives to prevent, diagnose, and improve service delivery for FASD, the Nation's leading preventable cause of developmental disabilities and birth defects, and a leading cause of behavioral and learning problems. For many years, the line item has been labeled "Fetal Alcohol Syndrome". But the CDC typically uses the term "Fetal Alcohol Spectrum Disorders" or FASD as the umbrella term adopted in 2004 to describe the spectrum of developmental disabilities that result from prenatal alcohol exposure.

We request the following specific report language for the CDC's National Center for Birth Defects and Developmental Disabilities "to support expansion and strengthening of existing national community-based and professional fetal alcohol spectrum disorder (FASD) networks to disseminate best practices and technical assistance on diagnosis, treatment, intervention, peer mentoring, and other essential services."

BACKGROUND

Prenatal alcohol exposure (PAE) of our children is a silent public health crisis within our families and communities. PAE is a major known cause of birth defects, brain damage causing neurodevelopmental impairments and learning problems—commonly known as Fetal Alcohol Spectrum Disorders (FASD).

Recent CDC data show increasing use of alcohol during pregnancy with 14 percent (1 in 7 previously 1 in 9) pregnant people reporting current drinking of alcohol and about 5 percent or 1 in 20 pregnant people reporting binge drinking.

How common is FASD in the U.S.? Until recently, we did not have reliable prevalence figures. However, a study on prevalence of FASD published in the February 2018 *Journal of America Medical Association* (JAMA. 2018;319(5):474–482) shows a more startling and more accurate picture of the problem. Researchers assessed 6,639 first graders in four U.S. regions and found up to 1 in 20 children with an FASD. They also suspected substantial under reporting of prenatal alcohol use and that "we are missing kids". So, these results are likely to be a conservative estimate on FASD prevalence in the U.S.

Why was this prevalence study so important? First, researchers screened and did in-person assessments for FASD (other prevalence studies have been based on birth record reports and record reviews). Second, researchers learned that youth with this disability can be readily identified in U.S. mainstream populations. Third, neither race nor ethnicity and social economic status were significant factors—the youth with FASD mirrored the demographics of their community. Also important: this prevalence data is approaching two times higher than autism's prevalence, yet autism Federal funding is nearly 10 times greater. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Director Dr. George Koob, "The findings of this study confirm that FASD is a significant public health problem, and strategies to expand screening, diagnosis, prevention, and treatment are needed to address it."

The study also confirmed that binge drinking is driving up the numbers of children with FASD. It provides useful data for targeted prevention efforts. Mothers of youth with FASD compared to a controlled population: (1) reported consuming significantly more drinks 3 months before pregnancy; (2) recognized that they were pregnant later; (3) had more first trimester alcohol consumption; (4) were more likely to binge with 5 or more drinks; (5) reported more drinking days in the past 30 days; and (6) reported that their husbands/partners consumed significantly more drinks per drinking day during pregnancy.

The above prevalence data, together with the increase in alcohol use during pregnancy, demands a renewed focus on the issue of binge drinking and other alcohol abuse and its harmful effects on our children.

Insufficient Federal Investment in FASD. In 1998, Congress first authorized Federal FASD-related programs at \$27 million annually (nearly \$48 million in today's dollars). Since then, however, Federal funding for FASD-related programs has declined. Funding has flatlined for the Centers for Disease Control and Prevention (CDC) at \$11 million for what is the most dedicated public health focus on FASD to support clinical and epidemiological research, public health initiatives and networks, and expansion of clinical interventions. Besides the \$30 million (FY 2022) for research through the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the only other specific FASD funding is \$1 million at the Health Resources and Services Administration (HRSA), Maternal and Child Health Block Grant, Title V SPRANS Set-Aside).

There remains an alarming gap in FASD-related diagnostic and clinical resources. Among medical and behavioral health professionals, their inconsistent use or limited knowledge of diagnostic criteria and clinical guidelines result in many (if not most) children and adults living with FASD going undiagnosed or misdiagnosed. Families in every State, and especially in the child welfare system, struggle with FASD, and they cannot find systems of care that are familiar with or are equipped to diagnose and address FASD-related disabilities.

Cost of FASD. Economic impact studies (*J Addict Med* 2018;12: 466–473) show that the costs of FASD are significant, totaling \$205 billion in the United States (health care, special education, residential care, productivity losses, and corrections). Costs to Tribal communities over an individual's lifetime with FASD can range from \$850,000 to \$4 million, according to the National Congress of American Indians (NCAI; #REN–19–037). Yet, evidence shows these risks/costs can be significantly reduced by FASD-informed families, communities, and healthcare and other providers working together to create a system of early identification, stable environment with enduring relationships.

The alarming increase in prenatal alcohol consumption (41 percent) due to the COVID pandemic, and the already soaring rates of FASD, justify additional Federal investment to strengthen CDC efforts to: expand prevention programs to heighten awareness of FASD and the risks associated with prenatal alcohol exposure; and increase existing national community-based FASD networks to expand access to diagnostic, treatment, intervention, and other essential services.

CDC's FY 2023 Congressional Justification. Last year, the House-passed FY 2022 Labor-HHS Appropriations bill included a \$1 million increase (from \$11 million to \$12 million) for the CDC's line item for FASD programs, but unfortunately the conference agreement retained the flatlined amount of \$11 million. With reference to the House-passed provision, the CDC included the following discussion in its FY 2023 Congressional Justification:

"CDC appreciates the Committee's support of awareness and prevention of fetal alcohol spectrum disorders (FASDs). CDC uses a comprehensive approach to address FASDs and the prevention of alcohol use during pregnancy. CDC conducts activities related to assessing trends in alcohol and polysubstance use in pregnancy and monitoring health care provider behaviors related to alcohol screening and brief intervention (SBI). CDC currently supports a network to reach health care providers across the Nation to implement evidence-based strategies to reduce alcohol use during pregnancy and develop and disseminate FASD training and educational resources. In FY 2022, women of reproductive age within 67 health clinics across four health care systems have received appropriate alcohol screening and brief intervention services. In 2021, CDC also partnered with the MITRE Corporation to develop five clinical decision support (CDS) tools on alcohol SBI to help screen and offer evidence-based prevention strategies to those at risk. In FY 2022, two of these CDS tools were piloted to assess their use in a clinical setting."

Notably, CDC's justification went on to state: ". . . in FY 2023, at level funding with FY 2022, CDC will continue to monitor trends in alcohol and polysubstance use in pregnancy and support partnership activities. In the absence of additional resources, CDC lacks capacity to expand prevention efforts and extend the reach of its national partnership network." (Emphasis added.)

In conclusion, the enormity of the problem of FASD and its impact on families and communities in the United State and the increasing use of alcohol during pregnancy justify an increase in investment by the Federal Government. Thank you so much.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR
EXPERIMENTAL BIOLOGY

Dear Chair Murray and Ranking Member Blunt:

On behalf of the 110,000 researchers of the Federation of American Societies for Experimental Biology (FASEB) from its 28 member societies, I am writing to recommend at least \$50 billion for the National Institutes of Health's base in FY 2023.

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—that led to the development of COVID–19 vaccines and also supports pre-clinical research involving the use of animal studies to achieve 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, research infrastructure such as core facilities, 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 NIH is the Nation's largest public funder of biomedical research in the world, providing competitive grants to support the work of 300,000 scientists at universities, medical centers, independent research institutions, and companies nationwide. The biomedical discoveries, innovations, and treatments that NIH support are possible because of scientific research with animals which provide in-depth knowledge of entire biological systems and complex disorders affecting multiple organs. As required by the Food and Drug Administration, animal research is also essential during the preclinical stage of drug development to determine the safety and efficacy of potential drugs and therapies prior to human clinical trials.

A recent example of NIH's effective ability to harness animal research and maximize its public-private partnerships, NIH collaborated with industry to develop a messenger RNA (mRNA) vaccine which was quickly adapted for COVID-19.³ The agency also accelerated the development and commercialization of COVID testing through the Radx initiative.⁴

With these resources, NIH has accelerated progress across all areas of medical science, including regenerative medicine, cancer immunotherapy, and neurological health.^{5,6,7} The agency is also committed to supporting the next generation of our biomedical research enterprise.⁸

Though the NIH is in a stronger position than it was a few years ago, Congress must continue to increase biomedical research funding to continue pandemic preparedness efforts, not to mention the largest 12-month increase in inflation since June 1982 at seven percent.⁹ Our nation is confronting public health threats, especially given global climate change that is negatively impacting biodiversity and one health—the intersection of biological science, earth sciences, and ecology. More research will be needed to address infectious diseases, and greater exposure to environmental threats that impact national security, public health, and economic progress.¹⁰ Additionally, having to operate under lengthy “continuing resolutions” over the last several fiscal years has impacted NIH's ability to provide predictable support to the research community due to not being able to fund new grants or projects until the agency received a final budget, and NIH has not been able to make all researchers set back by the pandemic whole.¹¹

In the U.S., we continue to address the needs of a growing aging population and the serious disease of obesity.^{12,13} NIH research is developing therapies for a whole spectrum of age-related disorders.¹⁴ Obesity impacts 42 percent of the U.S. population and increases the likelihood of developing costly medical conditions such as diabetes, cancer, and heart disease.¹⁵ Additionally, minority populations experience a higher prevalence of these diseases.¹⁶

Our recommendation of at least \$50 billion allows NIH to continue support for the Next Generation Researchers Initiative; and expand dual purpose research in biomedicine and agriculture among NIH and other Federal agencies.¹⁷

¹ <https://nces.nsf.gov/pubs/nsb20201/executive-summary>.

² STEM and the American Workforce. You've heard it before: STEM jobs—... | by Science is US | Medium.

³ <https://www.niaid.nih.gov/diseases-conditions/coronaviruses-therapeutics-vaccines>.

⁴ <https://www.nih.gov/research-training/medical-research-initiatives/radx#overview>.

⁵ NIH Regenerative Medicine Innovation Project, National Institutes of Health, Bethesda, MD.

⁶ NCI's Role in Immunotherapy Research, National Cancer Institute, Bethesda, MD.

⁷ The BRAIN Initiative Summary, National Institutes of Health, Bethesda, MD.

⁸ NIH Grants and Funding, Next Generation Research Initiative, National Institutes of Health, Bethesda, MD.

⁹ <https://www.bls.gov/news.release/cpi.nr0.htm>.

¹⁰ IPCC AR5 Climate Change 2014, Chapter 11: Human Health: Impacts, Adaptation, and Co-Benefits.

¹¹ Ad Hoc Group Statement on RISE Act Introduction and Research Relief Feb. 5, 2021.

¹² <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>.

¹³ NIDDK Health Information.

¹⁴ Aging Well in the 21st Century: Strategic Directions for Research on Aging, National Institute on Aging, Bethesda, MD.

¹⁵ CDC Obesity Data.

¹⁶ Special issues regarding obesity in minority populations—PubMed (nih.gov).

¹⁷ BILLS-116RCP68-JES-DIVISION-H.pdf (house.gov) (pg. 63).

Respectfully Submitted.

[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 2023. FABBS represents twenty-seven scientific societies and over fifty university departments whose members and faculty share a commitment to advancing knowledge of the mind, brain, and behavior. For fiscal year 2023, FABBS encourages your subcommittee to provide the National Institutes of Health (NIH) with a budget of at least \$49 billion and the Institute of Education Sciences (IES) within the Department of Education a budget of \$815 million.

NATIONAL INSTITUTES OF HEALTH

FABBS thanks the subcommittee for the consistent increases to NIH in recent years. As a member of the Ad Hoc Group for Medical Research and the Coalition for Health Funding, FABBS recommends at least \$49 billion for NIH in fiscal year 2023 and suggests that any funding for other targeted programs supplement the base budget, rather than supplant the essential foundational investment in the NIH.

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.

—Office of Behavioral and Social Science Research (OBSSR)

FABBS members are especially grateful for the increase of over \$9 million to OBSSR included in the joint explanatory statement for the fiscal year 2022 appropriations legislation. This growth to the Office's baseline budget provides OBSSR with consistent and reliable funding to provide essential support across NIH Institutes and Centers (ICs).

OBSSR coordinates and promotes 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 able to leverage investments across the NIH to broadly improve the quality and effectiveness of federally funded research. We encourage the committee to once again express its strong support for this integral office.

—National Institute of Mental Health (NIMH)

FABBS members are particularly interested in NIMH, which serves as the premier Federal agency responsible for developing a deeper understanding of and effective interventions to improve mental health and treat mental illness. We encourage you to provide robust funding for NIMH in fiscal year 2023 commensurate with any increase to the overall NIH budget 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 all.

In your recent hearing reviewing the President's budget request for the Department of Health and Human Services, we were grateful to see a focus on mental health and bipartisan support for increases in mental healthcare funding related to both the 988 national suicide prevention lifeline and Certified Community Behavioral Health Clinics.

To fully capitalize on these bipartisan committee priorities and improve the mental health of all Americans, we recommend that the committee continue to prioritize investments in the NIMH.

—Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

As a member of the Friends of NICHD, FABBS recommends that NICHD receive an increase in fiscal year 2023 commensurate with any increase to the overall NIH budget. NICHD has facilitated extraordinary achievements in brain and behavioral research with far reaching implications for public health, maternal, child, and family health, and learning and language development.

For example, NICHD-funded researchers have recently:

- Shown that infants of mothers in low-income households receiving monthly cash payments were more likely to show faster brain activity in a pattern associated with learning and development at later ages.
- Devised a procedure for amputations below the knee that allows for sensory feedback from a prosthetic limb, and used machine learning to improve the interface of brain-controlled prosthetics, making them easier to use.
- Discovered that a certain plant compound could one day be administered to expectant mothers as a treatment to improve cognitive outcomes for people with down syndrome.
- Surveyed child forensic interviewers to develop new benchmarks to aid in preventing, treating, and reducing childhood abuse and neglect.

ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH (ARPA-H)

FABBS appreciates the funding for ARPA-H included in fiscal year 2022 appropriations, and we are grateful that this was independent of the NIH budget. As ARPA-H continues to take shape, we encourage the subcommittee to ensure that additional appropriations for the Agency supplement, rather than supplant, funding for NIH.

FABBS was grateful for the opportunity to contribute to OSTP-NIH listening sessions on the proposed ARPA-H. We suggest that this new agency will be most effective if it takes a cross-disciplinary approach to questions that are not adequately addressed by the current organizational approach of NIH. These include investing in implementation science to bridge the gap between the latest scientific advances and medical practice.

INSTITUTE OF EDUCATION SCIENCES (IES), U.S. DEPARTMENT OF EDUCATION

We are grateful for the subcommittee's work to ensure a funding increase for IES in the fiscal year 2022 omnibus spending agreement. As members of the Friends of IES, FABBS encourages the subcommittee to appropriate at least \$815 million to IES in fiscal Year 2023. This funding level will allow the Institute to build on the fiscal year 2022 enacted budget to maximize its capacity to advance innovative research, develop the methodological skills of education researchers, and continue to support high-quality and trustworthy statistics and evidence-based resources.

We are especially grateful that the fiscal year 2022 omnibus provided IES with independent control over staffing. This new flexibility is key to capitalizing on new investments, and allows the Institute to be nimble, taking on high-impact approaches to research and implementation. For example, during the COVID-19 pandemic, IES launched Operation Reverse the Loss to identify specific and actionable interventions that can reverse learning losses for clearly identified populations of students. Ongoing support for dedicated staff will allow IES to continue its important work studying the Nation's most urgent education questions and facilitating the implementation of new and effective strategies.

The Institute recently commissioned a report on the future of education research from the National Academies of Science, Engineering, and Medicine (NASEM). The recommendations therein provide an exciting path forward for the agency, outlining approaches to move the field forward on issues of critical importance to education policy and practice and improve learner outcomes for all students. However, the report finds that "Given the breadth of what IES is expected to accomplish as mandated in ESRA [the Education Sciences Reform Act], its funding for both programmatic activities and staffing has historically been limited in comparison to other Federal science, research, and statistical agencies with similar objectives [and] in order to achieve the overarching vision presented through these recommendations, IES will require additional investments."

Thank you for considering this testimony.

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, Flux: The Society for Developmental Cognitive Neuroscience, International Congress of Infant Studies, International Society for Developmental Psychobiology, 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 College; Boston University; California State University, Fullerton; Carnegie Mellon University; Duke University; East Tennessee State University; Florida International University; George Mason University; George Washington University; Georgetown University; Harvard University; Indiana University Bloomington; Johns Hopkins University; Lehigh University; Massachusetts Institute of Technology; Michigan State University; New York University; North Carolina State University; The Ohio State University, Center for Cognitive and Brain Sciences; Pennsylvania State University; Princeton University; Purdue University; Rice University; Southern Methodist University; Syracuse University; Temple University; Texas A&M University; Tulane University; University of Arizona; University of California, Berkeley; University of California, Irvine; University of California, Los Angeles; University of California, Riverside; University of California, San Diego; University of Chicago; University of Delaware; University of Illinois at Urbana-Champaign; University of Iowa; University of Maryland, College Park; University of Michigan; University of Minnesota; University of Minnesota, Institute of Child Development; University of North Carolina at Greensboro; University of Oregon; University of Pennsylvania; University of Texas at Austin; University of Texas at Dallas; University of Virginia; University of Washington; Virginia Tech; Wake Forest University; Washington University in St. Louis; Western Kentucky University; Yale University

[This statement was submitted by Julianne Baron, Executive Director, Federation of Associations in Behavioral and Brain Sciences.]

PREPARED STATEMENT OF FLORIDA A&M UNIVERSITY

Chairman Leahy, Chairwoman 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 2023 appropriations bill. Florida A&M University (FAMU) is grateful for the historic support of Congress during the pandemic. Maintaining or enhancing funding is critical 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 significant support to the University, our students as well as other institutions of higher education across the Nation.

Florida A&M University, based in the State capital of Tallahassee, Florida, was founded in 1887 with only 15 students and two instructors. Today, FAMU offers 95 degree programs to nearly 10,000 students. We are proud to be the highest ranked among public Historically Black Colleges and Universities (HBCU) for three consecutive years, according to the 2022 U.S. News and World Report National Public Universities. The University is 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 undergraduate degrees and 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 enhance 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 the allocation of resources 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 sustain our academic, administrative, and fiscal capabilities.

The President's fiscal year 2023 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.

We support the President's fiscal year 2023 budget request of \$102.3 million for the Strengthening Historically Black Graduate Institutions as well, which funds 5-year grants to provide scholarships for disadvantaged students, academic and counseling services to improve student success, and supports infrastructure and facilities improvements.

FAMU, like other HBCUs, has a critical need for funding to support equipment upgrades and purchases, construction and renovation of our facilities, and the 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 the fiscal year 2022 House recommended allocation of \$24.484 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 funding requested would be used to pay the loan subsidy costs in guaranteed loan authority under the program. We urge the subcommittee to provide increased funding for fiscal year 2023, which will allow HBCUs to continue to refinance previous capital project loans, renovate existing facilities, or build new facilities in alignment with our peer 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.

Over 60 percent of our enrolled students rely on Pell grants to attend our institution. As Pell Grants account for less than one-third of the average cost of attendance at public 4-year universities, we join many national education associations in requesting an increase in the maximum individual award to \$12,990. By nearly doubling the award, Congress will 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. 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.

National Institutes of Health Research Centers in Minority Institutions

FAMU supports funding at the fiscal year 2022 House recommended allocation of \$88 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, like COVID-19, that disproportionately affect minority populations. Notably, the employees at the FAMU community testing site were selected as the Tallahassee Democrat “Person of the Year” and have provided more than 630,000 tests and 25,000 vaccines to the Big Bend area since April 25, 2020.

Since program inception, the FAMU RCMI Center has greatly benefited from this program, which has provided critical infrastructure to enable the College of Pharmacy and Pharmaceutical Sciences | Institute of Public Health 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, pharmaceuticals, and environmental toxicology. With 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, Health Careers Opportunity Program

FAMU supports the fiscal year 2022 House recommended allocation of \$20.5 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 a health or allied health professions school. 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 fiscal year 2023 budget increases funding for HRSA’s Health Professions Training for Diversity Programs, including the HCOP. Continued funding is critical for these programs that help address the shortage 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, President, Ph.D., Florida A&M University.]

PREPARED STATEMENT OF FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY

Chairman Leahy, Chairwoman 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) 2023 appropriations bill. Florida A&M University (FAMU) is grateful for the historic support of Congress during the pandemic. Maintaining or enhancing funding is critical 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 significant support to the University, our students as well as other institutions of higher education across the Nation.

Florida A&M University, based in the State capital of Tallahassee, Florida, was founded in 1887 with only 15 students and two instructors. Today, FAMU offers 95 degree programs to nearly 10,000 students. We are proud to be the highest ranked among public Historically Black Colleges and Universities (HBCU) for three consecutive years, according to the 2022 U.S. News and World Report National Public Universities. The University is 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 undergraduate degrees and 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 enhance 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 the allocation of resources 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 sustain our academic, administrative, and fiscal capabilities.

The President's FY 2023 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.

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NATIONAL INSTITUTES OF HEALTH RESEARCH CENTERS IN MINORITY INSTITUTIONS

FAMU supports funding at the FY 2022 House recommended allocation of \$88 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, like COVID-19, that disproportionately affect minority populations. Notably, the employees at the FAMU community testing site were selected as the Tallahassee Democrat "Person of the Year" and have provided more than 630,000 tests and 25,000 vaccines to the Big Bend area since April 25, 2020.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, HEALTH CAREERS OPPORTUNITY PROGRAM

FAMU supports the FY 2022 House recommended allocation of \$20.5 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 a health or allied health professions school. 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.

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social skills, and other competencies to increase their competitiveness for admission to a post-secondary health professions program.

The President's FY 2023 budget increases funding for HRSA's Health Professions Training for Diversity Programs, including the HCOP. Continued funding is critical for these programs that help address the shortage 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 FOCUSED ULTRASOUND FOUNDATION

Thank you for the opportunity to comment on the National Institutes of Health (NIH) budget priorities for FY 2023. We provide this testimony in support of the investment in innovation in health and medicine, particularly transformative new therapies like focused ultrasound.

We offer views from the perspective as the only 501(c)(3) medical research, education and advocacy organization solely dedicated to advancing the development and clinical adoption of focused ultrasound, a noninvasive therapeutic medical device technology, for the treatment of a wide range of medical conditions. FUSF was founded in 2006 by Dr. Neal Kassell, a world-renowned neurosurgeon who has authored more than 500 publications and was named to the Blue Ribbon Panel of then Vice President Joe Biden's Cancer Moonshot initiative. Our mission is to accelerate the development and adoption of evidence-based focused ultrasound therapy to improve the lives of countless individuals with serious medical disorders, including essential tremor, Parkinson's disease, Alzheimer's, chronic pain, various cancers, uterine fibroids, depression—more than 150 indications in total. We aim to bring focused ultrasound treatments to patients as quickly as possible, to improve patient outcomes and lower healthcare costs.

FUSF encourages NIH to seriously examine Federal research investment in transformative cross-cutting platform technologies that can offer new treatments across multiple diseases and conditions. An example of such a technology is focused ultrasound, which offers unparalleled versatility due to its more than 18 different biological mechanisms of action, including tissue destruction, anti-cancer immune response, neuromodulation, localized and targeted drug delivery, transient opening of the blood-brain barrier, and many others. While this field of medicine is still emerging, various existing focused ultrasound applications have demonstrated its potential. With increased NIH investment, we can build on this knowledge and expand applications for many other diseases and conditions.

To ensure that NIH delivers on its mission to foster innovative research for the betterment of patients, reviewers and program managers must truly understand a broad array of science and technology and be willing to invest in cross-cutting therapies. Despite extensive evidence of efficacy for many conditions and the immense potential to transform treatments for many others, as well demonstrated improvement to patient outcomes and reduction of healthcare costs, focused ultrasound is not widely accessible. One reason is the lack of funding needed for translational research to bring these innovations to patients. The current nature of funding agencies organized by organ system and the cross-cutting nature of research in focused ultrasound often means that reviewers and program officers lack the expertise or interest to fund these proposals, instead funding more familiar work deemed more mainstream and less risky. Ensuring that NIH program managers and reviewers have a wide array of expertise in transformative and innovative technologies and value high-risk, high-reward investments will ensure much-needed diversification in our Nation's publicly funded research.

FUSF also strongly suggests that NIH place a strong focus on addressing health and healthcare disparities. Women's health issues continue to be under-represented in terms of Federal research dollar allocation, with dire consequences. Endometriosis is an example of one chronic, debilitating condition that needs to be addressed. An irreversible disease known to cause a wide spectrum of physical and psychological symptoms from chronic pain to infertility to increased risk of suicide, endometriosis is regularly mis-diagnosed or diagnosed up to seven to 9 years after the onset of painful symptoms despite it impacting 10–20 percent of the overall female population and 5–50 percent among women with infertility. These symptoms

are extremely painful and uncomfortable and range from pain during intercourse and bowel movements to excessive bleeding. If this chronic pelvic pain is detected and treated early, laparoscopy surgery may be avoided in favor of a non-invasive procedure like focused ultrasound, saving patients from unnecessary and invasive surgery and our healthcare system from preventable expenditures.

A non-invasive treatment would be a significant improvement over surgery and would reduce resulting opioid reliance as well as related costs. However, these advancements can't be realized unless funding for women's health issues is increased exponentially, particularly for debilitating conditions like endometriosis. In the case of endometriosis specifically, this is a significant unmet need as evidenced by the number of physicians and providers who are asking for a way to better diagnose and treat these patients. We must bring medical innovations to all patients and ensure both diversity and inclusion are incorporated throughout our research, treatment, and coverage systems.

In sum, investing in transformative, cross-cutting research is critical during a time when scientific achievements are more numerous than ever. We must ensure that patients are at the center of our healthcare system, and that the goal of improved patient outcomes drives funding decisions across the government landscape. It is crucial that we invest in innovation to ensure patients everywhere can access current and future life-changing and often life-saving technology. Thank you very much for consideration of our comments.

PREPARED STATEMENT OF THE FRED HUTCHINSON CANCER CENTER

Fred Hutchinson Cancer Center (Fred Hutch) appreciates the robust and reliable funding Congress has provided for the National Institutes of Health (NIH) in the past, and strongly urges continued support for this vital funding moving into the future. Prioritizing NIH funding as a key national investment helps to establish the United States as a world leader in health innovation, biomedical research and scientific advancement, and empowers the education and careers of our next generation of scientific and health care leaders. Critical investments in the NIH lead to more discoveries and increased development of therapies, treatments, and cures, helping patients to live longer and healthier lives.

For fiscal year (FY) 2023, Fred Hutch urges the subcommittee to support a program level of at least \$49 billion in base funding for the NIH.

Strong, bipartisan support from the Appropriations subcommittee on Labor, Health and Human Services, Education and Related Agencies (Labor-HHS) over the last seven budget cycles has helped NIH to thrive, yielding a significant number of scientific advances to improve health outcomes for patients. These scientific advancements include the lifesaving COVID-19 vaccines that are helping our world to progress beyond the pandemic. As the fiscal Year2023 appropriations process continues, Fred Hutch is committed to working with Congress and the Administration to further bipartisan support for increasing this vital national investment and to ensure NIH funding remains a top priority.

As with scientific discovery, and aligning with changing needs of our region, 2022 marks an exciting evolution for Fred Hutch. On April 1, 2022, Fred Hutchinson Cancer Research Center and Seattle Cancer Care Alliance came together into one, independent entity, to form Fred Hutchinson Cancer Center (Fred Hutch). This opportunity to clinically integrate world-class research with one of the top cancer care hospitals in the Nation will lead to greater advances in adult oncology—bringing the research bench to the bedside. We anticipate increased numbers of clinical trials, as well as increased access to groundbreaking research and clinical care.

Fred Hutch is guided by the mission to eliminate cancer and related diseases that cause human suffering and death and is now integrated with the expert clinical care to directly help patients live longer and healthier lives. 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. To date, performing more than 17,000 bone marrow transplants makes Fred Hutch one of the most respected and successful programs in the world.

As the only Dedicated Cancer Center in the Pacific Northwest, serving patients in five northwestern States, Fred Hutch is actively identifying and working to fill gaps in cancer care by prioritizing an increasingly diverse patient population. It is our role to build caring relationships with all communities, and especially those experiencing disparities. Strategic outreach in traditionally underserved communities is one of the many ways Fred Hutch is developing relationships with our neighbors in all corners of our region.

Mitigating Health Inequities in Clinical Trials. History demonstrates that racial and ethnic minorities have been underrepresented in clinical trials and genetic studies. People from racial and ethnic minorities hold a heavier burden of negative health and economic impacts, and studies show these same individuals have higher rates of cancer and are more likely to die from the disease. Greater inclusion helps to further sharpen precision medicine and ultimately brings us closer to achieving our mission to find cures for cancers and diseases in all people—and there is still a lot of work to be done to improve.

While health inequities have had a disproportionate impact on racial and ethnic minorities in the United States for a long time, the COVID-19 pandemic brought these disparities into stark focus, highlighting social, political, economic, and environmental factors that play an important role in health disparities. In order to reduce these disparities and promote inclusion and participation of individuals from diverse groups in clinical trials, Fred Hutch leveraged the infrastructure already in place from coordinating the global vaccine trials for HIV for more than 20 years through the HIV Vaccine Trials Network (HVTN) to lead operations for the COVID-19 Prevention Network (CoVPN), funded by the National Institute of Allergy and Infectious Diseases. The CoVPN included five large-scale COVID-19 vaccine efficacy trials with more than 200 clinical trial sites across the world, which included more than 600,000 volunteers. As a result of this and ongoing work, the trials for CoVPN were some of the most diverse in history.

Empowering Early Career Researchers and Other Health Experts. The focus on health equity underscores all work of Fred Hutch, which includes building a more diverse and innovative scientific and clinical workforce. Robust funding for the NIH not only bolsters important research programs—it secures the future of science. Increases in NIH funding enable initiatives to reduce barriers to academia and provide training and education for young scientists, as well as encourage more culturally inclusive research.

Fred Hutch invests \$2 million annually in science education programs and is currently in the process of expanding to allied health and other types of opportunities. Scientific internships at Fred Hutch range from high school and college, as well as mentorship and development resources for graduate students, postdoctoral fellows, and early-career faculty. The Science Education Partnership, which started in 1991, has paired researchers with more than 580 secondary school science teachers in Washington state through workshops and a summer professional development program.

Recruitment and Retention of Exceptional Researchers. Fred Hutch opposes provisions such as directives to reduce salary support for extramural researchers, that would harm the appeal of academic research. Policies to cut salary support would undermine Fred Hutch's ability to recruit and retain the talented researchers that keep our U.S. institutions thriving. Emphasized in the current workforce climate, there are countless desirable options for researchers and health care experts to pursue and their retention is essential to maintain our Nation's innovation ecosystem.

The partnership between the NIH and the research institutions and scientists across America is highly productive. The Federal Government has an irreplaceable role in supporting biomedical research, with no other entity willing or able to provide the broad and sustaining funding that leads to innovative breakthroughs. Fred Hutch depends on NIH funding to conduct basic, translational, clinical, public health, and infectious disease research, as well as the ability to respond rapidly and expertly to the needs of our Nation, such as during the COVID-19 pandemic. Sustained and robust funding for the NIH will contribute to our efforts to support future pandemics and numerous other global health challenges for the years ahead.

With President Biden's announcement and reinvigoration of the Cancer Moonshot, Fred Hutch and the larger cancer community stand poised to accelerate work already underway. Increasing funding for NIH as well as the creation of the Advanced Research Projects Agency for Health (ARPA-H) will help to achieve our goals. Consistent with our mission and values, Fred Hutch will continue working to increase access to the highest quality cancer treatments and services for all patients. We will continue to hone scientific innovation, such as telehealth and data science, to increase prevention efforts across entire populations and also to connect with individual patients—in ways that ultimately improve cancer outcomes for everyone.

Fred Hutch appreciates the Labor-HHS subcommittee for your continued leadership and dedication to ensuring the continued and robust funding for the NIH. Thank you for the opportunity to share our recommendation to provide at least \$49 billion in fiscal Year 2023 for the NIH base program, in addition to funding for ARPA-H. As our Nation continues to rebuild and looks ahead to prepare for potentially future pandemics, now is the time to rededicate the commitment to science and support for efforts to seize upon the abundance of scientific opportunities.

[This statement was submitted by Thomas J. Lynch Jr., MD, President and Director, Fred Hutchinson Cancer Center.]

PREPARED STATEMENT OF THE FRIENDS OF HRSA

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 \$9.8 billion for the Health Resources and Services Administration in FY 2023. We are grateful for the increases provided for HRSA programs in FY 2022 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 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 2022 and provide at least \$9.8 billion for HRSA's total discretionary budget authority in FY 2023. Additional funding will allow HRSA to pave the way for new achievements and continue supporting critical HRSA programs, including:

- HRSA supports more than 13,500 community health center sites which provide high quality primary care services to nearly 29 million people and reduce barriers such as cost, lack of insurance, distance and language for their patients.
- HRSA supports the health workforce across 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.
- HRSA's maternal and child health programs support patient-centered, evidence-based programs that optimize health, minimize disparities and improve health promotion and health care access for medically and economically vulnerable women, infants and children.
- HRSA's Ryan White HIV/AIDS Program provides medical care and treatment services to over half a million people living with HIV. Ryan White programs ef-

fectively engage clients in comprehensive care and treatment, including increasing access to HIV medication, which has resulted in 89.4 percent of clients achieving viral suppression, compared to just 65.5 percent of all people living with HIV nationwide.

- HRSA supports healthcare systems and programs that access and availability of lifesaving bone marrow, cord blood and donor organs for transplantation. Additionally, the Healthcare Systems Bureau supports poison control centers, which contribute to significantly decreasing a patient's length of stay and save the Federal Government \$1.8 billion each year in medical costs and lost productivity.
- HRSA supports community- and State-based solutions to improve rural community health by focusing on quality improvement, increasing health care access, coordination of care and integration of services that are uniquely designed to meet the needs of rural communities.
- The Title X Family Planning program reduces unintended pregnancy rates, limits transmission of sexually transmitted infections and increases early detection of breast and cervical cancer by ensuring access to family planning and related preventive health services to millions of women, men and adolescents.
- HRSA also supports training, technical assistance and resource development to assist public health and health care professionals to better serve individuals and communities impacted by intimate partner violence.
- 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 over \$18 billion to providers for testing and treatment provided to uninsured individuals.

The nation faces a shortage of health professionals and a growing and aging population which will demand more health care. Additionally, the COVID-19 pandemic reaffirmed the critical nature of a robust workforce in responding to public health emergencies. HRSA is well positioned to address these issues and to continue building on the agency's many successes, but a stronger commitment of resources is necessary to effectively do so. We urge you to consider HRSA's central role in strengthening the Nation's health and support a funding level of at least \$9.8 billion for HRSA's discretionary budget authority in FY 2023.

[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 coalition of scientific and professional societies, K-12 and higher education organizations, universities, and independent research organizations committed to supporting the mission of IES and the use of research and statistics. We recommend at least \$815 million for the Institute of Education Sciences (IES) in the FY 2023 Labor, Health and Human Services, and Education Appropriations bill.

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.

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. Research supported by NCER and NCSER have been incorporated in classrooms to enhance instruction and support students' academic and non-academic outcomes. Recent examples include the Intelligent Tutoring System for the Structure Strategy, used by middle school students; Assessment-to-Instruction, which has resulted in a partnership between Learning Ovations and Read Memphis that is supporting the literacy development of young readers; and IES-supported collaborative work that resulted in the development of the Washoe County School District Social and Emotional Competency Assessments.

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 in exacerbating pre-existing learning gaps.

FY 2022 appropriations for IES represent less than one percent of the total discretionary funding for the Department of Education. Similar to the investment that the Federal Government makes in medical research at the National Institutes of Health to advance health outcomes, the investment in IES is essential to address persistent challenges in education. A recent report from the National Academies of Science, Engineering, and Medicine (NASEM) highlighted an observation regarding IES funding in the Federal research landscape: “Given the breadth of what IES is expected to accomplish as mandated in ESRA, its funding for both programmatic activities and staffing has historically been limited in comparison to other Federal science, research, and statistical agencies with similar objectives.”(p. 3–3)¹ Providing at least \$815 million for IES in fiscal Year 2023 would serve as one important step toward more fully supporting the education research and statistical infrastructure essential to education policy and practice.

IES remains constrained in its flexibility to fully fund emerging research areas and scale up promising interventions and resources. About one of every 10 grant proposals receives funding support, limiting the ability of IES to tackle pressing questions in education. With appreciation for the boost provided in FY 2022, additional funding for Research, Development, and Dissemination (RD&D) is essential to support needed research in foundational and emerging topics, including measures and assessments in career and technical education; the development and testing of education technology products that can personalize instruction; and approaches to teacher recruitment, retention, certification, assessment, and compensation. RD&D funding is critical to help improve education and better support the achievement of our Nation’s students. Additional investment in RD&D is essential to the support of new high-risk, high-reward research with the potential for transforming education, along with 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 works with stakeholders to provide relevant data through administrative and longitudinal surveys, but limited funding and staff resources over the past decade has resulted in constraining NCES in its capacity to meet the real-time data needs of researchers and policymakers. Additional funding for NCES would provide greater flexibility to develop surveys such as the School Pulse Panel and more quickly release important educational indicators. Restoring purchasing power NCES has lost over the past decade would also expand the agency’s capacity to 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 State-wide Longitudinal Data Systems (SLDS) program, providing critical investment for States to link K–12, postsecondary, and workforce systems to gain a better understanding of education and workforce outcomes. This work is particularly important for questions of national interest, such as interest and persistence in STEM areas to develop needed workforce talent. IES is also emphasizing the research use of SLDS to measure the effects of interventions on long-term student outcomes and in examining the impact of State education policy actions in supporting learning recovery, such as the Additional Days School Year initiative in Texas. 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 (NCSE) is the only Federal agency specifically designated to develop and provide evaluations for programs for

¹National Academies of Sciences, Engineering, and Medicine. 2022. *The Future of Education Research at IES: Advancing an Equity-Oriented Science*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26428>.

students with disabilities, but currently has a budget that has remained relatively flat since FY 2014 and still below its FY 2010 funding level. Due to limited funding, NCSER did not run competitions in FY 2022 for its annual special education research and training grants.

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.

We also appreciate the inclusion of language in recent appropriations bills calling for the Department of Education to address how it will ensure adequate staffing levels, including in IES. We are particularly grateful for the inclusion of a new program administration line item within IES in the FY 2022 omnibus appropriations bill, which will provide additional flexibility for IES to hire staff to support the increased work that comes with added funding. A recent report from NASEM noted the specific staffing challenges that NCES has faced, seeing the attrition of more than 20 staff positions between FYs 2015 and 2021. This has resulted in the discontinuation of 12 programs.² We look forward to your continued oversight on this issue to ensure IES has the resources to employ the necessary staff to effectively carry out its mission.

To this end, we recommend that the committee provide IES at least \$815 million in FY 2023. With continued emphasis on evidence-based policy and practice as our Nation continues to recover from the pandemic, IES plays an essential role in responding to key research questions, disseminating data to inform decisions, and developing resources to guide learning and instruction. Sustained, robust investment in the education research and statistical infrastructure at IES is necessary to support the success of our Nation's students, teachers, and education leaders.

[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 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 non-profit 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 \$49 billion in fiscal year 2023 for base spending at NIH for current institutes and operations, which corresponds with the overall recommendation of the Ad Hoc Group for Medical Research;
- continued efforts in establishing the Advanced Research Projects Agency for Health (ARPA-H) at NIH. However, investment in ARPA-H should not come at the cost of the existing NIH institutes and centers conducting and supporting research on aging. We support an increase of \$4 billion for ARPA-H to supplement the core investment.
- a minimum increase of \$226 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;
- an increase of \$60 million to support the Brain Research through Advancing Innovative Technologies (BRAIN) Initiative.

NIA sponsors and conducts the vast majority of Federal aging-related research, and this pioneering science contributes significantly to the improved care and quality of life for all of us as we age. 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

²National Academies of Sciences, Engineering, and Medicine. 2022. A Vision and Roadmap for Education Statistics. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26392>.

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.

In the area of dementia, NIA supports vital research where more scientific investigation is needed to improve AD/ABDRD 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/ABDRD 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).

Medical and health research and development investment accounts for 5.9 percent of overall health spending in the U.S., or just under 6 cents of each health care dollar according to a recent report by Research!America.¹ The Science & Technology Action Committee also recently estimated that the U.S. should double its R&D investment by 2026 in order to remain a global competitor in science, technology, engineering, and math.² As the world's premier public funder of medical research, the NIH is a critical international leadership, and robust annual growth in support for NIH will be key to achieving these objectives.

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 United States, and acts as an economic engine and multiplier in local and regional communities. According to United for Medical Research, total FY21 NIH research spending supported more than 552,000 American jobs and generated nearly \$94.2 billion in economic activity, in all 50 States.³

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 pdantonio@geron.org.

Sincerely,

[This statement was submitted by Patricia M. D'Antonio, BSPharm, MS, MBA, BCGP, 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.

¹ US Investments in Medical and Health Research and Development 2016–2020. <https://www.researchamerica.org/sites/default/files/Publications/Research%21America-Investment%20Report.Final.January%202022.pdf>. Accessed 5/9/2022.

² Science & Technology Action Committee. (2022 January). Briefing Paper: A Roadmap for Investment in Science and Technology. <https://sciencetechaction.org/news-item/white-paper-a-roadmap-for-investment-in-science-and-technology/>.

³ NIH's Role in Sustaining the U.S. Economy 2022 Update. https://unitedformedicalresearch.org/wp-content/uploads/2022/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-FY21.pdf. Accessed 4/28/22.

In the Fiscal Year 2023 Labor, Health and Human Services Appropriations bill, Friends of NIDA joins with the Ad Hoc Group for Medical Research in recommending a program level of at least \$49.048 billion for the base budget of the National Institutes of Health (NIH), which would represent an increase of \$4.1 billion over the comparable Fiscal 2022 funding level. For the National Institute on Drug Abuse (NIDA), Friends of NIDA encourages the Committee to provide at least the President's recommended funding level of \$1.843 billion, which would represent an increase of \$248 million over the comparable Fiscal 2022 funding level for the Institute.

Friends of NIDA also supports the proposal included in the President's Fiscal Year 2023 budget to change the name of the National Institute on Drug Abuse to the National Institute on Drugs and Addiction.

We also respectfully request the inclusion of the following NIDA specific report language.

Opioid Initiative. The Committee continues to be concerned about the high mortality rate due to the opioid 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 provisional data from the Centers for Disease Control and Prevention that shows opioid overdose fatalities were predicted to exceed 100,000 in the 12-month period ending in June 2021, with the primary driver being the increased overdose deaths involving synthetic opioids, primarily illicitly manufactured fentanyls. More research is needed to find new and better agents to prevent or reverse the effects caused by this class of chemicals and to provide improved access to treatments for those addicted to these drugs. To combat this crisis the Committee has provided within NIDA's budget no less than \$405,400,000 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 provisional data released by the Centers for Disease Control and Prevention, over 45,000 overdose deaths involved drugs in the categories that include methamphetamine and cocaine in the 12-month period ending in June 2021, an increase of 25 percent in a single year. 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. No FDA-approved medications are available for treating 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 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, and were predicted to exceed 100,000 in the 12-month period ending in June 2021, 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 continue to support 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 soci-

ety, 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.

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 and follow them and their children up to age 10 to characterize the influence of a variety of factors on neurodevelopment and long-term outcomes. The study aims to enroll approximately 7,500 women from 25 sites across the US, including regions of the country significantly affected by the opioid crisis. Participants will include women from the general population of pregnant women to assess normative development; those who have or are using opioids and/or other substances during their pregnancy; and women from comparable environments to the latter, but who have not used substances during their pregnancy. This knowledge will be critical to help predict and prevent some of the known impacts of pre- and post-natal exposure to drugs or adverse environments, including risk for future illicit substance use, 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 additional NIH support for this important study.

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. NIH 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.

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 disorder -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 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 treated effectively and compassionately.

We understand that the fiscal year 2023 budget cycle will involve setting priorities and accepting compromise, however, in the current climate we believe a focus on SUDs deserves to be prioritized accordingly. Thank you for your support for the National Institute on Drug Abuse.

PREPARED STATEMENT OF THE FRIENDS OF NICHD

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 well-being 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 \$1.816 billion in Fiscal Year (FY) 2023, an increase of \$133 million over FY 2022. We also respectfully ask the subcommittee to maintain its commitment to increasing funding for the National Institutes of Health (NIH) by providing \$49 billion in fiscal Year 2023 and give special attention to ensuring that overall funding increases for the NIH are shared evenly across the agency.

We are pleased to support the extraordinary work of NICHD to meet 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. By enacting our funding request, Congress can ensure that NICHD's base budget grows proportional to that of its counterpart institutes and the institute can build upon the initiatives detailed 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. For instance, NICHD is leading research to understand long COVID in children and pregnant women, develop evidence-based COVID-19 mitigation measures to allow children with special health care needs to remain in school safely, and identify effective strategies to improve COVID-19 vaccine uptake. The institute also continues to advocate for inclusion of its key populations in major trans-NIH COVID-19 research programs funded by Congress.

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 remain unacceptably high in the United States and significant racial and ethnic inequities persist. In recent years, NICHD has led the Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) Initiative, which seeks to eliminate disparities among populations with greater rates of maternal mortality and morbidity. With additional funding, NICHD can support additional research to identify ways to improve maternal and infant health.

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-à-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. The BPCA NIH program has been successful in accomplishing its intended purpose, leading to updated pediatric labeling in 17 drugs. However, the program has been flat funded at \$25 million since it was originally authorized in 2002. This funding level is insufficient to meet needs, particularly when accounting for biomedical research inflation, and has prevented NIH from funding additional drug trials in children. Additionally, BPCA NIH has never received a direct appropriation from Congress as authorized by law but rather has been funded by contributions from NIH institutes and centers. We urge increased, dedicated support from Congress to ensure this program can fund additional studies to improve pediatric drug labeling to provide clinicians with needed guidance for drugs prescribed in children. 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 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 and social media 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, which affect 25 percent of American women, represent a major public health burden with high prevalence, impaired quality of life, and substantial economic costs. 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): In 2018, the NICHD-led PRGLAC Task Force submitted recommendations to Congress on opportunities to achieve broader inclusion of pregnant and lactating women in research and expand the workforce of clinicians and researchers with expertise in obstetric and lactation pharmacology and therapeutics. In 2020, the Task Force released a second report with a detailed plan to implement those recommendations. We encourage NICHD to continue activities to advance PRGLAC recommendations in the coming year.

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 bio-

logical 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 understanding and treating this class of disorders that affect so many. We urge resources and support for the IDDRCs for research infrastructure and expansion of cores 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. NICHD also supported a groundbreaking study showing that infants of mothers in low-income households that received monthly cash payments were more likely to show faster brain activity in a pattern associated with learning and development at later ages.

Male Infertility: Male infertility is another relevant area of inquiry that would benefit from additional 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 Matthew Mariani, 2022 Chair, Friends of NICHD and Policy Associate, Federal Advocacy, American Academy of Pediatrics.]

PREPARED STATEMENT OF THE FSHD SOCIETY

Honorable Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you. We are requesting the FY 2023 appropriation of an amount of \$25 million for the agency U.S. DHHS National Institutes of Health (NIH) to sustain and continue its research program on facioscapulohumeral muscular dystrophy (hereafter called FSHD). We are requesting an additional \$5 million for specifically targeted FSHD research through the NIH as requested herein.

Madam Chairman, this is my sixty-third testimony before the U.S. Congress' Appropriations subcommittee on this matter. I have been professionally engaged in FSHD research since 1987, with a focus on funding research on the fundamental pathophysiology, molecular biology and genetics of the disease. I am co-founder, past-Chairman, -President & CEO, and -CSO of FSHD Society, and have been involved in the evolution and design of FSHD research, gene mapping and genetics more or less from its inception to the present. My work and the FSHD Society's funding spans nearly every research lab working on FSHD, the tactical and strategic planning that have led to understanding how FSHD¹ and FSHD^{2,3} work, Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 (MD-CARE Act, Public Law 107-84), advocacy and policy, and the relationship of the scientific community to the larger societal context in which FSHD is embedded.

I am approaching near thirty years of testifying as a patient with FSHD for Appropriation of funding for FSHD. I have had this disease for twice that time. That is a long time to live with a disease of this burden. I have now seen, experienced

the entire effects, and borne almost the full brunt of what FSHD can do to you. FSHD is a heritable disease and one of the most common neuromuscular disorders with a prevalence of 1:8,000.⁴ 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 any skeletal muscle, it can bring with it respiratory failure and breathing issues,⁵⁻⁷ mild-profound hearing loss,⁸ eye problems and cardiac bundle blockage and arrhythmias.^{9,10} FSHD causes significant disability and death according to the U.S. Centers for Disease Control and Prevention (CDC), National Center on Birth Defects and Developmental Disabilities, Atlanta, Georgia and others.^{11,12}

The NIH is currently the principal worldwide source of funding of biomedical research on FSHD. Currently annual funding specifically targeted for FSHD listed in NIH RCDC is \$10 million. Given the remarkable advances and momentum in FSHD research in the past 8 years; it is appalling that FSHD funding has not grown according to NIH RCDC. This indicates a mismatch between NIH funding mechanisms and the external community working on FSHD.

FSHD RESEARCH DOLLARS & FSHD AS A PERCENTAGE OF TOTAL NIH
MUSCULAR DYSTROPHY FUNDING
[Dollars in millions]

Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021e	2022e
All MD (\$ millions) ...	\$86	\$75	\$75	\$76	\$78	\$77	\$79	\$81	\$81	\$83	\$95	\$97	\$102
FSHD (\$ millions)	\$6	\$6	\$5	\$5	\$7	\$8	\$9	\$11	\$11	\$10	\$9	\$9	\$10
FSHD (% total MD)	7%	8%	7%	7%	9%	10%	11%	14%	14%	12%	9%	9%	10%

Sources: NIH/OD Budget Office & NIH OCPL & NIH RePORT RCDC (e=estimate, a=actual)

Currently active projects listed in NIH RePORTer as having application to FSHD are \$17.507 million FY 2022 (actual 04May2022), a 17.2% portion of the estimated \$102 million spent on all muscular dystrophies. A year ago at this time in fiscal year 2021 the NIH portfolio of active projects was \$16.554 million (actual 23June2021), a 17.1% portion of the estimated \$97 million spent on all muscular dystrophies. (source: NIH Research Portfolio Online Reporting Tools (RePORT) keyword 'FSHD or facioscapulohumeral or landouzy-dejerine').

In my role, I provide initiator and seed funding to bring new ideas and researchers online and am asked to evaluate and compare the various research projects we have funded and understand their commonalities and differences. I have, if I had to estimate, made a fairly extensive study of five to six hundred FSHD projects and proposals. My effort to solve FSHD has been persistent in yielding refined advances, it is novel and original, and is clearly driven by an overall sense of goals and concepts that are meaningful to patients and their families. The research we've started is forward-looking, as illustrated by the number of industry and philanthropic partners/researchers that have picked up on this seminal work and contributed to it.

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) gene¹³⁻¹⁶. DUX4 is a transcription factor that kick starts the embryonic genome during the 2- to 8-cell stage of development.¹⁷⁻¹⁹ 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,^{20-26,27,28} 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.²⁹⁻⁴² 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."⁴³ Add to this that FSHD was the sole disease mentioned in the recent tour de force Science publication 'The complete sequence of a human genome.' The paper is proof that scientists were able to sequence every base in the genome using at least one of six methods! FSHD was highlighted as having a bunch of newly assembled paralogs in the assembly; some of which showed evidence of being transcriptionally active. Great exposure for FSHD! This article will be read by the majority of genomics researchers worldwide—so should definitely increase awareness.⁴⁴

Blocking DUX4's DNA, DUX4's RNA or DUX4's protein ability to activate its targets has profound therapeutic relevance.⁴⁵⁻⁴⁸ 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. 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.

Our FY 2022 testimony on FSHD was quite comprehensive in scope, complete with 82 references, with a broad call to action in research areas from bench-side to clinic. Rather than restating—we ask the Committee to urge NIH to move forward on the many priorities listed.

In FY 2023, we request NIH to additionally make an immediate and targeted push to answer the following three questions. Answers to these questions will help remove the obstacles to measuring disease progression, help measure if novel therapeutics are making a difference in stopping the disease and elucidate if muscle can grow again and be restored. At present, measuring disease progression and the effectiveness and safety of drugs remains ambiguous and the path forward deep and hard-going for industry, clinical partners and patients.

Three Key Research Questions

How does DUX4 expression lead to pathophysiology? We know a lot of what can happen when DUX4 is expressed in a cell (mostly forced experimental expression), but not a lot about what happens when an FSHD muscle cell expresses DUX4 that leads to pathology.

Can FSHD muscle pathology be reversed once DUX4 expression starts the pathogenic cascade in a particular muscle? This is a key question when looking to improve outcomes with either muscle building or DUX4 halting therapies.

Is there a systemic effect of local DUX4 expression that leads to amplification of muscle decline, either immune or some extracellular signaling? Answering this question will help delineate where along the travels of DUX4 from its birth and death in muscle we can intercept and control the disease process.

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.

We request for fiscal year 2023, increasing NIH FSHD research funding/appropriation of the standard portfolio to \$25 million. The growth has been slow, continuous and prone to year-to-year fluctuations downward and upward according to NIH funding data. Additionally, we request a one-time boost of \$5 million to solicit applications to answer the three questions of key import. At this moment in time, FSHD needs an infusion of both longstanding and immediate discovery 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). This is NIH's wheelhouse and forte without a doubt.

Madam Chairman, thank you for this opportunity to update you on FSHD with this testimony.

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greater number of nerve sites involved. However, unlike CIDP, MMN is asymmetric and affects the right and left side of the body differently. The clinical course of MMN is chronically progressive without remission.

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|CIDP community. During the pandemic, 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. This however was not the size and scope of the original planned meeting. 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 over 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 \$49 billion to the NIH with proportional increases to NIAID and NINDS to continue the potentially life-saving 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/CIDP Foundation International.]

PREPARED STATEMENT OF HELEN KELLER INTERNATIONAL

Madam Chairwoman, thank you for this opportunity to provide testimony to the subcommittee on behalf of Helen Keller Intl's U.S. Vision Programs. Helen Keller Intl respectfully requests this subcommittee recommend that the United States Department of Education and Department of Health and Human Services support programs that provide no-cost vision care for children from low-income families in fiscal year 2023.

It is Helen Keller Intl's hope that, with the renewed support of the Department of Education, as well as continued support of our private donors, we will be able to deliver free vision screenings, eye exams, and prescriptions eyeglasses to thousands of economically disadvantaged and vulnerable children who may not otherwise have access to them. We also request that the Department of Health and Human Services consider funding school-based programs that identify vision issues and provide prescription eyeglasses to children from marginalized and low-income families whose educational performance and future vocational success may be hindered because of uncorrected vision problems.

OUR PROGRAM

Helen Keller Intl's U.S. Vision Programs exist to make clear vision accessible to all. Our model was first established in 1994 in the Washington Heights neighborhood of Manhattan. Since that time, we have reached more than 2 million individuals with vision screenings, eye exams, and free prescription eyeglasses. And yet, the need for accessible eye health services has not diminished. In fact, with low-income communities continuing to deal with economic fallout of the COVID-19 pandemic, we believe that this need has only grown.

Despite the fact that routine, comprehensive vision care is a standard part of preventive health, as many as 12 million adults and 4 million children in the United States suffer from impaired vision due to uncorrected refractive error, which can easily be corrected with a pair of prescription eyeglasses. According to a recent study in Investigative Ophthalmology and Visual Sciences, Americans of color are significantly more likely to have uncorrected or under-corrected refractive error (otherwise known as nearsightedness, farsightedness, and astigmatism) than white Americans. These rates are even higher when the populations are low-income or uninsured. In this way, a lack of access to clear vision exacerbates racial and economic inequality in this country.

In school, students who are not able to see clearly may have difficulty engaging with their schoolwork and their peers. Studies have found that children with vision issues are three times more likely to fail at least one grade. They may also be misdiagnosed with learning disabilities and are more likely to be socially isolated.

Although refractive error is easily addressed with a pair of prescription eyeglasses, many individuals across this country cannot afford or easily access an eye exam or glasses. In an informal survey our organization conducted with low-income clients nationwide, nearly 2 in 3 reported that they could not access an annual visit to the optometrist. The barriers to access for this essential care included cost, insurance, transportation, and long wait times at local clinics.

Our U.S. Vision Programs are prepared to help meet this need by providing free eye health services directly on-site at low-income schools and other community-

based locations around the United States. Our three-step model is simple, flexible, and cost-effective: we bring trained staff and optometrists directly into school buildings or community partner sites to provide vision screenings and eye exams at no cost to students or their families. If our team determines that a child requires eyeglasses, they can try on and select a frame from a large assortment of stylish, durable options. We return to fit each student with their glasses and provide literature regarding the importance of eye health and instructions on proper eyeglass care. In the instance that a child has symptoms of a more complex eye disorder (such as strabismus or amblyopia) we will provide a referral to one of our partnering ophthalmologic clinics for follow-up care.

The services we offer are comprehensive and high quality, and this model is time-tested. We have refined our approach so that we can continue to provide this critical care during the COVID-19 pandemic, utilizing PPE, physical distancing, and the sanitization of surfaces and equipment to ensure that our clients and our staff stay healthy and safe.

POSITIVE RESULTS

The impact of a pair of eyeglasses can be transformative. For many of the young people we serve, our program provides their first eye exam and their first pair of eyeglasses. Many students don't even realize that they are seeing the world differently from their peers until they first try on their glasses.

Researchers at the University of Minnesota have determined that the provision of eyeglasses to school-aged children leads to increased reading scores and improved education outcomes. Our own surveys have reflected an increase in self-esteem among students who have received eyeglasses. Teachers we have surveyed also report that students who receive eyeglasses participate in class at a higher rate. Nearly 100-percent of the school nurses we have surveyed state that Helen Keller Intl fills a glaring gap that exists between state-mandated vision screenings and the actual provision of exams and eyeglasses.

This work has the capacity to change lives by removing the primary barriers that exist to clear vision: access and expense. Since 1994, we have provided more than 2 million vision screenings and delivered nearly 400,000 pairs of free prescription eyeglasses to children in need. With support from this subcommittee, we hope to see many more.

PUBLIC/PRIVATE UNDERTAKING

Our U.S. Vision Programs are truly a public/private endeavor. In each of the five States in which we currently operate we bring together a wide range of community stakeholders, from parents and teachers to physicians and business people, all of whom are dedicated to restoring clear vision. This work is funded through a combination of public and private dollars—in addition to municipal contracts, we have more than a dozen corporate and foundation partners. They include the Lavelle Fund for the Blind, Alcon Laboratories, the Overdeck Family Foundation, the Wilf Family Foundation, Latter-day Saints Charities, the New York Community Trust, the Rose Hills Foundation, the Michael J. Connell Foundation, Healthcare Foundation of New Jersey, and Reader's Digest Partners for Sight Foundation, among others.

Previously, the endorsement and support of the Department of Education played an integral role in our program, allowing us to reach larger numbers of students in more diverse locations, including rural communities in New Mexico, Texas, and Mississippi. With some of the restrictions surrounding the COVID-19 pandemic lifting, we endeavor to once again expand the scope of this work, and hope that we will have to subcommittee's support in doing so.

CONCLUSION

Helen Keller Intl's U.S. Vision Programs provide an invaluable—and often life-changing service to underserved youth in a manner that is both comprehensive and cost-effective. Our program reaches some of the most vulnerable children in the country, and provides them with free vision screenings, free eye exams, and free eyeglasses.

We ask this subcommittee to recommend in its fiscal year 2023 Committee report that the United States Department of Education and the Department of Health and Human Services support programs that provide vision care for children from low-income families. These funds will support ongoing programs, such as ours, and will provide the eye health services that these young people need to succeed in the classroom and beyond.

As our founder, Helen Keller, once said: *Alone we can do so little; Together we can do so much.*

[This statement was submitted by Kathy Spahn, President and Chief Executive Officer, Helen Keller International.]

PREPARED STATEMENT OF THE HEPATITIS B FOUNDATION
HBF RECOMMENDATIONS FOR FISCAL YEAR 2023 APPROPRIATIONS

National Institutes of Health

- Along with the biomedical research community, the Hepatitis B Foundation (HBF) supports the biomedical research community's request for at least \$49 billion for the National Institutes of Health (NIH). This funding request is for the NIH's base level programs, any funding for the new ARPA-H, or for other targeted programs like pandemic preparedness, should supplement the \$49 billion recommendation for NIH's base budget.
- HBF commends NIAID, NIDDK, NCI for the call to update the 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 \$11 billion for the Centers for Disease Control and Prevention programs in FY 2023, and within that \$140 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 and the Immunization Services Division (ISD) to take lead on the implementation of the November 2021 Advisory Committee on Immunization Practices (ACIP) recommendation that all adults between 19 and 59 be vaccinated for hepatitis B.

HHS Office of the Secretary

- HBF urges the Office of the Secretary and the Office of the Assistant Secretary for Health fully support the CDC to ensure the ACIP recommendation that all adults between 19 and 59 be vaccinated for hepatitis B is implemented as early as possible in FY 2023.
- HBF urges the Public Health Service Corps to update their policies to align with the CDC's guidelines and allow individuals with chronic Hepatitis B to serve in the Public Health Service Corps.

Ms. Chairwoman and Members of the subcommittee, thank you for the opportunity to provide testimony as you consider funding priorities for Fiscal Year (FY) 2023. 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.

Ms. Chairwoman, HBF strongly supports the biomedical research community's request for \$49 billion for the NIH base budget. 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 to eliminate the 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 \$11 billion for the Centers for Disease Control and Prevention in the FY 2023 bill. Within that total, we join the Hepatitis Appropriations Partnership in urging \$140 million for the CDC's Division of Viral Hepatitis.

Finally, we would urge that the November 2021 ACIP recommendation that all adults between 19 and 59 be vaccinated for hepatitis B be fully implemented as

early as possible in FY 2023. We urge the Office of the Secretary and the Office of the Assistant Secretary for Health to host an inter-agency Summit to discuss dissemination and implementation of the new recommendation.

RECOGNIZING THE LEADERSHIP OF THE SUBCOMMITTEE

Ms. 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 community's request for \$49 billion for the NIH. While we support the President's ARPA-H initiative, and recognize the importance of pandemic preparedness funding, it is imperative that the funding for these initiatives be additional funding, above the \$49 billion basic request for NIH. It is crucial 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 to fund identified research opportunities that would help cure and eliminate the disease once and for all. The Hepatitis B Foundation appreciated the NIH's call for an update to the Strategic Plan for Trans-NIH Research to Cure Hepatitis B and we look forward to the final report. Report language is requested in the FY 2023 Report urging the NIAID and NIDDK to issue targeted calls for hepatitis B research proposals in FY 2023 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 \$70 million in FY 2023.

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, 1.5 million people worldwide are newly 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 percent.

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 178 organizations in the CDC Coalition and urges a funding level of at least \$11 billion for CDC's programs in FY 2023. This is \$375 million 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 \$140 million for the DVH in FY 2023.

In November 2021, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend universal hepatitis B vaccination for all adults ages 19 to 59 in the U.S. This simplified, updated recommendation, as it is implemented, will significantly increase the vaccination rate of adults in the U.S. (currently only 30 percent of U.S. adults are vaccinated). Now, these recommendations need to be implemented. We urge the CDC, with support from the Office of the Secretary and the Office of the Assistant Secretary for Health, to ensure the ACIP recommendation is implemented as early as possible in FY 2023. As a first step, we urge the Office of the Secretary and the Office of the Assistant Secretary for Health to host an inter-agency Summit to discuss dissemination and implementation of the new recommendation. The CDC is further urged to promote awareness about the new vaccination guidelines among medical and health professionals, communities at high risk, and the public, and to improve collaboration and coordination across CDC to achieve this goal.

OFFICE OF THE SECRETARY

The Hepatitis B Foundation continues to be concerned that the Surgeon General's office maintains a hiring policy for Public Health Service employees that is inconsistent with the recommendation of the CDC by refusing to hire anyone with chronic hepatitis B. We urge the Surgeon General's office to change this policy to align with the "Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Health-Care Providers and Students," which is based on science and recognizes that individuals living with chronic hepatitis B are not a risk to others. Compliance with the CDC policy is also necessary to meet the nondiscrimination obligations under the Americans with disabilities Act, Section 504 of the Rehabilitation Act and section 1557 of the Affordable care Act. The Public Health Service must update their guidelines.

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 HISPANIC ASSOCIATION OF COLLEGES AND UNIVERSITIES

Chairwoman Murray, Ranking Member Blunt, and Members of the Committee, thank you for the opportunity to submit this testimony on behalf of the Hispanic Association of Colleges and Universities (HACU). Founded in 1986, HACU is the only national association that represents the 559 Hispanic-Serving Institutions (HSIs) in the country, including the District of Columbia and Puerto Rico. We appreciate the opportunity to provide our views regarding the Department of Education (DOE) Fiscal Year 2023 budget. Our requests for this fiscal year are:

- \$250,000,000 for Developing Hispanic-Serving Institutions (Title V, Part A): \$67,150,000 above fiscal year 2022; and
- \$100,000,000 for Promoting Postbaccalaureate Opportunities for Hispanic Americans (Title V, Part B): \$80,340,000 above fiscal year 2022.

HACU commends the committee for increases to Title V Part A and Part B in recent years, including the \$34.12 million increase for Part A and \$5.81 million increase for Part B in fiscal year 2022. These funds are critical to HSIs as these are their main Federal funding vehicles. Unfortunately, funding levels have not kept up with the number of HSIs. Since their codification in 1992 as part of the amendments to the Higher Education Act of 1965, as amended, HSIs have continued to grow exponentially from 311 in 2010 to 569 in 2019, for example. However, the pandemic saw the number of HSIs decrease, for the first time in 20 years, to 559, partly due to the economic and social impacts that disproportionately impacted Hispanic students as the entry requirement for HSI status is to serve 25 percent or more such students in their total FTE enrollment.

HSIs educate more than 5 million students, including two-thirds of the estimated 3.8 million Hispanic students in American higher education, most of whom are first-generation college students and come from low-income families. HSIs also enroll twice as many African American students as Historically Black Colleges and Universities (HBCUs), 41 percent of all Asian Americans, 21 percent of all Native

Americans, and 16 percent non-Hispanic White students in U.S. higher education. Additionally, while only accounting for 16 percent of higher education institutions, HSIs enroll 31 percent of Pell recipients. Despite their great diversity and need, HSIs remain at the bottom of the Federal funding priorities, compared to other Minority-Serving Institutions (MSIs) and HBCUs.

HSIs are consistently asked to do more with less. The first Congressional HSI appropriation in FY1995 was a meager \$12 million for more than 125 HSIs. As the number of HSIs has climbed rapidly, Federal funding has been paltry over the years and amounted to a mere \$315.7 million in FY21, including \$221.6 in discretionary funds.

Coupled with persistent Federal underfunding, COVID-19 has exacerbated the financial needs of HSIs: delayed deferred maintenance, access to broadband, classroom facilities enhancements, and much needed wrap-around student services, particularly health and psychological services. As the pandemic lingers on, the funding needs of HSIs will become more critical. In a report released by HACU in September 2021,¹ HACU surveyed HSIs and received 111 responses on their infrastructure needs that require capital financing. More than nine in every 10 HSIs need funding for construction of new buildings, facilities, and classrooms; eight of every 10 for deferred maintenance; three of every four for IT infrastructure; and more than two-thirds for repairs.

Federal investments are essential to strengthen our workforce by enhancing educational attainment, especially in STEM and other fields of national priority. The U.S. Census Bureau reported that from 2010 to 2020 Hispanics accounted for more than half the total growth of the National population and are now over 63 million, and it estimates that the Hispanic population will grow by 93.5 percent from 2016 to 2060.²

HSIs educate and train the most diverse and underserved communities and do so with fewer Federal resources per student than their peer institutions. As the Nation looks to rebuild the economy after the pandemic, it is critical that Federal investments strengthen our workforce by enhancing the educational infrastructure of HSIs to pave the path of success and opportunity for Hispanic Americans for the fiscal year 2023.

As the Hispanic growth-rate in K-12 enrollment continues to accelerate, the number of Hispanic high-school graduates is expected to increase by 49 percent between 2012-13 and 2028-29, compared to 23 percent for Asian/Pacific Islanders, and to a net drop of 3 percent and 15 percent for Blacks and Whites, respectively. In fact, NCES projected in the same study an increase of 14 percent in Hispanic college enrollment between 2017 and 2028 from 3.5 million to over 4.0 million, but it may be under-projecting as in 2020 there were already 3.8 million Hispanics college students, 67 percent of them at HSIs.³

Investing in HSIs is an investment in the success American workforce. Given the preceding demographic trends and projections, it is evident that the Nation's labor force is also becoming increasingly Hispanic. The U.S. Bureau of Labor Statistics (BLS) reports that Hispanics have the highest participation rate in the American labor force, which in 2019 was 66.8 percent, compared to 63.0 percent for Whites and 62.4 percent for Blacks.⁴

A U.S. BLS study projected that the Latino share of the workforce will increase dramatically from 1 in 10 in 2010 to 1 in 3 by 2050, while Whites will decrease from 81 percent to 75 percent, Blacks will remain at 12 percent, Asian Americans will increase from 5 percent to 8 percent and all others from 2 percent to 5 percent during the same span of time.⁵ Currently, more than half of all the new workers joining the Nation's labor force is Hispanic. For America to remain competitive in the global economy, a much better educated and trained Hispanic labor force is required. As the backbone of Hispanic postsecondary education, HSIs must be placed at the top of Federal investment priorities without any further delay.

HACU and its supporters wholeheartedly commend the U.S. Congress and the Administration for investing significantly in HBCUs and other MSIs and urge them to continue doing so. Likewise, we exhort Congress and the President to invest with equal commitment in HSIs and their underserved students; they truly are the future of the Nation.

¹ <https://www.hacu.net/NewsBot.asp?MODE=VIEW&ID=3424>.

² <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>.

³ <https://nces.ed.gov/pubs2020/2020024abbrev.pdf>.

⁴ <https://www.bls.gov/emp/tables/civilian-labor-force-participation-rate.htm>.

⁵ <https://www.bls.gov/opub/mlr/2012/10/art1full.pdf>.

ABOUT HACU

The Hispanic Association of Colleges and Universities, founded in 1986, represents more than 500 colleges and universities in the United States, Latin America, Spain and school districts throughout the U.S. HACU is the only national association representing existing and emerging Hispanic-Serving Institutions (HSIs). The Association's headquarters in San Antonio, Texas, with regional offices in Washington, D.C and Sacramento, California.

[This statement was submitted by Antonio Flores, PhD, President & CEO, Hispanic Association of Colleges and Universities.]

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

Chairwoman Murray, Ranking Member Blunt and members of the subcommittee, my name is Marwan Haddad, MD, MPH, chair of the HIV Medicine Association (HIVMA), and I serve as the medical director of the Center for Key Populations at the Community Health Center Inc. (CHCI) in Middletown, Connecticut, one of the largest Federally Qualified Health Centers in the country. I am pleased to submit testimony on behalf of HIVMA. HIVMA represents nearly 5,000 physicians, scientists and other health care professionals around the country on the frontlines of the HIV epidemic. Our members provide care and treatment to people with HIV, lead HIV prevention programs and conduct research in communities across the country.

For the FY 2023 appropriations process, we urge you to appropriate funding to support the Ending the HIV Epidemic (EHE) initiative, including: increased funding for the Ryan White HIV/AIDS Program (RWHAP) at the Health Resources and Services Administration (HRSA) across all parts, increased funding for the Centers for Disease Control and Prevention's (CDC's) HIV, hepatitis and sexually transmitted infections (STI) prevention programs, and increased investments in HIV research supported by National Institutes of Health (NIH).

The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP), a coalition of HIV organizations from across the country. For a chart of current and historical funding levels and coalition requests for each program, please see FAPP's FY 2023 Appropriations for Federal HIV/AIDS Programs.

ENDING THE HIV EPIDEMIC INITIATIVE—U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

We urge the Senate subcommittee to build on the inroads made by the EHE initiative, now in its fourth year and strengthened by the Federal National HIV/AIDS Strategy (2022–2025). We recommend funding the EHE initiative at least at the President's budget request for \$850 million across CDC, HRSA and NIH for FY 2023, to be used for expanded access to antiretroviral treatment and pre-exposure prophylaxis (PrEP) to prevent HIV transmissions as well as improved access to routine and critical health services.

NATIONAL PREP PROGRAM—U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The President's budget calls for the creation of a national PrEP program to expand PrEP use and promote racial and ethnic equity in PrEP access. This much needed new program would provide access to PrEP at no cost for uninsured and underinsured individuals, as well as support and expand PrEP programs across a variety of agencies.

A national PrEP program is needed to dramatically reduce new HIV cases and address significant PrEP access disparities among populations the HIV epidemic has heavily impacted. While 1.2 million individuals could benefit from this prevention drug, only 25 percent have been prescribed PrEP. The numbers drop even further for Black and Latinx individuals, to 8 percent and 14 percent. HIVMA supports a program to scale up access to PrEP medication.

HEALTH RESOURCES AND SERVICES ADMINISTRATION—HIV/AIDS BUREAU

HRSA's Ryan White HIV/AIDS Program is critical to ensuring that individuals with HIV are linked to care, are retained in care, have medical adherence and achieve viral suppression. RWHAP has been critical to our HIV response by supporting care and treatment for people with HIV without another source of coverage. In 2020, the viral suppression among RWHAP clients reached a record high of 89.4 percent as compared to 65.5 percent among all people diagnosed with HIV in the

U.S. Sustaining an undetectable viral load in people with HIV is important to their health and to stop HIV transmissions. This is one of the many reasons RWHAP is a critical component of the EHE initiative in decreasing racial and ethnic, age-based and regional disparities. To sustain current services and to ensure more people with HIV benefit from HIV care and treatment, we urge Congress to fund the Ryan White HIV/AIDS Program at \$2.942 billion in FY 2023, an increase of \$447.5 million over FY 2022. In addition, we strongly recommend providing at least \$290 million in EHE funding for the Ryan White Program, a \$165 million increase over FY 2022.

HIVMA urges an allocation of \$231 million, a \$25.5 million increase over FY 2022, for Ryan White Part C programs. It is critical to ensure that clinics in all jurisdictions nationwide receive additional funding to increase access to HIV care and treatment to help end the domestic HIV epidemic. Approximately half of Part C providers serve rural communities, making the clinics the primary source for delivering HIV care to rural jurisdictions.

Part C of the Ryan White Program directly funds approximately 350 community health centers and HIV clinics, providing medical care to more than 300,000 people each year. 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 to prevent, intervene and treat substance use disorders as well as related infectious diseases, including HIV, viral hepatitis and STIs.

CHCI's Ryan White-Funded Clinic in Connecticut Is Leading on Expanding Access to HIV Prevention, Care & Treatment. The Center for Key Populations (CKP) at Community Health Center Inc. (CHCI) has received funding through the Ryan White Cares Act for more than 23 years, making us a leading source of HIV primary care in the State of Connecticut. Each year CHCI has increased the number of HIV patients served, the number of services offered and the number of HIV tests conducted based on the needs of the communities we serve.

The needs of both established and newly diagnosed patients with HIV are growing more complex, especially as the population ages. In 2021, even as HIV prevention methods became more available, CHCI 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 2021, 71 percent self-reported as racial and ethnic minorities and 56 percent reported food and housing insecurity as major barriers to achieving optimal health care. Additionally, 4 percent of all Ryan White patients were uninsured, 87.9 percent had at least one clinical comorbidity and 62 percent reported unmet mental health needs at the time of intake. Among Ryan White Program patients at CHCI, 60 percent reported experiencing stigma or discrimination based on their gender identity, sexual orientation or HIV status in the last year. As the country resumed "normal" activities after the COVID-19 pandemic, individuals living with HIV reported significant symptoms of isolation that were difficult to overcome.

CHCI's Ryan White Program eligible patients who are engaged in care are screened for substance use disorders routinely; in 2021, 59 percent screened positive, with 10 percent considering those needs urgent or severe. CHCI, like most Ryan White Part C programs, also receives funding from other parts of the Ryan White Program, and these help us provide support services that were particularly important in retaining patients in care and assisting in medication compliance. 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 health care outcomes for all patients.

The support services provided by Ryan White funding were pivotal in maintaining stability and transitioning care efficiently during the COVID-19 pandemic. The infrastructure developed over 23 years of funding gave Ryan White patients the additional support they needed to sustain healthy outcomes and return to care as soon as possible after the pandemic. These services are integral to the success of patients in maintaining viral load suppression to protect themselves and their communities.

HEALTH RESOURCES AND SERVICES ADMINISTRATION—BUREAU OF PRIMARY HEALTH CARE

We recommend appropriating \$172.3 million in new funding for HRSA's Community Health Center program for the EHE initiative, a \$50 million increase over FY 2022. As part of the EHE initiative, HRSA's community health center program is focused on expanding HIV prevention services, including outreach, care coordination and access to PrEP services. In 2020 and 2021, EHE resources were distributed to 213 health centers that received Health Center/Ryan White Program funding and/or were located close to a Ryan White Program where no jointly funded health cen-

ter currently existed in targeted jurisdiction sites. These health centers reported more than 151,000 patients receiving PrEP services in the first year of the EHE initiative—a significant accomplishment in scaling up PrEP among the most affected populations, 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 CDC's leadership role in responding to the COVID-19 pandemic to its ongoing efforts to address persistent public health epidemics and threats, such as HIV, STIs and viral hepatitis, CDC is a critical national and global expert resource and response center. To meaningfully address these epidemics and the co-occurring crisis of substance use disorder—especially injection drug use—we request a \$731.9 million overall increase above FY 2022 levels for a total of \$2.077 billion.

For the Division of HIV/AIDS Prevention (DHAP), we request a total of \$1.233 billion, which is a \$246 million increase over FY 2022 levels. DHAP conducts our National HIV surveillance and funds State and local health departments and communities 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 \$310 million requested by the Administration for the EHE initiative, a \$115 million increase above FY 2022, allowing CDC to scale up HIV testing to ensure early diagnosis and linkage to care, and PrEP programs to prevent new infections.

Additionally, we urge the appropriation of \$150 million for CDC to fund surveillance and programming, a \$132 million increase above FY 2022, to monitor and prevent injection-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 the National response to the opioid crisis, including expanding support for monitoring and data collection and strengthening national capacity to share information and expand access to effective prevention services, including syringe services programs.

For the Division of Viral Hepatitis (DVH), we request a total of \$140 million, which is a \$99 million increase over FY 2022 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 eliminating hepatitis as a public health threat.

For the Division of STD Prevention (DSTDP), we request a total of \$329.2 million, which is a \$164.9 million increase over FY 2022 levels. CDC's 2020 STD Surveillance Report shows syphilis among newborns (i.e., congenital syphilis) increased, with reported cases up nearly 15 percent from 2019 and 235 percent from 2016. Increases like these 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

The historical response to the COVID-19 pandemic over the last 2 years exemplifies the value of the Nation's longstanding commitment to NIH. Decades of medical research supported by NIH are the foundation for diagnostic, treatment and preventive interventions available today, and building on this research will be vital in finding a cure and vaccine for HIV. To advance these and other scientific discoveries, we ask that at least \$3.875 billion be allocated for HIV research in FY 2023, an increase of \$681 million over FY 2022.

CONCLUSION

Thank you for considering this request to support lifesaving investments in domestic HIV and infectious diseases programs in the FY 2023 (LHHS) appropriations bill. Fully funding these programs will ensure progress in ending the domestic HIV epidemic and help maintain the gains achieved in recent years. HIVMA looks forward to working with Congress to ensure that the resources necessary to make significant progress in preventing HIV and improving the health and well-being of people with HIV are provided. Please contact me or HIVMA's senior policy and advocacy manager, Jose A. Rodriguez, 4040 Wilson Boulevard, Suite 300, Arlington, VA, 22203, at JRodriguez@hivma.org if you have any questions or need additional information.

[This statement was submitted by Marwan Haddad, MD, MPH, Chair, HIV Medicine Association.]

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 2023 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.

Our nation is on a path to eliminating two infectious diseases, HIV and viral hepatitis, in the U.S., but we need increased funding to accelerate our efforts particularly in communities and populations disproportionately impacted. The ongoing COVID-19 pandemic has demonstrated the interconnectedness of communities and health conditions and has allowed innovative service delivery. Increased investment in surveillance, education, prevention, and care and treatment will ensure we continue to address HIV and viral hepatitis, including taking a syndemic approach in order to achieve maximum impact.

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 3 years, Congress has appropriated 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. Unfortunately, this funding has been far less than what estimates used in the creation of the EHE initiative deemed necessary and were proposed by both Presidents Trump and Biden. The initiative, which is currently focused on those jurisdictions that represent about 50 percent of diagnoses, has already shown success with the money appropriated to date. The Health Resources and Services Administration's HIV/AIDS Bureau reports that in 2020, the Ryan White Program served 11,139 new clients and re-engaged an additional 8,282 clients for a total of 19,421 clients during the first year of the COVID-19 pandemic when services often were disrupted. Additionally, community health centers funded by the EHE Initiative were able to increase PrEP (HIV prevention medication) to 389,000 people.

In FY 2023, we urge Congress to fund EHE activities at the level requested in President Biden's FY23 Budget Request. For FY 2023, we ask that you fully fund the fourth year of the initiative to continue to scale up the EHE initiative by supporting the president's budget request of \$850 million, an increase of \$377 million from FY 2021.

- \$310 million for the CDC Division of HIV/AIDS Prevention for testing, linkage to care, and prevention services, including pre-exposure prophylaxis (PrEP) (+ \$115 million);
- \$290 million for the HRSA Ryan White HIV/AIDS Program to expand comprehensive care and treatment for people living with HIV (+ \$165 million);
- \$172 million for the HRSA Community Health Centers to increase clinical access to prevention services, particularly PrEP (+ \$50 million);
- \$52 million for the Indian Health Service (IHS) to address the combat the disparate impact of HIV and hepatitis C on American Indian/Alaska Native populations (+ \$47 million); and
- \$26 million for NIH Centers for AIDS Research to expand research on implementation science and best practices in HIV prevention and treatment.

PREP

It is estimated that only 23.4 percent of people who could benefit from PrEP have received a prescription. PrEP coverage is highest among white people, at 63.3 percent, yet only 8.2 percent of black people and 14 percent of Hispanic/Latino people who could benefit from PrEP in the U.S. have a prescription. Additionally, PrEP coverage among women is only at 9.7 percent. Reducing these disparities must be a priority as we work to expand PrEP use.

We are thankful that there has been an increased focus on PrEP both in Congress and from President Biden. In his FY 2023 budget request, President Biden called for a new mandatory funding program to expand PrEP across the United States through providing medication to uninsured and underinsured individuals, as well as supporting and expanding PrEP programs across a variety of agencies. As the HIV community, relevant stakeholders, and Congress consider this proposal along with others, we urge you to support funding for new and innovative grant programs to expand PrEP access, ensure that those who want PrEP can easily access the medication without any costs or barriers, and increase demand for PrEP among people

who could benefit from this important medication. This can be accomplished with increased funding for PrEP services for community health centers, CDC's Division of HIV Prevention, and other programs.

HIV

Additionally, the success of the EHE initiative and PrEP delivery rests upon our underlying public health prevention, care, and treatment programs at the CDC, HRSA, and other agencies. Congress must ensure that these are also 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. Nearly 61 percent of clients live at or below 100 percent of the Federal poverty level and nearly three-quarters of the clients are from racial and ethnic minority populations. For over 30 years, the Ryan White program has pioneered innovative models of care which has resulted in over 89 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 ongoing economic impact of COVID-19. Without increased funding some ADAPs may be forced to institute wait lists for medications or other cost containment measures.

This program is especially important in many States where there are large healthcare coverage gaps because of States choosing not to expand Medicaid. There are approximately 400,000 people living with HIV who are not engaged in care and treatment. The Ryan White Program can play a large role in bringing these people into care and treatment and ensuring their virus is undetectable, which makes them untransmittable. The Ryan White Program also needs additional support to address the complex challenges of the overdose crisis, mental health crisis, and prevention and treatment of other infectious diseases, including COVID-19, viral hepatitis, and STIs. We urge Congress to fund the Ryan White HIV/AIDS Program at a total of \$2.942 billion in FY 2023, an increase of \$447 million over FY 2022, of which \$165 million is for the EHE initiative and \$68 million is for ADAPs.

There has been incredible progress in the fight against HIV over the last 40 years, but that progress has stalled with new infections plateauing since 2013. Increasing funding for high-impact, community-focused HIV prevention services through the CDC's Division of HIV Prevention has proven to result in a strong return on investment. HIV continues to disproportionately impact Black gay and bisexual men, Latinx gay and bisexual men, Black heterosexual women, transgender and gender nonconforming women, people who inject drugs, and people who live in the South. HIV prevention tools that meet the special prevention needs of these populations must be expanded.

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. Additionally, the CDC's national surveillance system is a key tool in identifying people and regions most impacted by the epidemic and tailoring prevention efforts to meet the needs of those populations and prevent HIV transmission. There is no single way to prevent HIV, but jurisdictions use a combination of effective evidence-based approaches including testing, linkage to care, condoms, syringe service programs, and PrEP. We urge you to fund the CDC Division of HIV Prevention at \$822.7 million in FY 2023, an increase of \$67 million over FY 2022, in addition to the \$310 million for EHE Initiative work at CDC.

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

Additionally, we respectfully request that you provide increased funding for viral hepatitis programs at the CDC. The CDC estimates that nearly 5 million people in the United States live with hepatitis B (HBV) or hepatitis C (HCV), and as many as 65 percent are 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 the 57,800 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.

CDC Division of Viral Hepatitis

The viral hepatitis programs at the CDC are severely underfunded, receiving only \$41 million—far short of what is needed to build and strengthen our public health response to hepatitis. The Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025) lays out an ambitious plan to end the hepatitis epidemic; however, health departments and community partners are in desperate need of additional resources. Increased investment would allow the CDC to enhance testing and screening programs, conduct additional provider education, enhance clinical services specific to hepatitis at sites serving vulnerable populations, and increase services related to hepatitis outbreaks and injection drug use. With the treatment of hepatitis D expected to be approved this year, there will be increased needs for testing and linkage to care programs. While we are pleased that the Biden administration has prioritized viral hepatitis in its FY23 budget with an increase of \$13.5 million, we urge you to provide the CDC Division of Viral Hepatitis with \$140 million, an increase of \$99 million over FY 2022 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. The U.S. is experiencing an ongoing public health emergency crisis with the U.S. surpassing 105,000 annual overdose deaths from opioid overdose in 2020, a more than 45 percent increase from January 2020. Providing full support for this program is another key step in preventing new cases of viral hepatitis and HIV, addressing overdose prevention, and putting the country on the path towards elimination. We urge the committee to fund this program to eliminate opioid-related infectious diseases at \$150 million, an increase of \$133 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.

FEDERAL HIV & HEPATITIS COORDINATION

Two important offices which coordinate the implementation of the NHAS and EHE activities need resources to bolster their ability to coordinate HIV and viral hepatitis activities across the Federal Government. The White House Office of National AIDS Policy and the HHS Office of Infectious Disease and HIV/AIDS Policy both play an important role in developing and implementing government-wide HIV strategies, as well as coordinating efforts among the wide range of Federal agencies working to end the HIV epidemic and the syndemics of STDs, hepatitis, TB, and overdoses. We urge you to provide a total of \$20 million for the HHS Office of Infectious Disease and HIV/AIDS Policy and \$3 million for the White House Office of National AIDS Policy in FY 2023.

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 hepatitis epidemics. Fortunately, we have the tools available to end both these epidemics; however, we must provide the necessary resources to accelerate our efforts to achieve these goals.

[This statement was submitted by Carl Schmid, Executive Director, HIV + Hepatitis Policy Institute.]

PREPARED STATEMENT OF HOPE CHARITIES
SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

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- Provide NIH with at least a \$3.5 billion increase in discretionary funding for FY 2023 to bring overall agency funding up to a minimum of \$49 billion annually.
 - Please provide proportional funding increases for NIH's various Institutes and Centers, such as the National Institute of Allergy and Infectious Diseases (NIAID) and the National Heart, Lung, and Blood Institute (NHLBI).
 - Please provide separate, additional funding to further support and advance implementation of the Advanced Research Projects Agency for Health (ARPA-H) to ensure this important initiative does not compete with (and ultimately compliments) ongoing NIH research efforts.
 - Provide the Centers for Disease Control and Prevention (CDC) with at least a \$2.55 billion increase in discretionary funding for FY23 to bring overall agency funding up to a minimum of \$11 billion annually.
 - Please provide established CDC Centers and Programs, such as the National Center for Chronic Disease Prevention and Health Promotion, with proportional funding increases.
 - Please provide the emerging CDC Chronic Disease Education and Awareness (CDEA) program with \$6 million for FY 2023, an increase of \$3 million over FY 2022.
 - Provide the Health Resources and Services Administration (HRSA) with a funding level of at least \$9.8 billion for FY 2023, an increase of roughly \$900 million over FY 2022.
 - Continue to support committee recommendations highlighting the value and importance of charitable assistance programs and encouraging proper access.
-

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to present the views of Hope Charities and the patient communities that we serve. Primarily, we thank you for your continued support for medical research and public health programs that serve blood disorders and rare disease patients through the FY 2022 omnibus package. For FY 2023, Hope joins the broader medical research and public health community in asking that the investment in NIH, CDC, and HRSA be maintained and responsibly increased.

About Hope Charities

Hope Charities is a national nonprofit organization, founded in 2009, based in Louisiana. The mission of Hope Charities is to act as a conduit of hope, strength, and resources to families in a crisis caused by a chronic illness. We accomplish our mission through several programs including our Resource Connection Program; direct patient assistance, which helps families by subsidizing the cost of utilities, food, housing, transportation, and medical equipment; access to care through health insurance premium assistance as well as educational programs.

Complimenting Public Health Programs

The Louisiana Department of Health classifies 63 percent (40 of 64) parishes as “rural.” The CDC reports that residents in rural areas have higher rates of poverty, less access to healthcare, and are less likely to have health insurance. Hope Charities works with Americans by increasing access to medical care for rural, underserved, and vulnerable populations. Our mission is to improve healthcare outcomes, which in turn decreases work absences, reduces the negative impact of chronic illness on mental health, and can lower the overall cost of healthcare.

NIH conducts important research into many rare and chronic conditions, such as hemophilia, that incrementally improves care and options for affected individuals. This work is essential to advancing innovative research, improving outcomes, and lowering healthcare costs. The CDC and HRSA also support hemophilia treatment centers and have a variety of line-item programs that assist with public health and care delivery for patients affected by a variety of conditions. These programs, particularly at CDC's National Center for Chronic Disease Prevention and Health Promotion, have only seen modest increases in recent years, but much more can be done with an infusion of timely resources.

Please note, as a safety net program, Hope Charities is pursuing a congressionally directed spending request to bolster efforts that support the work of hemophilia

treatment centers and community health centers, in addition to requesting discretionary funding increases for Federal programs.

About the Patients that We Serve

Hope recently received a request from Van, a 31 year old male who lives in Louisiana and has hemophilia. He was scheduled to have surgery at 5:30 a.m. on his right knee as a result of hemophilia-related injuries. He lives two hours away from his Hemophilia Treatment Center and the hospital where the surgery was to occur. He is on Medicaid and could not afford to travel to the hospital. Hope helped him with travel expenses and paid for a hotel room for him to stay the night before his surgery.

Anna resides in Illinois and lives 8 hours from her nearest Hemophilia Treatment Center. Her minor son has hemophilia B. She requested funding from Hope for travel to an appointment. We paid for a hotel room for Anna and her son the night before their appointment. They attended their appointment early the next day, then traveled home.

[This statement was submitted by Jonathan James, CEO, Hope Charities.]

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). HFES supports additional funding for the Advanced Research Projects Agency for Health (ARPA-H) through a supplement for the National Institute of Health (NIH) beyond the \$49 billion recommended in fiscal year (FY) 2023.

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 2021 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 supports the creation of Advanced Research Projects Agency for Health (ARPA-H) and advocates for additional funding to launch the agency in FY 2023. HFES advocates for \$49 billion for NIH and additional supplemental funding to expand the ARPA-H effort. ARPA-H will focus on high-risk, high-reward research that targets biomedical and health breakthroughs, while considering outcomes and the impact on healthcare and quality of life. These advancements will range from how to prevent, treat, and cure diseases that affect many Americans.

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; \$375.3 million for NIOSH, including \$34 million for the Education and Research Centers (ERCs); and funding a supplement for ARPA-H through beyond a recommended \$49 billion for NIH in FY 2023. 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 Christopher R. Reid, President, and Steven C. Kemp, CAE, Executive Director, Human Factors and Ergonomics Society.]

PREPARED STATEMENT OF THE INFECTIOUS DISEASES AND THE OPIOID EPIDEMIC PROGRAM

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 addressing for Public Health-Seattle & King County in Seattle, WA. In this role it is my responsibility to lead the overdose prevention work for the community.

I am pleased to submit testimony on behalf of King County, WA to urge Congress to appropriate \$150 million for the Infectious Diseases and the Opioid Epidemic program at the Centers for Disease Control and Prevention (CDC) 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).

The United States is experiencing an urgent and unprecedented drug overdose crisis, with more than 100,000 overdose deaths from 2021–2022. Like the rest of the Nation, King County, WA continues to experience record overdose deaths each year. There have been significant increases in the county over the past decade, from 248 deaths in 2010 to 511 deaths in 2020, to the biggest yearly increase yet in 2021 resulting in an estimated 719 deaths (some cases pending confirmation). The recent influx of fentanyl in the local drug supply has contributed significantly. Fentanyl is increasingly involved in overdose deaths, from 3 deaths in 2015 to 360 in 2021—a nearly 12,000 percent increase in just 6 years. Already marginalized demographic groups are disproportionately impacted. In King County, death rates (numbers per

100,000) in 2020 were 77.2 for American Indians/Alaskan Natives, 32.7 for Blacks, and 16.5 for Hispanics, compared to 16 for Whites.

It is imperative that congress respond to this overdose crisis with the urgency it deserves and requires. We know that a public health approach is the most humane and effective approach to tackling this crisis. SSPs are an essential, evidence based public health intervention and a vital component of overdose prevention. The CDC has documented over 30 years of evidence that shows 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, but they do reduce the amount of improperly discarded syringes and save money.

The King County Needle Exchange proudly serves clients by providing health education, naloxone training and distribution, safer sex supplies, and referrals for addiction treatment and other medical services, in addition to exchanging injection supplies. Our staff attempts to meet people where they are and help them address their needs in the safest and healthiest way possible, free of judgement and stigma. SSPs are among the only health care services trusted and used by people who use drugs, so SSP programs can effectively engage this highly stigmatized population.

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 percent of respondents experienced an increase in clients in 2020. During this time of skyrocketing need, 42 percent of respondents experienced funding cuts and were forced to lay off staff and reduce services, limiting access to life saving interventions. Increased Federal funding is needed to 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.

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.

With additional FY23 funding, CDC could 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 \$150 million for the program in FY23. Thank you also for your time and consideration of my testimony, and please do not hesitate to contact me at brad.finegood@kingcounty.gov if you have questions or need additional information.

Sincerely,

[This statement was submitted by Brad Finegood, MA, LMHC, Office of the Director, Strategic Advisor, Public Health—Seattle & King County.]

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 FY2023 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 \$397 million for the Antibiotic Resistance Solutions Initiative (ARSI) at the Centers for Disease Control and Prevention (CDC), \$6.7 billion for the National Institute of Allergy and Infectious Diseases (NIAID), \$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, high levels of antibiotic use have exacerbated existing antimicrobial resistance (AMR), deepening the need for antimicrobial stewardship, surveillance and new antimicrobial drugs. From March–September 2020, there was a 24 percent increase in hospital-onset, multidrug-resistant infections associated with COVID–19 surges. 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 \$397 million in funding for the Antibiotic Resistance Solutions Initiative in FY2023, the cornerstone of the Nation's efforts to detect, prevent, and respond to AMR. The President's budget proposal includes \$197 million in discretionary funding and \$200 million each year in mandatory funding from FY2023–2028 (as part of the larger pandemic preparedness request), for a total of \$397 million in FY2023. IDSA members see the impact that 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. Infections are a primary or associated cause of death in 50 percent of patients with cancer, as AMR can make these infections difficult or impossible to treat. Tragically some patients may be cured of their cancer but succumb to a resistant infection which can occur as a result of the effects of chemotherapy. AMR has a disproportionate impact on certain communities due to variance in risk of exposure, susceptibility to infection or treatment received. Rates of several serious antibiotic-resistant infections, including community-associated methicillin-resistant *Staphylococcus aureus* (MRSA) infections, are higher incidence in Black populations. Globally, resistant infections directly caused 1.27 million deaths in 2019 and played a role in 4.95 million deaths. If we do not act now, antibiotic-resistant infections will be the leading cause of death by 2050 and could cost the world \$100 trillion.

Recommended funding is needed to expand antibiotic stewardship across the continuum of care; double State and local grant awards; expand the AR 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. 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, global AMR prevention and surveillance, and responses to sexually transmitted infections and health care-associated infections. 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 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 FY2023.

Advanced Molecular Detection (AMD)

FY2023 funding of \$175 million for the Advanced Molecular Detection program would ensure continued innovation in the detection and tracking of existing and emerging resistant pathogens. Funding would also enable federal, State, and local public health laboratories to expand the use of pathogen genomics, sustain important partnerships with academic research institutions, and bolster training to ensure integration of genomics into AMR surveillance and response. The pandemic has resulted in a substantial ramping up of CDC capacity for sequencing pathogens. CDC is in the process of establishing "Centers of Excellence," linking together public health agencies and private sector partnerships focused on pathogen genomics and molecular epidemiology. The \$175 million would sustain the Centers of Excellence and support ongoing AMD activities.

National Healthcare Safety Network (NHSN)

FY2023 funding of \$100 million for the National Healthcare Safety Network (NHSN) will enable the program to meet its current and projected demands. Requested funding is needed to modernize and automate NHSN to alleviate the reporting burden and speed access to actionable data, which 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. In its FY2023 Inpatient Prospective Payment System (IPPS) rule, the Centers for Medicare and Medicaid Services (CMS) included a requirement that hospitals begin reporting antibiotic use and resistance data. IDSA has long advocated for this policy, which will strengthen our ability to detect and track emerging resistance threats and provide data to help evaluate stewardship interventions and inform best practices. Increased funding for NHSN will be essential to help hospitals that do not already report these data prepare to do so and to ensure the overall success of this initiative.

CDC Center for Global Health

IDSA urges the subcommittee to provide \$991 million in FY2023 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 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), 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, 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 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. Despite this progress, the pipeline of new antibiotics in development is insufficient to meet patient needs, and \$300 million in funding is needed to help achieve the goals of the 2020–2025 Action Plan to accelerate basic and applied research for developing new antibiotics and other products. Additional funding will help prevent a post-antibiotic era in which we lose many modern medical advances that depend upon the availability of antibiotics, such as cancer chemotherapy, organ transplants and other surgeries.

Project BioShield Special Reserve Fund (SRF), Broad Spectrum Antimicrobials

The Project BioShield SRF is positioned to support the response to public health threats, including AMR. Efforts by BARDA and NIAID have been successful in helping companies bring new antibiotics to market, but those companies 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 in which small biotechs that develop new antibiotics are particularly vulnerable. Funding is needed to expand this approach to better support the antibiotics market.

NATIONAL INSTITUTES OF HEALTH

National Institute of Allergy and Infectious Diseases (NIAID)

\$6.7 billion for NIAID, including \$585 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 FY2023 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.

With regard to AMR specifically, increased funding would support 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 resistant infections; and support for training more physician scientists and clinical investigators to improve AMR research capacity, as outlined in the 2020–2025 National Action Plan to Combat Antibiotic-Resistant Bacteria.

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. In 2021, only 70 percent of ID physician training programs filled their slots, leaving us with an inadequate pipeline of ID physician-scientists necessary to lead clinical trials and additional research to strengthen our prevention and responses to ID threats. Strong NIAID support for career development through increased FY2023 funding and other initiatives is critical to improving and diversifying 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.

CONCLUSION

Thank you for the opportunity to submit this statement. The nation's infectious diseases 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 Daniel P. McQuillen, MD, FIDSA, 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 FY 2023.

The Integrative Health Policy Consortium (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 research 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 additional support, NCCIH 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 also supports the Center's proposed pain management research agenda as outlined in the President's FY 2023 budget. According to the President's budget, pain "is a major public health problem and is the most common reason why Americans use complementary and integrative health practices." As a result, NCCIH supports a broad pain and pain management research portfolio that includes basic and clinical research and the development, evaluation, and implementation of complementary and integrative pain management techniques. NCCIH is a leader of the NIH-DoD-VA Pain Management Collaboratory, working with other Federal agencies to support research on nonpharmacologic approaches to pain management in innovative and integrative models of pain care delivery.

IHPC joins other organizations that belong to the Ad Hoc Group for Medical Research in asking the subcommittee to prioritize NIH funding by endorsing an appropriation of at least \$49 billion for the NIH, a \$4.1 billion increase over the NIH's program level funding in FY 2022. In addition, we urge the Committee to ensure that any funding for the new Advanced Research Project Agency for Health (ARPA-H), supplements the \$49 billion recommendation for NIH's base budget, rather than supplants the essential foundational investment in the NIH. Finally, we urge that NCCIH receive a commensurate funding increase (7.9 percent) in FY 2023.

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 \$1.8 billion in discretionary funding in FY 2023.

Thank you for considering our views. The IHPC looks forward to working with you to enact the FY 2023 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.homeopathicdirector.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 THE INTERSTITIAL CYSTITIS ASSOCIATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2023

-
- 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 \$49 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 endometriosis, 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 2023 (FY 2023) 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 FY 2023.

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 through videos, booklets, publications, presentations, educational kits, websites, self-management tools, webinars, blogs, and social media communities such as Facebook, YouTube, and Instagram. 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 pro-

vide 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 \$49 billion for NIH in FY 2023. 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 JAMESTOWN S'KLALLAM TRIBE

Chairwoman Patty Murray, Ranking Member Roy Blunt, and distinguished members of this subcommittee, on behalf of the Jamestown S'Klallam Tribe, I would like to thank you for this opportunity to submit written testimony on our funding priorities and recommendations for the FY 2023 appropriations process for the Department of Health and Human Services.

A. Tribal Specific Health Appropriation Priorities

1. Support the President's FY 2023 Budget Request for Tribal Health Programs and Mandatory Funding for the Indian Health Service (IHS)
2. 340(b) Drug Pricing Program

3. Ensure that Medicare Reimburses Tribal Providers for Telehealth Services at the IHS All-Inclusive Rate or OMB rate

B. Tribal Priorities Administration for Children and Families & the Administration for Community Living

1. Child Welfare Programs Tribal Allocations Subpart 1, \$350 million; Subpart 2, \$120 million \$3.6 million Tribal Set Aside

2. Promoting Safe and Stable Families \$650 million for mandatory programs and \$120 million for discretionary programs

3. Fund Long Term Care

4. Older American act Title VI, part A,B Native American Nutrition and Supportive Services- \$55.5 million Title VI, \$43 Million Nutrition and Support Services.

A. TRIBAL SPECIFIC HEALTH APPROPRIATIONS PRIORITIES

1. *Support the President's FY 2023 Budget Request for Tribal Health Programs and Mandatory Funding for the Indian Health Service (IHS).*—The President requested \$127.3 billion in discretionary funding and \$1.7 trillion in mandatory funding for the Department of Health and Human Services in FY 2023 Appropriations. This is inclusive of \$9.3 billion for the Indian Health Service. The request also seeks to reclassify the entire IHS budget as mandatory for FY 2023. We fully support the President's historical request and commitment to implementing long term solutions to addressing the chronic underfunding of Tribal health programs and delivering on the Nation's promises to Indian Country. To include the proposal to reclassify IHS funding and exempt the IHS budget from sequestration. We urge Congress to follow suit and adopt the President's FY 2023 budget proposal.

2. *340(b) Drug Pricing Program.*—The 340(b) program serves as a critical safety net drug discount program that Tribal communities rely on to serve their citizens and community members who comprise the most vulnerable, underserved and isolated populations. The program has grown tremendously bringing down the cost of prescription drugs by 25–50 percent. However, the actions of several drug manufacturers have undermined Congressional intent and the 340(b) program resulting in limitations on access to discounted prescription drugs. In 2021, HRSA issued violation letters to manufacturers who refused to comply with statutory obligations unless certain conditions were met. However, despite HRSA acting swiftly to address this issue, the manufacturers refused to come into compliance with the law. We urge Congress to take steps to ensure drug manufacturers are compliant with the law.

3. *Ensure that Medicare Reimburses Tribal Providers for Telehealth Services at the IHS All-Inclusive Rate or OMB Rate.*—Tribal healthcare systems are under unprecedented strain in the aftermath of the public health crisis and resulting economic crisis. The financial toll has led to reductions in the availability of healthcare services. During the public health crisis, many hospitals and clinics turned to telemedicine as a necessary tool for the provision of healthcare. In early 2020, the Centers for Medicare and Medicaid Services (CMS) waived many of the telehealth restrictions on providers, technology, geographic areas and services. As a result, use of telehealth visits increased substantially in the Indian Healthcare System. The telehealth flexibilities that were authorized by CMS increased access to primary, specialty and behavioral healthcare services during the pandemic and should be made permanent. However, while IHS and Tribal sites receive the IHS All-Inclusive Rate for telehealth services under Medicaid, Medicare is currently only reimbursing at the Part B rate which is only about \$14 dollars per unit of care. Medicare should reimburse at the full encounter rate to ensure providers can continue to utilize telehealth as a viable option for services.

B. TRIBAL PRIORITIES ADMINISTRATION FOR CHILDREN AND FAMILIES AND ADMINISTRATION FOR COMMUNITY LIVING

1. *Child Welfare Programs Title IV B (subpart 1)—Tribal Allocation \$350 Million & Promoting Safe and Stable Families Social Security Act Title IV B (subpart 2) \$120 Million Tribal Allocation \$3.6 Million.*—The pandemic amplified the existing disparities that Native children and families experience in child welfare systems. Limited access to supportive and rehabilitative services created an environment of enhanced risk for removal of Native children from their homes. Foster care is a reality that too many Native families face. Substance abuse, mental health challenges, economic instability, financial insecurity, and limited access to services continue to threaten the well-being of Native families, especially Native children. Tribes need the tools and resources to develop culturally based child centered trauma-informed care solutions including trained child therapists. Title IV B provides funding to Tribes to support community-based child welfare services. Tribal tradition and cul-

ture are an integral component of our child welfare programs because it has been proven that culturally tailored programs and services increase community participation and lead to better outcomes for American Indian and Alaska Native (AI/AN) children and families. Increased funding coupled with maximum flexibility to use these funds to provide ancillary child welfare services, including, parenting classes, conducting home visits, and addressing issues, such as, alcohol and substance abuse is essential so that AI/AN children can remain with their families and in their Tribal communities.

2. Promoting Safe and Stable Families \$650 million for mandatory programs and \$120 million for discretionary programs.—Increase funding for the Promoting Safe and Stable Families program so that more Tribes are able to access this critical funding. Addressing trauma, promoting stronger families, and reducing the rates of foster care placements are all important components of this program. We appreciate the Administration's FY 2023 request for increased mandatory funding to support this program. We recommend that the programmatic increases include \$650 million for mandatory programs and \$120 million for discretionary programs.

3. Fund Long Term Care.—Tribes are committed to ensuring that elders receive the respect, resources and care that they deserve; however, funding for elder programs is woefully inadequate to meet existing and future needs. Finding facilities to house our elders is a growing issue because many are cost prohibitive for both the elders and Tribal governments. Tribes want to keep elders on their homelands and in their homes so that they are close to their families and communities. Staying connected to their families, Tribal communities and cultures supports quality of life. In order to accomplish this we need resources to support assisted living, long term care, home and community based services and end of life hospice care. The Indian Healthcare Improvement Act (IHClA) grants the Indian Health Service authorities for the provision of long term care but funding needs to be appropriated to provide these services.

4. Older Americans Act Title VI, Part A, B Native American Nutrition and Supportive Services—\$55.5 million Title VI, \$43 Million Nutrition and Support Services.—Providing support services to our elders is deeply rooted in our beliefs and ensures the survival of our culture, traditions, and language. Title VI of the Older Americans Act is the primary funding source for the provision of nutrition, healthcare, and other holistic community-based cultural programs and supportive services. However, funding for elder programs is woefully inadequate to meet existing and growing needs. The Indian Healthcare Improvement Act (IHClA) authorized the Secretary of HHS to fund these services but, to date, no funding has been appropriated for these services.

The Jamestown S'Klallam Tribe continues to support the requests and recommendations of the Northwest Portland Area Indian Health Board, the National Indian Health Board, and the National Congress of American Indians. Thank you.

[This statement was submitted by Hon. W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe.]

PREPARED STATEMENT OF JOHNSON & JOHNSON

On behalf of Johnson & Johnson's 144,000 global employees, I am pleased to provide written testimony to the Senate Appropriations subcommittee on Labor, Health and Human Services, Education and Related Agencies in support of increased funding for the National Institutes of Health (NIH) Fiscal Year (FY) 2023 budget.

Robust funding for NIH is necessary to ensure the agency continues to have the ability to fuel innovation in medical research, improving the trajectory of healthcare in the United States and around the world. NIH funding also encourages the pursuit of innovative solutions essential in addressing the increasingly complex health threats confronting the United States.

As a physician and scientist, I have dedicated much of my life to translating basic scientific research into medical advances. In my role as Executive Vice President, Chief External Innovation, Medical Safety and Global Public Health Officer at Johnson & Johnson and as a board member of the American Association for Cancer Research, I am deeply aware of the value of our Nation's investment in research.

In the United States, the majority of medical research into the root causes of disease is publicly funded by the NIH through research grants to more than 2,500 institutions across the country. The foundational research conducted by NIH-funded investigators plays an important complementary role to private sector research and development efforts. Specifically, healthcare companies build upon this foundational research, and make substantial investments in R&D to transform this foundational research into the breakthrough healthcare products of tomorrow.

At Johnson & Johnson, we make a commitment to create life-enhancing innovations and to produce value through partnerships that will profoundly change the trajectory of health for humanity. To that end, in 2021, Johnson & Johnson invested nearly \$14.7 billion in research and development across our pharmaceutical, consumer, and medical technology companies. Our teams of scientists work tirelessly to accelerate the translation of scientific discoveries into meaningful solutions for patients and consumers. Much of our work, and that of scientists across the industry, is facilitated by our understanding of underlying disease biology—precisely the type of research funded by the NIH.

In addition, Johnson & Johnson recognizes the crucial importance of early-stage companies, and the critical role NIH plays in supporting these small businesses through Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) funding. Through Johnson & Johnson Innovation, entrepreneurs and startups can discuss the innovative ideas they're working on, seek to collaborate with Johnson & Johnson scientists, and access our global expertise and resources to accelerate their work. Through Johnson & Johnson Innovation—Johnson & Johnson Development Corporation, they may obtain venture capital funding to support their innovations. At Johnson & Johnson Innovation—JLABS incubator sites—including a new JLABS @ Washington DC site in collaboration with Children's National and BARDA—we support the life sciences ecosystem by helping entrepreneurs and scientists realize their dreams of creating healthcare solutions that improve lives. Their potentially disruptive, cutting-edge research may lead to novel platforms, products or technologies—advances that the scientific community could only imagine several years ago and that are becoming a reality today through the support of public-private partnerships like these.

The work of the NIH is tied not only to innovation and the vitality of the life sciences, but also to the health of our National economy and to the health of our Nation. In FY 2021, NIH research funding directly and indirectly supported over 552,444 jobs and spurred nearly \$94.18 billion in new economic activity. Moreover, diseases such as Alzheimer's, diabetes, cancer, and heart disease as well as current and future pandemics, threaten the lives of millions of our citizens and threaten to overwhelm our healthcare system in a matter of years, with enormous costs of care if we do not find ways to prevent, intercept, treat, and cure them. We must also continue to address public health crises and areas of pipeline need such as emerging infectious diseases and antimicrobial resistance. The pace of medical research must keep up with these challenges, and it is the NIH that must fuel that research.

Investments in medical research over the last several decades by the Federal Government and private life sciences companies, combined with the work of industry and NIH-funded investigators across the country, have produced fundamental scientific advances and increasingly sophisticated areas of scientific inquiry. As the NIH is working on projects in areas like precision medicine, gene therapy, and vaccines to prevent infectious diseases, there has never been a more critical and promising time to work in medical research, nor a more critical time to fund the NIH.

Johnson & Johnson believes that fully and consistently funding the NIH is critical to a commitment to fueling innovation in medical research. It is also a commitment to our communities by advancing science to match medical need, to our current and future generations of scientists by stimulating the life sciences ecosystem, and to the prosperity of our Nation as a worldwide leader in medical research. Sustainable, robust investment is needed to strengthen this research and to realize its benefits for improving people's lives and reducing the burden and associated costs of disease in the United States and around the world.

[This statement was submitted by William N. Hait, MD, PhD, Executive Vice President, Chief External Innovation, Medical Safety and Global Public.]

PREPARED STATEMENT OF KNOWLEDGE ALLIANCE

Knowledge Alliance (KA), a non-partisan, non-profit organization, is comprised of leading education organizations committed since 1971 to the greater use of high-quality and relevant data, research, evaluation and innovation in education policy and practice at all levels. Collectively, we have spent the last 50 years supporting a set of education programs focused on building and disseminating evidence to improve teaching and learning in our Nation's classrooms.

Knowledge Alliance believes that programs at the Institute of Education Sciences (IES)—such as the Regional Educational Laboratories (RELs) and the Research, Development, and Dissemination (RD&D) program—coupled with the Comprehensive Centers (CCs) and the Education Innovation and Research (EIR) program at the U.S. Department of Education (ED) are the foundation of the Nation's research, dis-

semination and technical assistance infrastructure. We deeply appreciate the increases in funding provided in Fiscal Year (FY) 22 for these critical programs to better tie evidence to practice in our schools and improve outcomes for students. Moreover, we know these funds will be critical in supporting schools as districts utilize evidence-based practices in their responses to COVID-19 learning loss and the other additional educational challenges posed by this transitional year, especially for student populations who have been historically underserved and were significantly impacted by the pandemic. We encourage Congress to continue to provide increases in each of these programs for FY23 to continue leveraging critical research, technical assistance, evaluation and innovation to help States, districts and schools.

KA priority programs require additional Federal resources to address the continuously growing State and local needs for education research and technical assistance, as these programs provide critical support for States, districts and schools. In response to challenges from COVID-19, REL West and Comprehensive Center Regions 2, 13 and 15 provided 8 workshops to approximately 570 state, regional, district and school staff on selecting and measuring evidence-based strategies using American Rescue Plan (ARP) funds. The primary focus of each event was to help State educational agencies (SEAs) develop strategies to support local educational agencies (LEAs) in using their ARP funds to address high-priority needs and select evidenced-based strategies. More recently, the National Comprehensive Center established three Communities of Practice (COP) to support SEAs and their partners in three areas: (1) Using ARP funds to implement evidence-based strategies; (2) Implementing school improvement strategies through an equity lens; and (3) Planning for summer/extended learning drawing from evidence-based practices where they exist. With recognition that States and districts can, and should, work together to solve common challenges, the National Comprehensive Center provides a unique space for SEAs and LEAs to learn from each other as they engage around specific problems of practice. In the COP around school improvement, SEA and LEA leaders have already reported how bringing together school leaders, teachers and districts in their community, through an equity lens, is inspiring new, innovative, approaches to help low-performing schools. Clearly, both RELs and CCs have been first in line to provide technical assistance and evidence-based resources to interested SEAs and LEAs. An increase in funding would allow these programs to expand their work and better meet the ever-growing need for support.

Despite the evident need for education research, dissemination and technical assistance infrastructure, evidence shows that this work remains underfunded. Three recently released reports by the National Academies of Sciences, Engineering and Medicine (NASEM) noted that IES is currently overburdened and underfunded, preventing efficient grant review cycles, adequate staffing levels and innovation within the agency. In the NASEM report titled “The Future of Education Research at IES,” there was consensus that “Congress should re-examine the IES budget, which does not appear to be on par with that of other scientific funding agencies.” The report notes that education research programs at the National Science Foundation (NSF) and National Institutes of Health (NIH) receive substantially more funds than IES despite working with similar constituents on comparable issues. Moreover, as the hub of all Federal education research work, IES is best situated to effectively create and disseminate evidence-based resources to the field. It is evident that KA’s priority programs require increases in FY23 to better meet the needs of States, districts, and schools nationwide.

To support continued education research, evaluation and innovation outlined above, we urge you to provide increases over FY22 levels in FY23 for existing Federal research and development infrastructure. KA proposes a critical investment of \$815.0 million for the Institute of Education Sciences (IES); \$267.9 million for the Research Development and Dissemination (RD&D) program at IES; \$65.0 million for the Regional Educational Laboratories (RELs) Program; \$60.0 million for the Comprehensive Centers (CCs); and \$514.0 million for the Education Innovation and Research (EIR) program.

This request translates to approximately a 10 percent increase for IES, RELs and CCs. We have requested an approximately 30 percent increase for RD&D to account for how, as the hub of general education research, it will be relied heavily upon to support research post-COVID. Finally, KA’s EIR request matches the President’s FY23 budget, which recognizes the importance of education research innovation and proposes a significant investment in addressing the educator shortage, an issue KA members are actively working on.

The below section provides greater detail on the request for each of the programs outlined above. Thank you for your consideration of these important recommendations. We believe that continued strong support for, and investment in, the education research and development infrastructure will help improve outcomes for stu-

dents and effectively leverage scarce Federal resources. Furthermore, it will empower States and local school districts to develop and implement the innovative, evidence-based approaches that work best for the students in their communities.

FY23 APPROPRIATIONS ASKS

The Institute of Education Sciences. IES is a major source of Federal funding for education research. Through its four research centers- the National Center for Education Research (NCER), National Center for Education Statistics (NCES), National Center for Education Evaluation and Regional Assistance (NCEE) and the National Center for Special Education Research (NCSE) -IES funds hundreds of grants and contracts annually that support a wide range of research projects. These centers support projects that provide vital information, often with an equity focus, on students with disabilities, teacher preparation and strategies for improving college and workforce readiness, among other topics. In the past year, IES has successfully pivoted its efforts to consider projects in the larger context of the COVID-19 pandemic and recovery.

The What Works Clearinghouse produces reviews of research on education curriculum and practice guides with evidence-based recommendations to support teaching and learning. According to the Jefferson Education Exchange, nearly a third of educators surveyed used resources from the What Works Clearinghouse. In direct response to the COVID-19 pandemic, the What Works Clearinghouse released a Rapid Evidence Review of Distance Learning Programs that identifies and reports on what works in distance learning educational programming from Kindergarten onwards. Additionally, the WWC provides educational webinars to better disseminate research in the field, most recently they held a webinar on providing reading interventions for students in grades 4-9.

Additional basic research could be done in areas of importance to educators and policymakers if more funding were available, particularly in the areas of postsecondary completion and workplace credentials. As basic research moves into the applied realm, the What Works Clearinghouse will continue to serve as a resource for educators looking for effective, research-based interventions.

Regional Educational Laboratories. The 10 RELs nationwide, which operate under 5-year contracts with ED, conduct applied research, develop and disseminate research-based products and provide training to States and school district staff as well as resources for educators, families and caregivers. Since the RELs have a broad set of regional stakeholders that extend beyond the SEA, they are well-attuned to a wider range of student and teacher needs. In addition to forming research partnerships focused on problems of practice in the field that provide relevant and responsive research and findings that address local needs; RELs utilize the resources of the WWC, such as the practice guides, to break down the evidence into digestible chunks for educator use. They have also developed webinars and other resources based on the practice guides to aide in translating research for educators. RELs are continuously developing tools that districts and schools use to improve teaching and learning. In response to the pandemic, RELs have provided evidence-based resources to help address a host of critical challenges facing States, districts, educators and families as they continue to navigate the impacts of COVID-19.

Education leaders in Michigan partnered with REL Midwest to develop the Midwest Alliance to Improve Teacher Preparation (MAITP). From 2017 to 2021, MAITP conducted research with education leaders, practitioners, policymakers and researchers in Michigan, Illinois and Indiana to address teacher recruitment and retention.

To increase the number of teachers available to Michigan public schools, MAITP members wanted to explore the validity of recruiting nonteaching certified teachers. In 2021, REL Midwest published a study that examined why some certified teachers no longer teach in Michigan public schools. The study found approximately 61,000 teachers certified in Michigan were not teaching in the State's public schools in 2017-18. The study also identified increased salary and simplification of certification requirements as desired incentives for teachers to consider returning to the classroom. REL Midwest created a companion infographic and documentary to communicate the study findings. The Michigan Department of Education drew on the findings and launched the "Welcome Back Proud Michigan Educator Campaign," an initiative that seeks to recruit individuals with expired teacher certificates into the teacher workforce by reducing-and in some cases, eliminating-professional learning requirements for recertification.

Education Innovation and Research. The EIR Program, authorized by Every Student Succeeds Act (ESSA), helps drive substantial and lasting improvements in student achievement by supporting the development and scale-up of successful innova-

tions at the State and local levels. EIR uses a tiered evidence approach that has two important design principles: it provides more funds to programs with higher levels of evidence, and it requires rigorous and independent evaluations so that programs continue to improve, and future competitions can be geared towards more promising areas of investment.

KA supports the Administration's FY23 EIR proposal which recommends a historic, and needed, increase in funding for the program. EIR would allow for the creation of more innovative evidence-based resources to address the myriad of educational challenges facing the Nation. Of this historic increase, \$350 million would target projects that identify and scale up evidence-based strategies to elevate and strengthen a teacher workforce hit hard by COVID-19. Given the educator workforce shortage, KA supports the use of these funds to support efforts to stabilize the profession through improved support for educators and expanded professional growth opportunities, including access to leadership opportunities that can lead to increased pay and improved retention for fully certified, experienced, and effective teachers.

Future Forward is a literacy intervention for students struggling with reading from kindergarten through third grade that combines intensive one-on-one tutoring during the school day with family engagement support embedded in all aspects of the program. Ongoing support from the U.S. Department of Education through the Education Innovation and Research (EIR) grant program has allowed Future Forward to rigorously evaluate their program with randomized controlled trials and multi-site regression discontinuity analysis. The external evaluation found the program yielded positive, statistically significant impacts on reading achievement, literacy, and regular school attendance. The EIR program has enabled Future Forward to subsequently sustain, replicate and scale those practices. In December of 2021, Future Forward was awarded an expansion-phase EIR grant and will work over the next 5 years to expand to several dozen new schools in rural communities across the country; prepare schools to take full ownership over long-term program implementation to ensure sustainability; and rebuild the online program management platform to become a first of its kind integrated reporting system for supplemental education programs. Future Forward was the recipient of a mid-phase EIR grant in 2017 (the program was known as "SPARK") as well as an Investing in Education (i3) grant in 2010.

Comprehensive Centers. The Comprehensive Centers (CCs) provide technical assistance that builds the capacity of SEAs to help districts and schools improve educational outcomes for all students, close achievement gaps and increase the quality of instruction. The CCs include 19 Regional Centers that work closely with States in their regions on implementation of critical reforms in elementary and secondary education, as well as one national center providing technical assistance to the regional centers and SEAs. The CCs operate under a Memorandum of Understanding with each SEA in the region, and the SEA sets the scope of work to be conducted through the 5-year agreement.

In 2021, the National Comprehensive Center and national partners launched the Summer Learning & Enrichment Collaborative ("the Collaborative") to support States, school districts and community partners in using ARP funds to implement and expand evidence-based summer learning and enrichment experiences for students, especially those most impacted by the pandemic. Throughout the summer of 2021, the Collaborative invited States, school districts, community partners, and other stakeholders to participate in a series of eight virtual learning opportunities to discuss and share promising practices in planning and implementing summer experiences for all students and student groups.

The Collaborative hosted over 50 topical sessions for over 1,300 participants across 49 States. Sessions addressed a wide range of topics from staff recruitment to student attendance, STEM partnerships, developing community-school agreements and many more.

PREPARED STATEMENT OF THE LEARNING AND EDUCATION ACADEMIC
RESEARCH NETWORK

We are writing on behalf of the LEARN Coalition to express our support for increased funding for several key education research programs that the LHHS subcommittee will debate as part of the Fiscal Year (FY) 2023 appropriations process. LEARN, a coalition of 41 leading research colleges of education across the country, supports critical investments in research aimed at advancing the scientific understanding of learning and development. We advocate for greater funding for these priorities across all Federal agencies, including the Institute of Education Sciences

(IES), the National Institute of Child Health and Human Development (NICHD), and the National Institute of Mental Health (NIMH). Specifically, LEARN is requesting no less than \$815 million for IES overall with \$225 million dedicated to the Research, Development and Dissemination (RD&D) line item and \$70 million for the National Center for Special Education Research (NCSE). Within the National Institutes of Health (NIH), LEARN requests that \$2.02 billion go towards NICHD and \$2.57 billion go towards NIMH. While advocating for these increased resources for fiscal year 2023, we want to express our appreciation for the increases for IES and NIH that were made in fiscal year 2022.

INSTITUTE OF EDUCATION SCIENCES

As the primary Federal agency charged with supporting research for education practice and policy, IES is essential to developing a comprehensive, reliable, evidence base and ensuring that teaching and learning practices are grounded in this evidence base. While 12–15 percent of NCER and NCSE's grant awards have been funded over the last several years, the number of grant competitions offered by IES are currently severely limited due to chronic understaffing within the agency. Furthermore, NCSE was unable to fund all the grant applications rated outstanding or excellent in fiscal year 2021 due to a lack of sufficient funds. Such evidence displays how IES is currently too understaffed and underfunded to support the Nation's education infrastructure to its best potential.

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. The increases provided to IES will support the continued examination of what works and what does not work to further our education system's curricula, instructional techniques and assessments. This additional funding will bolster IES' work in relation to education research overall as well as provide support as the Nation works towards COVID–19 recovery. Given the importance of developing reliable evidence during this critical time, LEARN is requesting \$815 million for IES overall and \$225 million for the RD&D line item within IES.

In addition, we recommend that funding for research in special education, through NCSE, be increased to \$70 million. NCSE 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 NCSE provides special educators and administrators evidence-based resources that improve academic outcomes for children with or at risk of disabilities. Special education students were dramatically impacted by the change in schooling due to COVID–19; additional funding to NCSE is necessary to support data and evidence-based resources that will ensure a strong recovery for these students.

Of note, prominent experts have expressed concern over the relatively small amount of funding being provided to IES compared to other Federal research agencies. In a 2022 National Academy of Sciences, Engineering and Medicine (NASEM) report titled "The Future of Education Research at IES," a diverse panel of 17 experts in the field came to consensus that Congress should re-examine the IES budget as it is currently severely underfunded despite the continuously expanding work of IES. After hours of research and discussion, the panel recognized that IES funding "does not appear to be on par with that of other scientific funding agencies," such as NIH or NSF, despite being charged to lead the Nation's education research agenda, collect and evaluate education research and disseminate evidence-based resources to classrooms nationwide. In alignment with this trusted outside evaluation, LEARN urges Congress to provide much needed fiscal support to IES by appropriating no less than \$815 million to the agency overall, \$225 million to the RD&D line item and \$70 million to NCSE.

NATIONAL INSTITUTES OF HEALTH

There are critical education research programs within the 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 \$2.02 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 long-term effects of COVID–19 on key at-risk populations, including the cognitive development of children and adolescents.

LEARN also supports an increase in funding for NIMH to \$2.57 billion. This increase will help further understanding of the behavioral, biological and environmental mechanisms necessary for developing interventions to reduce the burden of mental and behavioral disorders and optimize learning and development. At a time when the mental health impact to children and adolescents remains dire following the COVID-19 pandemic, this research is needed more now than ever.

The LEARN Coalition believes that collectively these key investments in education research will drive improvements in school, teacher and student performance in the coming years, strengthen the Nation's education infrastructure and ensure a strong, educated workforce in the long run. Thank you for considering these requests and please contact Alex Nock at anock@pennhillgroup.com with any questions, comments or concerns.

Sincerely,

Camilla P. Benbow, Ed.D., Co-Chair, Learning and Education Academic Research Network (LEARN)

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 (LEARN), Dean of the School of Education, University of Kansas

Glenn E. Good, Ph.D., Co-Chair, Learning and Education Academic Research Network (LEARN), Dean of the College of Education, University of Florida

PREPARED STATEMENT OF THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

The Low Income Home Energy Assistance Program authorized by 42 U.S.C. §§ 8621 et seq. (LIHEAP) is the cornerstone of government efforts to help needy seniors and families stay warm and avoid hypothermia in the winter, as well as stay cool and avoid heat stress (even death) in the summer. LIHEAP is an important safety net program for low-income unemployed and underemployed families struggling in this economy. LIHEAP helped approximately 6 million households afford their energy bills in FY 2019.¹ This crucial safety net program protects the health and well-being of low-income seniors, consumers with disabilities, and families with very young children. We respectfully request that LIHEAP be funded at no less than \$5.1 billion² for FY 2023 and an additional \$500 million in emergency contingency funding.³

The Urgent Need for Adequate LIHEAP Appropriations

Funding LIHEAP at no less than \$5.1 billion for the regular program in FY 2023 and an additional \$500 million in emergency contingency funding is imperative to address the record increases in energy prices⁴ coupled with the record increases in the cost of other essential necessities such as food and shelter⁵—price increases that hit the lower wealth households the hardest. The U.S. Bureau of Labor Statistics Consumer Price Index for April 2022 shows an 80.5 percent 12-month increase in the cost of fuel oil, an 11 percent increase for electricity service and an 22.7 percent increase for natural gas. These 12-month increases in energy costs have been amongst the highest increases in decades.⁶ Similarly the 12-month increase in the cost of food and shelter are also the highest increases in decades. Low-income households cannot escape these price increases. They are driving untenable choices between basic necessities.⁷

Moreover, as moratoriums on disconnections of utility service during COVID have ended, utility disconnections are at record high levels in many parts of the country.

¹ Testimony of the National Energy Assistance Directors' Association, House subcommittee on Labor, Health and Human Services and Education and Related Agencies (April 8, 2019).

² 42 U.S.C. § 8621(b).

³ 42 U.S.C. § 8621(e).

⁴ See U.S. Bureau of Labor Statistics, News Release, Consumer Price Index—April 2022 (May 11, 2022), available at <https://www.bls.gov/news.release/cpi.nr0.htm> (hereafter, "May 11, 2022 CPI Release"); Ivan Penn, "Get Ready for Another Energy Price Spike: High Electric Bills" (rates have jumped because of a surge in natural gas prices and could rise rapidly for years) (May 3, 2022), available at <https://www.nytimes.com/2022/05/03/business/energy-environment/high-electric-bills-summer.html>.

⁵ Fn. 5, May 11, 2022 CPI Release.

⁶ Fn. 5, May 11, 2022 CPI Release; NEADA, "Energy Inflation Hits Lowest Income Families Hardest" (April 12, 2022), available at <https://neada.org/energyinflationpr/>.

⁷ See e.g., Christine Stephenson, "Duke Energy, CenterPoint bills are spiking in Bloomington," The Herald Times (Feb. 22, 2022), available at <https://www.heraldtimesonline.com/story/news/local/2022/02/22/duke-energy-bills-spiking-bloomington-monroe-county/6882306001/>.

The need for substantial LIHEAP funding is greater than ever. One market analysis conservatively estimates that while utility sector bad debt had declined to an average annual rate of 2.9 percent (\$2.5 billion total) between 2000–2019, in 2020 utility bad debt jumped to \$5.2 billion.⁸ LIHEAP helps households at risk of energy disconnections due to non-payment remain connected to essential home energy and avoid choosing between energy bills and rent or food.⁹ For very poor, struggling households, LIHEAP helps bring the cost of these essential heating and cooling services within reach for an estimated 6 million low-income households and helps them stay connected.

Energy bills are not affordable for struggling, low-income households. The average LIHEAP household in 2015 devoted over 8 percent of total household income just for home energy services, compared to an average of under 4 percent for all U.S. households. Home energy is also more expensive during prolonged periods of extreme temperatures because households use more fuel to keep the home at safe temperatures. Prolonged colder than normal temperatures, such as the sharp cold wave that resulted in 22 deaths and affected a wide swath of the country January to March 2019,¹⁰ can result in an unexpected, increased use of heating fuels. Likewise, prolonged hot temperatures, which are becoming more common, can result in an increased need for air conditioning, particularly for consumers with certain medical conditions.¹¹

Yet, struggling low-income households are at risk of disconnection from essential utilities because they do not have the savings or income on hand to afford their energy bills. The Federal Reserve finds that 4 in 10 households report that they would have difficulty with an unexpected expense of \$400 and that 3 in 10 households are either unable to pay their bills or are a modest financial setback from hardship.¹² A growing body of research is documenting the rise in household income volatility (the dramatic fluctuation of income over time) and the impacts on household well-being.¹³ Approximately one-third of households experience income volatility¹⁴ and irregular work schedules were the leading cause of volatility.¹⁵ When income is hard to predict, paying for necessities such as utility service can be difficult, if not impossible, without help from programs like LIHEAP. Households experiencing income volatility tend to turn to more expensive alternative financial services products such

⁸ Kaulkin Ginsburg, “The Kaulkin Report 2022 Ed.” Kaulkin Ginsburg Co. at page 36; NEADA Press Release, “Families are Drowning in Utility Debt: NEADA Calls for Additional Funding for Energy Assistance” (April 26, 2022) (estimated utility arrearages increased to \$23 billion at the end of 2019; 20.1 million households had utility debt), available at <https://neada.org/wp-content/uploads/2022/04/utilitydebtpr4-26.pdf>.

⁹ See e.g., Tami Luhby, “Utility Shutoffs Loom as Energy Prices Soar and Moratoriums End, But Help Is Available” (April 24, 2022), available at https://www.abc12.com/news/national/utility-shut-offs-loom-as-energy-prices-soar-and-moratoriums-end-but-help-is-available/article_85b1942f-1f6d-5799-8278-cbf8bf303f79.html; Mark Wolfe, “Opinion: Struggling US Families Face a Wave of Power Shutoffs if Congress Doesn’t Act” (updated April 28, 2022), available at <https://www.cnn.com/2022/04/28/perspectives/utility-bills-power-shutoffs/index.html>.

¹⁰ See e.g., “Extreme cold in the Midwest led to high power demand and record natural gas demand,” US Energy Information Administration, Today in Energy (Feb. 26, 2019) available at <https://www.eia.gov/todayinenergy/detail.php?id=38472>.

¹¹ Lynne Page Snyder and Christopher Baker, *Affordable Home Energy and Health: Making the Connections*, AARP Public Policy Institute (June 2010) at pp.10–11, available at <https://www.aarp.org/money/low-income-assistance/info-06-2010/2010-05-consumer.html>.

¹² Board of Governors of the Federal Reserve, *Report on the Economic Well-Being of U.S. Households in 2018* (May 2019) at p.21, available at <https://www.federalreserve.gov/consumerscommunities/files/2018-report-economic-well-being-us-households-201905.pdf>.

¹³ See e.g., Federal Reserve Survey of Household Economics and Decisionmaking reports available at <https://www.federalreserve.gov/consumerscommunities/shed.htm>; The Aspen Institute Expanding Prosperity Impact Collaborative (EPIC) series on the issue of income volatility available at <http://www.aspenepic.org/epic-issues/income-volatility/>; Pew Charitable Trusts, *How Income Volatility Interacts with American Families: Financial Security* (March 9, 2017) available at <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>.

¹⁴ Daniel Schneider and Kristen Harknett, *Income Volatility in the Service Sector: Contours, Causes, and Consequences* (July 2017) at p.3, available at <http://www.aspenepic.org/epic-issues/income-volatility/issue-briefs-what-we-know/issue-brief-income-volatility-service-sector/>; Board of Governors of the Federal Reserve, *Report on the Economic Well-Being of U.S. Households in 2018* (May 2019) at p.2, available at <https://www.federalreserve.gov/consumerscommunities/files/2018-report-economic-well-being-us-households-201905.pdf>.

¹⁵ *Income Volatility: A Primer* (May 1, 2016) The Aspen Institute Financial Security Program and EPIC at p.5, available at <https://www.aspeninstitute.org/publications/income-volatility-a-primer/>; Daniel Schneider and Kristen Harknett, *Income Volatility in the Service Sector: Contours, Causes and Consequences* (July 2017) at p.3, available at <http://www.aspenepic.org/epic-issues/income-volatility/issue-briefs-what-we-know/issue-brief-income-volatility-service-sector/>.

as payday loans.¹⁶ Low and moderate income consumers who experience income volatility have much higher rates of skipped bills, skipped medical care, skipped housing payments and food insecurity.¹⁷

LIHEAP protects the health of the frail elderly, the very young and those with chronic health conditions, all of whom are highly susceptible to temperature extremes. LIHEAP also helps keep families together by keeping homes habitable during cold winters and sweltering summers.

LIHEAP Is a Critical Safety Net Program for the Elderly, the Disabled and Households with Young Children

Recent national studies have documented the dire choices low-income households face when energy bills are unaffordable. Because adequate heating and cooling are tied to the habitability of the home, low-income families will go to great lengths to pay their energy bills. According to the US Energy Information Agency (EIA), one in three households face challenges meeting energy needs, with over 20 percent forgoing basic necessities to pay their energy bills, over 10 percent report keeping their home at unsafe temperatures and almost 15 percent received a disconnection notice.¹⁸ EIA's analysis is consistent with other studies showing that low-income households faced with unaffordable energy bills cut back on necessities such as food, medicine and medical care.¹⁹ The U.S. Department of Agriculture has documented the connection between low-income households, especially those with elderly persons, experiencing very low food security and heating and cooling seasons when energy bills are high.²⁰ A pediatric study in Boston documented an increase in the number of extremely low weight children, age 6 to 24 months, in the 3 months following the coldest months, when compared to the rest of the year.²¹ It is shocking that in this wealthy nation, so many face heat-or-eat choices where families go without food during the winter to pay their heating bills, and their children fail to thrive and grow. A 2007 Colorado study found that the second leading cause of homelessness for families with children is the inability to pay for home energy.²²

When people are unable to afford paying their home energy bills, dangerous and even fatal results occur. In the winter, families resort to using unsafe heating sources such as space heaters, ovens and burners, all of which are fire hazards. Space heaters pose 3 to 4 times more risk for fire and 18 to 25 times more risk for death than central heating. In 2007, space heaters accounted for 17 percent of home fires and 20 percent of home fire deaths.²³ In the summer, the inability to keep the home cool can be lethal, especially to seniors. According to the CDC, older adults, young children and persons with chronic medical conditions are particularly susceptible to heat-related illness and are at a high risk of heat-related death. The CDC reports that 3,442 deaths resulted from exposure to extreme heat during 1999–

¹⁶ Daniel Schneider and Kristen Harknett, *supra*, fn. 15, at p. 9, available at [http://www.aspenepic.org/epic-issues/income-volatility/issue-briefs-what-we-know/issue-brief-income-volatility-service-sector/\(almost+a+quarter+of+consumers+reporting+week-to-week+volatility+report+using+payday+lenders\)](http://www.aspenepic.org/epic-issues/income-volatility/issue-briefs-what-we-know/issue-brief-income-volatility-service-sector/(almost+a+quarter+of+consumers+reporting+week-to-week+volatility+report+using+payday+lenders)).

¹⁷ Stephen Roll, David S. Mitchell, Krista Holub et al., *Responses to and Repercussions from Income Volatility in Low- and Moderate-Income Households: Results from a National Survey*, Aspen Institute EPIC, Center for Social Development, Intuit Tax & Financial Center (Dec. 2–17) at pp 6–7, available at <https://www.aspeninstitute.org/publications/responses-repercussions-income-volatility-low-moderate-income-households-results-national-survey/>.

¹⁸ “One in three U.S. households faces a challenge in meeting energy needs,” US Energy Information Administration, *Today in Energy* (Sept. 19, 2018) available at <https://www.eia.gov/todayinenergy/detail.php?id=37072>.

¹⁹ See e.g., National Energy Assistance Directors' Association, 2018 National Energy Assistance Survey, Tables in section IV, F and G (Dec. 2018) (to pay their energy bills, 32 percent of LIHEAP recipients went without food, 41 percent went without medical or dental care, 31 percent did not fill or took less than the full dose of a prescribed medicine, 13 percent got a payday loan). Available at <http://neada.org/wp-content/uploads/2015/03/liheapsurvey2018.pdf>.

²⁰ Mark Nord and Linda S. Kantor, *Seasonal Variation in Food Insecurity Is Associated with Heating and Cooling Costs Among Low-Income Elderly Americans*, *The Journal of Nutrition*, 136 (Nov. 2006) 2939–2944.

²¹ Deborah A. Frank, MD et al., *Heat or Eat: The Low Income Home Energy Assistance Program and Nutritional and Health Risks Among Children Less Than 3 years of Age*, *AAP Pediatrics* v.118, no. 5 (Nov. 2006) e1293–e1302. See also, Child Health Impact Working Group, *Unhealthy Consequences: Energy Costs and Child Health: A Child Health Impact Assessment of Energy Costs And The Low Income Home Energy Assistance Program* (Boston: Nov. 2006).

²² Colorado Interagency Council on Homelessness, *Colorado Statewide Homeless Count Summer, 2006*, research conducted by University of Colorado at Denver and Health Sciences Center (Feb. 2007).

²³ John R. Hall, Jr., *Home Fires Involving Heating Equipment* (Jan. 2010) at ix and 33.

2003.²⁴ The CDC also notes that air-conditioning is the number one protective factor against heat-related illness and death.²⁵ LIHEAP assistance helps these vulnerable seniors, young children and medically vulnerable persons keep their homes at safe temperatures during the winter and summer and also funds low-income weatherization work to make homes more energy efficient.

LIHEAP is an efficient and effective targeted health and safety program that works to bring fuel costs within a manageable range for vulnerable low-income seniors, the disabled and families with young children. We respectfully request that LIHEAP be funded at no less than \$5.1 billion in FY 2023 and an additional \$500 million in emergency contingency funding.

[This statement was submitted by Olivia Wein, Staff Attorney, National Consumer Law Center.]

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 \$49 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 \$11 billion for FY 2022 and enable \$6 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 2023 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 through education, research, and advocacy. These include lymphedema, lipedema, lymphatic anomalies, and the continuum of lymphatic diseases. 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 million 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

²⁴ CDC, "Heat-Related Deaths—United States, 1999–2003" MMWR Weekly, July 28, 2006.

²⁵ CDC, "Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety" available at http://emergency.cdc.gov/disasters/extremeheat/heat_guide.asp.

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 2023 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 and other lymphatic diseases truly treatable. 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 \$49 billion for NIH in FY 2023.

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. We appreciate some steps that NIH is taking to address the subcommittee's and our concerns about the National Commission, but we still are not at the point where the Commission is set to begin key work. While we remain hopeful that our continued work with NIH will continue to pay off, strong support from Congress remains essential for our success.

LE&RN also joins the public health community in asking Congress to provide the Centers for Disease Control and Prevention (CDC) with \$11 billion through FY 2023 and to increase funding to increase awareness, education, and surveillance of lymphatic diseases. We encourage the subcommittee to support \$6 million for the Chronic Disease Education and Awareness Program in FY 2023 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 MARCH OF DIMES

MARCH OF DIMES: FISCAL YEAR 2023 FEDERAL FUNDING PRIORITIES	
PROGRAM	FISCAL YEAR 2022 REQUEST
National Institutes of Health (total)	\$49,000,000,000
National Institute of Child Health and Development	\$1,815,957,000
National Institute of Environmental Health Sciences	\$908,700,351
National Children's Study Alternative (ECHO)	\$180,000,000
Centers for Disease Control and Prevention (total)	\$11,000,000,000
National Center for Birth Defects and Developmental Disabilities	\$205,000,000
<i>Emerging Threats to Moms and Babies</i>	\$100,000,000
Section 317 Immunization Program	\$10,675,000,000
Newborn Screening Quality Assurance Program	\$29,000,000
Polio Eradication	\$441,000,000
Division of Reproductive Health	Set-aside funding under SMI
<i>Safe Motherhood Initiative</i>	\$164,000,000
<i>Preterm Birth</i>	\$2,000,000
<i>Perinatal Quality Collaboratives</i>	Set-aside funding under SMI
<i>Maternal Mortality Review Committees</i>	Set-aside funding under SMI
Office on Smoking and Health	\$310,000,000
National Center for Health Statistics	\$210,000,000
Health Resources and Services Administration (total)	\$9,800,000,000
Title V Maternal and Child Health Block Grant	\$1,000,000,000
Heritable Disorders	\$29,883,000
Healthy Start	\$145,000,000
Grants for Maternal Depression Screening and Treatment	\$11,500,000
Maternal Mental Health Hotline	\$7,000,000
Title X Family Planning Program	\$512,000,000
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) 2023 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 ongoing and demonstrated commitment to maternal health in his HHS budget proposal for FY 2023, 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 \$1.816 billion for NICHD's groundbreaking biomedical research activities in FY 2023. 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 (Public Law 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 28 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: PQC's are state or multistate networks working to improve the quality of obstetric care and improve outcomes. Currently, CDC funds 13 State-based PQC's that are implementing recommendations across health facility networks. However, many PQC's lack adequate resources to meet demands and reach their maximum potential. We request a specific funding level be set-aside under the \$164 million Safe Motherhood Initiative request to fully scale these programs in all States.

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 MMRC's. 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 a specific funding level be set-aside under the \$164 million Safe Motherhood Initiative request to reach all 50 States, DC, and Puerto Rico and Tribes with enhanced technical assistance to maximize MMRC's.

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 \$29 million for NSQAP and \$29.883 million for the Heritable Disorders program for FY23.

In addition, we request \$15 million under the CDC to support full implementation of the Recommended Uniform Screening Panel (RUSP) in all 50 States. These additional resources for timely implementation of newborn screening conditions with a goal of complete RUSP implementation nationwide by 2025.

Lastly, we request \$2 million under HRSA to support a newborn screening study. It would direct HHS to commission a study with the National Academy of Medicine (NAM) on uniform screening panel review and recommendation processes to identify factors that impact decisions to add new conditions to the uniform screening panel, to describe challenges posed by newly nominated conditions, including low-incidence diseases, late onset variants, and new treatments without long-term efficacy data.

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 \$11.5 million in fiscal Year 2023 to add five programs and provide technical assistance to non-grantee States.

Maternal Mental Health Hotline: We thank the Committee for funding \$4 million in FY22 to the new maternal mental health hotline launched by HRSA. 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 support President Biden's request of \$7 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 2023 (FY23) 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 longstanding leadership and support for the program. For 50 years, these programs have served as daily lifelines, providing hundreds of millions of meals and vital social connection to a growing number of older adults who rely on the OAA Nutrition Program to meet their basic needs. The critical role and significance of this bipartisan legislation have been made even more evident throughout the COVID-19 pandemic, in which local home-delivered and congregate programs continue to experience dramatic and sustained increases in the number of older adults who require nutrition and social support.

To sustain these proven and effective nutrition programs that reduce senior hunger and loneliness, improve health and well-being, and enable independence, appropriations increases are urgently needed in FY 2023. Accordingly, we are calling for a minimum of \$1,933,506,000 for the OAA Nutrition Program to be included in the final FY 2023 Labor, Health and Human Services, Education and Related Agencies (Labor-HHS-Ed) Appropriations bill. The specific line-item requests are:

- Congregate Nutrition Services (Title III–C–1)—\$965,342,000
- Home-Delivered Nutrition Services (Title III–C–2)—\$791,342,000
- Nutrition Services Incentive Program (NSIP) (Title III)—\$176,822,000

This FY23 request 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 COVID-19 health and economic crises, these nutrition programs are a lifeline for millions of older adults and the services they provide must flex to meet the need. We must not go backwards and instead invest more significantly in these cost-effective programs that allow individuals to age at home, with better health and independence, outside of costly healthcare facilities.

Overseen by ACL's Administration on Aging and implemented at the local level through thousands of community-based providers, the OAA Nutrition Program delivers nutritious meals, 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 five decades.

Nutrition is a crucial part of overall health, development, and quality of life and is fundamental to healthy aging. Older adults who are food insecure and lack consistent access to nutritious meals experience worse health outcomes and are at increased risk for heart disease, depression, diabetes and declines in cognitive function and mobility than those who are food secure.¹ Most older Americans possess at least one factor that puts them at greater risk of food insecurity, malnutrition, social isolation and/or loneliness, thereby increasing the likelihood of experiencing negative health effects. Despite the wide recognition of the relationship between healthy aging and access to nutritious food and regular socialization, millions of older adults were struggling to meet these basic needs even prior to the COVID-19 pandemic.

The reality of senior hunger today is sobering, and there are millions more older adults who need our help, but who we are not reaching today. We know in 2020, during the pandemic, over 9 million (12 percent) older adults 60+ were threatened by hunger—nearly 5.2 million (7 percent) of whom experienced low food security or very low food security. Nationwide, that is one in eight older adults struggling with hunger—and the fraction of seniors experiencing very low food security has increased almost 90 percent since 2001.² It has also been estimated that up to almost half of all older adults may be at risk of becoming or is already malnourished.³ Today, millions of seniors experience some degree of food insecurity and are forced to make choices about the foods they eat due to financial strain, and/or forgo eating properly to pay for utilities, rent and/or medication.

As greater awareness of food insecurity, social isolation and loneliness and their negative effects on physical and mental health have emerged since the COVID-19 pandemic, it is important to note that older adults in particular—especially those who were already homebound and/or living in rural areas—have long been at higher risk of these threats to healthy aging. Older adults have unique challenges maintaining community connections and accessing healthcare, which can be further compounded if one has physical limitations, lack of transportation, inadequate financial resources, and/or other obstacles to accessing resources.

Certain segments of the population experience a range of different challenges at disproportionately higher rates. As examples, older adults who are racial or ethnic minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+); living with disabilities or limited mobility; living in or near poverty; and in rural areas face systemic inequities that too often result in a lack of adequate resources and/or access to services they need to remain well in later life.

The OAA Nutrition Program is designed to reduce hunger, food insecurity and malnutrition, and promote socialization and the overall health and well-being of older adults. OAA services, including congregate and home-delivered meals, 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 institutional care.

The impact of these services on seniors' lives is powerful, and older adults who receive them have better health because of participating. Most seniors receiving OAA nutrition services consistently report that participating in the program helps them feel more secure, prevents falls or fear of falling, and allows them to stay in their own home.^{4,5} In turn, this helps avoid preventable emergency room visits, hos-

¹Ziliak and Gunderson, 2021, *The Health Consequences of Senior Hunger in the United States: Evidence from the 1999–2016 NHANES*, report prepared for Feeding America, available at www.feedingamerica.org/research/senior-hunger-research/senior.

²U.S. Census Bureau, 2020, *Current Population Survey (CPS) December Food Security Supplement*, dataset available at https://www.census.gov/data/datasets/time-series/demo/cps/cps-suppl_cps-repwgt/cps-food-security.html.

³Kaiser et al., 2010, "Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment", *Journal of the American Geriatrics Society* 58(9):1734–8, abstract available at <https://pubmed.ncbi.nlm.nih.gov/20863332/>.

⁴Administration for Community Living (ACL), 2019, *National Survey of OAA Participants*, available on ACL's AGID Custom Tables, available at <https://agid.acl.gov/>.

⁵Meals on Wheels America, 2015, *More Than a Meal Pilot Research Study*, report prepared by Thomas & Dosa, available at www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study.

pital admissions and readmissions, extended stays in rehab, and premature institutionalization—ultimately reducing our Nation's health care costs.

A rigorously designed study from 2015 found that older adults receiving home-delivered meals experienced statistically significant improvements in health than their counterparts who did not receive services. The group who received home-delivered meals and safety checks were more likely to have improved physical and mental health, including reduced feelings of anxiety and loneliness, and fewer hospital admissions and falls.⁶ On the ground, senior nutrition program staff and volunteers delivering meals can help identify and promptly notify caregivers and healthcare providers of a change in an older adult's condition so that necessary steps can be taken to address urgent and/or developing health conditions and medical needs, both physical and mental.

It is often through an older adult's need for nutrition services that they become aware of and connected to other services available in their communities. For many Meals on Wheels participants, staff and volunteers may be the only individual(s) she or he sees that day. Social connection is part of the Meals on Wheels model and can include intentional and additional face-to-face conversation during delivery or enhanced programming, like friendly visiting or telephone reassurance calls. Further, in-home safety services include a regular environmental safety check and established approach for addressing identified hazards, fall risks, and home modification needs. For example, Meals on Wheels programs helped refer and/or serve an estimated 18,000 older adults who needed home repairs in 2018, and 34 percent of programs report directly offering home repair and modification services.⁷

The power and importance of the OAA Nutrition Program was never more clear than during the COVID-19 pandemic. Practically overnight, the thousands of programs across the country faced an unprecedented surge in demand as the number of older adults sheltering in place increased and congregate centers shifted ways of operating. Programs quickly adapted traditionally their high-touch service model to continue safely offering senior clients critical, person-centered supports that go well beyond the meal itself.

Programs like Meals on Wheels were and continue to be pivotal to our Nation's pandemic response and recovery, and senior nutrition programs have been highly sought out for the trusted nutrition and social connections they offer. Despite the incredible response from the senior nutrition network to quickly scale services, challenges remain in addressing the demand. A survey of Meals on Wheels America membership last year found 97 percent of programs believe that there continues to be substantial unmet need in their communities and about 60 percent of programs reported that the major limitation to serving meals to all the seniors in their community who need them is funding to pay for the meals.⁸ The gap between those struggling with hunger and those receiving nutritious meals through the OAA will continue to widen across the country if not adequately addressed with the necessary support and investment from both public and private sources.

Even prior to the pandemic, Federal funding for aging services was not keeping pace with increasing demand, rising costs and inflation. Now, more than 2 years into this public health emergency, programs are continuing to deliver life-saving services at sustained high rates with ongoing and emerging challenges and uncertainties. Currently, 8 in 10 Meals on Wheels programs are still serving more home-delivered meals and clients than they were before COVID-19, and many of them are taking drastic steps to sustain their programs due to funding challenges. Some of these measures include but are not limited to adding seniors to waiting lists, discontinuing, or cutting back services. As of April 2022, 20 percent of Meals on Wheels programs reported adding clients to a waiting list. Most senior nutrition programs are currently facing at least one significant barrier, such as rising costs of inflation, food, and gas (necessities like beef and gas have been up 16 percent and 38 percent, respectively) or sustaining funding, and a third have reported that increased operating costs are requiring them to tap into reserve funding.⁹

Thanks to your leadership, ACL received emergency funding necessary to help address the significant needs presented by the pandemic. ACL and its programs have subsequently been able to reach new communities and people who have long needed services, such as meals, but were not receiving them. Senior nutrition programs na-

⁶ See footnote 5.

⁷ Meals on Wheels America, 2021, Membership Perspectives and Practices Survey, research conducted by Trailblazer Research (report in publication).

⁸ Meals on Wheels America, July 2021, 2021 Mid-year COVID-19 Pulse Survey, available at www.mealsonwheelsamerica.org/learn-more/research/covid-19-research-portfolio.

⁹ Meals on Wheels America, April 2022, Spring Member Pulse Survey, available at www.mealsonwheelsamerica.org/learn-more/research/covid-19-research-portfolio.

tionwide have expanded capacity, innovated operations, and shown that their services can literally be a matter of life and death. Now we are at a crossroads. Pandemic-level funding for these programs must be sustained. We must not go backwards.

We understand the difficult decisions you face with respect to annual appropriations bills and other budgetary challenges. However, the risks and benefits of healthy aging cannot be underestimated, both in social and economic costs. The requested appropriations increase will help provide the funding levels necessary for community-based nutrition programs to serve more older adults and sufficiently address the increased demand for services and help offset the higher operating costs they are experiencing.

In closing, as the subcommittee develops its FY23 Labor-HHS-Education appropriations bill, we urge you to fund programs that are critical to healthy aging, including \$1.934 billion for the OAA Nutrition Program, so that local community-based senior nutrition programs can ensure the health, safety and social connectedness of our Nation's older adults, build the capacity of ACL's 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 older adult in America is left hungry and isolated.

[This statement was submitted by Ellie Hollander, President and CEO, Meals on Wheels America.]

PREPARED STATEMENT OF METAVIVOR

FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- Please provide the National Institutes of Health (NIH) with an increase of at least a \$3.5 billion for FY 2023 to bring total agency funding up to a minimum of \$49 billion annually.
 - Please provide separate and distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would further support this promising effort without disrupting ongoing NIH efforts.
 - 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 \$5 million for a pilot program at CDC to modernize the Surveillance, Epidemiology, and End Results Research Program (SEER) Registry to better capture the experience of metastatic cancer patients.
-

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 2023 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 this commitment for FY 2023 by supporting innovative medical research, including the reinvigoration of the “moonshot” and by providing adequate resources for public health programs, including new funds to modernize the SEER registry (building on prior committee recommendations).

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.

ABOUT SEER MODERNIZATION FUNDING

As the saying goes, what gets measured, gets done. Currently, cancer registries do not capture data on metastatic recurrence or metastatic progression. There are many opportunities though to properly incorporate critical metastatic cancer information into cancer registries moving forward, including squeezing more out of current registry data, linking registries to data resources that can inform about recurrence or progression, and build the infrastructure necessary to systematically incor-

porate recurrence information into registries. For example, NCI is working to enhance reporting through pathology, radiology, and hospitals while several research teams are exploring algorithms that use administrative data to identify recurrence events. Currently these efforts are concentrated in areas in which information infrastructure exists to support them and are not yet nationally scalable. A key emerging conclusion is that there would be a tremendous value in “A Big Count” of breast cancer metastases on an ongoing basis. This would be achievable if States would develop scalable processes and invest the time and resources to do the counting and gather the data. This could incorporate the utilization of innovative tools developed by NCI or could be complementary to those efforts.

The community asks Congress to establish a \$5 million pilot program administered by CDC that can provide grants to a few meritorious States to develop and test local solutions to directly incorporate metastatic breast cancer recurrence and progression into current cancer surveillance activities. This would provide a handful of multi-year cooperative agreements to stakeholders at approximately \$250,000 annually. This modest investment would facilitate:

- The development of local information infrastructures to routinely count metastatic events at and after a cancer diagnosis;
- The creation of possibly the best MBC database in existence that researchers will want to access and will likely cite for decades to come;
- The ability to generate survival curves capturing the time to recurrence or metastasis after diagnosis overall and within different population subgroups;
- Key collaborations with NIH and CDC, including recommendations and best practices to advance systematic incorporation of this data moving forward.

[This statement was submitted by Jamil Rivers, Board Chair, METAvivor.]

PREPARED STATEMENT OF MICHELSON CENTER FOR PUBLIC POLICY

The Michelson Center for Public Policy (MCP) 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.

In year two of the COVID-19 pandemic, not only do lives continue to be lost but the U.S. economy continues to suffer as well. It is estimated that the COVID-19 pandemic will cost the U.S. economy more than \$16 trillion.¹ The NIH's fiscal year (FY) 2022 budget was less than 0.3 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. MCP urges the subcommittee to provide NIH with \$100 billion in base funding in FY 2023.

The Michelson Center for Public Policy (MCP) 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. MCP 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. MCP'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.

¹ <https://news.harvard.edu/gazette/story/2020/11/what-might-covid-cost-the-u-s-experts-eye-16-trillion/>.

MCCP is thankful for the strong bipartisan support that the subcommittee leaders, Chairwoman Patty Murray and Ranking Member Roy Blunt, have shown in providing the NIH with its seventh consecutive funding increase 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 \$49 billion in FY 2023, which includes \$4 billion for the Advanced Research Projects Agency for Health (ARPA-H). This is a good start, but it is not nearly enough. This is precisely the right time to be bold and go bigger. 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 NIH's base funding, 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.

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 2021, NIH invested \$35.73 billion, over 80 percent of its budget, in the biomedical research industry across the country. This investment supported more than 552,444 jobs nationwide and generated nearly \$94.18 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 U.S. economy—a 178-fold return on investment—and has paid for itself many times over in industry tax revenues returned to the government.³

MCCP is enthusiastic about the newly established Advanced Research Projects Agency for Health (ARPA-H) and the potential it has to 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. The research at ARPA-H must complement the work at the NIH, and not duplicate current research efforts at the NIH's Institutes and Centers. To have the largest impact on biomedical research, medicine, and healthcare, ARPA-H should focus on breakthrough technologies that are multi-disciplinary and operate across disease groups as well as focus on questions and topics that do not fit well within the confines of traditional biomedical research but may have clinical or commercial applications, something the NIH has historically been unable to do.

In addition, funding for ARPA-H should supplement, not supplant NIH's base budget funding. For ARPA-H to yield successful results with the most promise for transformative advances, NIH must receive adequate base funding to ensure breakthroughs in the same basic research that makes these transformative advances possible.

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 FY 2021, only one out of every five applicants was ultimately awarded NIH funding,⁴ 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.⁵ Furthermore, among early career researchers, women, parents, and those from underrepresented backgrounds in STEM bear a disproportionate amount of this burden. MCCP urges

² NIH's Role in Sustaining the U.S. Economy—2022 Update, https://unitedformedicalresearch.org/wp-content/uploads/2022/03/UMR_NIHs-Role-in-Sustaining-the-U.S.-Economy-FY21.pdf.

³ <https://www.nih.gov/about-nih/what-we-do/impact-nih-research/our-society>.

⁴ <https://report.nih.gov/nihdatabook/report/20>.

⁵ <https://nexus.od.nih.gov/all/2018/05/04/the-issue-that-keeps-us-awake-at-night/>.

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 10 percent of the agency's overall budget invested in the most promising young investigators conducting highly innovative research with truly transformative potential.

MCCP 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 \$100 billion in FY 2023. 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.

PREPARED STATEMENT OF THE MOREHOUSE SCHOOL OF MEDICINE
SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

Health Resources and Services Administration:

- \$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
- \$47.42 million for HRSA's Minority Centers of Excellence
- \$47.95 million for HRSA's Health Careers Opportunity Program.
- \$2 million for HRSA's Minority Faculty Loan Repayment Program.
- \$67 million for HRSA's Scholarships for Disadvantaged Students (SDS)
- \$67 million for HRSA's Area Health Education Center (AHEC) Program

Centers for Disease Control and Prevention

- \$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

National Institutes of Health

- \$49 billion for the National Institutes of Health
- \$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
- \$300 million for the Research Centers at Minority Institutions (RCMI)
- \$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
- \$100 million for NIH's Extramural Research Facilities program
- \$50 million to reinvigorate the NIMHD's Research Endowment Program (REP)

Office of the Secretary

- \$72 million for the Office of Minority Health at the Department of Health and Human Services.
- \$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

Department of Education

- \$100 million for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

Community Project Funding/Congressional Directed Spending Request (HRSA)

- \$950,000 request to continue the development of a Research and Academic Building on MSM's main campus (\$10 million total cost)
-

Chairwoman 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. Valerie Montgomery Rice, President, and Dean of Morehouse School of Medicine (MSM).

Morehouse School of Medicine was founded to address the disparities in health status and health care among vulnerable populations. Central to our mission is increasing the diversity and cultural competence of the health professional scientific workforce, addressing the primary health care, mental health and public health needs of underserved populations, as well as engaging in innovative research and

developing patient-centered programs aimed at advancing health equity in Georgia and across the Nation. This is a mission that we, and our Historically Black Colleges and Universities (HBCU) medical school colleagues, take seriously.

We are proud to be a one of the four institutions that comprise our Nation's HBCU medical schools. While each of our esteemed institutions brings something slightly different to the table, we all share one common goal: helping Americans achieve their optimal level of health. HBCU medical schools are distinguishable from our other institutional colleagues because health equity is at the core of everything we do. From the research opportunities that we engage in, to our prioritization of clinical continuity for underserved communities, to our commitment to providing access to trusted medical services for those who need it most, we have always existed to protect the most vulnerable amongst us.

We have learned valuable lessons over the past 2 years, and continue to respond the best we can to the pandemic, but we know that there is more work to be done. The country has now seen what MSM and other Historically Black Graduate Institutions (HBGIs) and HBCUs know and work towards everyday: the pitfalls and shortcomings of minority health. Our funding recommendations are robust and necessary given the discussion concerning the devastating effect of the pandemic on people of color and the need to address this effect for any future pandemic. To be as clear we can be, there must be more robust investment on minority health and disparities. To achieve this we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

Health disparities across racial and ethnic groups in the U. S. have been well documented over the last several decades and have remained remarkably persistent in spite of the changes in many facets of the society over that period. Moreover, the benefits of increasing diversity in the health professions to reduce such disparities have been studied at length, are based on empirical data, and are well understood by the medical community. Examples of these benefits include:

- Minority physicians are more likely to practice in medically underserved areas and care for patients regardless of their ability to pay.
- Minority physicians are more likely to choose primary care practices.
- Evidence suggests that improving cross-cultural communication between doctors and patients and providing patients with access to a diverse group of doctors improve adherence, satisfaction and health outcomes.
- There is evidence that the intellectual, cultural sensitivity, competency, and civic development of students is enhanced by learning in a diverse educational environment.
- A diverse health workforce encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities.

There is little left to discover or dispute with respect to the benefits of achieving greater racial and ethnic diversity of the Nation's health professionals—the attention has once again shifted to identifying the most effective and sustainable methods to do so. While there are many national campaigns underway to increase diversity in all medical and health professions schools particularly during this period of enrollment growth, it is imperative that we further recognize and leverage the public value of Historically Black Health Professions Schools.

The daunting news that Blacks Americans in the U.S. are disproportionately suffering and dying from COVID-19 unfortunately was not a tremendous surprise to those of us who regularly monitor and understand health status disparities in this nation. There are well-known health status challenges faced daily by Black Americans and minority health care providers, it also represents a surrogate for the glaring lack of health infrastructure in medically under-served communities. At MSM and other HBGI institutions, we have long been and remain committed to addressing these very same disparities in whatever way that we can, with an eye first and foremost towards the communities with the greatest need across our country.

Ironically, as a result of their mission focus the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions—with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors—these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability. Consequently, they are disproportionately dependent on the various Federal programs that support their core purpose.

Specifically, these programs include: the Title VII Health Professions Training Programs administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS); the Research Centers at Minority Institutions (RCMI), the Extramural Research Facilities; the Re-

search 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).

President Biden recently signed the John Lewis NIMHD Research Endowment Revitalization Act to revitalize this important initiative, and it is our expectation that NIMHD will act swiftly to reinvigorate the research endowment program so minority-serving institutions can participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Robust funding would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by communities of color, as well as other medically underserved populations. It would also help improve access to grants to fund research projects, as well as hire staff and provide scholarships for students who come from underserved communities. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program.

In addition to the recommendations referenced above, MSM has submitted a community project funding/congressionally directed spending request for continuing to develop a new academic and research facility that will provide critical support in the Institution's mission to improve and diversify the healthcare workforce. The recent growth in the size and diversity of the student body has not only made it necessary to train more healthcare professionals committed to underserved communities, but it also requires expanded space and resources on campus. More classrooms, lecture spaces, learning communities, research laboratories, and common spaces for knowledge sharing are all needed to meet the needs of a growing student body.

Madam Chair, unfortunately, over the past several years funding for diversity-focused programs has deteriorated in varying degrees. Absent a monumental overall investment the financial position and academic viability of historically black health professions schools will deteriorate rapidly. The front loaded investment in health professions training programs, graduate programs in biomedical sciences and public, and safety net providers is more cost effective than absorbing uncompensated care originating from minority and underserved communities. Now is the time for targeted investments in historically black health professions schools to ensure a steady pipeline of minority healthcare providers, biomedical scientists, and other health practitioners prepared to support and advance the delivery of high quality, culturally appropriate, evidence-based health care. Thank you all again for the opportunity to share the priorities of the Morehouse School of Medicine.

[This statement was submitted by Valerie Montgomery Rice, M.D., President and Dean, Morehouse School of Medicine.]

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 2023 report language for paid work-based learning 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 120,000 high school students in 35 States and territories. NAF is focused on helping to eliminate systemic, educational, and professional barriers, especially those faced by students of color.

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 teens 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.

Research shows that participation in work-based learning during high school has a positive impact on students, including completing high school, securing higher-quality jobs, and boosting equity and economic opportunity.¹ Work-based learning is the continuum of activities both in classroom learning and the workplace setting that leads students to gain real world experience. Work-based learning has proven impacts on earnings, job quality and stability and is a critical lever in addressing systemic racial and economic inequities.

Students in NAF academies are more likely to graduate on-time than their peers who are not involved with career academies. NAF has an overall positive effect on all students but is particularly impactful for those at-risk of not graduating-with full, 4-year program participation in a high-quality career academy, these students were 10 percentage points more likely to graduate on-time than their non-NAF counterparts. Black and Hispanic students attending NAF academies also are shown to have higher high school graduation rates.ⁱⁱ

Students who graduated from a career academy amassed 11 percent more total earnings each year, over the 8 years following high school than those who did not attend a career academy. Youth who drop out of high school can expect to earn \$10,000 less annually compared to high school graduates.^{2,3} In 2020, NAF academies reported 99 percent of the seniors graduated with 87 percent of graduates planning to go to college.

Work-based learning helps students to build relationships, sharpen essential skills 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. Eighty percent of jobs are filled through personal and professional connections.⁴ Young people deserve an education that builds workforce essential skills, helps them create social capital, and connects them to opportunity.

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 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.

While funding to schools for career and technical education is provided through the Perkins Career and Technical Education Act, this funding cannot be used to pay students for their work. However, paid internships are vital to closing the equity gap. Moreover, opportunities to intern in the nonprofit and government sectors can foster interest in public service careers among financially disadvantaged students. This potential for increased awareness of civic affairs would represent an important step toward a more engaged and inclusive democracy.

To build upon Congress' previous support for work-based learning coordinators at the secondary education level, NAF urges the subcommittee to support and advocate for the inclusion of the following report language in the fiscal year 2023 Appropriations bill, "The Committee includes \$5,000,000 to provide grants to no more than three national, non-profit education organizations, which work collaboratively with Title I public high schools to facilitate paid internships for enrolled high school stu-

¹ Sun, J., & Spinney, S. (2017). Transforming the American High School Experience: NAF's Cohort Graduation Rates from 2011–2015. ICF International.

² Kemple, J. J., & Willner, C. J. (2008). Career Academies Long-Term Impacts on Labor Market Outcomes. mdr.

³ ICF. (2017). Transforming the American High School Experience: NAF's Cohort's Graduation Rates from 2011–2015. 2017.

⁴ Fisher, J. F. (2020, February 14). How to get a job often comes down to one elite personal asset, and many people still don't realize it. Retrieved from CNBC: <https://www.cnbc.com/2019/12/27/how-to-get-a-job-often-comes-down-to-one-elite-personal-asset.html>.

dents completing secondary career and technical education in information technology, finance, health sciences, hospitality, and engineering. Ninety percent of funds shall be used by grantees to support paid internships with local employers, which shall include, but not be limited to, non-profit and government agencies. Preference shall be given to organizations with existing internship preparation programming and internship assessment tools in order to provide an evaluation of outcomes to the Department.⁵

CONCLUSION

Work-based learning is advantageous for employers and communities. It is a proven way to grow the talent pipeline and help students be ready for the workforce.⁵ By partnering with high schools to provide work-based learning opportunities to students, employers help develop a talent pipeline aligned with their workforce needs. Employers also gain the opportunity to observe prospective employees in action before making the investment to hire them.⁶ The nation must invest in work-based learning, so workers have the skills they need to succeed; and employers have the diverse talent they need to thrive. 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 EYE AND VISION RESEARCH

Serving as “Friends of the National Eye Institute,” the National Alliance for Eye and Vision Research (NAEVR) is a 501(c)4 non-profit advocacy coalition comprised of over 55 organizations, research institutions, and companies involved in and supportive of eye and vision research. NAEVR is grateful to Congress, especially the House and Senate Labor, Health, and Human Services (LHHS) Appropriations subcommittees, for the strong bipartisan support for NIH funding increases over the past 7 years. The \$14.88 billion increase during that timeframe has helped the agency, and researchers, regain lost ground after a decade of effectively flat budgets.

SUPPORT NIH BASE FUNDING OF AT LEAST \$49 BILLION

The past increased investments in NIH have continued to improve our understanding of fundamental life and health sciences, advance research across conditions, and prepare the Nation to combat existing and future health threats, including COVID-19. To maintain and build on this momentum, NAEVR strongly supports a funding level of at least \$49 billion for the NIH’s base program level, a \$4 billion increase over the comparable FY22 enacted level, with an emphasis that any additional funds for the Advanced Research Projects Agency for Health (ARPA-H) supplement, rather than supplant, this core investment in NIH. This increase would help keep NIH’s base budget ahead of the biomedical research and development price index (BRDPI) and provide for inflation plus growth to support promising science across the Institutes and Centers.

NAEVR continues to support ARPA-H funding and supports any funding above the \$1 billion allocated in FY22 to be supplemental to the NIH base budget as referenced above. NAEVR is further interested in identifying and supporting ways that vision researchers can engage in advanced research projects through ARPA-H given how vital vision researchers have proven to be across advancements in multiple conditions.

NAEVR is also supportive of the proposed use of mandatory funding to supplement NIH’s base funding to improve pandemic response and readiness. COVID-19 has continued to impact research and our society and focusing research to address these issues is vital.

SUPPORT NEI FUNDING OF \$950 MILLION

NAEVR also urges Congress to fund the National Eye Institute at \$950 million, an \$86.1 million increase over the comparable FY22 enacted level. Vision researchers continue to perform extremely well in cross NIH initiatives because of how central the eye is to not only vision, but it provides one of the best windows into the

⁵ Ross, M., Moore, K. A., Murphy, K., Bateman, N., DeMand, A., & Sacks, V. (2018, October). Pathways to high-quality jobs for young adults. Retrieved from Brookings: <https://www.brookings.edu/research/pathways-to-high-quality-jobs-for-young-adults/>.

⁶ Benefits of Work-Based Learning. (n.d.). Retrieved from JFF: <https://www.jff.org/what-we-do/impact-stories/center-for-apprenticeship-and-work-based-learning/benefits-work-based-learning/#:~:text=Jobseekers%20also%20see%20work%2Dbased,of%20%20a%20skilled%regional%20workforce.>

brain and brain function. While funding for NEI has increased along with other NIH institutes, the FY22 funding level continues to remain below 2012 inflation-adjusted dollars.

NEI will play an even greater role in research that can stem the tide of the looming vision epidemic in the United States. The Centers for Disease Control (CDC) estimates that three-in-five Americans over 40 have eye and vision problems (90 million Americans). By 2050, CDC estimates a 72 percent increase in diabetic retinopathy, an 87 percent increase in cataracts, a 100 percent increase in glaucoma, a 100 percent increase in macular degeneration, and a 150 percent increase in vision impairment and blindness. Americans are facing an increasing burden of vision impairment and eye disease due to an aging population, the disproportionate impact risk and incidence of eye disease in fast-growing minority populations, and comorbidities impacting vision from numerous chronic conditions such as diabetes. With an ever-increasing reliance on electronic communication and screen time for children and adults, increased rates of myopia, dry eye, and eye strain are all expected to impact future generations.

Maintaining the momentum of vision research and increasing the investment in vision research is vital to not only vision health but also to Americans' independence and quality of life. In a 2014 Research!America and Alliance for Vision Research (AEVR) survey of over 2,000 adults, vision loss was rated as potentially having the greatest effect on their day-to-day life, greater than the loss of limb, memory, hearing, and speech. Maintaining the momentum of vision research is vital to vision health, as well as to overall health and quality of life. Since the United States 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 aged 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 iPSC 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) 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.

ECONOMIC BURDEN OF EYE AND VISION CONDITIONS

Vision disorders represent the fifth-highest direct medical cost in the United States. In a 2014 Prevent Blindness study, it was reported that vision disorders will cost an estimated \$182.5 billion in 2022—only less than heart disease, cancers, emotional disorders, and pulmonary conditions. Left unaddressed, and with the looming vision epidemic, this is projected to grow to an inflation-adjusted \$717 billion by 2050. The U.S. is spending over \$545 per American on the treatment of vision disorders every year while only spending \$2.50 per American on research that can improve outcomes. [<http://costofvision.preventblindness.org/>]

NEI's breakthrough research is a cost-effective investment that has led to treatments and therapies that may delay, save, and prevent health expenditures. It can also increase productivity, help individuals maintain their independence, and improve their quality of life as vision loss is associated with increased depression and accelerated mortality.

SUMMARY

NAEVR supports the efforts of Congress to provide an eighth consecutive year of increases in the base funding for NIH. This funding is vital to building on the momentum of existing research and NAEVR is confident a funding level of at least \$49 billion will provide the necessary increase in FY23 to continue this growth. Inflation plus growth investment for the National Institutes of Health (NIH) and specifically the National Eye Institute (NEI), is vital to ensure we do not fall short of the Institute's ability to respond to the research needs of today to improve the outcomes of patients in the future.

NAEVR supports the NEI and believes that a funding level of \$950 million would reflect the urgent need to address eye and vision research in the United States. This funding would allow NEI to support researchers to identify new treatments, therapies, and interventions and address the future crisis in vision care as Americans age and more Americans rely on increased screen time to remain productive.

NAEVR thanks the LHHS Appropriations subcommittee for the opportunity to submit this written testimony, especially as it continues to grapple with the multitude of short and long-term challenges exacerbated by the COVID-19 pandemic.

For more information, or if the subcommittee has additional questions, please contact Dan Ignaszewski, Executive Director of NAEVR at Dan@eyersearch.org. Additional information can also be found on NAEVR's website at www.eyersearch.org. Thank you again for your time and consideration,

Sincerely,

[This statement was submitted by Dan Ignaszewski, Executive Director, National Alliance for Eye and Vision Research.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR PANS/PANDAS ACTION

Madam Chairwoman,

It is an honor to provide testimony to the subcommittee on behalf of thousands of children and young adults across the country who have had their lives turned upside down by Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS), which are Childhood Post-Infectious Neuroimmune Disorders (CPINDs). We are requesting support of report language and \$5,000,000 in program funding for PANS and PANDAS in the fiscal year 2023 Labor, Health And Human Services, Education and Related Agencies bill.

First, I would like to thank the Committee for the strong language included in past Committee reports. It has been effective and has brought attention to PANS and PANDAS. However, it is now time to take decisive action to direct NIH and other Federal agencies to increase funding for investigations into these conditions.

I am the parent of three children with PANDAS, a founding member of the National Alliance for PANS/PANDAS Action (NAPPA), and co-founder of the Mending Minds Foundation. I helped start these organizations to drive much-needed research and awareness.

PANS and PANDAS are neuroimmune disorders caused by a misdirected immune response following an infection. In short, antibodies and immune cells that would normally fight infection “go rogue” and attack the brain. The resulting inflammatory process leads to debilitating neurological and behavioral changes in young people.

PANS and PANDAS cause life-altering and horrific symptoms. The first sign is dramatic deterioration in one or more areas of functioning including cognitive, motor, sensory, executive, social, and emotional. These disorders have an alarming impact on mood and personality, rendering an adolescent who thrived in school suddenly unable to leave the house, or an exuberant healthy child intensely phobic and anorexic. Restrictive eating, severely impulsive, self-harming behavior, and suicidal ideation may necessitate hospitalization. Children’s lives are in danger.

My family’s story illustrates the devastating reality posed by these diagnoses. My two older children presented with primary mental health and neurological symptoms and, as a result, the underlying immune dysfunction was missed. Psychotropic medications did not alleviate these symptoms, and my children continued to deteriorate. We finally arrived at the true cause of their illness: undiagnosed, untreated strep infection, the same bacteria that causes a sore throat. When they received medication to address this underlying infection, they began to respond and improve in ways that had not been possible with mental health treatment alone.

Like many children with PANS and PANDAS, their identification and treatment was delayed due to limited awareness and clinical understanding. Unfortunately, lack of medical care to address the underlying infectious, inflammatory, and/or immune process resulted in symptom escalation and prolonged illness. The risk of misdiagnosis is greater in communities already facing barriers due to income and racial disparities in health care.

My children also exemplify the contrast between delayed and early identification. My oldest two 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. My youngest was treated successfully when her symptoms began, and she recovered quickly. Catching this illness early is the best path to full and complete recovery. When left undiagnosed and untreated, the condition may worsen and lead to chronic illness in young adulthood and beyond.

Caring for youth in a sustained crisis places a heavy financial burden on families, health care systems, and schools. Parents endure lost wages and out-of-pocket medical costs. Insurers incur immense costs due to repeated emergency room visits, inpatient medical and psychiatric stays, and years of pharmacological and behavioral therapies for symptom management.

Educational systems face an enormous financial burden when providing special education services for children who need increased academic support, one-to-one aides, home tutoring, or out-of-district placements. Shortening the time to identification and appropriate medical treatment would significantly minimize these societal costs.

In the past 2 years, COVID-19 has brought increased recognition of the irrefutable link between infections and delayed, but highly disruptive, immune and inflammatory reactions in the body and brain, including post-infectious psychosis, depression, and anxiety. Medical illness triggering psychiatric symptoms is not a new phenomenon and holds the key to understanding the connection between the body’s response to infection and mental illness.

The youth mental health crisis, which arose out of the global pandemic, is staggering. Suicide is a leading cause of death in young people beginning at age 10. Children and adolescents with PANS and PANDAS have a high degree of impulsivity and often have intrusive thoughts of self-harm and of killing themselves. Tragically, many young people have lost their lives from PANS and PANDAS as a result of impulsive acts causing self-injury or persistent thoughts of death, including Louisa, the 13-year-old daughter of one of NAPPA’s founding members.

Prior to the onset of PANDAS, Louisa flourished socially and academically—a straight A student with much promise who aspired to become a doctor. The day that Louisa became ill was her last day at school. She was never able to return and suffered terribly for two and a half years until her untimely death. Her parents donated Louisa’s brain to Georgetown University’s brain bank dedicated to PANS/PANDAS research. Growing this critical research and ensuring that all children are routinely screened for PANS and PANDAS will save lives.

Researchers can develop better screening tools and biomarkers to identify youth with underlying medical illnesses. Larger and longer-term studies can lead to more effective individualized treatment. Across the U.S., dedicated scientists and clinicians are doing groundbreaking work that cannot continue without funding.

They cannot achieve the breakthroughs our children so desperately need alone. A \$5 million commitment from Congress and NIH to dedicate funding to PANS and PANDAS will promote the development and application of diagnostic tools and effective interventions early in the course of illness, when affected youth can recover quickly and return to thriving in their homes, schools, and communities.

The ability of children suffering from PANS and PANDAS to regain their quality of life with appropriate intervention is exemplified by the story of Tim:

Tim was a happy, healthy 10-year-old, thriving in school and engaged in many extracurricular activities. He was an avid reader and a valued contributor on his chess, soccer, and tennis teams. He was honored as an exemplary school community member. Shortly after an infection, he became so riddled with OCD that he was unable to leave his bedroom to attend school or medical appointments, and some days he refused to eat.

He lost his reading, writing, and math skills. He was in physical pain and could not sleep at night. When Tim suddenly began attempting to jump off the balconies of his house and running into traffic, his parents had to provide round the clock supervision. This continued despite repeated trips to numerous doctors and therapists. His family said it was as if an alien had invaded his brain and his body. The stress took an enormous toll on their family, including their other children. Medical providers were baffled, had a 10-year-old somehow become bipolar overnight? Thanks to the family's persistence and a dedicated medical team familiar with PANDAS, the root cause was finally identified. All of this mayhem stemmed from a simple strep infection. With treatment for his underlying infection and immune dysfunction, Tim returned to school and resumed his activities. The crippling OCD is gone, the dark thoughts are gone, the arthritis is gone, and the headaches are gone. He has his life back.

We are living in complicated times when our vulnerability to infectious diseases has never been so glaring. We turn to medicine and science for the rapid development of tests, treatments, and vaccines to harness the immune system in the fight against COVID-19. We must now use those tools to improve the lives of children with PANS and PANDAS. Funding research will be a vital next step for the health of our country and the future of our children.

I would like to conclude by emphasizing the following points:

- Early intervention lowers the risk of chronic illness and alleviates the heavy financial burden on families, school systems, health care systems, and insurers.
- When left untreated, PANS and PANDAS can result in unintentional loss of life. Directing resources to screening young people will save lives.
- The association between neuropsychiatric illness and infections has become even more evident because of SARS CoV-2 and provides increasing opportunities for breakthroughs in research and treatment.
- 25 years after NIH began researching PANDAS, program funding remains insufficient to develop diagnostic tests and to identify more effective treatments.
- NIH research funding for PANS/PANDAS would bring much-needed attention to these diagnoses in the medical community, thereby aiding in early identification and treatment.

Advancing our understanding of PANS and PANDAS through a \$5 million commitment will contribute to a paradigm shift in research, medicine, and mental health care. Such a Federal investment in scientific research will dramatically change the lives of many young people affected by these neuroimmune disorders.

America's youth deserve the best that our healthcare system has to offer—not a lifetime of pain and symptom management. Your support will help PANS and PANDAS families achieve their dream of solving this nationwide health crisis.

[This statement was submitted by Amanda Peel Crowley, Founding Member, National Alliance for PANS/PANDAS Action.]

PREPARED STATEMENT OF THE NATIONAL ALLIANCE OF 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 (the National Alliance) on the Fiscal Year (FY) 2023 appropriation for the Charter Schools Program (CSP) and other programs administered by the U.S. Department of Education. The National

Alliance is the leading national nonprofit advocacy organization committed to advancing the public charter schools movement.

I would like to thank the subcommittee for maintaining support for the CSP at a funding level of \$440 million in FY 2022, as the program helps expand educational opportunities for children and families and drives improvements in educational outcomes nationwide. Indeed, the importance of charter schools (supported by the CSP) in offering choices to needy families has been demonstrated by the continued growth in charter school enrollments during the ongoing COVID-19 pandemic. As the subcommittee considers the budget for FY 2023, we ask that you increase the CSP appropriation to at least \$500 million.

The National Alliance also strongly supports the provision of additional resources for Federal K-12 education programs that fund schools more generally, including Title I Grants to Local Educational Agencies (LEAs) and the State Grants under the Individuals with Disabilities Education Act. We endorse the Administration's request for increased funding for these programs, which will help public schools, including charter schools, address the challenges they now face in enabling students to recover from learning losses attributable to the pandemic and to reach the outcomes we want all students to achieve.

The Operation of Charter Schools During the Pandemic

In the wake of the pandemic, charter schools acted more quickly than district-managed schools to provide real-time virtual instruction, made more regular contact with students and families, and were more likely to track online attendance.¹ Charter schools may have also been faster to deliver remote learning tools and technology to students, to a student population that was more likely to lack access to internet connectivity and devices than their traditional public school counterparts.² When asked if they felt they had the resources and support they needed to teach effectively during the pandemic in spring 2020, 66 percent of charter school teachers said yes compared to 61 percent of district school teachers.

A 2020 report that we produced in partnership with the organization Public Impact found that small charter school 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.

And what was the impact of these efforts? Charter school enrollments grew by 7 percent in school year 2020-2021, the largest increase in half a decade. Preliminary data for 2021-22 show that charter enrollment continues to increase nationally. Moreover, charter schools continue to be the only sector within the public school universe that grew during this period. Parents clearly appreciated the options offered by charter schools and took advantage of those options by enrolling their children.

Charter School Enrollments, Operations, and Accomplishments

In school year 2020-2021 more than 3.6 million students enrolled in some 7,700 charter schools, representing about 7.2 percent of total public school enrollment. As the charter school sector has grown, it has continued to serve students and families whose needs were not being met by district schools and who desired additional options. The most recent data indicate that some 60 percent of charter school students are eligible for free or reduced-price school meals and over two-thirds are students of color. Both of these percentages exceed those of district schools. To reiterate, charter school enrollments have grown in large measure because of what the schools offer to families of historically underserved students.

Notwithstanding charter schools' growth and achievements, recent years have seen the proliferation of a number of misconceptions about these schools. One is that they are not public schools and represent an attempt to "privatize" public education. Let's be clear: charter schools are public schools, and open to all students. A second misconception is that charter schools are unaccountable. To the contrary,

¹ Linda Jacobson, "Charters Were Quicker to Provide Instruction, Regular Contact During Closures, Reports Say," *The 74 Million*, April, 2020, <https://www.the74million.org/article/charters-were-quicker-to-provide-instruction-regular-contact-during-closures-reports-say-but-thats-also-how-they-keep-the-kids-one-expert-explains/>; CREDO, "Charter Schools' Response to the Pandemic in California, New York and Washington State," Stanford University, February, 2022, <https://credo.stanford.edu/wp-content/uploads/2022/02/Charter-School-COVID-Final.pdf> (pg. 17-18).

² National Center for Education Statistics, "Impact of the Coronavirus (COVID-19) Pandemic on Public and Private Elementary and Secondary Education in the United States (Preliminary Data)", U.S. Department of Education, February, 2022, <https://nces.ed.gov/pubs2022/2022019.pdf>.

they are subject to public accountability requirements as set forth in State authorizing legislation and in their individual charters. Unlike schools in general, if they do not produce results they will close. Further, while charter schools typically have more flexibility than district schools (in such areas as determining curriculum and employing staff), they are held to the same testing and accountability requirements as other schools under the Elementary and Secondary Education Act (ESEA).

And charter schools are delivering results. 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 attended 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.

Most recently, a 2021 meta-analysis of research on charter school effects and competitive influence by the National Bureau of Economic Research (NBER) highlighted trends from three decades of research. It found that charter schools located in urban areas boost student test scores, particularly for Black, Latinx, and low-income students; that attending some urban charter schools increases college enrollment and voting; and that the competitive impact of charter schools on traditional public schools suggests a small beneficial influence on neighboring schools' student achievement.³

A 2020 study from the Program on Education Policy and Governance at Harvard University, using results from National Assessment of Educational Progress fourth- and eighth-grade reading and math assessments, found greater academic gains between 2015 and 2017 for students in charter schools than for students in traditional public schools. The study found particularly significant gains for African American and low-income students attending charter schools, they 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

Since its creation in 1994 during the Clinton Administration, the CSP has received bipartisan support. The program was originally authorized to provide start-up funding for new charter schools, but it has evolved to address additional objectives, including meeting the needs of charter schools for adequate facilities and supporting the expansion and replication of high-quality charter schools operated or managed by charter management organizations.

Since the program's inception, the Congress has appropriated some \$6.8 billion for the CSP. To put that number in context, it is equivalent to less than 2 percent of the appropriations for Title I LEA Grants over that time. This modest investment has enabled the number of charter schools to grow from only a handful in the early 1990s to the 7,700 or so operating today. Because States have not typically financed the planning and initial start-up costs of their new charter schools, it is inconceivable that the charter sector would have grown as rapidly and successfully without this Federal investment. Nor have States and localities provided charter schools the same facilities and facilities funding that are available to district-operated schools; Federal funding for the two CSP facilities programs, while not adequate, has thus addressed a gaping unmet need.

Charter school enrollment has grown rapidly, but it has not kept up with family demand. Surveys indicate that some 3.3 to 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.

Regulation of the Charter Schools Program

As you may know, on March 14 of this year the Administration published for public comment a Notice of Proposed Priorities, Requirements, Definitions, and Selection Criteria (NPP) for the CSP. This notice came out late in the fiscal year, jeopardizing the ability of the Department of Education to review and respond to comments, decide on final rules, conduct CSP competitions, and make awards before the

³ Cordes, Sarah A. 2018. "In Pursuit of the Common Good: The Spillover Effects of Charter Schools on Public School Students in New York City." *Education Finance and Policy* 484–512. https://www.mitpressjournals.org/doi/abs/10.1162/edfp_a_00240.

end of the fiscal year. It also was issued in violation of Section 4307 of the ESEA, which requires stakeholder engagement prior to rulemaking that impacts charter schools and the CSP. Because of this poor timing and the fact that the NPP included provisions that raised grave concerns within the charter school community, the National Alliance has called on the Administration to put the proposed rules on hold, conduct the FY 2022 competitions under the current rules, and use the next year to engage with the community about what improvements are needed in the program and how those improvements can best be accomplished through regulation. The National Alliance is grateful that many thousands of individuals and organizations expressed the same concerns in their comments on the rule.

To be clear: we are not opposed to greater transparency in the operation of the program, although we note that the transparency-related provisions of the NPP were vague and would have led to confusion and inconsistent implementation. Nor do we dispute the Administration's contention that the statute requires that grantees and subgrantees retain administrative control over their grants and subgrants. However, the administration has put forward appropriations language on the charter school management issue that is unclear and was developed, like the NPP, without consultation or stakeholder input. We believe it should be possible to work out an acceptable regulatory solution on this issue without additional appropriations language, such as including current guidance on contracting with for-profit entities as in program regulations. Therefore, we do not support the proposed language.

Further, in response to concerns about charter schools that receive start-up support but never open, we can endorse the proposed regulation prohibiting schools from receiving implementation funding until they have obtained a charter and a facility, so long as such a school may receive support for such planning and program design activities as curriculum development, hiring and training staff, carrying out community engagement activities, and purchasing books, other materials, supplies, and equipment.

On the other hand, we will never support regulations that limit charter schools to operating in communities with overcrowded schools, give district school officials the ability to veto the opening of charter schools, or demand that charter schools have demographically diverse enrollments and staff even when the communities they serve are not diverse. Again, we thank the many commenters who expressed their opposition to these and other provisions of the NPP.

FY 2023 REQUEST

Our request for fiscal Year 2023 is \$500 million, a \$60 million increase. We also recommend that the appropriations act give the Department of Education sufficient flexibility to allocate funds across CSP programs in response to current needs of the field. \$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 enable the expansion of high-quality schools and reduce wait lists in order to 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. We also request report language that would ensure that State entity grantees have access, at the beginning of the grant period, to the full seven percent reservation for technical assistance as provided for in the statute.

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. 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.

[This statement was submitted by Nina Rees, President and CEO, National Alliance of Public Charter Schools.]

PREPARED STATEMENT OF THE NATIONAL ALOPECIA AREATA FOUNDATION THE FOUNDATION'S FISCAL YEAR 2022 L-HHS APPROPRIATIONS RECOMMENDATIONS

—At least \$49 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 In-

fectious Diseases (NIAID) and the National Center for Advancing Translational Science (NCATS)

—Please provide \$11 billion for the Centers for Disease Control and Prevention (CDC).

—Please provide \$6 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 FY 2023 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. 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 Nicole Friedland, President & CEO, National Alopecia Areata Foundation.]

PREPARED STATEMENT OF THE NATIONAL AREA HEALTH EDUCATION CENTERS ORGANIZATION

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to submit testimony on behalf of the National AHEC Organization (NAO). I serve as the chief executive officer of NAO with over 14 years of experience as an AHEC Center Director from Kentucky. The NAO is the professional organization that represents Area Health Education Centers (AHECs) across the country. We support advances in the AHEC network to improve health by leading the Nation in recruiting, training, and retaining members of a diverse health workforce in rural and underserved communities. As a member of the Health Professions and Nursing Education Coalition (HPNEC), NAO is pleased to recommend \$790 million for the health professions training programs under Title VII and VIII of the Public Health Service Act that are administered by the Health Resources and Services Administration (HRSA). Of this amount, the NAO recommends \$67.00 million in fiscal year (FY) 2023 for the Area Health Education Center program.

The national AHEC network consists of more than 300 AHEC program offices and centers, serving over 85 percent of the counties in the United States. With 50 years of operation, AHECs meet the current and emerging needs of the communities they serve through robust community-academic partnerships, with a focus on exposure, education, and training of the current and future health care workforce.

HIGHLIGHTED AHEC PROGRAMMATIC ACTIVITIES

—*AHEC Scholars Program*: This 2-year program initiative recruits, trains, and supports interdisciplinary groups of health professions students committed to increase health care quality through community-based service and health care

transformation. Every AHEC Scholars program includes 40 hours of didactic and 40 hours of community-based or clinical activities each year. Through these experiences, Scholars develop new skills and knowledge designed to expand their understanding of the social determinants of health and health equity (or lack of), for populations living in rural and underserved communities. This curriculum is a critical tool to prepare a diverse, equitable, compassionate, qualified health care workforce.

- Continuing Education:* The NAO and member AHECs provide accredited continuing education programs and professional support for healthcare professionals who seek licensure and certification credits with an emphasis on rural health and health care in underserved areas.
- Health Professions Pipeline:* AHECs expose students in grades 9–12 to health careers through job shadowing, health career presentations, and summer programming. Undergraduates participate in AHEC networking/enrichment programs to enhance their knowledge, experience, and forward the pathway to health professions school admission.
- Clinical Rotations:* Clinical training rotations are available throughout most of the AHEC network to enhance clinical expertise for medical students, residents, pharmacy, PA, APRN and other health professions students in rural and underserved communities.

The AHEC program is reauthorized through FY 2025. The AHEC authorization language recommends a funding level of \$250,000 annually for each AHEC Center. A FY 2023 funding level of \$67 million would facilitate that recommendation.

JUSTIFICATION FOR NAO'S FUNDING RECOMMENDATION

Funding the AHEC program at \$67 million provides critical opportunities to support AHECs as they:

- Foster strategic community-based partnerships within the communities they serve to address the health workforce needs related to the emerging health issues such as COVID–19 pandemic;
- Strengthen linkages between academic health science centers and community health service delivery systems to provide additional training opportunities for students, faculty, and practitioners;
- Increase the return on Federal investment by leveraging State and local resources to meet the required 1:1 funding match in support of health workforce development;
- Expedite the transformation of the health care system by training the current and future workforce for a value-based, patient-centered, team-based practice environment for innovative models of care.

The AHEC network is a part of a critical pipeline that fuels the recruitment, training, distribution, and retention of a national health workforce. At a time where the AAMC projects our Nation will have a shortage of nearly 120,000 physicians by 2030, AHEC stands as a central access point in meeting this demanding shortage area. Primary care practitioners are the front-line in prevention of disease and providing cost savings in the United States healthcare system. In recognizing this, the AHEC program engages in pre-pipeline, pipeline, and post-pipeline activities that guide individuals through health careers pathways and beyond, with a special emphasis on primary care providers. In the 2020–2021 academic year, AHECs introduced more than 178,000 students, ranging from high school to collegiate status, to careers in the health professions and health workforce. AHECs facilitated 24,766 student clinical rotations, many of which were in rural and underserved. Additionally, AHECs were responsible for training 416,862 professionals through continuing education, and more than 7,000 students were enrolled in the AHEC Scholars program. Madam Chair, these facts make AHECs integral in the recruitment, interdisciplinary training, and retention of the healthcare workforce.

AHECs have a continual focus on improving the health care system by working with 120 medical schools, 600 nursing and allied health schools, healthcare settings like CHCs, behavioral health practices, and community-based organizations across the Nation. Through these longstanding partnerships, the AHECs employ traditional and innovative approaches to develop and train a diverse health care workforce prepared to deliver culturally appropriate, high-quality, team-based care for rural and underserved communities. AHECs are embedded in the communities they serve, positioning them to respond rapidly to emergent training needs of health professionals, health professions students, and inter-professional teams on issues associated with natural disasters, disease outbreaks, and substance use disorders.

Madam Chair, thank you and the committee for the opportunity to present the views of the National AHEC Organization. Allow me to re-emphasize the funding

request of \$67.00 million for the Area Health Education Centers program. As you begin the FY 2023 process, we look forward to working with the subcommittee to continue prioritizing health workforce initiatives that improve training opportunities, the quality of our healthcare workforce, and alleviate patient care, research in health disparities, and health professionals going into the health workforce.

[This statement was submitted by Dwain Harris, Chief Executive Officer, National Area Health Education Centers Organization.]

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 \$88.48 million for the DD Councils within the Administration for Community Living (ACL) in the Fiscal Year (FY) 2023 Labor-HHS-Education Appropriations Bill, the same level included in the President's FY23 budget.

We also respectfully request that the following report language be included in the Fiscal Year 2023 Labor, Health and Human Services, Education Appropriations bill:

Technical Assistance.—The Committee instructs the Department to provide not less than \$700,000 for technical assistance and training for the State Councils on Developmental Disabilities. In addition, the Committee encourages ACL to consult with Developmental Disabilities Act stakeholders prior to announcing opportunities for new technical assistance projects and to notify the Committee prior to releasing new funding opportunity announcements, grants, or contract awards with technical assistance funding.

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. 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 intellectual and developmental disabilities (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 FY 2023 is supported by the steadily and rapidly increasing numbers of people with developmental disabilities who continue to lack comprehensive and coordinated support systems to meet specific needs for full community inclusion. During the COVID-19 pandemic many people with developmental disabilities lost the assistance provided by families and other informal supports and people with disabilities disproportionately experienced loss of employment. Demand for services even after the pandemic has remained significantly higher than before 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 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.

During the COVID-19 pandemic, DD Councils provided life-saving access to information, resources, and support to people with I/DD and their families. The past 2 years underscored the critical role of the DD Councils to meet the needs of people with I/DD so they can live safely in the community and free from discrimination. States have called on DD Councils to create life-saving solutions to problems faced by people with I/DD during the pandemic. Federal agencies and States have looked

to DD Councils to bridge public health communication gaps with the I/DD community; advocate for non-discrimination in health care; promote immunization; distribute personal protective equipment; support access telehealth; and more. This funding request reflects the increased need for direct resources through partnerships with local non-profits, businesses and State and local governments, to provide innovative and cost-effective strategies so more people with I/DD can become independent, self-sufficient, and integrated into the community.

Thank you for consideration of our request. For more information, please contact Erin Prangle at eprangle@nacdd.org, National Association of Councils on Developmental Disabilities, 1825 K Street, N.W., Suite 600, Washington, D.C.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

The National Association of County and City Health Officials (NACCHO) is the voice of the nearly 3,000 local health departments across the Nation. Local health departments continue to lead the Nationwide response to COVID-19, while also working to protect the health and safety of their communities from a myriad of public health challenges, many of which have worsened during the multi-year pandemic response.

COVID-19 has brought to the fore the critical role of governmental public health, especially local health departments, in all aspects of daily life and exposed the consequences of years of underinvestment in our public health system. Congress has the opportunity now to rebuild the public health system to face current and future challenges. To enable local health departments to support Federal public health priorities and effectively lead in their communities, NACCHO requests Congress provide robust investments to the public health workforce and infrastructure, and exercise oversight to ensure Federal funds are efficiently and equitably allocated to the local level.

PUBLIC HEALTH LOAN REPAYMENT

The public health workforce is the backbone of our Nation's governmental public health system, but was understaffed and overworked even before the pandemic. Local health departments have lost over 20 percent of workforce capacity since 2008,¹ and over a third of the local public health workers were projected to leave the field in the next 5 years due to retirement or to pursue opportunities in the private sector.² Furthermore, at least 500 local and State health officials have reportedly left their positions during the pandemic due to politicization, harassment, termination, and burnout.³ Combined, these forces create an urgency to addressing our public health workforce crisis.

A bipartisan group of Senators have recognized this need and introduced legislation, the Strengthening the Public Health Workforce Act (S. 3506), that would authorize a public health workforce loan repayment program and give local, State, and Tribal health departments a vital tool to recruit and retain top talent. Additionally, Senators Murray and Burr have incorporated the proposal into the PREVENT Pandemics Act recently approved by the Senate Health, Education, Labor, and Pensions Committee. In conjunction with this legislation, NACCHO urges Congress to provide \$200 million for the establishment of a public health loan repayment program at the Health Resources and Services Administration so that health departments can immediately bolster their efforts to strengthen the public health workforce.

PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY

Local health departments operate on limited and unpredictable budgets that do not allow for long-term investments in needed infrastructure and cross-cutting needs. Federal public health funding has traditionally followed a boom-and-bust cycle in response to crises. Additionally, funds are often limiting, for example tied to a specific disease state or programmatic function, which makes it difficult to in-

¹ NACCHO, 2019 National Profile of Local Health Departments, https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf.

² Leider JP, Coronado F, Beck AJ, Harper E. Reconciling Supply and Demand for State and Local Public Health Staff in an Era of Retiring Baby Boomers. *Am J Prev Med*. 2018;54(3):334-340.

³ Baker M. and Ivory D. (2021, October 18). Why Public Health Faces a Crisis Across the U.S. The New York Times. <https://www.nytimes.com/2021/10/18/us/coronavirus-public-health.html>.

vest in or sustain critical health department functions not tied to a specific disease state. Local health departments need sustainable, disease-agnostic, predictable funding to support local public health infrastructure, including data modernization and workforce development. Such funding would allow local health departments to focus on certain skillsets that are critically necessary—like communication, outreach, data analysis, and digitalization—but that they largely lack due to current funding constraints. The lack of this ability at the local level hinders efforts to support Federal public health objectives.

NACCHO is grateful that Congress recognized this need and established a new Public Health Infrastructure and Capacity line within the CDC in fiscal year 2022, and NACCHO requests \$1 billion for this crucial program in fiscal year 2023. Importantly, funding to support cross-cutting core public health functions should supplement, not supplant the disease-specific funding that currently supports many critical health department activities. Indeed, new capabilities supported by disease-agnostic funding will ultimately enhance the functionality of existing programs. NACCHO also requests Congress require CDC to ensure at least 35 percent of a State's allocation be directed toward local health departments with clear expectations regarding the timing of such suballocations.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The CDC has unmatched expertise and experience in tackling a broad array of public health issues including the ongoing COVID-19 pandemic and other pre-existing challenges that have been exacerbated by the pandemic like mental health, substance use, sexually transmitted infections, and chronic disease. CDC serves as the command center for the Nation's public health defense system against emerging and reemerging infectious diseases, man-made and natural disasters, and other public health emergencies. Strong funding is critical to supporting all of CDC's activities and programs, which are essential to protect the health of our communities, and NACCHO requests \$11 billion for CDC in FY 2023. Due to years of underfunding, many CDC programs have not received the resources that are needed to address the many health challenges we face as a nation, resulting in many of CDC's most effective prevention programs not reaching all communities.

Additionally, Federal funding from the CDC intended for both State and local health departments continues to have variable reach to local public health agencies. Ensuring these resources reach the local health department level in a timely way is critical to enabling communities to address public health needs. NACCHO requests that Congress include report language similar to that included in the explanatory statement accompanying Division H (L-HHS) of the fiscal year 2022 Consolidated Appropriations Act (H.R. 2471) encouraging CDC to require States to fund local health departments when programmatically appropriate, and further urging CDC to publicly track and report to the Committee how funds provided to State health departments are passed through to local health departments, including amount, per grant award, by local jurisdiction, and date funds are made available to each local health department.

PUBLIC HEALTH EMERGENCY PREPAREDNESS COOPERATIVE AGREEMENT

The PHEP Cooperative Agreement provides funding to 50 States, 4 large cities (Chicago, Los Angeles County, New York City, and Washington, D.C.), and eight territorial health departments to strengthen public health departments' capacity and capability to effectively plan for, respond to, and recover from public health emergencies.

NACCHO urges \$1 billion for PHEP in fiscal year 2023, the level at which the program was originally funded when it was created after the 9/11 terrorist attacks. Public health emergencies have increased in number and scope since the establishment of the PHEP program, and PHEP funding has not kept pace. Restoring funding to \$1 billion is necessary to allow the program to comprehensively support local communities and States in their ability to prepare to respond to terrorist threats, infectious disease outbreaks, natural disasters, and biological, chemical, nuclear, and radiological emergencies, and other threats.

More than 55 percent of local health departments rely solely on Federal funding for emergency preparedness. However, funding from State health departments to local health departments can have a varied approach and have reduced over time as overall Federal appropriations fell. To ensure all communities have the resources they need to prepare for and respond to public health emergencies, NACCHO requests report language to provide increased transparency around suballocations of PHEP funding from States to local health departments, similar to language included in both the House (H. Rept. 117-96) and Senate Committee Reports for the FY22

Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill requesting a State distribution table in the fiscal year 2024 Congressional Budget Justification, showing how funding is being allocated to local health departments, how States are determining these allocations, and date funds are made available to each local health department.

DATA MODERNIZATION INITIATIVE

The local health department COVID-19 response was hampered by a historical lack of resources, outdated systems, and an overall underfunding of public health infrastructure. Public health needs a robust, modern, and secure public health information ecosystem capable of sustainment and surge that delivers real-time, accurate, and useful data to public health and policymakers at the local, State, and Federal levels. Across the country, local and State public health departments operate a mismatched network of siloed public health information systems, most of which do not talk to each other nor to the health care delivery sector, and all of which are in urgent need of upgrade to prepare for and respond to public health challenges. To meet these challenges, NACCHO requests \$250 million for the CDC's Data Modernization Initiative and asks Congress to urge CDC to consider local health department access and needs at all stages of data development.

EPIDEMIOLOGY AND LABORATORY CAPACITY AWARDS

The ELC program provides annual funding, strategic direction, and technical assistance to domestic jurisdictions for core capacities in epidemiology, laboratory, and health information technology activities. In addition to strengthening core infectious disease capacities nationwide, this cooperative agreement also supports a myriad of specific infectious disease programs. Like other Federal streams, funding through ELC grants has variable reach to the local level. NACCHO requests Congress urge CDC to work with States to prioritize funding to local health departments based on factors such as population size, disease burden, and other public health metrics to promote equitable funding distribution, and to publicly track and report how funds are passed through to local entities.

MEDICAL RESERVE CORPS

The Medical Reserve Corps (MRC) is a national network of local-organized volunteers committed to improving the public health and resiliency of their communities. Two-thirds of the Nation's 800 MRC units are housed within local health departments. MRCs are deployed to address public health emergencies and have stepped up to serve their communities during the COVID-19 response—in FY2021, MRC units provided 2.7 million hours of service, compared to about 300,000 hours in FY2019 prior to the pandemic. Additionally, the number of volunteers across the MRC network has grown from roughly 175,000 at the beginning of 2020 to over 300,000. The total economic value of MRC volunteer contributions is estimated at over \$91 million.

NACCHO advocates for \$12 million for MRC so that capacity built during COVID-19 can be sustained and at the ready for future public health emergency responses. NACCHO also requests Congress urge ASPR to continue the historical funding approach that provides funds directly to local MRC units and ensures efficient release and delivery of funds.

NACCHO appreciates the consideration of these requests and looks forward to working with Congress to strengthen and support local public health.

[This statement was submitted by Lori Tremmel Freeman, MBA, Chief Executive Officer, National Association of County and City Health Officials.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF FEDERALLY IMPACTED SCHOOLS

Dear Chairwoman Murray and Ranking Member Blunt:

The National Association of Federally Impacted Schools (NAFIS) strongly urges the Senate Labor-Health and Human Services-Education Appropriations subcommittee to continue recognizing the Federal Government's obligation to federally impacted communities as you set funding priorities for the U.S. Department of Education.

Based on our analysis, we urge you to provide at least a \$2 million increase for Federal Property and a \$55 million increase for Basic Support for FY 2023.

NAFIS represents the 1,100-plus Impact Aid-recipient school districts that together educate 10 million students across the Nation. Impact Aid is the oldest ele-

mentary and secondary education program and is a partnership between local communities and the Federal Government where there is significant non-taxable property, such as military installations, Indian treaty or trust land, Alaska Native Claims Settlement Act land, Federal low-rent housing facilities, national parks and national laboratories. Congress recognized in 1950 that the Federal Government had an obligation to help meet the local responsibility of financing public education in areas impacted by a Federal presence. That same recognition holds true today.

While the Administration has indicated it does not intend to support funding cuts to education programs, the President's FY 2023 budget request includes many—including a \$16 million cut to Impact Aid—because Congress finalized FY 2022 appropriations after the Administration finalized its FY 2023 request. It is particularly disappointing that the Impact Aid funding request is notably below the levels included in both the House and Senate FY 2022 appropriations bills, which were in conference at the time the FY 2023 budget was developed.

NAFIS is grateful for the subcommittee's past support of the Impact Aid program, and we hope to see that support continue in FY 2023. Federally impacted school districts cannot afford stagnant appropriations or a loss of funding. FY 2023 will require additional funds to build on the important funding progress made in the last few years.

Section 7003 Basic Support: Although appropriations have increased in recent years, Basic Support remains significantly underfunded. The Basic Support payment formula is based on several factors, including the actual cost of education. That cost is measured by the Local Contribution Rate (LCR), which is based on per pupil expenditures (PPE) from 3 years prior.

Basic Support is currently funded at about 60 percent of the payment formula. Because the program is so underfunded, the Impact Aid law includes a proration factor called the Learning Opportunity Threshold (LOT), which measures the need a school district has for Impact Aid funds. The higher a school district's LOT, the more reliant it is on Impact Aid.

In 2020, for the first time in more than a decade, LOT paid out at over 100 percent. That means the highest need Impact Aid districts got their full payment. However, hundreds of other school districts still received far less than they would have if the program were fully funded.

For FY 2021, the LOT Payout is estimated to be 98 percent. Whenever the LOT Payout is below 100 percent, all federally impacted school districts—including those with the most need that rely most heavily on Impact Aid funds to operate—receive payments below those calculated by the formula in the Impact Aid law.

fiscal year	lot payout	lcr rates
FY 2011	97.066 percent of LOT	\$5,215.00
FY 2012	96.109 percent of LOT	\$5,330.00
FY 2013	87.061 percent of LOT	\$5,404.50
FY 2014	91.730 percent of LOT	\$5,406.00
FY 2015	93.074 percent of LOT	\$5,386.00
FY 2016	93.690 percent of LOT	\$5,468.00
FY 2017	92.332 percent of LOT	\$5,635.50
FY 2018	96.187 percent of LOT	\$5,840.50
FY 2019	98.138 percent of LOT	\$6,036.00
FY 2020	101.15 percent of LOT	\$6,268.50
FY 2021	98 percent of LOT	\$6,495.00
FY 2022*	100+ percent of LOT	\$6,794.00

*Estimated final rates

We expect that the LCR in the Impact Aid formula could increase by 3.5–4 percent in FY 2023 based on projected increases in per pupil expenditures (NCES data will be available in September on which the FY 2023 LCR will be based). Without a corresponding increase in appropriations, the LOT Payout could drop substantially.

The increases in appropriations and LOT Payout have been critical for federally impacted school districts, especially given increased costs stemming from the COVID-19 pandemic. A \$55 million increase for FY 2023 would build on these increases and help the program keep pace with the rising costs of education. With that increase, the 7003 Basic Support formula will still be approximately \$850 million below fully funding its formula. We encourage Congress to make up this gap and set a glide path to fully fund the formula.

Section 7003(d) Children with Disabilities: Another important element of Impact Aid is the Children with Disabilities (CWD) section, which provides funding for mili-

tary-connected or Indian lands students with an active Individualized Education Program (IEP). It has been funded at \$48 million since 2008, despite rising costs of providing special education services. This currently means a school district receives approximately \$1,200 per eligible student living on Federal property (or \$600 for military-connected students who do not live on a military installation). As the cost of special education rises, this \$48 million appropriation is stretched too thin, especially given the chronic underfunding of IDEA. Payments per CWD dropped from \$1,215.65 in FY 2018 to \$1,205.00 in FY20. School districts are continuing to educate their students with disabilities, spending significant general funds to do so.

Section 7002 Federal Property: We thank you for the \$4 million increase in 7002 payments in FYs 2019 through 2022. For FY 2023, we request an additional \$2 million to build on these increases. These funds will partially offset new costs as the Federal Government continues to take property off local tax rolls and as the value of taxable land on which the funding formula is based increases.

Section 7007 Construction: Finally, the Construction section of Impact Aid receives very little support, languishing at a \$17 million level for the past several years. For comparison purposes, in FY 2005 Section 7007 received just over \$45 million. We recommend that FY 2023 Impact Aid Section 7007 funds be distributed under Section 7007(b) competitive grants, since FY 2022 funds will be dispersed through Section 7007(a) formula grants.

School superintendents are saying...

Impact Aid provides the necessary funding to ensure that all students in our district have access to a Free Appropriate Public Education and high levels of learning every day for every student to ensure that all students are prepared to graduate Life, College, and Career ready!—*Washington*

We would not be able to operate without Impact Aid; our Impact Aid funds pay for all support staff, consultants, utilities, daily operations, professional development, curriculum, materials, and technology needs.—*Montana*

Impact Aid money has helped improve our relations with the Southern Ute Tribe. Over the last 10 years, we have developed a meaningful MOU, included a representative from the Tribe on our administrative team, added a Ute Language Class, and had regular and meaningful community meetings with Tribal leaders to get important feedback.—*Colorado*

Because of Impact Aid, we have truly leveled the playing field and dramatically improved the working relationship with the Seneca Nation. Instead of the conversation being framed “you are not doing enough” the conversation is now “how can we partner to do more for all children”. Because we have been able to use IA funding to improve program, graduation rates, drop out rates, Advanced Placement rates our enrollment has dramatically increased in the past 5 years (+300 students). Simply put IA has made our “product” better, much better.—*New York*

Additional investments in Impact Aid are critical to help school districts close achievement gaps, update technology, expand access to early childhood and after-school programs, integrate culturally relevant curriculum, replace failing infrastructure, offer competitive salaries to recruit and retain school leaders, and more. These investments help school districts provide supportive and nourishing learning environments for all students. Through increased funding, we ask you to continue to view the program as a critical Federal investment and a tax replacement program for federally impacted communities.

Sincerely,

[This statement was submitted by Nicole Russell, Executive Director, National Association of Federally Impacted Schools.]

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 1.5 million graduates of treatment court programs and the 150,000 people treatment court programs will connect to lifesaving substance use and mental health treatment this year alone. Given the ongoing substance use crisis, 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 2023.

I am writing to you today as a husband, employee, taxpayer, and grateful drug court graduate. Before coming to the Lewis County Drug Court program, I spent much of my life cycling in and out of the justice system for crimes fueled by addiction. I went to jail seven times—and that doesn't encompass the many times I wasn't caught breaking and entering, stealing, and causing general harm to my community doing anything to support my addiction. I had also been to treatment multiple times, but without accountability, I'd never truly had the chance to heal from the trauma of my past, and I was never able to sustain my recovery. I often wonder what might have happened if there were no drug court available to me.

The multidisciplinary treatment court team, which includes case managers, treatment providers, and counselors, not only looked at the facts of my case, but they also looked at my entire criminal history, my addiction history, and my life experiences up to that point. They created a plan to ensure I received the treatment and social services I needed, while still holding me accountable for my actions and the requirements of the program. Receiving treatment for my addiction was only part of the process. Because sustained, long-term recovery is the goal, drug court helped me work on myself from the inside out, addressing issues that had been impacting my behavior since I was a child.

I completed the program in 2016, and I have dedicated myself to repairing the damage I caused by giving to others what was given to me. I first worked for an organization that conducts outreach to vulnerable populations with substance use disorders and helps them get their lives back on track. I also became 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.

In February of this year, I had to step down as president of that organization, but for good reason—I became the community outreach worker at the very same drug court that changed my life. The treatment court team is like a family, and I work every day alongside my fellow team members to ensure our participants are connected to the services and treatment they need to turn their lives around the way I did. And while I'm no longer president, I'm still a proud and active member of the nonprofit organization full of graduates like me. And taking "family" one step further, I recently married my wife.

I am proof that 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.

But don't just take my word for it; there is overwhelming empirical evidence showing the effectiveness of these programs. The Government Accountability Office has concluded the drug court model reduces crime by up to 58 percent. 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, and financial stability, as well as reduced foster care placements.

I am not alone in my success. This year, treatment courts will connect 150,000 people who have 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. 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 as our country continues to battle the ongoing opioid crisis, we know there are many more people 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 2023, so treatment courts in Washington and beyond can continue providing substance use treatment that allows people to heal from the inside out.

[This statement was submitted by Brant Byrd, graduate of Lewis County, Washington, Drug Court Chehalis, Washington.]

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF FREE AND CHARITABLE CLINICS

On behalf of the National Association of Free and Charitable Clinics (NAFC) Board of Directors, our patients, and the 1,400 Free and Charitable Clinics in the United States, thank you for the opportunity to submit this written testimony to the Labor, Health, and Human Services, Education, and Related Agencies subcommittee. The National Association of Free and Charitable Clinics is respectfully

asking for funding for the following HHS programs, the Federal Tort Claims Act (FTCA) for Free Clinics, the Nurse Loan Repayment Program, the National Health Service Corps, The Breast and Cervical Cancer Screening Program under Title X, and the Corporation for National and Community Service.

BACKGROUND

Annually, 2 million patients through 6.9 patient visits receive health care at America's Free and Charitable Clinics. This care is provided by a volunteer and staff workforce of over 200,000 individuals from medical and non-medical fields. Unfortunately, 96% of our patients are uninsured and living at 100 to 300% of the poverty level. In addition, 4% of our patient population is eligible for Medicaid in their States; however, they do not have access to dental care or affordable medications through their state Medicare/Medicaid programs. In addition, 58% of our patients are women, 37% of patients are Hispanic (Hispanic individuals make up 18% of the US population), 36% of patients are Caucasian (Caucasian individuals make up 60% of the US population), and 17% of patients are Black (Black individuals make up 13% of the US population).

Racial, societal, and economic factors directly impact people's health and ability to access health care and other resources needed to have a healthy life. Free and Charitable Clinics and Pharmacies are on the frontlines of natural disasters and the coronavirus pandemic, but they are on the frontlines of injustice in health care. We are committed to working toward health equity and addressing the racial, societal, and economic factors that influence people's health.

Free and Charitable Clinics and Charitable Pharmacies are safety-net health care organizations that utilize a volunteer/staff model to provide a range of medical, dental, pharmacy, vision, and behavioral health services to economically disadvantaged individuals. Such clinics/pharmacies are 501(c)(3) tax-exempt organizations or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal/sliding fee to patients, may still be considered Free or Charitable Clinics or Pharmacies provide essential services are delivered regardless of the patient's ability to pay. Free or Charitable Clinics and Charitable Pharmacies restrict eligibility for their services to individuals who are uninsured, underinsured, and have limited or no access to primary, specialty, or prescription health care.

APPROPRIATIONS REQUEST

Our clinics receive little to no State or Federal funding, we do not receive HRSA 330 funds, and we are not Federally Qualified Health Centers or Rural Health Centers. Therefore, our clinics rely heavily on the generosity of individual donors, foundations, and grants as funding sources.

Free and Charitable Clinics are a supreme example of private-public partnerships. We are excellent partners to the Federal Government because we provide access to health care to individuals who typically utilize the emergency department for routine care. Therefore, it is imperative to our operations that the Free Clinic Medical Malpractice (FTCA), the National Health Service Corps, the Nurse Corps Loan Repayment Program, The Breast and Cervical Cancer Screening Program under Title X, and the Corporation for National and Community Service programs continue to be adequately funded.

FTCA

The Federal Torts Claims Act Program allows volunteer medical providers to provide health care to our patient populations and receive malpractice protection from the Federal Government. In addition to saving the clinics money, this program allows providers to understand that their expertise is valued and essential to the health of our patients. Therefore, we request that this program be funded in FY23 at the FY22 level of \$1 million.

Nurse Corps Loan Repayment Program

The Nurse Corps Loan Repayment Program allows registered nurses (including advanced practice registered nurses and nursing faculty) to help to create healthy communities in poor urban and rural areas as they build their careers by paying off 60% of their unpaid nursing student loans in just 2 years- plus an additional 25% of the original balance for an optional third year. In return, NURSE Corps members fulfill a service obligation at one of the eligible entities located in designated mental health or primary medical care Health Professional Shortage Areas across the United States. This program allows free and charitable clinics to recruit talented nurses by assisting them with their nursing school loans. Therefore, we request that this program be fully funded in FY23 at the FY22 levels.

National Health Service Corps

The National Health Service Corps allows the next generation of medical providers to receive loan repayment for providing their time and expertise in a clinic that is in a health professional shortage area. Over 52% of clinics are in a health professional shortage area. The loan repayment program also allows for more medical students or nursing students to understand that the need for primary care doctors is at an all-time high in this country. Therefore, we ask that this program be funded at the FY23 budget request level of \$210 million.

Breast and Cervical Screenings

The Breast and Cervical Cancer Screening Program funded under Title X is how they receive routine cancer screenings for many uninsured women. According to a study conducted by the American Cancer Society, Emory University, and Dana Farber Institute: Differences in health insurance explained about 35% of the excess risk of death in black women compared with white women. Almost three times as many black women were uninsured or had Medicaid insurance (22.7%) compared to white women (8.4%). The study authors wrote, "Lack of insurance is a barrier to receiving timely and high-quality treatment and screening services." Free and Charitable Clinics utilize this program to ensure that our patients have access to screening, testing, and life-saving treatment. Therefore, we request that this program be fully funded in FY23 at the FY22 levels.

Corporation for National and Community Service

In addition to private donations, Free and Charitable Clinics need volunteers to increase our capacity at our locations across the country. The AmeriCorps Vista program allows clinics to enhance their operations, procedures, policies, and educational materials. The AmeriCorps Vista program is essential for expanding care and allowing volunteers to receive work experience in a non-profit setting. Therefore, we ask that this program be fully funded in FY23 at the FY22 levels.

CLOSING

Our patients face various complex challenges and barriers to health care access. Therefore, Free & Charitable Clinics have been deeply committed to providing whole-person health care and addressing social determinants of health and health disparities.

Please ensure that these programs continue to be fully funded, so we can continue to partner to ensure that every person has access to affordable quality health care. We thank you for the opportunity to share this written testimony.

[This statement was submitted by Nicole Lamoureux, CEO and President, National Association of Free and Charitable Clinics.]

PREPARED STATEMENT OF 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 FY 2023 appropriations for Federal programs that impact approximately 2.87 million Americans who are treated annually in emergency departments and hospitals for a traumatic brain injury (CDC, 2014). We appreciate your support for additional funding for FY 2022 to the U.S. Department of Health and Human Services' (HHS) Administration for Community Living (ACL) TBI State Partnership Program that helps States expand services to address the cognitive, behavioral and physical rehabilitative and long-term needs of Americans living with brain injury in accordance with the Traumatic Brain Injury (TBI) Program Reauthorization Act of 2018.

However, as not all States or territories are currently participating in the grant program, NASHIA is requesting increased funding for the ACL TBI State Partnership Program (TBI SPP) so that individuals living with brain injury and their families have resources and assistance to return to home and community, school and employment regardless of where they live in this country. In addition, we support full funding for the National Concussion Surveillance System administered by the CDC's National Center for Injury Prevention and Control (NCIPC). And, 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, which authorizes research, including research conducted by the TBI Model Systems. Specifically, NASHIA is requesting:

- \$19 million additional funding for the ACL TBI State Partnership Program to provide funding to all States, territories and District of Columbia;
- \$5 million 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 (\$2.5 million each; and
- \$1 million to expand TBIMS collaborative research projects for additional research on TBI as a chronic condition.

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 past 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 related to the pandemic. Thus, the Federal funding requested is critical to assist States with issues that emanated from the pandemic as programs and services are brought back to pre-pandemic status.

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, and Medicaid/Medicare) and payers (e.g., insurance, Workers' Comp, State and Federal programs). Twenty-eight States are currently funded by the ACL TBI SPP for 5 years. 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.

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. We are joined in this support by:

AANS/CNS Joint Section on Neurotrauma & Critical Care; Advancing States; Alzheimer's Association; American Academy of Physical Medicine and Rehabilitation (AAPMR); American Association of Neurological Surgeons; American Physical Therapy Association; Brain Injury Association of America; Concussion Legacy Foundation; Congress of Neurological Surgeons; Friends of TBI Model Systems; Injury Prevention Research Center at Emory; Matthew Gfeller Center, University of North Carolina at Chapel Hill; National Association of State Directors of Developmental Disabilities Services; National Association of State Mental Health Program Directors; National Athletic Trainers' Association; National Disability Rights Network; North American Brain Injury Society; Safe Kids Worldwide; SCORE Program, Children's National Hospital; The Center on Brain Injury Research & Training at the University of Oregon; The National Concussion Management Center; United States Brain Injury Alliance (USBIA); USA Field Hockey; USA Lacrosse; and USA Football.

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 is a nonprofit organization that 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 to the ACL TBI State Partnership Program; the ACL NIDILRR program to expand TBI research; and to 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, svaughn@nashia.org or Zaida Ricker, NASHIA Government Relations, zricker@ridgepolicygroup.com.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HOMELESS VETERANS

Dear Chair Murray and Ranking Member Blunt, Chairman Heinrich and Ranking Member Boozman, and Chairman Schatz and Ranking Member Collins:

As you begin work on the fiscal year 2023 Appropriations bills, the National Coalition for Homeless Veterans (NCHV) submits this letter as testimony, requesting your respective subcommittees to fully fund the programs that directly impact homeless veterans to perpetuate the successes in reduction of homeless veterans. Multiple Federal departments and agencies play vital roles in combatting, preventing, and ending veteran homelessness in America including the Department of Labor (DOL), the Department of Veterans' Affairs (VA) and the Department of Housing and Urban Development (HUD).

COVID-19 has continually impacted the economy in unprecedented ways, and as the VA's own Secretary testified, we have yet to reach peak requests for care. The Committee's diligence in providing emergency appropriations for these programs shows great foresight, yet now we must work toward permanent housing for those veterans housed with those funds, in regular program appropriations so we do not return veterans to pre-emergency levels of veteran homelessness. Every veteran deserves safe and permanent housing, whether they are currently experiencing homelessness or are facing housing-cost burdens that put them at risk of homelessness. We therefore ask that you fully fund the listed programs at the following levels:

DEPARTMENT OF LABOR

The Homeless Veterans' Reintegration Program (HVRP) provides services to assist in reintegrating homeless veterans into meaningful employment within the labor force and to stimulate the development of service delivery systems that will address the employment challenges facing homeless veterans. (\$107.5 Million)

DEPARTMENT OF VETERANS AFFAIRS

1. The Healthcare for Homeless Veterans Program (HCHV) performs outreach to identify veterans experiencing homelessness who are eligible for VA services and assist these veterans in accessing appropriate health care and benefits. (\$275 Million)

The Homeless Providers Grant and Per Diem (GPD) promotes the development and provision of transitional housing and services with the goal of helping homeless veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Includes \$180 million for post-covid per diem adjustments and \$50 million for the next round of Capital Grants. (\$500 Million)

The Healthcare for Reentry Veterans and Veteran's Justice Outreach program helps justice-involved veterans avoid the unnecessary criminalization of mental illness and extended incarceration by ensuring that eligible veterans have timely access to Veterans Health Administration. (\$75 Million)

The Supportive Services for Veteran Families (SSVF) program provides funding for very low-income veteran families in or transitioning to permanent housing. The Secretary has expressed a departmental goal of permanently housing an additional 38,000 homeless veterans by the end of the year and the funding should reflect that aim. NCHV is requesting continued report or bill language to ensure sufficient rapid rehousing and homelessness prevention capacity monitoring the expansion of the shallow subsidy initiative of the SSVF program until outcomes are tangible. (\$795 Million)

Case Managers working Case Management for the HUD-VASH Program work with homeless veterans can use this resource to address the multifaceted needs they have. Veterans must agree to participate in case management in order to receive a HUD-VASH voucher. The President's Fiscal Year 2023 Budget and the VA secretary have requested larger base increases to continue to hire full-time equivalent (FTE) case managers. (\$594 Million)

The Medical Support and Compliance (0152) accounts under VA Medical Services for homeless veteran programs requires additional funding to support the use of administrative fees for the hiring and retention of staff. (Highest Funding Possible)

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Additional funding for new HUD-VASH Vouchers provides a much-needed yearly increase in program funding to allow for continued referrals. Many factors contribute to underutilization like housing stock, case manager hiring and retention, and VA has been working to alleviate what it can and has made some progress on hiring FTEs. Additional vouchers will allow developers to operationalize additional supportive housing for veterans. Includes \$40 million for project-based vouchers. (\$90 Million)

Tribal HUD-VASH—Tribes have been working to actively increase capacity within HUD-VASH to meet community needs. (\$5 Million)

REPORTING

We request that each Secretary produce continuing reports on racial equity and access to programs providing services to homeless veterans. The reports track departmental expenditures within Homeless Veteran Programs specifically with regard for minority, female and LGBTQ populations. This report would be provided annually to the Appropriations and Veterans' Affairs subcommittees of jurisdiction. The information should be disaggregated by ethnicity, age, gender identity, and discharge status. The data collected to produce the report will be crucial in determining how to continue future homeless veteran population reductions and should be accessible to the general public.

We request report language in the VA appropriations bill to continue the implementation of a housing first oriented approach to addressing veteran homelessness. Given the research on its outcomes and cost effectiveness NCHV requests Congress direct the Department to continue implementation of housing-first oriented systems and efforts to meaningfully incorporate appropriate levels of transitional housing capacity into systems across the country to meet the needs of veterans who choose recovery services or transitional housing programs.

We request the VA Secretary produce a report regarding increased effectiveness and efficiency of VA's Grant and Per Diem. The report would include historical rate data (3–5 years) disaggregated by location & zip code and not solely by grantee name, in addition to ethnicity, age, gender identity, and discharge status. The report would include the number of beds indicated by geographic location and disaggregated by type of bed and their level of congregate setting. The report would also include a proposal and ramifications for decoupling GPD rates from the state home domiciliary rate in favor of more regional calculation based on area fair market rents. When the National Health Emergency sunsets the GPD rate will revert to 115 percent of the state home rate. NCHV has testified repeatedly that this rate is nowhere near sufficient to shelter veterans in major urban areas like California where the cost is over 400 percent of the state home rates.

We thank you for your past and continued support of veteran homelessness programs and your consideration of these important requests.

Sincerely,

[This statement was submitted by Kathryn Monet, Chief Executive Officer, National Coalition for Homeless Veterans.]

PREPARED STATEMENT OF THE NATIONAL COLLEGE ATTAINMENT NETWORK

On behalf of the National College Attainment Network (NCAN), we write to respectfully request that investments in education programs, such as funding for Federal student aid, remain a high priority for the Labor-HHS-Education subcommittee in Fiscal Year 2023. NCAN hopes that discretionary funding will rise in FY23 for programs that are critical to our Nation's students and future workforce. Thank you for your continued leadership on investing in the Federal programs that support students in their pursuit of postsecondary education.

For FY23, NCAN requests these funding levels for the U.S. Department of Education programs:

- NCAN recommends the requisite funding in FY23 so that the maximum Pell Grant award can be increased to \$12,990, double the maximum Pell Grant award (award year 2021–22).
- Supplementary Educational Opportunity Grant funding of \$1.09 billion.
- Federal Work-Study funding of \$1.52 billion.
- TRIO program funding of \$1.307 billion.
- GEAR UP funding of \$435 million.
- \$620 million increase in administrative funding for Federal student aid management.

Additionally, we request that the Corporation for National and Community Service receive \$1.34 billion in funding for FY23—and that the AmeriCorps program, that allows some college access programs to provide near-peer mentors for their students, receive \$557 million in funding.

Founded in 1995, NCAN represents more than 500 members across the country that all work toward a shared 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 percent less likely to enroll in postsecondary education directly after high school than a high-income student. Ultimately, only 35 percent of low-income high school students obtain a postsecondary credential by age 26, compared to 72 percent of high-income students.

To help close equity gaps in attainment, NCAN requests the following in Federal investments:

Pell Grant Investments

NCAN recommends that the maximum Pell Grant award be increased to \$12,990, double the maximum award (award year 2021–22).

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, far less students from low-income backgrounds would be able to access higher education. NCAN appreciates investments Congress has made to raise the maximum Pell Grant award in recent years.

Given that the previously required automatic inflationary increases have expired, annual investments by Congress are essential for our Nation's students who are least likely to have the means to pay for education after high school. Even with recent investments, the maximum Pell Grant award's purchasing power at a 4-year public institution only covers 30 percent of the cost of attendance. At its high in the 1970s, the maximum Pell Grant award could have covered more than three-fourths of the average cost of attendance—tuition, fees, and living expenses—at a 4-year public institution.

To address its long-term purchasing power, and so that the maximum award cover at least half of the cost of attendance at a 4-year public institution, the maximum Pell Grant award should be doubled. In the president's FY23 budget request, the administration requests Congress consider a Pell Grant increase of \$1,775, through discretionary and mandatory funding, to bring the maximum award to \$8,670 for the 2023–24 award year. If Congress adopted this increase, the maximum award's purchasing power would increase to 36 percent. Further, this historic investment is necessary to reach the goal outlined in the president's budget of doubling the Pell grant by 2029.

FAFSA Simplification

In the president's FY23 budget request, the administration requests a \$620 million increase in administrative funding for the management of Federal student aid. This funding is 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 1 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 FY23 so that institutions of higher education to support a greater percentage of our Nation's lowest-income students. For FY22, NCAN respectfully requests that Congress fund the SEOG program at a total of \$1.09 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 FY23, NCAN respectfully requests that Congress increase the FWS program budget for a total of \$1.52 billion.

Federally Funded College Access Programs—TRIO and GEAR UP

High school seniors, and especially students from low-income backgrounds, require a variety of programs to help assist as they strive to pursue education beyond high school. NCAN's members serve roughly two million students annually in their path towards attainment. To reach the students who need crucial assistance services, our members build important partnerships 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: \$1.307 billion for TRIO and \$435 million for GEAR UP.

Corporation for National and Community Service (CNCS)

For every dollar spent on national service, our Nation sees a major return on investment. Service plays an important role in the college access movement. Many of NCAN's largest members can maximize their impact for underrepresented students by participating in the AmeriCorps public-private partnership. Continuing support for CNCS, and specifically the AmeriCorps program, will enable additional volun-

teers 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 \$1.34 billion and \$557 million, respectively, for FY23.

Thank you for this opportunity to provide our funding priorities for fiscal year 2023. 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. NCAN appreciates your leadership in Congress to support these important Federal programs.

Sincerely,

[This statement was submitted by Kim Cook, Chief Executive Officer, National College Attainment Network.]

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS

On behalf of the National Congress of American Indians (NCAI), thank you for this opportunity to provide testimony on fiscal year 2023 funding for the Department of Labor (DOL), Department of Health and Human Services (HHS), Department of Education (Ed.), and the Corporation for Public Broadcasting (CPB).

Indian Country is socially, economically, and geographically diverse. Most Tribal lands are held in trust by the United States or have been completely taken from our Nations through the long history of Federal Indian policies of removal, assimilation, reorganization, and termination. As a result, we do not have the same asset base or tax base as other governments and our government revenue structure is different; Tribal Nations rely on Federal Government funding and on economic development. Policies failing to consider that we do not have the same capital equity as other American governments cause Federal programs and initiatives to be less successful than intended. Federal spending policy for programs that benefit Native Americans must be considered holistically across appropriations subcommittee jurisdictions and recognize the unique historical and political position forced upon Tribal Nations. The United States must be bold and look at new and unrealized solutions to Federal taxing and spending related to its trust and treaty obligations to Tribal Nations.

After the COVID-19 pandemic struck, the Federal Government listened to Tribal Nations' collective voice and provided the largest single infusion of Federal funding for Native Americans in U.S. history.¹ Funding from the American Rescue Plan Act embodied a simple and effective strategy to maximize the investment: empowering Tribal Nations to design their own solutions. This funding was not a panacea, particularly given that Tribal Nations began the pandemic on unequal footing compared to State and local governments, but it was historic, necessary, and essential. This historic inclusion in Federal spending for Indian Country must be the norm, and not the exception.

DEPARTMENT OF LABOR

Beginning in February 2022, the Bureau of Labor Statistics published monthly data on American Indian and Alaska Native (AI/AN) employment, using data that was previously available through the Census Bureau's Current Population Survey. The newly published data reveals a labor market that would be considered catastrophic if it were representative of the full U.S. economy, with an unemployment rate more than double that of the Nation's topline unemployment rate.² Indian Country is still recovering from the effects of the pandemic on the labor market, with unemployment rates reaching 28.6 percent during the peak of the pandemic fallout—an amount comparable to the National unemployment rate during the Great

¹Eric C. Henso et. al, "Assessing the U.S. Treasury Department's Allocations of Funding for Tribal Governments under the American Rescue Plan act of 2021", Harvard Project on American Indian Economic Development & Native Nations Institute, Policy Brief No. 7 (November 3, 2021), available at: https://ash.harvard.edu/files/ash/files/assessing_the_u.s.—treasury_departments_allocations_of_funding_for_tribal_governments.pdf?m=1635972521.

²Robert Maxim, Randall Akee, and Gabriel R. Sanchez, For the first time, the government published monthly unemployment data on Native Americans, and the picture is stark, available at: <https://www.brookings.edu/blog/the-avenue/2022/02/09/despite-an-optimistic-jobs-report-new-data-shows-native-american-unemployment-remains-staggeringly-high/#:~:text=Prior%20to%20the%20pandemic%2C%20Native,unemployment%20during%20the%20Great%20Depression,> Accessed: May 4, 2022.

Depression.³ As of January 2022, the unemployment rate for Native Americans was still greater than the peak unemployment rate for white workers during the pandemic.⁴

Even when controlling for a host of factors, the Brookings Institute posits that structural racism in the U.S. economy affects AI/AN access to education and attainment as well as employment opportunities.⁵ As traditionally place-based peoples with strong cultural and historical ties to the land, AI/ANs tend to not move away even when the economy goes bad. This means that the structural impediments to economic growth are focused and exacerbated on Tribal lands, underscoring the importance of DOL employment and training programs for AI/ANs. Unfortunately, spending for Native American programs within DOL represents 0.5 percent of total regular DOL budget authority in the fiscal year 2022 Omnibus, with an increase of less than 4.8 percent over 5 years—an amount that drastically fails to keep pace with inflation for that same period according to the Bureau of Labor Statistics' own inflation calculator. With Federal investment metrics such as these, it is no surprise that the labor market in Indian Country remains in a State of catastrophe by national standards, which dampens local, regional, and national U.S. economic productivity.

This subcommittee can correct this investment deficiency by providing at least \$61.5 million for DOL Native American Programs, \$15.5 million for Tribal grants within YouthBuild Activities, and not less than \$250 thousand to DOL Department Management for the Secretary's Native American Employment and Training Council, holding Native American Program resources harmless. Additionally, DOL has failed to make meaningful headway on the American Indian Population and Labor Force Report, required by Congress to be submitted every 2 years, despite several Tribal consultations on the need for it and meaningful/useful data. Instead, in February 2022, the DOL Employment and Training Administration issued a 96-page report on the difficulty of compiling the report and opted to further pass the buck on to the Bureau of Labor Statistics—wasting time and taxpayer resources while simultaneously failing to meet Congress' mandate. DOL must be directed to execute this long overdue and meaningful report in consultation and collaboration with Tribal Nations, and DOL resources must be conditioned on the completion of this unfulfilled obligation. Executive Branch agencies should be held accountable to fulfill Congressional and U.S. Code requirements—not waste Federal resources meant to support Indian Country to issue reports on why projects are difficult. DOL must work with Tribal Nations and across Federal agencies to develop the report Indian Country needs and deserves to support Tribal solutions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

As Congress declared in the Indian Health Care Improvement Act (25 U.S.C. § 1602), in order to fulfill its trust responsibility and treaty obligations, the U.S. must achieve the highest health care levels for AI/ANs and provide the requisite resources. While the Indian Health Service (IHS) is the primary source of Federal funds for healthcare for AI/ANs, annual appropriations for the IHS have never exceeded 50 percent of the demonstrated patient need. By cross-referencing Office of Management and Budget data with Appropriations Committee reports, regular appropriations for HHS in fiscal year 2022 for the benefit of Native Americans represents 0.68 percent of the total budget authority provided by Appropriations Committees. When this amount is controlled to remove IHS (funded within the jurisdiction of the Interior, Environment, and Related Agencies subcommittee), this subcommittee's investment in Indian Country is an appalling 0.15 percent of its regular budget authority appropriated for fiscal year 2022.

This (lack of) investment tells a vivid story of health and wellbeing in Indian Country and of Congress' priorities for health and wellbeing when controlling for all competing interests within this subcommittee's jurisdiction. It tells a story of how Congress values (or fails to value) its treaty and trust obligations and the human lives that it obligated itself to protect in exchange for the wealth and bounty that created the most economically prosperous and powerful country in world history. The ongoing Coronavirus pandemic uniquely impacted and exacerbated the health conditions of Indian Country, but AI/ANs began this pandemic already in a health crisis caused by the United States' chronic underinvestment in its own obligations; by the promises to its citizens that it broke—that remain broken. Even as we recover globally from the pandemic, additional emerging issues are disproportionately im-

³Id.

⁴Id.

⁵Id.

pacting Tribal communities. The loss of our loved ones, our economies, and the devastating effects of isolation with inadequate infrastructure are causing a mental health crisis across Indian Country. The rising costs of goods and lingering labor fallout are affecting early childhood development outcomes. The lack of adequate communications infrastructure is affecting our educational attainment. This crisis is not over for our people, even as we face new crises on practically every front.

The United States' trust and treaty obligations to Tribal Nations and their citizens cannot be singularly siloed into one bureau or agency. IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease research and prevention, early childhood development and welling education, injury prevention, and promotion of healthy lifestyles. HHS administers a wide array of health and wellbeing programs for Indian Country, including child and family welfare, mental health services, education, and cultural preservation. This subcommittee can address these compounded crises by providing not less than \$505.98 million for Tribal grants within Children and Families Services Programs—including \$349.98 million for Programs for Children, Youth and Families and not less than \$156 million for Native American Programs (Administration for Native Americans); \$203.52 million for Tribal grants within the Substance Abuse and Mental Health Services Administration; \$111.23 million for Tribal grants within the Administration for Community Living; \$17.41 million for Tribal grants within Promoting Safe and Stable Families; and \$14.01 million for the Tribal Home Visiting Program.

DEPARTMENT OF EDUCATION

The U.S. Department of Education funds promote the success of Native students in public schools, as well as Bureau of Indian Education-funded and tribally controlled schools and Tribal Colleges and Universities. An educated citizenry serves as a catalyst to boost prosperity and growth through a more competitive workforce, which can attract new businesses, stimulate Tribal economies, and foster entrepreneurial endeavors in the community. Tribal education is uniquely reliant on the Federal appropriations process because disparities in tax jurisdictions limit Tribal governments' ability to raise revenue in ways other governments take for granted. A growing body of research finds important positive connections between the linguistic and cultural environments in which Native American children grow and their outcomes. Congress must provide the resources to fulfill its trust and treaty obligations to Native Americans through culturally appropriate education.

In order to fulfill these obligations and improve on AI/AN education and attainment, this subcommittee should provide not less than \$2.095 billion for Indian Education programs—including \$2 billion for Tribal Local Education Agencies (LEAs); \$2 billion for Impact Aid for the benefit of Native students; \$20 million for Bureau of Indian Education school assessment maintenance; \$94.2 for Higher Education Tribal programs—including \$45 million for Tribal Colleges and Universities and \$15 million for Tribally Controlled Postsecondary Vocational/Tech Institutions; and \$76 million for the American Indian Vocational Rehabilitation Services Program.

CORPORATION FOR PUBLIC BROADCASTING

Native radio stations are critical to the communities they serve because they are often the first source of emergency reporting and information for Tribal citizens. Public broadcasters use datacast technology for public alert and warning systems, homeland security, and other public safety purposes. In addition to providing emergency information, Native radio stations provide vital access to healthcare information and other services specific to the Tribal communities they serve. Often, the only forum where Native stories and issues are broadly heard are on Native radio stations.

Since 1976, the Corporation for Public Broadcasting's (CPB) 2-year advance appropriations have served as a Congressional strategy to protect public media from any immediate political pressure. Community Service Grants (CSGs) account for approximately 70 percent of CPB's appropriation, which directly funds 1,300 local public television and radio stations—including 36 Native radio stations. CPB also funds the essential system-wide station support services provided by Native Public Media, Inc., and the content production and satellite programming distribution by Koahnic Broadcast Corporation. This funding ensures that Native radio stations stay on-air and provide broadcast services to some of the most rural and remote locations in the United States.

Congress should provide at least \$7 million (advance appropriation for fiscal year 2025) to fund American Indian and Alaska Native radio stations, at least \$500,000 (advance appropriation for fiscal year 2025) for Native Public Media, and at least

\$500,000 (advance appropriation for fiscal year 2025) for the Koahnic Broadcast Corporation.

CONCLUSION

Tribal Nations are uniquely reliant on the Federal Government to fulfill its promises made in exchange for the land that created the foundation of the bounty and wealth of the United States. Our people have paid for every penny obligated to Indian Country hundreds of times over by providing this Nation with our land. In order to uphold this Nation's promises to its people, it must first uphold its promises to this land's First Peoples. We expect to continue to be treated as sovereign nations with governmental parity. We must continue down that path of Nation-to-Nation growth, and only then will all of our people be able to fully flourish.

[This statement was submitted by Dante Desiderio, CEO, National Congress of American Indians.]

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR COMMUNITY AND EDUCATION PARTNERSHIPS

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 Mark Figueroa, 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 2023 to support an additional 80,000 students across our country so that they, too, can have the support I received in GEAR UP.

As you know, 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 knowledgeable about the steps necessary to prepare 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 percent higher than low-income students nationally.¹ Considering that GEAR UP achieves this critical goal at a cost of approximately \$645 per student, per year, I strongly believe that the investment in GEAR UP pays significant dividends. GEAR UP is a powerful catalyst for sustained community improvement.

I grew up in a place in Eastern Washington State in a region known as the Tri-Cities. This part of the country is fueled by passionate Latinx immigrant migrant families working in produce fields across the State of Washington. With long days and hard work, preparing for a higher education can be challenging for many. As a first-generation migrant student and the eldest of six in my family, post-secondary education seemed like a very distant, unknown land with no clear path toward it.

However, participating in the GEAR UP program helped me actualize my dreams of a post-secondary education through mentors, college & career fairs, FAFSA nights, and college admissions workshops. Being the first in my family to pursue a higher education, my parents and I had many questions. It is a daunting process, especially if done alone. Nevertheless, GEAR UP was there to support us, and walk with us all the way. Because of GEAR UP, I was admitted and graduated from Washington State University. With these experiences, and the confidence that GEAR UP gave me, I was able to develop strong leadership skills, community connections, and discovered all the ways to give back to my community. During my time at Washington State University, I connected with other first-generation migrant students and encouraged them to follow their dreams. I joined the only Aztec-based brotherhood in the Pacific Northwest, I served in student government, and helped lead a student ministry at the intersection of faith and culture. Having led

¹U.S. Department of Education (2016). fiscal Year2017 Department of Education Justifications of Appropriation Estimates to the Congress: Higher Education (Volume II). Retrieved from: <https://www2.ed.gov/about/overview/budget/budget17/justifications/index.html>.

the way, with the support of GEAR UP, I am now there for my parents and my five sisters as they navigate the college-going process.

Additionally, I was inspired by my experiences and the experiences of others with stories similar to mine, and I was able to bring awareness to various issues affecting college students from all walks of life. I currently volunteer with local civic engagement organizations to encourage members of my community to elevate their voices. I am a secondary education teacher, I coach soccer at the same high school where GEAR UP supported me, and I am working towards a master's degree in theology. I can attest to the truth that GEAR UP does work.

For me, none of this would have been possible without the guidance of the GEAR UP program. Through my own achievements in attending postsecondary education, I can see that generational barriers in my family have been removed for future generations and they may find the same successes that I have through education. While the support that GEAR UP provided me was truly priceless, the only way that other students will be able to access the educational experiences I had because of GEAR UP, will be to continue to increase funding. Acknowledging that I am just one of the thousands of families GEAR UP has positively impacted highlights the impact of the GEAR UP program.

As you take on the work of preparing for the fiscal year 2023 appropriations, I urge you to consider increasing the investment in the GEAR UP program to \$435,000,000 so that 80,000 more students just like me can benefit from the program as I did. Thank you to the committee for taking the time to read my testimony.

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR DIVERSITY IN 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 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) 2023 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 2023.

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 participating students by implementing tailored enrichment programs designed to address their academic and social needs.

NCDHP recommends \$47.95 million for the HCOP program in Fiscal Year 2023.

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 1-year programs, with 90% being accepted to medical school, of which >95% will graduate as physicians.

As you begin the FY 2023 process, NCDHP asks that you further prioritize Title VII health professions training programs. Chairwoman Murray and Ranking Member Blunt, 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 2023 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 COUNCIL OF URBAN INDIAN HEALTH

My name is Francys Crevier, I am Algonquin and the Chief Executive Officer of the National Council of Urban Indian Health (NCUIH). On behalf of NCUIH, the National advocate for health care for the over 70 percent of American Indians and Alaska Natives (AI/ANs) living off-reservation and the 41 Urban Indian Organizations (UIOs) that serve these populations, I would like to thank Chairwoman Murray, Ranking Member Blunt, and Members of the subcommittee for the opportunity to submit public witness testimony regarding Fiscal Year (FY) 2023 appropriations. We respectfully request the following:

- Fully fund the Indian Health Service (IHS) at \$49.8 billion and Urban Indian Health at \$949.9 million for FY23 (as requested by the Tribal Budget Formulation Workgroup)
- Advance appropriations for IHS until mandatory funding is enacted
- Increase funding for Electronic Health Record Modernization

- Increase funding to \$30 million for Good Health and Wellness in Indian Country (GHWIC)
- Permanently reauthorize Native Connections (Tribal Behavioral Health Grant)
- Include urban Indians in language for all health programs
- Include UIOs in critical opioid grants

Fully fund the Indian Health Service at \$49.8 billion and Urban Indian Health at \$949.9 million for FY23 (as requested by the Tribal Budget Formulation Workgroup)

While your leadership was instrumental in providing the greatest investments ever for Indian health and urban Indian health, it is important that we continue in this direction to build on our successes. The average health care spending is around \$12,000 per person, however, Tribal and IHS facilities receive only around \$4,000 per patient. UIOs receive just \$672 per IHS patient—that is only 6 percent of the per capita amount of the National average. That's what our organizations must work with to provide health care for urban Indian patients.

The Federal trust obligation to provide health care to Natives is not optional, and we thus request Congress honor the Tribal Budget Formulation Workgroup (TBFWG) FY23 recommendations of \$49.8 billion for IHS and \$949.9 million for urban Indian health. That number is much greater than the FY21 enacted amount of \$63.7 million, which truly demonstrates how far we have to go to reach the level of need for urban Indian health. At an IHS Area Report meeting where Tribal leaders presented their budget requests, one Oklahoma Tribal leader stated that "There are inadequate levels of funding to address the rising urban Indian population." Congress must do more to fully fund the IHS in order to improve health outcomes for all Native populations at the amount requested.

In 2018 the Government Accountability Office (GAO-19-74R) reported that from 2013 to 2017, IHS annual spending increased by roughly 18 percent overall, and roughly 12 percent per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar charge to IHS, increased by 32 percent overall, with a 25 percent per capita increase during the same period. Similarly, spending under Medicare and Medicaid increased by 22 percent and 31 percent respectively. In fact, even though the VHA service population is only three times that of IHS, their annual appropriations are roughly 13 times higher.

Currently, the entire Eastern seaboard is without any full-ambulatory UIOs due to lack of funding. The IHS has deemed the two remaining UIOs on the East Coast to be outreach and referral only, with a combined less than two-million-dollar budget. Unfortunately, the pandemic has shown that two outreach and referral UIOs to serve all urban Indians on the entire East Coast of the country is a failure to uphold the Federal trust obligation. It is evident the UIO line item is insufficient to allow IHS to authorize our East Coast UIOs to open fully operational clinics. Native American Lifelines is actually two programs run in both Boston and Baltimore with an annual budget for both cities of \$1.6 million. During the height of the pandemic, that meant Native people living in urban areas on the East Coast had to go back to reservations to get their vaccine to take advantage of the IHS authority that would give them the vaccine early and hopefully not become a mortality statistic.

The Federal Government owes a trust responsibility to Tribes and AI/ANs that is not restricted to the borders of reservations. Funding for Indian health must be significantly increased if the Federal Government is, to finally, and faithfully, fulfill its trust responsibility.

Advance Appropriations for IHS Until Mandatory Funding is Enacted

The Indian health system, including IHS, Tribal facilities and UIOs, is the only major Federal provider of health care that is funded through annual appropriations. If IHS were to receive mandatory funding or, at the least, advance appropriations, it would not be subject to the harmful effects of government shutdowns, automatic sequestration cuts, and continuing resolutions (CRs). When IHS is funded through a CR, the IHS can only expend funds for the duration of a CR, which prohibits longer term purchases, disrupts the contracts that allow UIOs to provide health care, and quite literally puts lives at risk. Because UIOs must rely on every dollar of limited Federal funding they receive to provide critical patient services, any disruption has significant and immediate consequences.

NCUIH supports the President's proposal in the FY 2023 Budget to fund the IHS through mandatory appropriations and to exempt IHS from proposed law sequestration. The 10 years of appropriated mandatory funding in the FY 2023 Budget will ensure predictability that will allow the I/T/U system to engage in long-term and strategic planning. The lack of consistent and clear funding creates significant barriers on the already underfunded IHS system. Until authorizers act to move IHS

to mandatory funding, we request that Congress provide advance appropriations to the Indian health system to improve certainty and stability.

Increase funding for Electronic Health Record Modernization

We request your support for the Indian Health Service's (IHS) transition to a new electronic health record (EHR) system for IHS and UIOs. As EHR modernization moves from planning to fruition, it is vitally important that appropriations continue to increase as appropriate to provide for its success. NCUIH Requests the committee to support this transition with \$355.8 million in FY23 appropriations. NCUIH is also supportive of the inclusion of report language suggested by members of Congress in a letter to the House appropriations committee.¹

CDC: Good Health and Wellness in Indian Country—\$30 Million Good Health and Wellness in Indian Country (GHWIC)

The GHWIC program is CDC's single largest investment in Indian Country. The program funds a total of 27 Tribes, Tribal organizations, and UIOs to improve chronic disease prevention efforts, expand physical activity, and reduce commercial tobacco use. The FY 2023 President's Budget proposes maintaining at current levels of \$22 million. NCUIH requests the Committee support the GHWIC program by increasing funding to \$30 million for FY 2023.

SAMHSA: Tribal Behavioral Health Grant (Native Connections)—\$23.2 Million

The Tribal Behavioral Health Grant (known as Native Connections) is a 5-year grant program that helps American Indian and Alaska Native communities identify and address the behavioral health needs of Native youth. The program supports grantees in reducing suicidal behavior and substance use among Native youth up to age 24, easing the impacts of substance use, mental illness, and trauma in Tribal communities, and supporting youth as they transition into adulthood.

As of June 2021, SAMHSA had awarded 242 5-year grants to eligible AI/AN entities including UIOs. The program is up for reauthorization in 2022 and the FY23 President's budget has a request of \$23.2 million for the program, an increase of \$2.5 million from the FY 2022 Annualized Continuing Resolution. NCUIH requests the committee support addressing the behavioral health needs of our Native communities by reauthorizing this critical program.

Include Urban Indians in Language for All Health Programs

The Declaration of National Indian Health Policy in the Indian Health Care Improvement Act States that: "Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." In fulfillment of the National Indian Health Policy, the Indian Health Service funds three health programs to provide health care to AI/ANs: IHS sites, tribally operated health programs, and Urban Indian Organizations (referred to as the I/T/U). Unfortunately, this system has been hampered by decades of chronic underfunding. Additionally, while the majority of the Native population resides in urban areas, only 1 percent of the entire Indian health budget is provided for urban Indian health.

When urban Indians are not specifically mentioned in programmatic language they are most often excluded from participating in such programs. Many programs in the Health and Human Services appropriations bills include language for Indian Tribes and Tribal organizations, but not for urban Indian organizations. Urban Indian Organizations are not considered Tribal organizations, which is a common misconception. Therefore, UIOs must be explicitly included to receive funding. UIOs also do not have access to other IHS line items like IHS and Tribal facilities and do not receive hospitals and health clinics money, purchase and referred care dollars, or IHS dental services dollars, and are not eligible for the IHS facilities fund.

As one advocate stated, "The language everywhere has to include the word 'urban'—urban Indian or urban Native. They have to say it, they have to write it and then it'll reach a critical mass, eventually. Because they don't get it, you know. We're just invisible."²

Include UIOs in Critical Opioid Grants

UIOs have repeatedly been left out of funding designed to help AI/AN communities address the opioid crisis. To address the opioid overdose epidemic in Indian

¹ <https://files.constantcontact.com/a3c45cb9201/562eb81b-dee4-48b8-8519-69bcbabb0ff2.pdf?rdr=true>.

² <https://www.usatoday.com/story/news/politics/2022/03/07/opioids-native-americans-funding/9380063002/?gnt-cfr=1>.

Country by increasing access to culturally appropriate and evidence-based treatment, Congress provided funding for Tribal Opioid Response grants. NCUIH has long advocated for UIOs to be added to the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Opioid Response (SOR) grants given the extent of the impact of the opioid epidemic on all AI/ANs regardless of residence. Since FY 2018, Congress has enacted set asides in opioid response grants to help Native communities address this crisis. However, it was only available for Tribes and Tribal organizations, meaning UIOs working against the same problem are left without the resources necessary to reach the highest health status for all AI/ANs as required of the Federal Government. This is a failure of equity. Without the necessary funding to address health crises in Indian Country, urban AI/AN people will again be left out of the equation.

Last Spring, Congress introduced the State Opioid Response Grant Authorization Act of 2021 (H.R. 2379), which included a 5 percent set-aside of the funds made available for each fiscal year for Indian Tribes, Tribal organizations, and UIOs to address substance abuse disorders through public health-related activities such as implementing prevention activities, establishing or improving prescription drug monitoring programs, training for health care practitioners, supporting access to health care services, recovery support services, and other activities related to addressing substance use disorders. NCUIH worked closely with Congressional leaders to ensure the inclusion of urban Indians in the funding set-aside outlined in this bill, which eventually passed the House on October 20, 2021. Despite this effort, UIOs were removed from the SOR Grant reauthorization, which saw a \$5 million increase (9 percent increase from FY 2021), included in the recently passed FY 2022 Omnibus (H.R. 2471). The final language in the Omnibus only listed "Indian Tribes or Tribal organizations" as eligible and did not use the language from H.R. 2379. When UIOs are not explicitly stated as eligible entities, we are excluded from critical resources and grants, which is a violation of the trust obligation.

We were disappointed to yet again be left out of this key resource as our communities are plagued by the opioid crisis. Inclusion in this program could have enabled UIOs to expand services or workforce or to help address the catastrophic impacts of the opioid epidemic in Indian Country. We urge you to work to ensure funding designated to help AI/AN communities have the proper language to prevent UIOs from lacking access to these critical funds.

Conclusion

These requests are essential to ensure that urban Indians are properly cared for, both during this crisis and in the critical times following. It is the obligation of the United States government to provide these resources for AI/AN people residing in urban areas. This obligation does not disappear in the midst of a pandemic, instead it should be strengthened, as the need in Indian Country is greater than ever. We urge Congress to take this obligation seriously and provide UIOs with all the resources necessary to protect the lives of the entirety of the AI/AN population, regardless of where they live.

PREPARED STATEMENT OF THE NATIONAL ECZEMA ASSOCIATION

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

-
- Provide the National Institutes of Health (NIH) with at least \$49 billion in funding, a \$3.5 billion increase over FY 2022.
 - Provide proportional funding increases for the individual NIH institutes and centers that manage the eczema portfolio, most notably the National Institute of Allergy and Infectious Diseases (NIAID) and the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).
 - Provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
 - Provide the Centers for Disease Control and Prevention (CDC) with \$11 billion in funding, an increase of \$2.55 billion over FY 2022.
 - Provide \$6 million in funding for the Chronic Disease Education and Awareness Program at CDC, an increase of \$3 million over FY 2022.
-

Thank you for the opportunity to present testimony on behalf of the National Eczema Association (NEA) and to share the experiences of the eczema community.

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for continuing to invest in medical research and public health programs through the FY 2022 omnibus appropriations package. Recent years of funding increases have led to notable advances in eczema research and new opportunities for meaningful public health collaborations. As you work with your colleagues on FY 2023 appropriations, please maintain the commitment to increase funding for medical research and public health programs that serve eczema patients and raise awareness of the wide-ranging impacts on affected individuals and their families.

ABOUT THE NATIONAL ECZEMA ASSOCIATION

The National Eczema Association is the largest patient advocacy organization dedicated solely to all forms of eczema, including atopic dermatitis (AD), the most common and chronic form of eczema. NEA represents the voice of over 31 million affected American adults, children, and their families, and is the driving force for an eczema community fueled by knowledge, strengthened through collective action and propelled by the promise for a better future.

ABOUT ECZEMA AND ATOPIC DERMATITIS

Eczema is the name for a group of conditions that cause the skin to become itchy, inflamed, and have a rash-like appearance. Atopic dermatitis (AD) is the most common type of eczema, affecting more than 9.6 million children¹ and about 16.5 million adults² of all races and ethnicities³ in the United States. We are entering a new era of care for eczema patients with several FDA-approved groundbreaking therapies for AD that have the potential to be transformative in their ability to ease the numerous physical, psychological, and quality of life burdens of eczema.^{4,5,6}

Research in this area is largely led by the National Institutes of Health (NIH) through the National Institute on Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and the National Institute of Allergy and Infectious Diseases (NIAID). Much more basic, translational, and clinical research is needed to further the scientific understanding of all forms of eczema, as recent breakthroughs have led to the advent of potential drug and biologic therapies for atopic dermatitis. However, despite life-changing therapeutic advances, these novel treatment options are presenting emerging coverage, access, and out-of-pocket cost barriers for the diverse community. Public health activities are also relatively modest with meaningful opportunities for enhanced surveillance, public awareness, and healthcare provider education.

QUICK FACTS

- 31 million people in America are living with eczema.^{7,8}
- The annual economic burden of AD (AD) is estimated to be over \$5 billion.⁹

¹ Shaw TE, Currie GP, Koudelka CW, Simpson EL. Eczema prevalence in the United States: data from the 2003 National Survey of Children's Health. *J Invest Dermatol.* 2011;131(1):67–73.

² Chiesa Fuxench ZC, Block JK, Boguniewicz M, et al. Atopic Dermatitis in America Study: A Cross-Sectional Study Examining the Prevalence and Disease Burden of Atopic Dermatitis in the US Adult Population. *J Invest Dermatol.* 2019;139(3):583–590.

³ Hanifin JM, Reed ML, Eczema Prevalence and Impact Working Group. A population-based survey of eczema prevalence in the United States. *Dermatitis.* 2007;18(2):82–91.

⁴ Drucker AM, Wang AR, Li WQ et al. The burden of Atopic Dermatitis: Summary of a report for the National Eczema Association. *J Invest Dermatol.* 2017;137(1):26–30.

⁵ Chiesa Fuxench ZC, Block, JK, Boguniewicz M, et al. Atopic dermatitis in America study: A cross-sectional study examining the prevalence and disease burden of atopic dermatitis in the US adult population. *J Invest Dermatol.* 2019;139(3):583–590.

⁶ Silverberg J, Gelfand J, Margolis D et al. Patient burden and quality of life in atopic dermatitis in US adults. *Ann Allergy Asthma Immunol.* 2018;121(3):340–347.

⁷ Hanifin JM, Reed ML, Eczema Prevalence and Impact Working Group. A population-based survey of eczema prevalence in the United States. *Dermatitis.* 2007;18(2):82–91.

⁸ Silverberg JI, Hanifin JM. Adult eczema prevalence and associations with asthma and other health and demographic factors: a US population-based study. *J Allergy Clin Immunol.* 2003;112(5):1132–1138.

⁹ Drucker AM, Wang AR, Li WQ, Severson E, Block JK, Qureshi AA. The Burden of Atopic Dermatitis: Summary of a Report for the National Eczema Association. *J Invest Dermatol.* 2017;137(1):26–30.

—55 percent of affected adults with AD currently report inadequate disease control.^{10,11}

NIH RESEARCH

Ongoing congressional support for NIH has allowed for growth of the NIH annual budget to \$42.9 billion in FY 2021 from \$34.1 billion in FY2017. As a result of additional resources and high-quality investigator-initiated research proposals, the eczema research portfolio has grown from \$32 million in FY 2017 to \$46 million in FY 2021. While the eczema portfolio is increasing, so are research costs, and this current funding translates to approximately \$1.42 in annual research funding per American affected by eczema. More can be done as gaps in our basic understanding of eczema remain and patients continue to have limited treatment options. With additional NIH support, more ambitious projects can be initiated, including timely translational research and larger clinical studies.

CDC PUBLIC HEALTH EFFORTS

The CDC budget's growth has been modest in recent years and as such the National Center for Chronic Disease Prevention and Health Promotion has been working in several priority areas with limited resources. Presently, and despite a significant U.S. disease prevalence, there are few public health efforts taking place in eczema. Additional public awareness, professional education, and related efforts would be of tremendous benefit to the eczema patient, caregiver and health care provider communities. The Chronic Disease Education and Awareness (CDEA) program provides an opportunity to infuse identified disease areas with additional needed resources and is currently supporting four novel projects through its first round of funding. Increasing CDEA funding to \$6 million for FY 2023 will facilitate growth in the program while providing another opportunity to submit for projects in disease areas, such as eczema, not yet supported by the CDEA program or broader CDC efforts.

PATIENT STORIES

Akilah from Pennsylvania: NEA Ambassador and parent of a teenager living with eczema

Akilah is one of NEA's Ambassadors and she is the parent of a teenager living with eczema. Her son has severe eczema and was diagnosed at a young age. As a parent, Akilah worked closely with her son's doctor to try and find a treatment that would work for him. This resulted in trying and failing a variety of treatments. Finally, they learned that a biologic was available but due to step therapy Akilah's son would have to try and fail methotrexate, which has a plethora of severe side effects and could damage internal organs. Akilah made the tough decision to say no to this treatment option and had a frank conversation with the doctor. Would you put your own child on this drug when there is a safer treatment available? She feels strongly that parents shouldn't have to have this conversation and they shouldn't have to battle with insurance companies to get the right treatment at the right time for their child. Her doctor helped her find a clinical trial for her son—and he has since been prescribed the biologic. She is a strong believer in research and that more treatment options need to be approved in the eczema space, especially in patients of color.

Christy from Utah: NEA Ambassador and a patient with atopic dermatitis

Christy is one of NEA's Ambassadors and she has atopic dermatitis. She feels lucky to have had a great relationship with her dermatologist for the past 10 years. During this time, she has tried and failed a variety of treatments—until she finally found a treatment that worked for her. Unfortunately, when she switched jobs, she had a new insurance company that mandated step therapy. She was then forced to fail on medications that she's tried before. This made zero sense, both to her health and to her pocketbook, to have to try medications that were already documented as failure. Ultimately, she was able to get back on the right medication, but it took perseverance from her dermatologist as well as being her own advocate.

¹⁰ Simpson EL, Guttman-Yassky E, Margolis DJ, et al. Association of Inadequately Controlled Disease and Disease Severity With Patient-Reported Disease Burden in Adults with Atopic Dermatitis. *JAMA Dermatol.* 2018;154(8):903–912.

¹¹ Wei W, Anderson P, Gadkari A, et al. Extent and consequences of inadequate disease control among adults with a history of moderate to severe atopic dermatitis. *J Dermatol.* 2018;45(2):150–157.

[This statement was submitted by Julie Block, President & CEO, National Eczema Association.]

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) 2023 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, including proposing a historic \$500 million for Title X in the FY 2022 bill, and urge you to take at least this substantial step forward in this year's bill.

NFPRHA is a non-partisan, non-profit membership association that supports the work of family planning providers and administrators, especially in the safety net. NFPRHA membership includes more than 1,000 entities 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. As a leading expert in publicly funded family planning, NFPRHA conducts and participates in research; provides subject matter expertise to policymakers, health care providers, and the public; and offers its members capacity-building support aimed at maximizing their effectiveness and financial sustainability as providers of essential health care. Currently, more than 80 percent of all Title X grantees are NFPRHA members.

Title X is the only Federal program dedicated to providing family planning services for people with low incomes. Title X-funded health centers are lifelines in their communities, providing high-quality reproductive and sexual health care, including cancer screenings, testing and treatment for sexually transmitted infections, contraceptive services and supplies, pregnancy testing, and other essential health care services. These centers offer care to people who often face severe structural barriers to accessing quality health care, such as people with low incomes, people who are un- or under-insured, people of color, people who live and work in rural areas, and LGBTQ people. Prior to the implementation of the Trump administration's devastating program rules in 2019, nearly 4,000 health centers in the Title X network served close to 4 million patients annually.¹ In addition, six in 10 women who used Title X-funded health centers in 2016 said that provider was their only source of health care for the entire year.²

For FY 2022, Title X is funded at \$286.5 million, well below the \$500 million proposed in the Senate bill and the \$737 million 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.³ We respectfully request that the Senate match that federally recommended level of funding, \$737 million, for the Title X program in FY23. That funding level would allow the program to rebuild from crises experienced in recent years and expand to reach millions more Americans. We also note that this recommendation, based on the number of women in need, is a significant under-estimate of the true need, as the program now serves more than 100,000 men and nonbinary individuals each year.

An influx of funds is particularly important given the continued impacts that recovery from the Trump administration's 2019 program rule and the COVID-19 pandemic are having on the program, the providers funded by it, and most importantly the patients for whom Title X sites serve as critical, and sometimes their only, points of access to care. On July 15, 2019, the Trump administration's new 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, including all of the health centers in six States. Then, in March 2020, family planning providers, like all frontline health care workers, needed to adapt overnight to the realities of serving under-resourced communities during a global pandemic.

¹Christina Fowler et al, "Family Planning Annual Report: 2018 National Summary," RTI International (August 2019). <https://opa.hhs.gov/sites/default/files/2020-07/title-x-fpar-2018-national-summary.pdf>.

²Meghan Kavanaugh, "Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016," Guttmacher Institute (June 2018).

³Euna 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.

In September 2021, OPA released the first Federal data showing the impact of the rule and COVID-19, and the results were devastating: relative to 2018, Title X-funded health centers provided family planning services to 2.4 million fewer patients in 2020, a staggering 61 percent decrease over just 2 years. This drastic decrease translated to millions of fewer contraceptive services provided, more than 4.3 million fewer STI and HIV tests administered, and more than 800,000 fewer life-saving breast and cervical cancer screenings performed with Title X funds. OPA attributed 63 percent of the decrease in patients served to the 2019 rule and 37 percent to the pandemic.⁴ Compounding these challenges in accessing Title X-funded services, a 2020 study showed the COVID-19 pandemic 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.⁵ Women of color and women with low incomes were more likely to report both findings.

The Biden-Harris administration has made significant progress toward restoring the Title X program, including finalizing a new rule in October 2021,⁶ distributing \$6.6 million in Title X funds to communities with a dire need for family planning services in January 2022,⁷ and distributing \$256.6 million for Title X projects across the country just last month.⁸ However, the administration was unable to fund many qualified applicants, and under-funded dozens more, due to insufficient funds. While a small number of past grantees received additional funds in May 2022, it is clear that current funding of \$286.5 million annually is simply insufficient to meet the needs of providers and patients across the country. Without additional funds, grantees and subrecipients are at significant risk of reducing service availability, laying off frontline health care workers, and even closing health centers.

With a significant increase in funds in FY23, OPA can make real progress toward rebuilding the Title X program and serving more people in need of these critical services. We thank you for your consideration of this request and look forward to working with you throughout the FY23 appropriations process. If you have questions about this request, please contact Lauren Weiss, Director, Policy & Communications, at lweiss@nfpf.org.

Sincerely,
Clare Coleman

PREPARED STATEMENT OF THE NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE
AND KIDNEY DISEASES

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 \$49 billion for the National Institutes of Health base budget in Fiscal Year (FY) 2023, an increase of 7.9% that will provide real growth above biomedical research inflation, 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. As Congress considers authorizing and providing additional appropriations for the Advanced Research Projects Agency for Health (ARPA-H), our request will ensure that funding for the new entity will supplement, not sup-

⁴ Christina Fowler, Julia Gable, and Beth Lasater, "Family Planning Annual Report: 2020 National Summary," RTI International (September 2021). <https://opa.hhs.gov/sites/default/files/2021-09/title-x-fpar-2020-national-summary-sep-2021.pdf>.

⁵ 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/earlyimpacts-covid-19-pandemic-findings-2020-guttmacher-survey-reproductive-health>.

⁶ HHS Press Office, "HHS Issues Final Regulation Aimed at Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," US Department of Health and Human Services (October 4, 2021). <https://www.hhs.gov/about/news/2021/10/04/hhs-issues-final-regulation-aimed-at-ensuring-access-to-equitable-affordable-client-centered-quality-family-planning-services.html>.

⁷ ASH Media, "HHS Awards \$6.6 Million to Address Increased Need for Title X Family Planning Services," US Department of Health and Human Services (January 21, 2022). <https://www.hhs.gov/about/news/2022/01/21/hhs-awards-6.6-million-address-increased-need-for-title-x-family-planning-services.html>.

⁸ ASH Media, "HHS Awards \$256.6 Million to Expand and Restore Access to Equitable and Affordable Title X Family Planning Services Nationwide," US Department of Health and Human Services (March 30, 2022). <https://www.hhs.gov/about/news/2022/03/30/hhs-awards-256-million-to-expand-restore-access-to-equitable-affordable-title-x-family-planning-services-nationwide.html>.

plant, those funds provided to NIH to support much needed basic research and training programs in kidney disease.

In addition, our organizations request that the committee include report language in the Labor, Health and Human Services, and Related Agencies (LHHS) appropriations bill to support achieving kidney health equity and a strong kidney health workforce. We request that Congress address kidney health equity by allocating resources at NIDDK to study improved methods for diagnosing kidney diseases that do not rely on race-based variables. Further, we request that Congress ensure there is a physician-scientist workforce ready to meet the current and future needs of people with kidney diseases by making certain new training programs, such as the Division of Kidney, Urologic, and Hematologic Diseases (KUH) U2C grant mechanism, increase the number of training slots for adult and pediatric physician-scientists. Greater investment in kidney research is needed to advance the 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 these conditions.

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 and has a survival rate worse than most cancers (and comparable with brain cancers). While a kidney transplant is the optimal therapy for most patients, it is often inaccessible due to a shortage of organs and inequities in our Nation's transplant health system. Both dialysis and transplant patients are immune compromised, which puts them at increased risk of communicable diseases—especially COVID-19. Devastatingly, COVID-19 has caused a 20% increase in mortality among people receiving dialysis, the first-ever decrease of people enrolled in the Medicare ESRD program. 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.

Almost 50 years ago, Congress made a commitment to treat all Americans with irreversible kidney failure, regardless of age, through the Medicare End-Stage Renal Disease (ESRD) Program. Medicare annually spends approximately \$125 billion on the care of people with kidney diseases, or 24% of all Medicare fee-for-service spending. Of this amount, \$37 billion, or 7% of Medicare fee-for-service spending, is spent managing kidney failure. These costs do not include expenditures from Medicare Advantage or non-Medicare plans, which together cover 62% of people with kidney failure. 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.

Even as Congress has provided steady increases for the NIH over the past decade, NIH funding for kidney disease research has lagged far behind that of NIH overall; between fiscal years 2015 and 2020, funding for NIH rose 37%, compared to just 19% for kidney research. Additionally, no dedicated funding has been provided to NIDDK to study the impact of COVID-19 on kidney health despite the severe impact of COVID-19 on people with kidney diseases. As a result, research of this critical topic has come at the expense of existing, and underfunded, research opportunities. Increased investment in kidney health research will improve outcomes for people living with kidney diseases and reduce costs to the US health care system. As Congress considers establishing new programs to fund science and innovation such as ARPA-H, our organizations request that the committee maintain and increase investment in kidney disease research by providing a \$49 billion increase for NIH in FY 2023 with an at least proportional increase for NIDDK.

IMPROVING EQUITY IN THE DIAGNOSIS OF KIDNEY DISEASES

People with kidney diseases face stark racial and socioeconomic disparities in disease burden and access to care. For instance, Black Americans and Hispanic Americans are more than four and two times as likely than White Americans respectively to have kidney failure. 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.

One factor contributing to disparities in access to care—especially transplantation—is the inclusion of race as a variable in the diagnosis of kidney diseases. Kidney function is commonly assessed using an equation to estimate glomerular filtration rate (GFR). In 2021, ASN and NKF finalized a recommendation to remove a patient's race as a variable in equations to estimate GFR. Our organizations re-

quest the committee consider including report language in the FY 2023 LHHS appropriations bill directing NIDDK to prioritize research on new approaches for estimating GFR that do not include race as a modifier, such as the below:

“Improving the Diagnosis of Kidney Diseases.—The Committee understands that current equations for assessing glomerular filtration rate (GFR), a key measure of kidney function, include the patient’s race, and that this practice may lead to disparities for African Americans in terms of access to care and kidney transplantation. NIDDK should prioritize research on new approaches for estimating GFR that do not include race as a modifier.”

ENABLING A STRONG KIDNEY HEALTH WORKFORCE

Most people with kidney diseases experience comorbidities such as cardiovascular disease (including heart attack and stroke), anemia, bone disease, hypertension, and diabetes, and face increased risk from communicable diseases, including COVID-19 which has increased hospitalization and mortality among this vulnerable population. Pediatric kidney disease patients are often more complex than adult patients, many are living with rare medical conditions with unique needs which must be better understood. A strong, demographically representative, and culturally competent workforce of physician-scientists is needed to meet the needs of adults and children living with kidney diseases, especially while they face deadly consequences of the COVID-19 pandemic in their daily lives. Our organizations request that the committee ensure NIDDK is providing adequate support for training the next generation of kidney health scientists by requesting NIDDK to report the number of adult and pediatric training positions funded by the newly established U2C grant mechanism compared to prior mechanisms. Draft report language to support this request is provided below:

Kidney, Urologic, and Hematologic Research Training Awards.—The Committee understands that NIDDK’s Division of Kidney, Urologic, and Hematologic Diseases replaced its T32 training grant mechanism, which provided grant support to institutions whose programs promote diversity and offer doctoral degrees in the health professions or health-related sciences in these three disciplines, with a new U2C grant mechanism, which requires institutions to submit a single application to receive training slots in all three research areas. The T32 program maintained a strong record of success in training new members of the biomedical research workforce in nephrology, urology, and hematology, including future pediatric researchers. With this in mind, the Committee is concerned that the new U2C mechanism may lead to a reduction in training slots for adult and pediatric researchers in these three disciplines. The Committee requests the Institute provide a comparison of training positions, adult and pediatric, funded by discipline under the T32 mechanism in 2018–19 to the number of slots currently funded and projected to be funded in the next 3 years under the U2C mechanism within 120 days of enactment.

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 kidney diseases and its progression in adults and children, combined with improved methods for detecting kidney diseases and a highly skilled workforce of physician-scientists, may even prevent irreversible kidney failure in the future.

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; Zach Kribs with the American Society of Nephrology at zkribs@asn-online.org; or Lauren Drew with the National Kidney Foundation (NKF) at lauren.drew@kidney.org.

ABOUT THE AMERICAN SOCIETY OF NEPHROLOGY

Since 1966, ASN has been leading the fight to prevent, treat, and cure kidney diseases throughout the world by educating health professionals and scientists, advancing research and innovation, communicating new knowledge, and advocating for the highest quality care for patients. ASN has more than 20,000 members representing

132 countries. For more information, visit www.asn-online.org and follow us on Facebook, Twitter, LinkedIn, and Instagram.

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 long-standing 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 Zach Kribs, Senior Government Affairs Specialist, American Society of Nephrology.]

PREPARED STATEMENT OF THE NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The Friends of the NIEHS are pleased to submit the following testimony regarding Fiscal Year (FY) 2023 Federal appropriations for the Labor, Health and Human Services, Education, and Related Agencies in support of the vital work being carried out by the NIH/NIEHS as a result of the annual appropriation provided for this work in the subcommittee's bill. We ask you to provide at least \$909 million for NIEHS in FY 2023 as part of an overall appropriation for NIH of \$49.048 billion not inclusive of other funds for the Advanced Research Projects Agency for Health (ARPA-H) or pandemic preparedness. We further request additional funding of at least \$100 million for NIEHS to lead research efforts on climate change and health, in partnership with other Institutes and Centers at NIH, to a total funding level of at least \$1.01 billion.

Our coalition of organizations represents a variety of interests, including medical and scientific professional societies, environment and public health focused organizations, children's health advocates, women's health advocates, and many others. Collectively, our community supports and calls attention to the vital work being done by the National Institute of Environmental Health Sciences. NIEHS, one of the component institutes and centers of the National Institutes of Health (NIH), focuses on the prevention of health problems and diseases with special emphasis on the intimate interactions between our bodies and the environments where we live, work, and play over our lifetimes.

NIEHS PLAYS A UNIQUE ROLE IN ADVANCING PUBLIC HEALTH PRIORITIES

The NIEHS plays a unique role within the NIH; it 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, Parkinson's disease, autoimmune diseases, chemical intolerance or toxicant-induced loss of tolerance, and chemical sensitivities. Expert research funded by NIEHS addresses diseases across all the NIH Institutes and Centers and identifies environmental contributors to health disparities. Specific research areas with projects that address national priorities include:

Climate Change and Health: NIEHS-funded scientists are poised to make major discoveries that will help us appreciate and address the ongoing impacts of climate change on public health. However, additional funds are needed for NIEHS to maximize the potential for biomedical research to meet the public health needs driven by climate change. Additional research is necessary to design and tailor interventions that will reduce the impact of climate change on the incidence and severity of disease, in particular for disadvantaged communities that may not have resources to mitigate the effects of climate change. We strongly support additional appropriated funds for NIEHS so that NIEHS can work with all the Institutes and Centers at NIH to develop solutions that build on existing knowledge and promote

transdisciplinary collaborations to meet the needs of communities affected by climate change.

Breast Cancer and Health Disparities: NIEHS-funded studies have been instrumental in advancing our new knowledge about the causes of cancer, including the discovery of the first breast cancer susceptibility gene. In 2019, the NIEHS Sister Study, a national cohort of over 50,000 women, found that women who use chemical hair dye and chemical hair straighteners have an increased risk of breast cancer, particularly black women. The study results suggest that chemicals in hair products may play a role in breast carcinogenesis.

Maternal and Children's Health and Environmental Exposures: NIEHS-funded research also helps us understand how and why pregnant women and children are uniquely vulnerable to harmful substances in their environment. Today's pediatric health challenges include chronic conditions such as obesity, asthma and neurodevelopmental disorders including learning disabilities and the impacts of COVID-19. Increasingly, in utero and early childhood exposures are correlated with life-long consequences including whether such exposures increase child and adolescent susceptibility to future illness and learning challenges. NIEHS research is critical, since children have unique susceptibility to toxicants due to their ongoing development and face higher rates of exposure to contaminants than adults by virtue of their size and developmentally-appropriate behaviors. Importantly, NIEHS helps us identify and act on risks to children's health. A recent NIEHS-funded study found fewer new asthma cases and an up to 20 percent lower rate of asthma after air quality improvements, including reductions in nitrogen dioxide and PM_{2.5}, were made.

Pandemic and Disaster Preparedness: Researchers funded by NIEHS have highly relevant expertise that has enhanced our response to COVID-19 and prepared us for future pandemics, for example by identifying interventions to protect health care workers facing occupational exposure to SARS-CoV-2 and how environmental exposures such as air pollution impact individual susceptibility to infection and severity of disease. NIEHS can also positively impact our response to and recovery from natural disasters and climate change. For example, the Disaster Research Response Resources Portal (DR2) and Climate Change and Human Health Literature Portal provide researchers and the public with resources and tools to design studies in partnership with communities and rapidly translate research results into actionable interventions.

Endocrine Disrupting Chemicals: NIEHS-funded research teams have led the way in advancing our understanding of how chemicals that interfere with the normal function of hormones and endocrine systems, also known as endocrine-disrupting chemicals (EDCs) can cause adverse health effects. New scientific knowledge on EDCs has established that these chemicals may have nontraditional dose response curves, developmental effects with long-term consequences, and unique effects at low doses due to the sensitive nature of the endocrine system. The decades of scientific contributions of NIEHS to this field resulted in a 2019 paper identifying key characteristics of EDCs.

INCREASED FUNDING FOR NIH AND NIEHS IS NECESSARY IN FY 2023

In conclusion, to ensure that NIEHS-funded researchers are able to continue to advance research in support of the Nation's public health priorities, the Friends of NIEHS recommend that the subcommittee provide at least \$909 million for NIEHS in FY 2023 as part of an overall appropriation for NIH of \$49.048 billion in the FY 2023 Labor, Health and Human Services, Education, and Related Agencies appropriations bill. Further, the subcommittee should provide an additional \$100 million for NIEHS to support necessary research on climate change and public health to a total level of \$1.01 billion. Finally, we request that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) agency complement this funding recommendation for NIH's base budget, rather than supplant the essential investment in the NIH, to ensure that NIH can continue to support and grow the investigator-initiated research programs that have provided the foundation for our collective successes in biomedical research.

[This statement was submitted by Joseph Laakso, Director of Science Policy, Endocrine Society.]

PREPARED STATEMENT 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 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 (SUDs). 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 SUD field.

In the Fiscal Year 2023 Labor, Health and Human Services Appropriations bill, CPDD joins with the Ad Hoc Group for Medical Research in recommending a program level of at least \$49.048 billion for the base budget of the National Institutes of Health (NIH), which would represent an increase of \$4.1 billion over the comparable Fiscal 2022 funding level. For the National Institute on Drug Abuse (NIDA), CPDD encourages the Committee to provide at least the President's recommended funding level of \$1.843 billion for NIDA, which would represent an increase of \$248 million over the comparable Fiscal 2022 funding level for the Institute.

CPDD also supports the proposal included in the President's Fiscal Year 2023 budget to change the name of the National Institute on Drug Abuse to the National Institute on Drugs and Addiction.

We also respectfully request the inclusion of the following NIDA specific report language.

Opioid Initiative. The Committee continues to be concerned about the high mortality rate due to the opioid 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 provisional data from the Centers for Disease Control and Prevention that shows opioid overdose fatalities were predicted to exceed 100,000 in the 12-month period ending in June 2021, with the primary driver being the increased overdose deaths involving synthetic opioids, primarily illicitly manufactured fentanyls. More research is needed to find new and better agents to prevent or reverse the effects caused by this class of chemicals and to provide improved access to treatments for those addicted to these drugs. To combat this crisis the Committee has provided within NIDA's budget no less than \$405,400,000 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 provisional data released by the Centers for Disease Control and Prevention, over 45,000 overdose deaths involved drugs in the categories that include methamphetamine and cocaine in the 12-month period ending in June 2021, an increase of 25 percent in a single year. 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. No FDA-approved medications are available for treating 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 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, and were predicted to exceed 100,000 in the 12-month period ending in June 2021, 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 con-

ducting research on the adverse impact of the pandemic on SUDs and encourages the Institute to continue to support 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.

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 and follow them and their children up to age 10 to characterize the influence of a variety of factors on neurodevelopment and long-term outcomes. The study aims to enroll approximately 7,500 women from 25 sites across the US, including regions of the country significantly affected by the opioid crisis. Participants will include women from the general population of pregnant women to assess normative development; those who have or are using opioids and/or other substances during their pregnancy; and women from comparable environments to the latter, but who have not used substances during their pregnancy. This knowledge will be critical to help predict and prevent some of the known impacts of pre- and post-natal exposure to drugs or adverse environments, including risk for future illicit substance use, 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 additional NIH support for this important study.

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. NIH 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.

Substance use disorders 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 disorder -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 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 treated effectively and compassionately.

We understand that the FY 2023 budget cycle will involve setting priorities and accepting compromise, however, in the current climate we believe a focus on SUDs deserves to be prioritized accordingly. Thank you for your support for the National Institute on Drug Abuse.

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, society, 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 an increase for kidney research activities under the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) that is at least proportional to the funding increase for NIH overall. We also request that appropriations for the Advanced Research Projects Agency for Health (ARPA-H) be in addition to a robust increase for NIH. Lastly, we urge greater collaboration between NIDDK and other Institutes studying related comorbidities and conditions that occur in kidney patients, such as hypertension, cardiovascular disease, immunology, disparities, and genomics.

ABOUT CKD

Chronic kidney disease impacts an estimated 37 million American adults and is the Nation's 10th leading cause of death, and 1 in 3 Americans are at risk of developing it. Although it is detectable through simple blood and urine tests, an estimated 90 percent of patients are undiagnosed, often until advanced stages when it is too late for interventions to slow disease progression (up to 40 percent of people with advanced kidney disease have not seen a nephrologist prior to progressing to kidney failure). Alarming, some patients are not diagnosed until they have progressed to irreversible kidney failure (end stage kidney failure, or ESKD) and must undergo urgent start dialysis. Nearly 800,000 Americans have ESKD, requiring kidney dialysis at least 3 times per week at a dialysis center, daily home dialysis, or a kidney transplant to survive. The 5-year survival rate for a dialysis patient is only 35 percent. The mortality rate for dialysis patients aged 66–74 is twice that of heart failure and 2.5 times that of cancer.

Medicare spends an estimated \$153 billion annually (fee-for-service and Medicare Advantage combined), nearly 25 percent of Medicare expenditures, on the care of people with a kidney disease diagnosis. Individuals with ESKD represent 1 percent of Medicare beneficiaries but comprise 7 percent of Medicare fee-for-service expenditures. The need for an increased Federal commitment to address the societal and economic burdens of CKD is undeniable.

CKD is a disease multiplier, with patients often experiencing cardiovascular disease, bone disease, anemia and fatigue, and increased hospitalization. Quality of life is impacted by cognitive challenges, depression, infection, dietary restrictions, and other factors. 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 stark racial, ethnic, and socioeconomic disparities. Blacks/African Americans, Hispanics/Latinos, Asian Americans and Pacific Islanders, and Native Americans and Alaska Natives are at higher risk for CKD and ESKD. Blacks/African Americans make up 13 percent of the U.S. population, but account for 35 percent of Americans with kidney failure. Kidney failure among Blacks/African Americans and Hispanics/Latinos are 4 times and 1.3 times more likely compared to Whites, respectively. Blacks/African Americans and Hispanics/Latinos 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. Blacks/African Americans and Hispanic/Latinos have less access to the kidney wait list, experience a longer wait once listed, and are less likely to receive a transplant from a living donor compared to Whites. The prevalent kidney transplant population with a functioning graft is 52 percent White, 20 percent Blacks/African Americans, and 16

percent Hispanics/Latinos. Among patients waitlisted in 2014, the median wait time for a transplant was 37 months for Whites, 64 months for Blacks/African Americans, and 57 months for Hispanics/Latinos.

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. This 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. COVID-19 hospitalizations in April 2021 were 8,617 per 100,000 Medicare ESKD beneficiaries, compared to 1,932 per 100,000 Medicare beneficiaries overall. Transplant recipients in particular face higher COVID-19 mortality risk. In addition, patients with 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.

CDC CHRONIC KIDNEY DISEASE INITIATIVE

The CDC Chronic Kidney Disease Initiative comprehensive public health strategy was created at the urging of Congress and NKF more than 15 years ago. Annual funding fluctuated between \$1.6 million and \$2.6 million until Congress provided \$3.5 million for FY 2022, for which we are most appreciative. The CKD Initiative supports a web site, surveillance and epidemiology activities, and assistance to the National Center for Health Statistics for CKD data collection. However, in order to address the roughly 90 percent of patients who are unaware they have CKD, and the 40 percent who receive no kidney-specific care before crashing into dialysis in full kidney failure, we must improve awareness of CKD among the public and health care practitioners to improve early detection, provide early intervention and improve outcomes. Early intervention can slow CKD progression and, in some instances, prevent kidney failure, reduce the impact of comorbidities, and reduce hospitalizations and readmissions. A sustained 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. Especially in light of the connection between surviving COVID-19 and increased risk of developing kidney disease, the time is right for a major nationwide program to improve awareness and early detection of kidney disease.

To expedite activities to improve early detection and intervention measures, NKF requests \$15 million for the CKD Initiative to increase public awareness, educate clinical professionals and expand health system capacity to diagnose and manage CKD, implement systemic changes to reduce disparities, and spur innovation by entities that serve the kidney disease community. Additional funding also would 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 researchers from estimating CKD persistence.

NIDDK

Despite CKD's impact on patients and Medicare, NIH funding for kidney disease research is only about \$700 million annually, or about \$19 per CKD patient, a fraction of what is provided on other major diseases. Fiscal Year 2021 funding for NIDDK increased by less than 1 percent, the smallest percentage increase of any disease Institute, and the FY 2022 increase was 3.4 percent. From FY 2015–2020, NIH monetary support for kidney research increased at half the rate of NIH funding increases overall. As a result, innovation in kidney research and treatment has lagged that of other diseases. Scientists however are at the cusp of potential breakthroughs in improving our understanding of CKD. 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 given its unique Medicare coverage.

In October 2021, NKF released a Research Roadmap containing recommendations for opportunities in pre-clinical and clinical research in which additional funding could help bridge existing deficits in kidney disease detection and management, reduce incidence and disparities, improve outcomes, and lower healthcare costs. Key recommendations include increasing the number of and access to clinical trials related to kidney disease (including increased participation by under-represented pop-

ulations) and identifying and implementing strategies to improve the delivery of evidenced-based care in under-represented populations. Our roadmap was the culmination of input from nephrology leaders and from kidney patients, family members and care givers, and living kidney donors. NKF leadership and staff presented the final recommendations to NIDDK staff and to representatives from other Institutes and participated in a briefing that was available to congressional staff and the public.

As the first step towards expanding kidney research opportunities, NKF requests a substantial funding increase for NIDDK that is commensurate with the percentage increase to NIH as a whole. Within that increase, we respectfully request a percentage increase for kidney research proportional to if not greater than that of NIH overall. NKF applauds recent clinical practice changes in the diagnosis of kidney disease and requests priority consideration of new markers to estimate kidney function. NIDDK should prioritize research into the adoption of new equations for estimating the Glomerular Filtration Rate (eGFR) that do not include race as a modifier. We also request NIDDK give priority consideration to additional investments in CKD clinical trials, including diversity of participants, and initiatives to improve evidence-based care in under-represented populations.

Lastly, we request Congress encourage related Institutes to consider additional funding of 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 2023.

[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 2023, we respectfully request that the subcommittee increase funding for the Program to the amount of \$38,000,000 to eliminate financial and socioeconomic barriers that reduce access to cellular therapies for thousands of primarily traditionally underserved patients.

With our Program being founded under the direction and guidance of our initial Congressional champion, the late Congressman C.W. Bill Young, NMDP/Be The Match has facilitated over 111,000 bone marrow, blood stem cell, and cord blood transplants. Each of these transplants represents a person and a family hoping above all else that cellular therapy would be the cure to save themselves or a loved one. As the home of the Nation's Registry, we are forever grateful to Mr. Young for his legacy of caring for blood cancer and blood disease patients. And, we are equally honored that Senator Roy Blunt has taken up the charge with his steadfast determination to ensure that NMDP/Be The Match has the support of Congress to continue and expand upon how we deliver cures to patients every single day. Through his commitment to seeing our patients as people he can help, Senator Blunt's longstanding promise of expanding the reach and resources of the Nation's Registry has saved thousands of lives. We know our patients are thankful beyond measure for his support and we feel that Congressman Young would be quite proud of Senator Blunt's wholehearted dedication to furthering the mission of saving lives through cellular therapy.

By establishing a national bone marrow donor registry in the mid-1980s, Congress promised patients with blood cancers, like leukemia and lymphoma and other life-threatening diseases, 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 75 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 10 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 2 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 2 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, 115,000 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 we are seeking in Fiscal Year 2023, 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 long-standing 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 \$38,000,000 to immediately provide access to therapy at the point of diagnosis for all patients.

Our request this year builds upon past funding to clear a pathway for more patients, especially those from minority and rural communities, to be able to access transplant services. It would enable targeted donor recruitment efforts, expand early intervention with community referring physicians upon patient diagnosis to accelerate the path to transplant, and propel innovation to improve outcomes and establish new treatment options to ensure a matched donor for all searching patients, regardless of their racial/ethnic background or the complexity of their DNA, ensuring access to transplant and equal and successful outcomes for all.

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 PANCREAS FOUNDATION

SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- The Foundation joins the broader research community in requesting that the National Institutes of Health (NIH) receive a funding increase of at least \$3.5 billion for FY 2023 to bring total agency funding up to a minimum of \$49 billion annually.
 - Please provide proportional increases for the various NIH Institutes and Centers, including the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the National Cancer Institute (NCI).
 - Please provide separate and distinct funding to further support the emerging Advanced Research Projects Agency for Health (ARPA-H) initiatives, which would ensure this important new effort does not supplant any ongoing NIH activities.
 - The Foundation joins the broader public health community in requesting that the Centers for Disease Control and Prevention (CDC) receive a funding increase of at least \$2.55 billion in discretionary resources to bring total agency funding up to a minimum of \$11 billion annually.
 - Please provide \$6 million in dedicated, line-item funding for the Chronic Disease Education and Awareness (CDEA) Program within the National Center for Chronic Disease Prevention and Health Promotion to facilitate support for meritorious and timely public health campaigns.
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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 treatment progress for pancreatitis. We also thank you for the ongoing support for the CDEA program at CDC. The Foundation has developed a strong proposal and additional resources will allow us (along with many other patient groups) to apply and compete for a CDC cooperative agreement. For FY 2023, we urge you to maintain this commitment to medical research and to similarly increase support public health programs. 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 like insulin. 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.

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.

Over recent years, key Committee Recommendations have been included that have moved key pancreas research projects forward and it is our hope that the subcommittee will continue to demonstrate an interest in this area during the FY 2021 process as treatment development activities reach a critical phase.

CDC PUBLIC HEALTH OPPORTUNITIES

The National Center for Chronic Disease Prevention and Health Promotion coordinates line-item public health programs on a variety of conditions. Recently, CDC has limited their public health activities almost exclusively to these named efforts. While these programs have been highly successful for the conditions they represent, there is a tremendous public health need to launch a similar program for pancreatitis.

A lack of adequate professional and public information about pancreatitis leads to a suboptimal situation where patients are not effectively managing the condition and as it progresses inappropriate interventions occur, most notably unnecessary surgery to remove the pancreas. The CDC can fill key knowledge gaps with a pan-

creatitis program to disseminate best practices to the professional community and make sure public health messages reach at-risk individuals. Pancreatitis can often be managed if the proper information is available, which can prevent the progression of disease, including the onset of pancreatic cancer.

Increasing funding for the CDEA program to \$6 million will provide CDC with the resources and flexibility it needs to hold another competition and award a third cohort of 3-year cooperative agreements through this mechanism. The collaborative public health efforts already underway with CDC have been meaningful for their communities and we look forward to pursuing a similar program and impact for pancreatitis.

AFRICAN AMERICAN INITIATIVE

The incidence of pancreatitis is higher in African Americans than any other racial group in the U.S. Many studies suggest that environmental and socioeconomic factors have contributed to the increased risk of pancreatitis among African Americans. Other preventable risk factors that are more common among African Americans that increase the risk of pancreatitis include type 2 diabetes, and obesity. Although smoking is not a cause of pancreatitis, it can accelerate the progression of the disease.

To promote health equity and address health disparities within the community, the Foundation worked with a diverse team of leading medical experts to develop and advance a pancreatitis and pancreatic cancer awareness campaign with the African American community. We welcome Federal collaborations to support further awareness and bolster critical public health activities.

Diane Tonelli's Story

I am a resident of Massachusetts and I have chronic pancreatitis. I was first diagnosed in 2002 w acute pancreatitis-idiopathic just shy of 2 years after my dad had died from pancreatic cancer. I was hospitalized 2 times, managed for pain and treated with TPN.

I struggled intensely the first few years. I lost 28 pounds, down to 92 pounds by mid-summer of 2002.

During the first few years I had genetic testing which was positive for genetic mutation CFTR R117H-cystic fibrosis and negative for BRCA1 and 2, SPINK1 and PRSS1.

Over the years since initial diagnosis I have had yearly screening. The disease had progressed to chronic pancreatitis with imaging revealing moderate to severe disease. I've had a sweat test which revealed probable Cystic fibrosis and bone density testing has revealed osteoporosis (density of an 80-year-old) due to decreased nutrition related to pancreas insufficiency.

Currently I take pancreatic enzymes and continue to follow with GI for pancreas severity and have screening for pancreatic cancer.

Lee Zeidman's Story

My name is Lee Zeidman. I am a Strategic Communications Consultant and pancreatic cancer survivor. I'm a native Washingtonian. I was part of the team that launched CNN in 1980. I also was a local sportscaster early in my career in Washington, D.C. and New York City.

I came down with an acute case of pancreatitis while on a business trip on the west coast. It was the worst pain I've ever felt—and I've broken bones playing sports. I went to the emergency room. I flew home to New York City the next day and was admitted into Weill-Cornell Medical Center where I spent 10 days in the hospital.

The doctors at Weill-Cornell diagnosed acute pancreatitis and told me it was manageable. My wife was concerned that it was cancer. She insisted they do a biopsy to rule out cancer. The doctor insisted there was no relationship between pancreatitis and pancreatic cancer (this was back in 2013, now doctors routinely look for cancer when treating pancreatitis). Grudgingly, the doctor agreed to do a biopsy after my wife repeatedly insisted. I was put on a liquid diet and sent home. Two days later the doctor called and told us to come back to the hospital, they needed to have an urgent conversation about my health. At that moment I knew the doctors had been wrong—I knew it was pancreatic cancer. The doctor refused to acknowledge the diagnosis and the news had to be delivered face-to-face. I quickly realized that had my wife not insisted on the biopsy, I might have died from pancreatic cancer within months.

My surgery was 9 years ago. It gave me a new lease on life. I still go to Sloan Kettering for annual check-ups, but I remain cancer-free. I am diabetic and wear an insulin pump, but that's a small price to pay for surviving pancreatic cancer.

[This statement was submitted by David Bakelman, Chief Executive Officer, National Pancreas Foundation.]

PREPARED STATEMENT OF THE NATIONAL SCLERODERMA FOUNDATION
THE FOUNDATION'S FISCAL YEAR 2023 L-HHS APPROPRIATIONS RECOMMENDATIONS

- \$11 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).
 - \$6 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 \$49 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).
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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 FY 2023 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 National Scleroderma Foundation is a 501(c)(3) charitable organization founded in 1998 to advance medical research, promote disease awareness, and provide support and education to people with scleroderma. Supported by a network of thousands of individuals across the United States, the Foundation is a leader in funding peer-reviewed, innovative research to discover the cause, understand the mechanism, and overcome scleroderma forever.

One of the most challenging things about scleroderma is that it shows up differently in each person. Scleroderma is complicated to manage, since it does not follow one clear path. At the National Scleroderma Foundation, we know that no two scleroderma journeys are the same. We help people find the resources that are right for them so they can live better with scleroderma.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Early recognition and 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 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. Because of this, it is important to promote cross-cutting research across such Institutes as NIAMS and NHLBI.

Please provide NIH with a significant funding increase so the scleroderma research portfolio can continue to expand and facilitate key breakthroughs. Continued support in the following areas is critical to improving the health of people with scleroderma:

- The Trans-NIH Working Group on Fibrosis, which is working to promote cross-cutting research across Institutes.
- The Scleroderma Lung Study II, being led by NNHLBI, which is comparing the effectiveness of two drugs in treating pulmonary fibrosis in scleroderma.
- Leading efforts to discover whether three gene expression signatures in skin can serve as accurate biomarkers predicting scleroderma as well as 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 being led by NIAMS.

Every story we hear from someone living with scleroderma reminds us how disruptive and life-altering this disease is. Now more than ever, it is important it is for us to understand scleroderma and find a cure.

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 must 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.”

[This statement was submitted by Mary J. Wheatley, IOM, CAE, Chief Executive Officer, National Scleroderma Foundation.]

PREPARED STATEMENT OF THE NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Chairwoman Murray, Ranking Member Blunt and Members of the Committee:

I respectfully submit the FY 2023 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 also prepares professionals to work in fields related to deafness. 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.

BUDGET REQUEST

On behalf of NTID, for FY 2023 I would like to request \$95,200,000 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 25 percent of NTID's Operations budget coming from non-federal funds, up

from 9 percent in 1970. Since FY 2013, NTID raised more than \$11 million in support from individuals and organizations.

Like all college campuses, NTID is seeing a greater demand for mental health and counseling services, a phenomenon that has been exacerbated by the COVID-19 pandemic. With 45 percent of NTID students being eligible for Pell Grants, many of these students do not have access to external resources and rely on what they receive at RIT/NTID. This FY 23 request includes funding to hire three additional counselors to provide students with and connect students to the mental health and case management services they need. It also includes funding to hire 13 additional captionists, a crucial service for deaf and hard-of-hearing students to access content inside and outside of class and another area where NTID has seen a dramatic increase in student requests.

NTID's FY 23 request also includes funding to establish a new Bachelor's of Science in Applied Internet of Things (IoT). This interdisciplinary field involves the application of interconnected devices embedded with electronics that communicate and share information across the Internet. The new degree will address the four major areas of IoT—hardware, software, communication and cybersecurity—and will be applied across the many employment sectors of IoT, including agriculture, manufacturing, healthcare, and government.

NTID's secondary mission includes preparing professionals to work in fields related to deafness, such as sign language interpreting, teaching deaf students, and audiology. NTID's FY 23 request would provide significant scholarships to support students in NTID's American Sign Language and Interpreting Education program and Master of Science in Secondary Education of Students who are Deaf or Hard of Hearing program, as well as provide externships to audiologists. The scholarships would aim to address the shortage of students going into these fields, as well as increase underrepresented students in these occupations.

For FY 23, NTID hopes to increase outreach funding for the NTID Regional STEM Center (NRSC) partnership by \$1,000,000 to expand NRSC programs. The NRSC partnership serves deaf and hard-of-hearing students primarily 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.

ENROLLMENT

Truly a national program, NTID has enrolled students from all 50 States. In Fall 2021 (FY 2022), NTID's enrollment was 1,166 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 2022, 245 deaf and hard-of-hearing high school students enrolled in dual-credit courses at partner high schools.

NTID ACADEMIC PROGRAMS

NTID offers 21 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. NTID also offers two bachelor's degree programs (ASL-English Interpretation and Community Development & Inclusive Leadership) as well as an MS in Secondary Education of Students who are Deaf and Hard of Hearing.

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, 219 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 2-year and 4-year colleges. For NTID deaf and hard-of-hearing graduates, over the

past 5 years, an average of 95 percent have found jobs commensurate with their education level. Of our

FY 2020 graduates (the most recent class for which numbers are available), 95 percent were employed 1 year later, with 72 percent employed in business and industry, 21 percent in education and non-profits, and 7 percent 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 percent of NTID deaf and hard-of-hearing graduates with bachelor degrees and 73 percent with associate degrees report earnings, compared to 58 percent of NTID deaf and hard-of-hearing students who withdrew from NTID and 69 percent 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 percent of NTID deaf and hard-of-hearing associate and bachelor degree graduates participated in the SSI program compared to 8 percent of deaf and hard-of-hearing students who withdrew from NTID. Similarly, at age 50, only 18 percent of NTID deaf and hard-of-hearing bachelor degree graduates and 28 percent of associate degree graduates participated in the SSDI program, compared to 35 percent 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 2021, 117,831 hours of interpreting and 27,744 hours of real-time captioning were provided to students.

SUMMARY

NTID's FY 2023 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 percent over the past 5 years. Therefore, I ask that you please consider funding our FY2023 request of \$95,200,000 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, Vice President and Dean, Rochester Institute of Technology.]

PREPARED STATEMENT OF THE NATURE CONSERVANCY

Chair Murray, Ranking Member Blunt and members of the subcommittee, thank you for the opportunity to submit recommendations for fiscal year 2023 (FY23) appropriations for programs under the Department of Labor (DOL). The Nature Conservancy (TNC) is a nonprofit conservation organization working around the world to protect ecologically important lands and waters for people and nature. Our mission is to conserve the lands and waters upon which all life depends.

TNC appreciates Congress's work last year to pass the bipartisan Infrastructure Investment and Jobs Act (IIJA), which included significant investments in developing employee training and an equitable workforce. This will help strengthen our communities, create jobs and build a more prosperous future for all. These investments complement but do not supplant the need for ongoing program funding through the appropriations process. We ask the subcommittee to advance a robust appropriations package that will serve as the foundation for implementing the IIJA and ensuring long-term success for critical programs under the panel's jurisdiction.

The pandemic made evident the economic disparities that exist due to low-wage jobs. We appreciate concerns about the country's current economic scenario where the Congress must balance job growth while also addressing inflation. We see investments in employment training and on-the-job training experiences as a tremendous opportunity to contribute to the Nation's economy. By supporting workforce development programs like the Job Corps and AmeriCorps, we can provide career development opportunities for youth and the unemployed through conservation and restoration projects on lands across the country.

An example of the significant impacts investments in corps programs have on communities, their economies, and the environment is the work being done by the GulfCorps program. Over the last 5 years, TNC has worked extensively to develop, design and implement a region-wide, GulfCorps program, a five-state (Alabama, Florida, Mississippi, Louisiana and Texas) conservation corps program in the Gulf of Mexico region. This program was carried out under a contract with National Oceanic and Atmospheric Administration (NOAA) with funding from the Deepwater Horizon oil spill settlement. TNC has operated GulfCorps in partnership with NOAA, the RESTORE Council, the Student Conservation Association, The Corps Network and local conservation corps and community development organizations.

In 2021, the RESTORE council voted to renew the program for additional 4 years and awarded \$11.9 million to GulfCorps. The program will use the additional funding to create more than 400 conservation jobs over 4 years in the Gulf of Mexico. As of July 2021, this program has restored, conserved, and monitored 10,000 acres of TNC and partner lands. Additionally, 60 percent of the National AmeriCorps program alumni have taken their experience and skills and applied them to full-time positions in the conservation field (both within TNC and with partners).

The DOL budget levels detailed below represent a significant investment in our Nation's future. TNC asks your support for the following requests:

DEPARTMENT OF LABOR

AmeriCorps: TNC supports no less than \$1,340,000,000, which is consistent with the president's FY23 budget request. This amount represents a \$140 million increase from FY22 funding. The AmeriCorps program (officially known as the Corporation for National and Community Service) supports approximately 77,500 members providing service to communities across the country through local organizations and Governors' State Service Commissions. The AmeriCorps' state and national programs accomplish critical projects like disaster response and recovery, infrastructure, wildfire remediation, public lands access, and disconnected youth and veteran engagement. AmeriCorps and the country's network of conservation corps aim to develop a service ethic in young people; build and support diverse, inclusive and equitable American communities; provide education and vocational training; complete significant amounts of high-quality work in communities and on our public lands and waters; and prepare participants to advance to a career in conservation.

Conservation and restoration work that AmeriCorps supports has been shown to yield a high return on investment. For example, when performing coastal restoration work, on average 15 jobs are created per million dollars invested and this increases to up to 30 jobs per million dollars invested for the more complex, labor-intensive restoration projects, according to data collected by National Oceanic and

Atmospheric Administration. Similarly, every \$1 invested by the U.S. Forest Service (USFS) in resource management generates \$1.43 in GDP and, on average, 19 jobs are created per million dollars invested. Additionally, projects completed by AmeriCorps and the network of conservation corps will help improve and support the local economies of the communities they are located in. We appreciate the increased funding provided in FY22 for AmeriCorps and TNC urges the subcommittee to continue strong funding for this program in FY23.

Job Corps: TNC supports funding no less than \$1,778,964,000, which is consistent with the president's FY23 budget request. This amount represents a \$30 million increase from FY22 funding. DOL co-leads Job Corps with USFS. For almost 100 years, USFS has combined land stewardship with education and training, beginning with the development of the Civilian Conservation Corps in the 1930s. The agency manages 20 percent of the DOL Job Corps through their Civilian Conservation Centers. We would like to see USFS participation continue to be supported by DOL at least at this level. The mission of the Forest Service Job Corps Civilian Conservation Centers is to train eligible youth ages 16 to 24 with educational, social and vocational skills, while offering an integrated approach to address the Nation's conservation challenges. As first responders during local, State and national disasters, USFS Job Corps students also are trained by local agency units to assist during national emergencies, including those caused by wildfires, floods, hurricanes and tornados. Each year, Civilian Conservation Centers serve about 3,800 students and about 85 percent of the graduates start new careers, enroll in higher education programs or join the military, according to USFS. As mentioned in the previous section, projects supported by corps programs produce a high return on investment and aid in the economic recovery of local communities. TNC supports continued robust funding for the Job Corps program and its Civilian Conservation Centers.

Thank you for the opportunity to submit TNC's recommendations for the FY23 subcommittee on Labor, Health and Human Services, Education and Related Agencies Appropriations Bill. Please contact me if you have any additional questions or would like additional information.

[This statement was submitted by Sarah Murdock, Director, U.S. Climate Resilience and Water Policy, The Nature Conservancy.]

PREPARED STATEMENT OF NEPHCURE KIDNEY INTERNATIONAL

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2023

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- Provide \$49 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 \$11 billion for the Centers for Disease Control and Prevention (CDC) and \$6 million for the Chronic Disease Education and Awareness Program.
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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 because 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 that lower the immune system and contribute to severe bacterial infections, high blood pressure, and other problems in patients, particularly child patients. In addi-

tion, 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 percent 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 percent of its entire budget, on ESRD. In 2005, FSGS accounted for 12 percent 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, 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 5-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 trials leading to more trials than ever before. This has led to the creation of the Kidney Health Gateway Clinical which will connect patients with breakthrough clinical trials and access to 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 FY 2022 and encourage continued support by providing \$6 million for this critical program in FY 2023.

Patient Perspective

Meet 16-year-old Macy! She was diagnosed with Nephrotic Syndrome and later FSGS when she was three. Her 13-year journey with kidney disease has been long and hard. Macy did not respond to treatments for her kidney disease and within 2 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, IVs, 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 Josh M. Tarnoff, CEO, 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 2023 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, 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 have a higher chance of developing 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. NF1 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 percent 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 incidence 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 millions of 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 \$28 million in FY 2022. 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.

PREPARED STATEMENT OF NEW LEADERS

Thank you for the opportunity to provide testimony regarding the fiscal year 2023 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill.

New Leaders is a national nonprofit organization dedicated to ensuring high academic achievement for all children, especially students in poverty and students of color, by developing transformational school leaders and advancing the policies and practices that allow great leaders to succeed. Together with our school system partners, we build the capacity of equity-minded school leaders who are committed to the success of every child. Our leaders remove barriers to success for underrepresented and underserved students, supporting students in fully realizing their futures as the next generation of great thinkers, innovators, and leaders for our society. Over the past 20 years, we have trained more than 8,000 equity-focused leaders—sixty percent of whom identify as leaders of color. Our leaders impact more than 2 million students in our K–12 school system annually and serve as powerful and positive forces for change in their communities. In addition, our programs are evidence-based. Multiple independent studies have found that students who attend New Leader schools outperform their peers by statistically significant margins specifically because of the strong leadership of their New Leader principal.¹ And a recent review of school leadership interventions cited New Leaders as the principal preparation program with the strongest evidence of positive impact on student achievement.²

New Leaders is committed to getting a well-prepared, well-supported principal in every school so that our Nation's teachers and students can thrive. More than a decade of research shows that well-prepared, well-supported principals have a huge influence on teacher practice and student success. School leaders account for 25 percent of a school's impact on student learning,³ and an above-average principal can improve student achievement by 20 percentage points.⁴ And school leaders transform the lowest-performing schools, where the positive effects of strong leadership on student achievement are most pronounced.⁵ In fact, a landmark study found “virtually no documented instances of troubled schools being turned around without intervention by a powerful leader.”⁶

We were pleased that the Biden Administration has proposed funding the School Leader Recruitment and Support Program (SLRSP) at \$40 million in FY23, and we strongly encourage Congress to fund the program at this level.

The School Leader Recruitment and Support Program (SLRSP) was authorized under ESSA with bipartisan support and is the only Federal program with an exclusive focus on evidence-based school leadership interventions for high-need schools. SLRSP updates the School Leadership Program (SLP), the program included in the previous version of the Elementary and Secondary Education Act, and provides districts with resources to develop and support dynamic leaders who have a measurable, positive impact on student achievement. The program empowers eligible enti-

¹Gates, S.M., Baird, M.D., Doss, C.J., Hamilton, L.S., Oppen, I.M., Master, B.K., Tuma, A.P., Vuollo, M., Zaber, M.A., (2019). Preparing School Leaders for Success Evaluation of New Leaders' Aspiring Principals Program, 2012–2017. RAND Corporation RR-2812–NL.

Gates, S., Hamilton, L., Martorell, P., et. al. (2014). Preparing Principals to Raise Student Achievement: Implementation and Effects of the New Leaders Program in Ten Districts. The RAND Corporation. Retrieved from http://www.rand.org/pubs/research_reports/RR507.html.

²Herman, R., Gates, S. M., Chavez-Herreras, E. R., and Harris, M. (2016). School Leadership Interventions Under the Every Student Succeeds Act (Volume I). The RAND Corporation. Retrieved from http://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1550/RAND_RR1550.pdf.

³Leithwood, K., Seashore Louis, K., Anderson, S., & Wahlstrom, K. (2004). How leadership influences student learning: A review of research for the Learning from Leadership Project. New York, NY: The Wallace Foundation. Retrieved from <http://www.wallacefoundation.org/knowledge-center/Pages/How-Leadership-Influences-Student-Learning.aspx>.

⁴Marzano, R. J., Waters, T., & McNulty, B. A. (2005). School leadership that works: From research to results. Alexandria, VA: Association for Supervision and Curriculum Development.

⁵Seashore Louis, K., Leithwood, K., Wahlstrom, K., & Anderson, S. (2010). Investigating the links to improved student learning. Washington, DC: Wallace Foundation. Retrieved from <http://www.wallacefoundation.org/knowledge-center/Pages/Investigating-the-Links-to-Improved-Student-Learning.aspx>.

⁶Leithwood, K., Seashore Louis, K., Anderson, S., & Wahlstrom, K. (2004).

ties—including State or local educational agencies—to pursue a range of activities in support of school leadership for high-need schools, such as the development and implementation of leadership training programs, the provision of ongoing professional development for school leaders, and the dissemination of best practices regarding the recruitment and retention of highly effective school leaders. In addition, eligible entities may carry out projects in partnership with nonprofit organizations and institutions of higher education. Finally, under priorities set forth in the reauthorized statute, SLRSP incentivizes eligible entities to focus on principal preparation and professional development practices for which there is evidence of effectiveness, as demonstrated through rigorous research.

Of critical importance right now, SLRSP can help combat the deleterious effects of the COVID pandemic on our educator workforce. According to a recent poll conducted by the National Association of Secondary School Principals (NASSP), 45 percent of principals report that pandemic working conditions are accelerating their plans to leave the profession, and nearly four out of 10 principals plan to leave the profession in the next 3 years.⁷ Leadership transitions are disruptive and negatively impact students' learning experiences. Through high-quality professional development and support, we can support the steady, determined leadership of experienced principals even as we invest in preparing the next generation of school leaders. Further, many teachers are burned out and suffering from low morale, with more than half of teachers reporting they plan to quit due to COVID-related workplace stressors.⁸ Yet we know that effective school leaders can make all the difference: 97 percent of teachers list principal quality as critical to their retention and career decisions—more than any other factor.⁹ And we know that strategies to address principal burnout, which disproportionately affects high-need schools,¹⁰ can yield huge cost savings for school systems,¹¹ which can be reinvested in pandemic recovery efforts.

The Federal Government has a crucial role to play in advancing innovation and sharing best practices with the field so that State and local leadership strategies, especially for high-need schools, can be strengthened, now and in the future, by a strong and growing evidence base. The SLP helped launch and expand some of the country's most innovative and effective leadership development programs, including New Leaders, New Teacher Center, NYC Leadership Academy, and TNTP. Since receiving SLP grants, these organizations have grown exponentially to reach many more schools, teachers, and students in high-need communities—greatly expanding the impact of the Federal Government's initial investment. Further, SLP grantees, including those affiliated with the University Council of Educational Administrators (UCEA), have demonstrated a remarkable commitment to programmatic evaluation, continuous improvement, and transparency. By proactively sharing their lessons and resources open-source with the field, these organizations have helped to galvanize dramatic changes to the principal preparation sector as a whole¹²—inspiring necessary changes to the way principals are trained to lead our Nation's schools in States and districts across the country.

We urge Congress to restore funding for SLRSP at \$40 million to support innovative, evidence-based school leadership programs that promise a return for students and schools that far exceeds this targeted investment.

Thank you for the opportunity to provide the views of New Leaders on the FY 2023 appropriations. If you would like to discuss our recommendations, please do not hesitate to contact policyteam@newleaders.org.

⁷National Association of Secondary Principals. (2020). NASSP Survey Signals a Looming Mass Exodus of Principals From Schools. Retrieved from <https://www.nassp.org/news/nassp-survey-signals-a-looming-mass-exodus-of-principals-from-schools/>.

⁸National Education Association. (2022). Poll Results: Stress And Burnout Pose Threat Of Educator Shortages. Retrieved from https://www.nea.org/sites/default/files/2022-02/NEA_percent20Member_percent20COVID-19_percent20Survey_percent20Summary.pdf.

⁹Scholastic Inc. (2012). Primary Sources: America's Teachers on the Teaching Profession. New York, NY: Scholastic and the Bill and Melinda Gates Foundation. Retrieved from http://www.scholastic.com/primarysources/pdfs/Gates2012_full.pdf.

¹⁰According to 2014 data from the National Center for Education Statistics, high-need schools must also grapple with an overall principal turnover rate of 28 percent, significantly higher than schools in more affluent communities.

¹¹According to School Leaders Network (2014), up to \$330K annually for a typical urban district.

School Leaders Network. (2014). Churn: The High Cost of Principal Turnover. Retrieved from http://connectleadsucceed.org/sites/default/files/principal_turnover_cost.pdf#page=1&zoom=auto,-15,792.

¹²University Council for Educational Administration and New Leaders. (2016). State Evaluation of Principal Preparation Programs Toolkit. Retrieved from www.sepkit.org.

[This statement was submitted by Jean Desravines, CEO, New Leaders.]

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 2023. 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 2023 HHS appropriations.

The NPAIHB is a Tribal organization, established in 1972, under the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 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.

These past 2 years, COVID–19 has dramatically impacted Northwest Tribes and carries long-term effects physically, mentally, emotionally and physically. We are grateful for the diligent service of our Congressional representatives in ensuring that Tribal Nations were provided with resources, including vaccines and medical supplies, to battle this pandemic. We know that working together improved our ability to 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 subcommittee must honor Tribal sovereignty and trust and treaty obligations as to HHS funding to Tribal Nations. For FY 2023, we ask this subcommittee 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 subcommittee consider the important role that Tribal Epidemiology Centers (TECs) 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 2023, 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 2022. For FY 2023, 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 Prevention 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 cul-

turally-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 2023, 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 2022. For FY 2023, 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 and continuing the important program work that is already in place. We thank OASH for the relationship it has created with IHS and Tribes over the past 15 years.

Climate Change. Climate change has been significantly impacting our Northwest Tribes. Tribal communities are facing increased flooding that impacts our health care operations and continually threatened by increased forest fires year after year. We request that this subcommittee provides additional funding to support Tribal capacity building and training for Tribal communities. This would allow Tribes to be in charge of collecting and monitoring their own scientific data. We also request a 5 percent set aside of all climate change funding for Tribes.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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 2023, 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. Through the Tribal Public Health Emergency Fund, disease intervention services—which played such a vital role in COVID-19—could be used to respond to the syphilis outbreaks across Tribal communities.

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 2023, we recommend that the subcommittee 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 healthy, culturally appropriate and locally-produced foods and the nutritional and healing qualities of these food in a time of crisis. Likewise, the importance of protecting and promoting our traditional first food, human milk for our youngest members. 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 subcommittee allocate at least \$32 million in fiscal Year 2023 to the Good Health and Wellness in Indian Country.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare and Medicaid Legislative Initiatives. HHS must work with Congress to pass legislation that: expands Part B coverage for services furnished by licensed marriage and family therapists, licensed professional counselors, peer counselors, and our CHAP behavioral health aides; creates the authority for States to extend Medicaid eligibility to all AI/AN people with household incomes up to 138 percent 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 IHCP; extends 100 percent FMAP permanently to States for Medicaid services furnished by urban Indian providers permanently; excludes Indian-specific Medicaid provisions in Federal law from state waiver authority; and re-

moves 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 subcommittee support legislation to make all Medicare telehealth services and flexibilities permanent at the OMB encounter rate at I/T/U facilities, authorize Medicare telehealth furnished services by federally qualified health centers and rural health clinics be reimbursed at the encounter rate, 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.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

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 subcommittee 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. For fiscal Year 2023, we request additional funding to support our CHAP education programs including, \$4.2 million for the Dental therapy education programs with a \$1.7 million earmark for Portland Area and \$2.5 million to support Alaska and \$5 million to build clinical classrooms to train community health aide providers throughout the Portland Area.

Provider Relief Funds. Many Tribal health programs are facing significant administrative burdens on reporting their Provider Relief Funds. The Tribal health programs need additional time and support to compile the necessary information for reporting. We request that the subcommittee supports legislation that allows health care providers to expend all Provider Relief Funds by at least 90 days after the conclusion of the Public Health Emergency and to direct HRSA to simplify reporting requirements for Tribal health programs.

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 2023, we recommend increased funding for the NARCH program to \$20 million and request that 30 percent 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 subcommittee on FY 2023 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. For more information, please contact Candice Jimenez, cjimenez@npaihb.org.

[This statement was submitted by Nickolaus Lewis, Chair, Northwest Portland Area Indian Health Board.]

PREPARED STATEMENT OF THE NURSING COMMUNITY COALITION

As the Nation evaluates lessons learned from 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 investments in nursing education, workforce, and research in Fiscal Year (FY) 2023 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), and at least \$210 million for the National Institute of Nursing Research (NINR), 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 nursing education, research, practice, and regulation. Collectively, the NCC represents Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs),¹ nurse leaders, students, faculty, and scientists, as well as other nurses with advanced degrees. As the largest segment of the health care profession,² nursing is involved at every point of care, which was further exemplified 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.

THROUGH THE NURSING LENS: PROVIDING CARE TO ALL AMERICANS

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. As the largest dedicated funding for nursing, Title VIII programs are instrumental in bolstering and sustaining the Nation's diverse nursing pipeline by addressing all aspects of nursing workforce demand. The Bureau of Labor Statistics (BLS) projected that by 2030 demand for RNs would increase 9 percent, illustrating an employment change of 276,800 nurses,³ and demand for most APRNs is expected to grow by 45 percent.⁴

The need for nurses and APRNs is not only outlined by BLS, but can be seen in communities across the Nation, including rural and underserved areas. In fact, the American Association of Critical-Care Nurses outlined, "92 percent of nurses surveyed said they believe the pandemic has depleted nurses at their hospitals and, as a result, their careers will be shorter than they intended."⁵ Further, the American Nurses Foundation's second COVID-19 impact study noted that 52 percent of nurses during the pandemic considered leaving their position, up from 40 percent a year earlier!⁶ If that was not enough, "more than one-fifth of all nurses reported they plan to retire from nursing over the next 5 years."⁷

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. Each program under Title VIII is unique and plays an important role in supporting our nursing workforce. For example, in Academic Year 2020–2021, the Advanced Nursing Education programs, which help APRN students and nurses to practice on the frontlines and in rural and underserved areas throughout the country, supported more than 8,800 students, many of whom were trained in medically underserved areas and primary care settings.⁸

¹APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).

²United States Census Bureau. (2021) Who are our Health Care Workers? Retrieved from: <https://www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html>.

³U.S. Bureau of Labor Statistics. (2021). Occupational Outlook Handbook- Registered Nurses. Retrieved from: <https://www.bls.gov/ooh/healthcare/registered-nurses.htm>.

⁴U.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>.

⁵American Association of Critical-Care Nurses. (2021). Hear Us Out Campaign. Retrieved from: <https://www.aacn.org/newsroom/hear-us-out-campaign-reports-nurses-covid-19-reality>.

⁶American Nurses Foundation. (2022). Pulse on the Nation's Nurses Survey Series: COVID-19 Two-Year Impact Assessment Survey. Retrieved from: <https://www.nursingworld.org/-/492857/contentassets/872ebb13c63f44f6b11a1bd0c74907c9/covid-19-2-year-impact-assessment-written-report-final.pdf>.

⁷National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers (2021) The 2020 National Nursing Workforce Survey. Retrieved from: [https://www.journalofnursingregulation.com/article/S2155-8256\(21\)00027-2/fulltext](https://www.journalofnursingregulation.com/article/S2155-8256(21)00027-2/fulltext).

⁸Health Resources and Services Administration. Fiscal Year 2023, Pages 164–170. Budget Justification. Retrieved from: <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>.

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. With more than four million nurses throughout the country,⁹ we strongly urge historic support for these programs in FY 2023.

Therefore, the Nursing Community Coalition respectfully requests at least \$530 million for the Title VIII Nursing Workforce Development programs in FY 2023.

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. NINR's research is aimed at reducing the impact of social determinants of health and creating a more equitable health care system by promoting patient-centered care across the life continuum. The translational research by our Nation's nurses and scientists is essential to developing new evidence-based practices to care for all patients. It is imperative that we continue to support the necessary scientific research, which is why the Nursing Community Coalition respectfully requests at least \$210 million for NINR in FY 2023.

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.

59 Members of the Nursing Community Coalition Submitting this Testimony

Academy of Medical-Surgical Nurses
 Academy of Neonatal Nursing
 American Academy of Ambulatory Care 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 Anesthesiology
 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 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
 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

⁹National 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>.

National Association of Clinical Nurse Specialists
 National Association of Hispanic Nurses
 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 Forum of State Nursing Workforce Centers
 National Hartford Center of Gerontological Nursing Excellence
 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
 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 AND MEDICAL FOODS COALITION
 SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

-
- Please provide the National Institutes of Health (NIH) with at least \$49 billion.
 - Please provide proportional funding increases for individual NIH Institutes and Centers to advance efforts like those being led by the Office of Nutrition Research.
 - Please provide additional, distinct funding for the emerging Advanced Research Projects Agency for Health (ARPA-H) at NIH, which would facilitate implementation of this important program without supplanting ongoing NIH research activities.
 - Provide the Centers for Disease Control and Prevention (CDC) with at least \$11 billion.
 - Please enhance support for the Centers for Medicare and Medicaid Services (CMS) and work with the administration on innovative models to facilitate coverage and access for medical foods.
-

Thank you for the opportunity to submit testimony on behalf of the Nutrition and Medical Foods Coalition and the diverse community of patients that rely on medical foods. Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for continuing to invest in medical research, public health, and patient care through the FY 2022 appropriations process. Please maintain this commitment and further enhance support for medical research and public health programs as you work with your colleagues on appropriations for FY 2023. Please also continue to include committee recommendations encouraging ongoing scientific progress and appropriate coverage and access for medical foods.

ABOUT THE COALITION

The Nutrition and Medical Foods 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.

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.”

POLICY RECOMMENDATIONS

Due to the tireless work of the patient advocacy community, there is a growing awareness of the challenges to patient access that impact individuals and families in need of medical foods. At this time, we ask that you consider the following:

- Due to advancement in science and the advent of medical foods for a variety of conditions, a timely opportunity exists to promote and provide access by removing outdated restrictions in Medicare Part D.
- The Centers for Medicare and Medicaid Innovation (CMMI) at CMS are interested in evaluating a variety of options to improve proper coverage of meritorious medical foods and Congress should encourage and collaborate on these efforts.
- Please promote coverage and access across all forms of coverage by supporting legislation that seeks to enhance access to medical foods and work with your colleagues to consider options to provide a regulatory framework for medical foods that is distinct from the drug approval pathway and capable of identifying safe and effective products.
- There exist persistent misperceptions about medical foods that often jeopardize coverage, including the mis-categorization of medical foods as “over the counter” products in contravention of FDA guidance, and opportunities exist to identify and correct barriers stemming from incorrect information or a lack of understanding. HHS through a variety of public health and patient care mechanisms can raise awareness of medical foods and address current gaps in understanding and care delivery.

RECOMMENDED REPORT LANGUAGE

Centers for Medicare and Medicaid Services Program Management

Medical Foods.—The Committee recognizes ongoing scientific advancement and innovation in the medical foods space that has demonstrated the impact of nutrition and related interventions to a variety of patient communities, in addition to digestive and metabolic health. The Committee also notes the potential cost-effectiveness of many medical foods as part of a physician-directed treatment, including with potential applications for non-opioid pain management. CMS is encouraged to engage with the medical foods stakeholder community on efforts to better understand health and cost effectiveness and approach proper coverage paradigms that reflect the growing relevance of medical foods within the broader treatment and care landscape.

CONCLUSION

Please consider NMFC a resource as you work on relevant funding issues for FY 2023 and work with your colleagues to advance health policy legislation. If you have any questions or if you would like to discuss medical foods coverage and access policy further with the coalition, please consider us a resource.

[This statement was submitted by P. Keith Daigle, Acting Director, Nutrition and Medical Foods Coalition.]

PREPARED STATEMENT OF PACER CENTER

PACER Center would like to thank the subcommittee on Labor, Health and Human Services, Education and Related Agencies (LHHS) for soliciting the views and recommendations of public witnesses on Fiscal Year (FY) 2023 funding.

PACER is a Statewide and national parent center founded in 1978 and based in Minneapolis, Minnesota. PACER's mission is to enhance the quality of life and expand opportunities for children, youth, and young adults with all disabilities and their families so each person can reach his or her highest potential. PACER is staffed primarily by parents of children with disabilities. PACER also works to strengthen engagement between families and their schools to ensure that parents can be fully involved in the education of their children.

This testimony highlights several critical issues. First, we respectfully request that the subcommittee match the President's FY 2023 request of \$45 million for the Parent Information Centers (PIC) program, provide \$20 million for the Statewide Family Engagement Centers program, match the President's FY 2023 request of \$2.9 billion for Part B of the Individuals with Disabilities Education Act (IDEA) and \$1.4 million for the Parent Center program funded under the demonstration authority of the Rehabilitation Act of 1973. Second, we request that the subcommittee maintain bill language that was included in the FY 2022 bill that would permit States to subgrant funds under Part C of IDEA and report language that ensures that no less than the level provided in FY 2022 for the parent center program under Rehabilitation Act of 1973 be provided through the FY 2023 bill.

IDEA Parent Information Centers

PACER respectfully requests that the subcommittee provide \$45 million for the PIC program at the U.S. Department of Education (ED). This level of funding is in line with President Biden's budget request for a \$15 million increase for the program. The PIC program provides crucial assistance to families of children with disabilities, helping parents navigate the special education process and ensuring that they have the opportunity, knowledge, and skills to help their children with disabilities succeed. It also assists parents in navigating the early intervention system for infants and toddlers with disabilities and developmental delays from birth to age three.

The PIC program funds Parent Training and Information Centers (PTIs), Community Parent Resource Centers (CPRCs), and technical assistance for parent centers. Under this program, each State has at least one PTI, with a combined total of nearly 100 centers, technical assistance centers, and CPRCs targeting underserved populations. Centers funded under this program make valuable contributions at the State and local level by helping schools improve services and outcomes for students with disabilities and providing critical information on resolving disputes that may arise between schools and families.

We appreciate the \$2.7 million increase provided for the Parent Information Centers program in FY 2022. Prior to FY 2022, the PIC program was level funded for a decade. Despite the level funding of this program, the number of IDEA-eligible students has increased dramatically. In 2010, approximately 6.6 million students were served under IDEA. In its most recent Congressional Justification, ED estimates that nearly 7.4 million eligible students will be served in 2023. The PIC program also serves students who are eligible under Section 504 of the Rehabilitation Act. Such students numbered 1.4 million in 2017–2018 and represented 2.7 percent of school enrollment. These increased numbers have required the Centers funded under the PIC program to try to do more with less. We believe that the rising enrollment of students with disabilities warrants the requested increase in funding for the institutions such as PACER and other PTIs that provide crucial support to the families of students with disabilities.

In addition to the general increase in the number of children with disabilities and their families seeking services from centers funded under the PIC program, ED has cited rising service demands on centers due to the COVID–19 pandemic. In the Administration's FY 2023 budget proposal, ED cited that the "demand for PTI services has increased dramatically" during the COVID–19 pandemic including the need for increased virtual trainings. Children with disabilities were also one of the hardest hit populations during the pandemic, often having subpar access to online learning opportunities and having the most disruption to services, supports and accommodations they need to succeed academically.

Statewide Family Engagement Centers

PACER Center also requests \$20 million in funding for the Statewide Family Engagement Centers (SFEC) program to help achieve the goal of having an SFEC in every State and territory. PACER, in addition to serving as a PTI center, also serves as an SFEC and as such provides much-needed technical assistance and partnership development to States and school districts to foster meaningful engagement with families to further their children's academic and developmental progress. As with the PTI program, PACER Center appreciates the \$2.5 million increase included for the SFEC program in the FY 2022 funding bill.

SFECs provide vital direct services to improve engagement between children, parents, teachers, school leaders, counselors, administrators, and other school personnel. While SFECs work with all parents and schools throughout their state, many, including PACER Center, focus on students of color, English learners, and recent immigrant children working to integrate into their new communities. Research has shown that family engagement in a child's education increases student

achievement, improves attendance, reduces the dropout rate, and advances the emotional and physical well-being of children. Students whose families are involved in their children's academic success attend school more regularly, earn better grades, enroll in more challenging academic programs, and have higher graduation rates. The SFEC program harnesses effective practices to help schools and districts implement systematic family engagement programs that build ties between the community, families, students, and schools.

IDEA

We also request a \$2.9 billion increase in Part B of the Individuals with Disabilities Education Act (IDEA), matching President Biden's FY 2023 budget proposal. IDEA funding for Part B is critical in our home state of Minnesota and around the country. The Federal resources provided to meet the guarantee of a free appropriate public education under IDEA are critical as States and local school systems construct their annual budgets. This is especially true now as educators help children with disabilities recover lost learning time resulting from the COVID-19 pandemic. As stated above, the pandemic hit children with disabilities among the hardest and States, school districts, and schools need this significant increase in Federal resources to meet the needs of their children.

While this focus on pandemic recovery and the need for resources is more recent, IDEA's current funding level continues to fall short of a path to full funding of Part B of IDEA. The Administration's budget estimates that their call for a \$2.9 billion increase will raise the Federal share to 15 percent. This amount of a funding increase will restart the program on a path to full funding.

With respect to Part C of IDEA, we request that the subcommittee maintain bill language that would permit States to subgrant Part C funds to organizations to carry out Part C State-level activities. This authority has been extremely useful in Minnesota to allow the State to reach families eligible for Part C across the State by avoiding the need to conduct such activities via a contract.

REHABILITATION ACT PARENT TRAINING AND INFORMATION CENTERS

We also support the Administration's request to increase funding by \$1.4 million under the Demonstration and Training Authority in the Rehabilitation Act of 1973 for the National Parent Training and Information Center as well as the eight Regional Parent Training and Information Centers. The Administration's FY 2023 budget request documents how existing funding levels are insufficient to support the current workload. The budget request would allow the Regional Parent Training and Information Centers to expand collaboration and enhance services to consumers in their respective regions.

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. I am submitting this testimony to request that the Committee include language in the fiscal year 2023 Labor, Health and Human Services report expanding NIH research funding and awareness efforts on amyloidosis.

The COVID pandemic has brought about an awareness of the need to address health issues through increased investment in research. This investment in COVID has resulted in research that is saving lives through vaccines, early diagnosis and programs of awareness. It has heightened the need to accelerate research and awareness of amyloidosis, to prevent deaths, and to help patients with amyloidosis related multi-organ dysfunction.

A further commitment to amyloidosis research, I believe, would prove to be a life-saving investment.

I want to thank this subcommittee for its efforts to raise awareness and funding for issues related to amyloidosis. Progress has been made on research into treatment and awareness. 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.

However, the causes of amyloidosis remain elusive. 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.

I have endured two stem cell transplants and chemotherapy in order to fight the deadly disease amyloidosis and have been one of the lucky ones to survive the dis-

ease for 19 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.

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. Secondary or reactive amyloidosis occurs in patients with chronic infections or inflammatory diseases.

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.

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.

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.

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 transplantation 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.

FISCAL YEAR 2023: MORE RESEARCH IS NEEDED

The COVID pandemic has illustrated the need to accelerate research and treatment on diseases such as amyloidosis. Here are the main points for taking action in the fiscal year 2023 bill:

1. Thousands of people die because they were diagnosed with amyloidosis too late to obtain effective treatment. Many people are diagnosed after the point that they are physically able to undertake treatment.

2. Thousands of others die never knowing they had amyloidosis.

3. 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.

4. Additional funding for amyloidosis research and equipment is needed to increase the survival rate and to find safe treatments to help more patients.

5. Although amyloidosis is often fatal, Federal and foundation support over the past years has given hope for successful new treatments.

6. More efforts are needed to alert health professionals to identify this disease, to accelerate research and awareness of the disease, and to help patients with amyloidosis related multi-organ dysfunction.

Amyloidosis is vastly under-diagnosed. 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 reality, 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.

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. Expanding funding for research and treatment of amyloidosis is key to preventing death from amyloidosis.

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 this 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) 2023 appropriations and to highlight the importance of NIH-funded 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 have come together to support this growing field. We appreciate the sustained, robust funding for NIH provided by the subcommittee in recent years, which has allowed NIH to continue building the foundation of scientific knowledge underpinning personalized medicine in the midst of unprecedented challenges. Sustaining this momentum will be essential to support further discovery of targeted health care interventions for patients with cancer as well as rare, common, and infectious diseases. As the subcommittee begins work on the FY 2023 Labor, Health and Human Services, Education and Related Agencies appropriations bill, we request at least \$49.048 billion for NIH’s base program level budget. We also urge you to ensure that funds for targeted programs, like those supporting the new Advanced Research Projects Agency for Health (ARPA-H) and pandemic preparedness, supplement this request for NIH’s base program level budget.

Our funding request for FY 2023 amounts to a \$4.1 billion (or nearly 8 percent) increase to the NIH budget, including funding for specific initiatives under the 21st Century Cures Act (Cures Act). This request would allow for meaningful growth above inflation in NIH’s base budget and expand NIH’s capacity to support progress in personalized medicine.

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 the government’s investment in 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

Decades of NIH-funded biomedical research on the genetic and biological underpinnings of disease have contributed to the development of personalized treatments that patients are benefitting from today. As of 2020, this research has informed the development of more than 286 personalized treatments² and over 166,703 genetic testing products.³ These numbers continue to grow, with personal-

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>.

ized medicines accounting for more than a quarter of all new drugs approved by FDA each of the past 7 years and with more than half of new personalized treatments being approved for indications outside of oncology.⁴ Nearly 20 years since the historic completion of the Human Genome Project in 2003, researchers recently finished deciphering the final 8 percent of the roughly 3-billion-base human genome sequence that was previously impossible to decode.⁵ Having a complete, gap-free reference sequence of human DNA will further improve our understanding of how genes influence human health. In recent years, scientists have also made notable progress in assessing biomarkers beyond the genome, such as proteomic and metabolic biomarkers.⁶ Harnessing the power of personalized medicine to better diagnose, treat, and prevent disease will require a continued commitment by Congress to fund NIH's basic and translational research.

II. SUSTAINING BASIC AND TRANSLATIONAL RESEARCH FOR PERSONALIZED MEDICINE

NIH is leading much of the 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 NIH are contributing 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), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the National Center for Advancing Translational Sciences (NCATS), and the National Institute on Minority Health and Health Disparities (NIMHD). A robust base budget for NIH in FY 2023 would protect the agency's foundational role in the identification and development of treatments, technologies, and tools for personalized medicine.

Cancer care has been and will continue to be profoundly influenced by new personalized medicine approaches for detecting and treating early- and late-stage cancers. In 2021, for example, FDA approved two new chimeric antigen receptor (CAR) T-cell-based immunotherapies for patients with refractory large B-cell lymphoma and refractory multiple myeloma.⁷ These treatments work by genetically re-engineering a patient's own immune cells to combat cancer. Over the past decade, personalized treatments harnessing the immune system have also driven declines in mortality for lung cancer and melanoma. Recognizing the potential of multi-cancer early-detection tests designed to find evidence of cancer wherever it occurs in the body from a simple blood draw, NCI is also exploring large national trials to evaluate these novel tests and is already funding the collection of blood samples to serve as controls. These tests may provide less invasive testing options that could detect a patient's cancer 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. Over the past decade, programs at NCATS have helped shift the scientific approach to researching rare diseases from one disease at a time to many diseases at a time. 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 and diagnostic options. Accelerating this research can help shorten the average of 6 years it takes for a rare disease patient to find the correct diagnosis and lower the nearly \$1 trillion annual economic burden of rare diseases.⁸

Other patients are living with highly prevalent diseases where personalized medicine can offer better treatments or a cure. For example, the Alzheimer's Association estimates that 6.2 million Americans are living with Alzheimer's disease.⁹ Despite increasing numbers of Alzheimer's diagnoses, researchers still need to study the ge-

⁴ https://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/Personalized_Medicine_at_FDA_The_Scope_Significance_of_Progress_in_2021.pdf.

⁵ <https://www.nih.gov/news-events/nih-research-matters/first-complete-sequence-human-genome>.

⁶ https://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/PMC_The_Personalized_Medicine_Report_Opportunity_Challenges_and_the_Future.pdf.

⁷ https://www.personalizedmedicinecoalition.org/Userfiles/PMC-Corporate/file/Personalized_Medicine_at_FDA_The_Scope_Significance_of_Progress_in_2021.pdf.

⁸ <https://everylifefoundation.org/burden-study/>.

⁹ <https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf>.

netic 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 (AMP) for Alzheimer's disease, led by NIH, has identified over 500 drug targets, and in 2021 the public-private partnership launched a second iteration to enable a personalized medicine approach to researching new treatments.¹⁰ Other new and ongoing AMP projects aim to facilitate the development of gene therapies for rare diseases as well as treatments and diagnostics for type 2 diabetes, rheumatoid arthritis, lupus, Parkinson's disease, common metabolic diseases like kidney and heart disease, and schizophrenia.

Ensuring that 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 and clinical trials. Multiple initiatives at NIH to improve research policies and incorporate diverse perspectives into solving complex scientific problems—such as through the UNITE initiative, NHGRI's action agenda for a diverse genomics workforce, and the forthcoming NIH-Wide Diversity, Equity, Inclusion, and Accessibility Strategic Plan—will play a key role in addressing these disparities, as will the research led by NIMHD on improving minority health and understanding factors contributing to health disparities.

III. ACCELERATING PERSONALIZED MEDICINE RESEARCH

Increasing NIH's base budget will also ensure that the agency has the resources necessary to advance the longstanding aspects of its mission without de-prioritizing supplemental initiatives in personalized medicine provided for by Congress in the Cures Act.

The first of these initiatives made possible in part by the Cures Act, the All of UsTM 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 March 2022, over 475,000 individuals consented to participate, with more than 326,000 being fully enrolled.¹¹ More than 80 percent of the enrolled individuals are from groups historically underrepresented in research¹² such as seniors, women, Hispanics and Latinos, African Americans, Asian Americans, and members of the LGBTQ community. Extensive efforts are also underway to engage American Indian and Alaska Native communities. Reaching a significant milestone, the program recently released its first dataset of nearly 100,000 whole genome sequences,¹³ and over 1,100 research projects have been launched using the program's groundbreaking dataset. Later this year, the program also plans to begin sharing results with participants on their hereditary disease risk and medication-gene interactions. Pooling health care data across large datasets that span populations and disease areas will play a key role in advancing research for personalized medicine approaches to care.

The second initiative spurred by the Cures Act, the Beau Biden Cancer Moonshot, aims to transform the way cancer research is conducted by fostering collaboration and data sharing. As it enters its seventh year, the Cancer Moonshot has grown to support over 240 new research projects¹⁴ and has established a significant infrastructure for conducting cancer research and sharing resources.¹⁵ Collaborations formed by the program include the Partnership for Accelerating Cancer Therapies (PACT), which consists of 12 pharmaceutical companies, the Foundation for NIH, and FDA working together to identify, develop, and validate biomarkers advancing the discovery of new immunotherapy treatments. This year, President Biden announced a bold new goal for the initiative of ending cancer as we know it. Funding provided by the Cures Act ends in FY 2023, and additional base budget funding will help NCI sustain this progress that has already been made in cancer research once the Cures Act funding expires.

IV. CONCLUSION

PMC appreciates the opportunity to highlight NIH's importance to the continued success of personalized medicine. PMC believes that basic and translational re-

¹⁰ <https://www.nih.gov/research-training/accelerating-medicines-partnership-amp/alzheimers-disease>.

¹¹ <https://www.joinallofus.org/newsletters/2022/march>.

¹² <https://officeofbudget.od.nih.gov/pdfs/FY23/br/Overview%20of%20FY%202023%20Presidents%20Budget.pdf>.

¹³ <https://directorsblog.nih.gov/2022/03/29/nih-all-of-us-research-programs-first-nearly-100000-complete-human-genome-sequences-set-stage-for-new-discoveries/>.

¹⁴ <https://doi.org/10.1016/j.ccell.2021.04.015>.

¹⁵ <https://www.cancer.gov/research/annual-plan/directors-message>.

search at NIH is key to bringing us closer to a future in which every patient benefits from an individualized approach to health care. Therefore, we urge the subcommittee to appropriate at least a \$49.048 billion budget to support existing centers and programs at NIH, in addition to funding Congress may provide for targeted initiatives.

[This statement was submitted by Cynthia A. Bens, Senior Vice President, Public Policy, Personalized Medicine Coalition.]

PREPARED STATEMENT OF THE PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

The Physician Assistant Education Association (PAEA), representing the 287 accredited PA programs in the United States that graduate more than 10,000 students each year, appreciates the opportunity to submit the following testimony on the Association's funding priorities for Fiscal Year (FY) 2023. Throughout the COVID-19 pandemic, the issue of provider shortages, particularly in historically underserved communities, has received renewed attention. As practicing providers have experienced unprecedented strain during the past 2 years, increasing rates of burnout and attrition has made congressional action to support workforce development an urgent imperative. To address these challenges and mitigate further projected workforce shortages, it is critical that Congress make bold investments in both proven and new programs that support the development of a sufficient supply of well-trained, diverse providers in the communities where they are needed most.

PAEA joins with the Health Professions and Nursing Education Coalition, a national alliance of more than 90 organizations, to request a total of \$1.51 billion in FY23 for the Title VII health professions and Title VIII nursing workforce development programs administered by the Health Resources and Services Administration (HRSA). This funding level, a significant increase from the \$799 million allocated for Title VII and VIII in FY22, would provide the resources necessary to meet workforce demand and promote equitable outcomes for all patients.

BACKGROUND ON THE PA PROFESSION AND PA EDUCATION

As Congress seeks to bolster the health workforce following the pandemic, PAs are uniquely equipped to be a key part of the solution given the accelerated training model and wide practice flexibility that has characterized the profession since its inception. Following their baccalaureate-level education, all PA students complete a rigorous graduate-level curriculum based upon the more than 100-year-old model of medical student training. The typical PA program curriculum consists of approximately 1 year of classroom-based training followed by 1 year of clinical rotations under the supervision of practicing preceptors. During their clinical year, students complete placements in family medicine, emergency medicine, surgery, pediatrics, women's health, and behavioral health in a wide array of practice settings. This generalist approach to PA education provides graduates with the necessary knowledge and experience to switch specialties over the course of their careers based upon workforce needs without additional required post-graduate training.

In recognition of the quality of services rendered by PA graduates and in response to significant projected physician shortages, the number of PA programs has risen significantly in the past decade, growing from 149 in 2010 to 287 as of 2022. While the promise of this expansion to combat workforce shortages is considerable, its sustainability depends upon PA programs having access to the resources necessary to provide high-quality training to students. Despite widespread vaccine availability and reduced pressure on health systems as COVID-19-related hospitalizations have fallen, nearly 85 percent of PA programs indicate that their existing clinical training sites continue to take fewer students than prior to the pandemic.¹ This reduction in clinical education capacity is the most daunting challenge facing PA programs across the Nation and, if left unaddressed, threatens the ability of programs to meet demand for graduate services.

In response to this challenge, HRSA has taken steps to expand clinical site access but currently has limited resources to address the crisis. In September 2021, HRSA released the Primary Care Training and Enhancement—Physician Assistant Rural Training funding opportunity, explicitly allowing grantees to pay preceptors to train students in rural communities in order to expand access to placements. While this program is well-aligned with the needs of PA education, current PCTE funding levels only allowed 7 PA programs to receive an award through this competition. If the

¹Physician Assistant Education Association. (2021). COVID-19 Rapid Response Report 3. <https://paea.edcast.com/insights/ECL-c621408d-c82a-43f5-a067-75a03494d8be..>

program is to meaningfully achieve its intended aim, significantly increased funding will be needed to broaden the scope of this opportunity.

Beyond PCTE grants, an additional critical source of support to expand clinical education capacity is Area Health Education Centers (AHECs), which facilitate clinical placements for PA and other health professions students in underserved areas through community partnerships. In academic year 2020–2021, AHEC grantees facilitated over 27,000 clinical rotations for health professions students with approximately 70 percent taking place in medically underserved communities and 60 percent occurring in primary care settings.² To further expand clinical education capacity and meet workforce demand, PAEA urges the subcommittee to support a funding level of \$98 million for PCTE grants and \$86 million for AHECs in FY23.

PROMOTING WORKFORCE DIVERSITY

As Congress works to address the toll that COVID–19 has taken on the Nation’s health workforce, particular emphasis must be placed on reducing barriers that prevent the workforce from reflecting the communities that it serves. Across disciplines, students from marginalized communities often face daunting socioeconomic challenges to successfully entering the health professions and practicing in the communities where their services are needed most. In the case of PA education, only 3.9 percent of first-year PA students identify as Black or African American and 9.1 percent identify as Hispanic or Latino as of 2019.³ Representation steadily declines among graduates with 3 percent identifying as Black or African American and 6.8 percent identifying as Hispanic or Latino.³

To combat these trends and promote the availability of culturally competent care for patients, PAEA believes it is critical to significantly increase the scale of HRSA’s existing workforce diversity programs, which aim to provide support to marginalized students throughout the continuum of their education. Specifically, the Health Careers Opportunity Program (HCOP) provides targeted K–16 programming targeted to marginalized students to expose them to the possibility of pursuing a career in the health professions and ensure they have the resources necessary to matriculate into a program. In FY20, HCOP grantees provided this type of support to 2,452 underrepresented minority students interested in pursuing careers in the health professions.²

Beyond HCOP, HRSA programs also seek to ensure that students are retained in their programs through graduation. The Scholarships for Disadvantaged Students (SDS) program provides financial support to meet this aim. In FY20, SDS supported more than 2,600 disadvantaged health professions students with 65 percent being from underrepresented minority communities.² To ensure that these programs are scaled to meet patient demand for a diverse health workforce, PAEA urges the subcommittee to fund HCOP and SDS at a level of \$30 million and \$103 million, respectively, for FY23.

COMBATING MATERNAL MORTALITY DISPARITIES

While COVID–19 has been the predominant focus of national public health policy since 2020, other long-standing public health challenges have persisted throughout the pandemic. Currently, the United States has one of the highest maternal mortality rates among industrialized nations at a rate of 23.8 deaths per 100,000 live births as of 2020 with many deaths concentrated in historically underserved areas.⁴ Black or African American women continue to be disproportionately affected by this crisis with a mortality rate of 55.3 deaths per 100,000 live births—nearly three times the rate of non-Hispanic white women.⁴ While the causes of maternal mortality disparities are multifactorial, a key concern is limited access to well-trained providers with the capacity to provide the culturally competent care that patients deserve.

Ensuring the availability of a high-quality workforce requires investments in clinical training in the communities where care is most needed. However, at a time when providers are most needed to address this issue, the availability of training opportunities for students is significantly declining. Nearly 75 percent of PA pro-

²Health Resources and Services Administration. (2022). Justification of Estimates for Appropriations Committees. <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>.

³Physician Assistant Education Association. (2020). By the Numbers: Student Report 4: Data from the 2019 Matriculating Student and End of Program Surveys. <https://paeonline.org/wp-content/uploads/imported-files/student-report-4-updated-20201201.pdf>.

⁴Centers for Disease Control and Prevention. (2022). Maternal Mortality Rates in the United States, 2020. <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>.

grams indicate that it is either harder or much harder to secure clinical rotations in obstetrics/gynecology/women's health than prior to the COVID-19 pandemic—a critical threat to the ability of PA education to respond to demand for providers.¹

Recognizing this challenge, Congress authorized a new Rural Maternal and Obstetric Care Training demonstration program in the omnibus appropriations legislation enacted for FY22. This program is intended to provide funding to PA education and other health professions programs to support clinical training opportunities in community-based settings with the aim of strengthening the pipeline and increasing the supply of providers practicing in these communities. PAEA strongly supports this program's authorization and urges the subcommittee to provide \$5 million for its initiation in FY23.

FISCAL YEAR 2023 RECOMMENDATION

To mitigate the toll that COVID-19 has taken on providers across the country, Congress must seize the opportunity to make bold investments to strengthen the supply and diversity of the health workforce and ensure access to high-quality care for all patients. The Association joins the Health Professions and Nursing Education Coalition in requesting \$1.51 billion in funding for the Title VII health professions and Title VIII nursing workforce development programs in FY23. PAEA thanks the subcommittee for the opportunity to submit testimony and looks forward to the opportunity to serve as a resource to members and staff.

[This statement was submitted by Kara Caruthers, MSPAS, PA-C, President, Physician Assistant Education Association.]

PREPARED STATEMENT OF THE PHYSICIANS COMMITTEE FOR RESPONSIBLE MEDICINE

On behalf of the Physicians Committee for Responsible Medicine, thank you for the opportunity to submit this written testimony. The Physicians Committee is a nonprofit organization with more than 175,000 members worldwide that works to make medical research more effective and ethical. As the subcommittee crafts the FY 2023 Labor, Health and Human Services, Education, and Related Agencies Appropriations bill, the Physicians Committee asks that you please consider the following provision to increase transparency and public accountability regarding research funded by the National Institutes of Health (NIH).

THE PROBLEM

Research transparency and accountability are vital to ensure that the United States remains a global leader in medical research. While the governments of other countries—including the United Kingdom, Canada, and the entire European Union—collect and publish detailed information on the number of animals used in research and testing, the United States lags far behind. Estimates of the number of animals used each year in U.S. laboratories vary wildly—from 10 million to 110 million¹—and the vast majority of those animals are utilized by federally funded labs. The drastic difference in estimates demonstrates that accurate reporting is needed.

The U.S. commitment to the “3Rs” principles of refinement, reduction, and replacement of animals in research is described in the Guide for the Care and Use of Laboratory Animals,² the use of which is required by the Public Health Service Policy. Integral to this commitment are the accurate counting of animals used in experiments and the accurate reporting of Federal funding dedicated to projects involving animals. It has been the NIH's policy since 1985 to collect an “average daily inventory”³ of vertebrate animals housed in research facilities that wish to receive agency funding. This “average” is highly inaccurate; it is only a crude estimate of how many animals are present in the facility on any given day, not an annual total, and facilities are only required to file such documentation every 4 years as part of an Animal Welfare Assurance. Further, copies of these documents are available to the public only through Freedom of Information Act requests, making large-scale tracking and accountability efforts impossible.

¹Carbone, L. Estimating mouse and rat use in American laboratories by extrapolation from Animal Welfare Act-regulated species. *Sci Rep* 11, 493 (2021). <https://doi.org/10.1038/s41598-020-79961-0>.

²National Research Council. 2011. *Guide for the Care and Use of Laboratory Animals*: Eighth Edition. Washington, DC: The National Academies Press. <https://doi.org/10.17226/12910>.

³National Institutes of Health, Office of Laboratory Animal Welfare. PHS Policy on Humane Care and Use of Laboratory Animals. <https://olaw.nih.gov/policies-laws/phs-policy.htm>.

THE SOLUTION

Congress must improve the accuracy and transparency of animal use in federally funded research by instructing the NIH to do two things:

1. NIH must provide a plan to Congress detailing how the agency will annually collect an accounting of vertebrate animals from all agency-funded researchers, organized by species and pain and distress category. The plan should also require the NIH to detail how it will provide public access to this information.

2. NIH must also provide a plan for tracking and publishing information on NIH-funded projects involving the use of vertebrate animals. The NIH currently collects such information with every grant application using the Research & Related Other Project Information form, which asks applicants to answer “Yes” or “No” to the question “Are Vertebrate Animals Used?”⁴ Making the answer to this question searchable for each funded project via the NIH’s Research Portfolio Online Reporting Tools website⁵ or a similar database is a vital step toward greater transparency of Federal research spending.

RECENT HISTORY

A similar requirement was included in the House-passed H. Rpt. 117–96 and the Senate draft FY 2022 committee report.⁶ However, the finalized text in the omnibus joint explanatory statement (JES) failed to include important specifics included in the aforementioned committee reports, and detailed in the requested language below, including the directives to (1) create plans for collecting and reporting animal numbers and species used and (2) identifying which NIH grants involve animals. Instead, the omnibus FY 2022 JES language requested a report from the NIH outlining a plan to “increase the accuracy and transparency of the data collected” and to detail “how NIH will address any incomplete reporting of NIH-funded research with animals.” To ensure that the forthcoming report meaningfully achieves the goals described above, it is crucial that these specifics are restored.

REQUESTED REPORT LANGUAGE

“Collection and Reporting of Animal Research Numbers and Agency Funding.— The Committee recognizes that Congress has long expressed an interest in reducing the use of nonhuman animals in NIH-funded research and replacing animals with valid, reliable alternatives. In the National Institutes of Health Revitalization Act of 1993, Congress first requested that the agency create a plan for doing so. The Committee also recognizes the scientific community’s stated commitment to the “three Rs” of replacement, reduction, and refinement. Integral to that commitment are the accurate counting of animals used in research and testing and the accurate reporting of NIH funding dedicated to projects involving animals. The Committee recognizes that it has been NIH’s policy since 1985 to collect an “average daily inventory” of vertebrate animals housed in research facilities that wish to receive agency funding. The Committee understands that domestic facilities are required to file such documentation every 4 years as part of an Animal Welfare Assurance and that copies of the documents are available to the public only through Freedom of Information Act requests. The Committee anticipates the report requested in the Joint Explanatory Statement for the Consolidated Appropriations Act, 2022 (Public Law 117–103) outlining a plan to improve the accuracy and transparency of collected data. However, the Committee directs NIH to include in the forthcoming report how the agency plans to annually collect from each research facility that receives NIH funding the total number of animals bred, housed, and used in the previous year, sorted by species and pain and distress categories. Further, the Committee directs NIH to include in the report a draft form for collecting this information annually. NIH should also include details on how the agency will create a publicly accessible online database for dissemination of the information collected via the new annual forms. The Committee directs NIH to include in its report a plan for implementing a system that identifies which agency-funded projects involve the use of animals and makes the information publicly accessible. The Committee recognizes

⁴National Institutes of Health. “G.220—R&R Other Project Information Form.” Accessed August 20, 2020. <https://grants.nih.gov/grants/how-to-apply-application-guide/forms-e/general/g.220-r&r-other-project-information-form.htm>.

⁵National Institutes of Health. “RePORTER.” Accessed February 4, 2022. <https://reporter.nih.gov/>.

⁶United States Senate Committee on Appropriations, “Chairman Leahy Releases Remaining Nine Senate Appropriations Bills.” https://www.appropriations.senate.gov/imo/media/doc/LHHSREPT_FINAL3.PDF.

that NIH currently collects such information with every grant application using the Research & Related Other Project Information form, which asks applicants to answer "Yes" or "No" to the question "Are Vertebrate Animals Used?" NIH's plan should ensure that the answer to that question for each funded project is searchable via the Expenditures and Results module of NIH's Research Portfolio Online Reporting Tools website."

[This statement was submitted by Ryan Merkley, Director of Research Advocacy, Physicians Committee for Responsible Medicine.]

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 fiscal year 2023, we urge the subcommittee to adopt the following funding recommendations for agencies under its jurisdiction: \$49 billion, NIH; \$210 million, NCHS; \$815 million, IES; and \$814 million, BLS. In addition, we urge the subcommittee to accept report language, previously submitted, regarding population research programs and surveys supported by the National Institute on Aging and Eunice Kennedy Shriver National Institute on Child Health and Human Development at 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 \$49 billion for the NIH, a \$4.1 billion increase over the NIH's program level funding in fiscal year 2022. In addition, we urge the Committee to ensure that any funding for the new Advanced Research Project Agency for Health (ARPA-H), supplements the \$49 billion recommendation for NIH's base budget, rather than supplants the essential foundational investment in the NIH. Finally, we urge that NIA and NICHD, as components of the NIH, receive commensurate funding increases (7.9 percent) in fiscal year 2023.

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 fiscal year 2023, 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 fiscal year 2023, 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 and proceed with plans to integrate the population sciences into the Institute's Geroscience research agenda.

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. Population scientists support NICHD exploring the use of existing and new mechanisms to enhance research regarding the effects of COVID on fertility trends and reproductive health overall and developing informed frameworks for conceptualizing and measuring social determinants of health, including structural racism. With additional funding in fiscal year 2023, the Institute could sustain its existing population research activities as well as pursue our field's recommendations regarding these additional research activities related to COVID and social determinants of health.

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 members of the Friends of NCHS, recommend the agency receive \$210 million in fiscal year 2023, which is \$30 million above its fiscal year 2022 appropriation, restoring the agency to its FY2010 inflation adjusted level. 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). 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. PAA and APC are especially supportive of NCHS using additional funding to improve the quality of vital statistics data to inform research regarding the underlying causes of mortality and health disparities across different population and geographies.

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 grateful to the subcommittee for providing the agency with steady increases since fiscal year 2018-especially after years of flat funding. We are also pleased that the subcommittee included language in its fiscal year 2022 report expressing support 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 are enthusiastic about the new NLSY cohort and urge the subcommittee to sustain its support for its development. We urge the subcommittee to provide BLS with \$814 million in fiscal year 2023 and to adopt, once

again, report language urging the agency to maintain its plans for a new NLSY cohort.

INSTITUTE OF EDUCATION SCIENCES (IES)

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 an array of topics, such as linkages between educational access/attainment to health outcomes of specific populations, economic well-being, and incarceration rates. PAA and APC were pleased that Congress enacted a substantial, nearly 15 percent increase for IES in fiscal year 2022, which, in addition to investments in other priorities, will allow the agency to finally address longstanding staffing shortfalls. We were disappointed that the President's Budget Request (PBR) would reverse that investment by recommending an overall cut of 10 percent at IES. Although the National Center for Education Statistics (NCES) was not targeted for a cut per the PBR, we assume this is due to NCES not receiving an increase in fiscal year 2022. Adoption of the PBR line item for NCES would represent three consecutive years of flat funding; the last increase, enacted in fiscal year 2021, was less than 1 percent over fiscal year 2020. We therefore urge the committee to provide IES with at least \$815 million in fiscal year 2023, an amount recommended by the Friends of IES, and to ensure that NCES receives an increase over its fiscal year 2022 level, \$291.5 million.

Thank you for considering our support for these agencies as the subcommittee drafts the fiscal year 2023 Labor, Health and Human Services and Education Appropriations bill.

[This statement was submitted by Mary Jo Hoeksema, Director, Government and Public Affairs, Population Association of America/Association of Population Centers.]

PREPARED STATEMENT OF PrEP4ALL

On behalf of PrEP4All, thank you for the opportunity to comment on fiscal year (FY) 2023 appropriations for a National PrEP Program. Founded in March 2018, PrEP4All is an organization of community members, healthcare professionals, lawyers, and academics all dedicated to increasing access to lifesaving HIV medications. Every member of PrEP4All has been personally affected by the HIV epidemic, and most of us rely on HIV treatment and pre-exposure prophylaxis (PrEP) medications every day. As patients ourselves, we have all experienced the shortcomings in the domestic HIV response first hand.

We are calling on Congress to allocate \$400M for a National PrEP Program to the Department of Health and Human Services (HHS) in its FY23 budget, a necessary first step to implementing the ambitious reforms to PrEP access proposed in President Biden's FY23 budget.

The nation will not meet the goals of its Ending the HIV Epidemic initiative without a new approach to PrEP. In 2019, nearly 37,000 people in the U.S. were diagnosed with HIV. Black and Latinx/Hispanic individuals comprised 42 percent and 29 percent of new diagnoses, respectively. Despite the availability of PrEP—antiretroviral medication that if taken regularly drastically reduces the risk of acquiring HIV—since 2012, relatively few people in the U.S. are able to access it. In 2020, only 25 percent of people who could benefit from PrEP actually received it, with large and growing disparities by race, ethnicity, gender, and geography. Sixty-six percent of White Americans recommended for PrEP received a prescription in 2020, compared to only 16 percent of Latinx/Hispanic Americans and just nine percent of Black Americans.

A National PrEP Program must move away from a patchwork approach to access that requires uninsured individuals to navigate a set of separate and confusing programs for PrEP medications, labs, and necessary ancillary services. A National PrEP program must create simple pathways to PrEP access for those who need it most and engage a broader network of PrEP providers. Over 20 national HIV organizations have signed onto a letter supporting a National PrEP Program and calling for a program to be guided by the following core principles: accessibility, equity, simplicity, affordability, sustainability, and adaptability.

We urge Congress to recognize the urgency of addressing the Nation's broken and inequitable PrEP financing and delivery system and allocate \$400M for this program in its FY23 budget.

Please reach out to me if I can be of any assistance; I can be reached at 185 Hall Street #105, Brooklyn, NY 11205, Jeremiah@PrEP4All.org.

Sincerely,

[This statement was submitted by Jeremiah Johnson, PrEP Project Manager, PrEP4All.

PREPARED STATEMENT OF PREVENT BLINDNESS

Chairman Murray, Ranking Member Blunt, and Committee Members: I appreciate the opportunity to submit testimony to the subcommittee on behalf of Prevent Blindness—the Nation’s leading nonprofit, voluntary organization committed to preventing blindness and preserving sight for Americans of all ages, racial and ethnic backgrounds, communities, and socioeconomic circumstances. We stand ready to work with the subcommittee and Members of Congress to advance policies that seek to improve our Nation’s vision and eye health.

Prevent Blindness respectfully requests the following allocations in Fiscal Year (FY) 2023 to vision and eye health programs at the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion:

- \$5,000,000 for Vision and Eye Health to conduct necessary national-level surveillance of vision impairment and eye disease, and continue state and community partnerships that promote early detection and access to eye care treatment; and
- \$4,000,000 for Glaucoma, which will help to achieve a reduction in the incidence of glaucoma in high-risk patient populations through screening, referral, and treatment.

We are grateful to and applaud this Committee’s recognition of the importance of the CDC’s Vision and Eye Health program with an allocation of a much-needed increase in FY 2022. This new funding level of \$1.5 million will better inform interventions—particularly around the social, economic, and environmental contexts as related to eye health care disparities—and allow for stronger integration of vision and eye health into current and ongoing community approaches around aging, childhood development, mental health services, referral to care and care coordination, and chronic disease prevention.

In order to improve upon existing State- and community-based data, to fully capture what is happening at the National-level, and get ahead of the most serious consequences of preventable vision loss, Prevent Blindness respectfully calls on the Senate to build upon the investments made in FY 2022 with a total allocation of \$5 million to the CDC’s Vision and Eye Health program. This funding will serve two purposes:

- (1) It will allow the CDC to place ophthalmology examinations and visual content on The National Health and Nutrition Examination Survey (NHANES) and collect national-level examination-based data that will identify those who are unaware of their risk for vision loss or eye disease; thus, creating a much more accurate and authentic illustration of prevalence, and
- (2) Use this data to improve health equity through State and community partnerships by determining the burden of vision loss against demographic factors like racial or ethnic background, age, socioeconomic circumstances, geography, or health status and improving existing interventions to include these approaches to preventing vision loss and blindness.

Currently, the CDC relies on a patchwork of best-available data pieced together through claims, registries, and self-reported national-level surveys. The 2005–2008 data set is the last collection of reliable, national-level prevalence estimates of vision impairment and eye diseases; meaning that our best available data on our National vision loss and eye disease burden is nearly 15 years old with current state and community interventions based on 10 to 14-year-old data. We cannot respond to the needs of patients who may not know that they are living with blinding eye disease, low vision, or vision loss using data that predates such trends as our rapidly aging population, skyrocketing rates of chronic disease, our National mental health crisis, new stresses to our eye health such as prolonged and frequent use of technology, and rising costs of health care. In the long term, not having this critical information base will create gaps in our knowledge of COVID–19 and other infectious diseases—the consequences of which may include gaps in research at the National Institutes of Health.

Vision is a critical sensory enabler that allows us to live and function in our daily lives. From early in life as a part of childhood development and enabling readiness to learn in school, for adults who seek a sense of well-being through economic inde-

pendence, pursuit of professional and personal interests, and recreational activities, and for older Americans to age healthfully and independently with a high quality of life and strong social connections, good vision enables all aspects of a productive, satisfying, engaging, and healthy life. New research published by CDC in 2022 estimates that the annual economic burden of vision loss and blindness was \$134.2 billion, including over \$40 billion in excess and potentially avoidable long-term care expenses, and \$16.2 billion resulting from reduced labor force participation.¹

Forthcoming research, using the federally funded American Community Survey (ACS), the Behavioral Risk Factor Surveillance System (BRFSS), and available data from NHANES, has found that vision loss is strongly associated with social determinants of health and regional variation at the community level. That research illustrates that presenting vision loss is strongly associated with poor economic conditions, and could be addressed nationwide with additional support. Those with incomes lower incomes, educational attainment, food security were significantly more likely to have evaluated presenting vision problems or to self-report being blind or having serious difficulty seeing compared to those with higher incomes and educational attainment and those with fewer issues with food security. People living in rural areas were more likely to experience vision problems than their urban counterparts, as were unmarried persons (whether they were single, divorced, or widowed). Using ACS data, the research found that approximately 20% of the variation in self-reported vision problems was explained by community level differences beyond those described by economic and demographic variables in the ACS. Additional research is required to understand the social determinants of vision health at the community level, and to design public health programs that help all Americans maintain the highest level of vision possible.

And yet, despite its significance, we tend to accept vision loss as inevitable to aging, a consequence of chronic disease, family history, personal risk, socioeconomic circumstances, or a result of under-development in childhood or adolescence. Vision loss and eye disease often come at significant cost to the patient and to our National health care system as they contribute to or worsen many conditions like diabetes, stroke, hypertension, cardiovascular problems, mental health concerns like anxiety, depression, social isolation, cognitive decline, and injury related to falls. Incidents of avoidable vision loss each represent a missed opportunity when considered that timely diagnosis and early treatment could prevent up to 98%² of visual impairment and blindness in the U.S.

Unfortunately, vision loss and eye disease are often left on the margins of important policy conversations around social determinants of health, health equity, access to care including coverage and costs of obtaining eye care, and improving health outcomes, which creates a significant disadvantage in efforts to improve our National public health and lower personal and national health expenditures. Vision loss and eye disease are linked to numerous social determinants of health, including: lower income levels, lower levels of attained education, residence in low-quality housing or an unsafe neighborhood which limits physical activity and increases psychological distress, and inability to access care due to cost, lack of coverage, transportation issues, and refusal of services by providers. Lack of provider availability is a major complication in access to eye care as it is estimated that 721 of 3,006 (roughly 24%) American counties have no ophthalmologist or optometrist,³ even as approximately one-fifth of the Nation's population lives in rural America and only 10% of the country's physicians currently practice in rural communities.⁴

A May 2021⁵ analysis from the CDC and the NORC at the University of Chicago that summarizes these data sources, as well as data from the last use of visual content on NHANES from 1999–2008, has found that over 7 million in the U.S. are living with vision loss or blindness and 1.62 million people who live with vision loss or blindness are under age 40. This same study determined that vision loss or blindness is 68% higher than previous published estimates, with higher prevalence among Black and Hispanic populations and women more than men. This data analysis is based on best estimates of vision loss only, and its authors conclude that examination-based information would create stronger national-level and State-based

¹ Rein DB, Wittenborn JS, Zhang P, et al. The Economic Burden of Vision Loss and Blindness in the United States. *Ophthalmology*. Apr 2022;129(4):369–378. doi:10.1016/j.ophtha.2021.09.010.

² Centers for Disease Control and Prevention, 2018: <https://www.cdc.gov/media/releases/2018/a0726-vision-health.html>.

³ <https://pubmed.ncbi.nlm.nih.gov/25602911/>.

⁴ <https://www.ruralhealthweb.org/>.

⁵ https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2779910?guestAccessKey=fb84d04c-a5f4-4753-a5f8-835f528ea50e&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf1&utm_term=051321.

data that can lend better to more targeted efforts to prevent and treat vision loss and eye disease.

Our nation needs a strong, public health approach to vision and eye health that includes surveillance, evidence-informed early detection and interventions, public awareness and community-level education, and measures to address and eliminate barriers in access to eye care. will create a stronger understanding of how vision loss intersects with other chronic health conditions, population demographics, and social determinants of health. We urge the Committee to direct \$5 million to the CDC's Vision and Eye Health program to ensure we are doing everything we can to protect Americans' vision and eye health.

GLAUCOMA AT THE CDC

Glaucoma is known as the “thief sneak of sight” due to its progressive nature that is often undetectable until changes to vision are noticed by the patient—which is often when vision loss has become irreversible and permanent. According to the National Eye Institute,⁶ women account for 61% of glaucoma cases in the U.S. with black Americans over the age of 40 at highest risk for developing glaucoma. In addition, according to the CDC,⁷ Hispanics and Latinos are the largest and fastest-growing minority group in the United States, by 2050, half of people living with glaucoma will be Hispanic or Latino.

Glaucoma is the second leading cause of blindness worldwide. Treatment has been shown to reduce the progression of visual field loss from glaucoma, but population-based studies suggest that even in developed countries, half of the people with glaucoma do not know that they have the disease. Because glaucoma is usually asymptomatic until the very late stages, affected individuals may not have a reason to seek eye care before the optic nerve is irreversibly damaged. Unfortunately, people in whom glaucoma is diagnosed late in the disease process are at greatest risk for going blind.

There are two main pathways for high-risk minority populations to result in blindness due to glaucoma. The first is through low community resources, which leads to a lack of program funding, lack of transportation systems, and low paying jobs that do not provide adequate health benefits. Lack of program funding and lack of transportation converge directly on a lack of primary health care clinic locations, whereas low paying jobs includes the mediators of lack of education and lack of adequate healthcare coverage, to lack of available eye care providers that can provide treatment in a timely manner. A lack of access to health care providers leads directly to lower rates of routine screening for glaucoma. These lower screening rates cause delayed detection of glaucoma. A lack of eye care providers also leads to delayed treatment, even in the absence of lower screening rates. Delayed treatment for glaucoma causes higher rates of permanent vision impairment or blindness both directly and through a lack of treatment options. A lack of treatment options is also affected by a lack of healthcare, making it a major compounding factor.

The second pathway for high-risk minority populations is a lack of education. A lack of education refers specifically to a lack of proper information of glaucoma risk and maintaining proper vision health. A lack of overall education likely compounds the effects of each link of the pathway. A lack of subject specific education leads to lower rates of routine glaucoma screening, delayed detection of disease during a treatable stage, and increased social isolation due to vision impairment. Social isolation is a compounding factor in reduced capacity to maintain one's health, be a productive member of society, and engage in appropriate physical activity.

The pathways between high-risk minority populations and higher rates of vision loss due to glaucoma are complex, and there are many opportunities for intervention. The most promising intervention comes from a change in the location where glaucoma screening is performed. Until recently, the most reliable way to detect and initiate treatment of glaucoma was through a comprehensive eye examination performed by an optometrist or an ophthalmologist—something which data demonstrates is not done in this high-risk population. The advent of teleretinal eye screenings in a primary health care and community settings provide an increased opportunity to identify glaucoma in high-risk populations and properly refer individuals for treatment of this eye disease.

Several research studies funded by the CDC since 2014 have initiated and refined the protocols for the addition of teleretinal vision screening services in primary

⁶ <https://www.nei.nih.gov/learn-about-eye-health/outreach-campaigns-and-resources/eye-health-data-and-statistics/glaucoma-data-and-statistics>.

⁷ <https://www.cdc.gov/visionhealth/resources/features/hispanic-latino-vision-health.html#:~:text=High%20blood%20pressure%20can%20cause,will%20be%20Hispanic%20or%20Latino.>

health care and community settings of minority and underserved populations. As such, we ask the Committee to maintain the CDC's glaucoma program at \$4 million in FY 2023, which will improve glaucoma screening, referral, and treatment particularly for populations that face disparity in access to glaucoma care through innovative, community-based approaches and models of care that connect glaucoma patients to sight-saving glaucoma care.

Thank you.

[This statement was submitted by David B. Rein, PhD, MPA, NORC, at the University of Chicago.]

PREPARED STATEMENT OF PROVENTUTORING

As providers of scalable research-proven tutoring models designed to rapidly recover from the negative impact of COVID on student learning, we propose the following legislative language to encourage application of funds to needed approaches:

Proposed Language

High-Quality Tutoring.—The Committee notes that to address significant learning loss due to disruptions caused by Covid-19, particularly among historically disadvantaged students, many LEAs have dedicated Title I and other Federal resources to support academic tutoring. It is estimated that more than \$3.6 billion in Federal relief funds could be spent on tutoring between 2022 and 2024. Research shows that using high-quality tutoring programs with evidence of effectiveness as defined in the 2015 ESSA law can have a significant impact on addressing learning loss. These integrated systems include three to five half-hour (or longer) sessions a week, delivered by a human tutor to a group of 1 to not more than 4 students at a time, and use a well-structured process, high-quality materials designed for tutoring during the school day, ongoing professional development and coaching for tutors, and assessment tools to benchmark student achievement. Proven tutoring models can close the gap and bring struggling students up to the level of their peers. The Committee encourages the Department to promote and provide technical assistance to LEAs to ensure the implementation of tutoring models that have evidence of effectiveness.

BACKGROUND

Introduction

The educational crisis created by the pandemic and the unprecedented Federal funding to address it have generated widespread attention toward the most effective tool to accelerate learning: research-proven tutoring models. Now is the time to ensure districts are making solid investments of Federal dollars by encouraging the adoption of tutoring programs that have evidence of increasing student achievement. This outside witness testimony outlines the crucial features of high quality tutoring models and proposes language for the Committee to consider including in the FY 2023 budget to encourage the adoption of such tutoring models.

Research shows that high-quality tutoring programs that have been evaluated and proven to improve student achievement can have a strong impact on learning loss when they are delivered by a human tutor during the school day. Therefore, funding that is available for tutoring should be invested in these models to ensure that tutoring is advancing an equitable learning recovery.

Road-Tested Tutoring Models

There is a critical need at the State and local levels for guidance around the characteristics and value of high-quality tutoring models. Dozens of State and district tutoring programs launched this year, but many lack crucial features: a replicable tutoring system, delivered by a human tutor during the school day, that has evidence of improved student achievement compared to a control group.

A replicable tutoring system is essentially a road-tested model that possesses several interdependent, essential components:

- Structured instructional process
- High dosage format (3–5 times a week)
- Professional development and ongoing coaching for tutors
- High-quality materials designed for tutoring
- A system of assessment and data collection tools for measuring student achievement

Each component supports the other to ensure optimal impact on achievement. The professional development and coaching are specific to the program's procedures and materials. A system of regularly-scheduled assessments and data collection ensures

that students are working at the appropriate levels and helps to move them through a program efficiently. The high dosage format ensures the program is delivered consistently, providing students with ongoing support.

Road-tested models are distinct from other tutoring initiatives because they have been shown to make meaningful gains in student achievement in studies that meet the evidence standards of the Every Student Succeeds Act (ESSA). Tutoring during the school-day with proven, integrated models can double the rate of growth in reading skills for struggling readers—students tutored for half a year can grow a full year more in reading skills than similar students not receiving tutoring. Similar growth is possible in secondary math. With evidence of effectiveness, these models provide the greatest promise of impact.

A Human Tutor

Human tutors are a crucial component of effective tutoring programs. An invested, trained, and qualified tutor can develop a human connection with a student in the way that a technology platform never can, can answer questions on the spot, and can adapt instruction to address student needs. The human connection can provide students with emotional support and bring joy to the process. Successful tutors can be paraprofessionals employed by the school or external staff. When they are highly trained and guided by an evidence-based program, tutors support the classroom teacher in their efforts to accelerate learning for struggling students. Online tutoring platforms are tempting for many districts because they are affordable and easy to adopt, but a large number of students who need the intervention do not engage with these platforms. Human tutors provide structure, consistency, and the in-person connection that students lost during the pandemic. Of course, human tutors can serve in-person, or can connect remotely to students in the schools on platforms designed to recreate in-person relationship-based tutorials.

School Day Tutoring

In order for tutoring to be delivered consistently and reach the students who need it the most, it must be conducted during the school day. Out-of-school time tutoring contends with issues of attendance and students having to “opt-in” to the intervention. Embedding tutoring during the school day guarantees access to the students who need it, particularly those students who have been disproportionately impacted by the pandemic.

Signatories:

Nancy Madden, Founder of ProvenTutoring, Professor, School of Education, Johns Hopkins University
 Alan Safran, CEO and co-founder, Saga Education
 Dr. Claire Hagen Alvarado, Director, Literacy First at UT Austin
 Kate Bauer Jones, Executive Director, Future Forward Literacy
 Julie Wible, Executive Director, Success for All Foundation

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION PHA’S FISCAL YEAR 2023 L–HHS APPROPRIATIONS RECOMMENDATIONS

- At least \$49 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).
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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 FY2023 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 FY 2023.

NATIONAL INSTITUTES OF HEALTH

Please provide NIH with meaningful increases—including at least \$49 billion in program funding in FY 2023—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 current 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 are 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 3-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 percent chance of survival over the next 5 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 FY 2023 L–HHS Appropriations bill.

PREPARED STATEMENT OF REBUILDING AMERICA'S MIDDLE CLASS

On behalf of (RAMC), a coalition of State and individual community college systems from across the Nation—representing over 120 colleges and 1.5 million students, I appreciate the opportunity to provide written comments on the funding in the fiscal year 2023 Labor, Health and Human Services, Education and Related Agencies (LHHS) appropriations bill that is essential to community colleges and the students that we serve.

Community colleges have an unparalleled commitment to accessibility, which encourages traditionally underrepresented audiences to pursue a college degree. We serve 45 percent of all first-time freshmen, and 40 percent of our students are the first in their family to attend college. Forty two percent of all African American undergraduates, nearly half of all Hispanic undergraduates, and 56 percent of Native American undergraduates attend community colleges.

Community colleges are open access, seek to make higher education accessible and affordable for everyone, and matches employers' need for a larger, more diverse workforce. Preparing more Americans to enter the workforce with the skills necessary to compete for in-demand jobs, especially during difficult economic times, is

a top priority for all RAMC members. With this in mind, we make the following recommendations to improve Federal financial aid policies to support community college students, particularly those from nontraditional background who continue to rely on our schools for access to higher education:

Increase the Maximum Pell Grant.

RAMC members believe that the Pell Grant program is the key to ensuring low-income students can afford college. Community colleges are the most affordable of the many options facing students; yet, even at our institutions, low-income community college students overwhelmingly rely on this critical Federal student aid program. Even with our low tuition institutions, Pell grants allow such students to afford books and supplies and help with housing, childcare, food and other basic needs. For these reasons we urge the subcommittee to adopt the discretionary portion of the Administration's call for a \$1,775 increase in the maximum Pell grant as part of the President's fiscal year 2023 budget request.

We also strongly support the expansion of Pell to cover short-term certificates that open pathways to high paying employment options. While we are working closely with the House and Senate Conference Committee on the United States Innovation and Competition Act to maintain House language on this matter, we welcome the opportunity to work with that conference Committee or the House and Senate appropriations committee to achieve this important policy goal. The expansion of Pell to allow short-term credentials will provide an immediate boost to a significant number of our students focused on obtaining the workforce skills they need to earn middle class incomes.

Increase Career Technical Education State Grants.

The Administration's fiscal year 2023 request proposes to decrease CTE State Grants by \$25 million compared to the fiscal year 2022 level. RAMC believes that career and technical education certificates and degrees provide essential value to those that earn them. Accordingly, RAMC believes that Congress should again provide an increase in funding to the CTE grant program as part of the fiscal year 2023 appropriations process.

Support the Title III Strengthening Institutions Program.

The fiscal year 2023 budget request includes an increase of \$98.9 million for the Strengthening Institutions Program (SIP). RAMC institutions utilize SIP funds to increase student retention, provide enhanced faculty professional development and expand access to high-demand STEM programs through the conversion of high-demand courses. We strongly support the Administration's request for an increase and urge the subcommittee to include it in the fiscal year 2023 LHHS appropriations bill.

Expand Strengthening Community Colleges Program.

The Strengthening Community College Training Grant program provides vital capacity building resources at community colleges to build training programs that partner with industry. Community colleges are always at the forefront of developing and supporting education and training opportunities that enable individuals to acquire the skills they need to obtain jobs for which businesses are hiring. The Administration's budget calls for a \$55 million increase for this initiative. RAMC supports this increase and urges the subcommittee to include it in the fiscal year 2023 LHHS appropriation bill.

Support Apprenticeships and Innovative Partnerships.

As community college leaders, RAMC members are at the forefront of working to expand apprenticeships and create opportunities for students to earn while they learn. As such, we applaud the fiscal year 2023 proposal that includes \$303 million for the Apprenticeship Program, an increase of \$68 million above the fiscal year 2022 funding level. We support the President's proposal and would urge the subcommittee to consider the \$68 million increase for this program in the fiscal Year 2023 appropriations process.

Thank you for your consideration of our comments. RAMC members stand ready and willing to help you in any way we can as the fiscal year 2023 Appropriations process moves forward.

[This statement was submitted by Dr. Monty Sullivan, President, Rebuilding America's Middle Class: A Coalition of Community Colleges.]

PREPARED STATEMENT OF REFUGEE COUNCIL USA

Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee, thank you for this opportunity to submit these funding and oversight recommendations for Fiscal Year (FY) 2023 on behalf of the 29-member organizations of Refugee Council USA (RCUSA) dedicated to refugee protection, welcome, and integration and representing the interests of refugees, refugee families, and volunteers and community members across the country who support refugees and resettlement. RCUSA recommends FY 2023 funding levels of \$9,991,000,000 for the Department of Health and Human Services' (HHS) Refugee and Entrant Assistance (REA) account.

The REA account funds the Office of Refugee Resettlement (ORR) within HHS' Administration of Children and Families (ACF). ORR funding provides critical Federal investments in the States and local communities that welcome refugees and is a crucial component of fostering refugee integration and economic contributions. In addition to new refugee arrivals, ORR provides essential services to refugees who have arrived in recent years, asylees, Cuban and Haitian Entrants, Iraqi and Afghan recipients of Special Immigrant Visas (SIVs), trafficking and torture survivors living in the United States, certain Amer-Asians, Afghan humanitarian parolees who arrived under Operation Allies Welcome, and unaccompanied refugee and immigrant children.

RCUSA recommends an increase for the Transitional Medical Assistance (TAMS) program to \$2,530,000,000 to fund critical initial assistance to refugees and other new arrivals, programs for vulnerable unaccompanied refugee children, and the highly effective Matching Grant program, which leverages public funds with private donations, empowering refugees to secure employment within 6 months. RCUSA also recommends increases for Refugee Support Services (RSS) programs to \$1,400,000,000; for domestic and foreign-born trafficking survivor services to \$50,000,000; for torture survivor assistance to \$28,000,000; and for unaccompanied children to \$5,100,000,000. We also recommend the creation of an emergency contingency fund for needs across ORR-eligible populations appropriated at \$100,000,000.

In addition, we recommend new funding for family reunification for separated asylum-seeking families (\$533,000,000) and legal representation needs for Afghans evacuated to the U.S. under Operation Allies Welcome (\$250,000,000).

Robust Appropriations to Support the Rapid Rebuild and Expansion of the Resettlement Network

Throughout the previous administration, the U.S. Refugee Admissions Program (USRAP) was steadily dismantled: refugee admissions decreased by 80 percent and one-third of all resettlement offices in the U.S. closed. From the outset, the Biden administration committed to rebuilding a robust and innovative USRAP and set an ambitious refugee admissions goal of 125,000 for FY 2022. There were soon new and urgent demands on resettlement service providers: following the U.S. military withdrawal from Afghanistan, over 75,000 U.S.-affiliated and at-risk Afghans have been welcomed into the United States under Operation Allies Welcome. The domestic network of resettlement agencies was quickly mobilized to receive and support the integration of this newly arrived Afghan population. There are currently 271 resettlement offices providing Reception & Placement (R&P) services to refugees—an over 35 percent increase from 199 offices at the beginning of 2021.

Six of the nine voluntary agency networks are faith-based and harness the energy of many faith communities to help welcome newcomers to their new communities. These community organizations ensure the provision of a core set of services during someone's first months in the U.S., including the provision of food, housing, clothing, employment services, follow-up medical care, and other necessary services. After this initial period, ORR funds integration services through both the States and resettlement providers around the country.

Once refugees arrive in the U.S., they are supported in orienting to their new community, learning English, enrolling their children in school, and finding employment. With this crucial support, they often are not only able to support themselves and their families but also become contributors to their new communities, integrating with and bringing innovation to our neighborhoods. The following highlights critical needs within the REA account but does not include all program activities:

Legal Services for Afghans Arriving Under Operation Allies Welcome

The needs of newly arrived Afghan evacuees are distinct from other groups served by ORR. Unlike immigrant visas or the refugee program, humanitarian parole is not a pathway to permanent status; it is a temporary allowance to enter and remain in the United States. As such, Afghans who have been or will enter the U.S. with humanitarian parole under Operation Allies Welcome find themselves under a cloud of legal uncertainty and must seek an existing immigration pathway in order to re-

main in lawful status once their parole expires. In all likelihood, many will need to pursue asylum. This is a complex legal process for any immigrant to navigate, let alone for the many Afghans who arrived with little more than the clothes on their backs. It is essential that these Afghan neighbors have access to reliable legal counsel to assist them in their immigration process.

While resettlement agencies across the country are practiced at assisting refugees in adjusting their immigration status, requiring their existing legal service providers to assist with hundreds of asylum applications—simultaneously—will overburden available resources. Resettlement agencies do not have enough Department of Justice accredited representatives and on-staff immigration attorneys to meet this need. Indeed, even with legislation to provide a pathway to lawful permanent residency, such as an Afghan Adjustment Act, the reliance on these providers will be substantial.

As such, RCUSA is recommending \$250,000,000 for legal representation needs for Afghans evacuated to the U.S. under Operation Allies Welcome.

Trauma-Informed Care for Unaccompanied Children

Unaccompanied children (UC) are immigrant children who arrive in the U.S. without legal guardians and who require special protections. Care for unaccompanied children is mandated by the Trafficking Victims Protection Reauthorization Act (TVPRA) and governed by the TVPRA, the Homeland Security Act of 2002, and the *Flores* Settlement Agreement. ORR is the legal caretaker of unaccompanied children until they can be reunited with family. ORR funds a network of shelters where UC stay while reunification happens and ORR's primary goal is the safe and secure placement of each child with a sponsoring family.

In FY 2021, 121,000 unaccompanied children arrived in the United States, an all-time high. RCUSA's recommendation of \$5,100,000,000 will provide for an increased number of beds in licensed facilities. The increased arrivals over FY 2021 led to the use of both influx facilities and Emergency Intake Sites due to lack of online licensed bedspace. While the pandemic took many beds offline, ORR still needs to increase licensed placements. This funding will allow the necessary network growth in small-scale shelters, which are much better suited to meeting the needs of UC.

This critical funding will also provide universal access to post-release services (PRS) for both children and their sponsors. Post-release services are bridging services that assist children and sponsors adjust to their new lives together after reuniting. We know that trauma responses from migration or home-country experiences often manifest after the initial "honeymoon" period ends, and access to social workers and community services is critical in these cases. Historically, around 25 percent of UC have received PRS; ORR intends to provide these services to 85 percent of UC in FY22 and 100 percent of UC by FY23.

RCUSA does not support an expansion of detention, including through large-scale institutional facilities, or efforts to support forced family separation.

PREPARED STATEMENT OF RESEARCH!AMERICA

On behalf of Research!America's alliance, which advocates for science, discovery, and innovation to achieve better health for all, thank you for this opportunity to share our views on Fiscal Year 2023 (FY23) appropriations under the jurisdiction of the subcommittee on Labor, Health and Human Services, Education, and Related Agencies.

And, to all members of the subcommittee, thank you for all your work to include strong FY22 funding levels for critically important Federal health research agencies, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare Research and Quality (AHRQ); and for including funding to get ARPA-H off the ground. We were also so pleased that the subcommittee was able to include language naming the Roy Blunt Center for Alzheimer's Disease and Related Dementias Research Building in the FY22 Omnibus Appropriations Act.

THE NATIONAL INSTITUTES OF HEALTH

We are particularly concerned about funding for the National Institutes of Health. While there were many positive provisions in the President's FY23 budget proposal, Research!America was deeply disappointed by the shockingly low (0.6% percent) funding increase included for the NIH. We recommend that the subcommittee allocate at least \$49.1 billion, an increase of \$4.1 billion over FY22, for our Nation's flagship research institution. This funding level, inclusive of 21st Century Cures funding, would empower NIH to grow the number of progress-fueling grants the In-

stitutes can support. The American people need and value fast-paced medical progress, which cannot be accomplished without funding barrier-breaking, foundational research.

The NIH is the world's leading funder of basic biomedical research, and Americans recognize the value of this research. Since 1992, Research!America has commissioned national and State-level surveys to assess public sentiment on issues related to research and innovation. According to a January 2022 national survey commissioned by Research!America, 85% of Americans believe it is important for Congress and the President to prioritize achieving faster medical progress. Americans want medical progress, and they want the U.S. to drive it.

NIH awards more than 80% of its funding in the form of 50,000 competitive grants to more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every State and around the world. Research supported by NIH is directed at the early, non-commercial stages of the research pipeline, which complements later-stage research funded primarily by the private sector. NIH-funded research fuels the entry of new drugs into the market, providing an estimated return to public investment of \$1.43 for every dollar invested. Among its many success stories, the NIH supported research which helped create the first kinases-targeted category of cancer treatment drugs, launching a new wave of drug development targeting similar molecules to treat cancer and other diseases. In the case of the COVID-19 pandemic, the NIH had already invested in research to develop vaccine platforms, which enabled it to jumpstart development of powerful COVID-19 vaccines and treatments once the pandemic hit.

NIH advances our Nation's interests in other important ways. For example, the All of Us Research Program at NIH is advancing the largest clinical trial in our Nation's history to accelerate precision medicine and advance a host of other medical and health research objectives. NIH has also prioritized diversity, equity, inclusion, and accessibility through its implementation of its NIH Cross-agency DEIA Strategic Plan. Its Human Genome Project has produced \$1 trillion of economic growth—a 178-fold return on investment. The Helping to End Addiction Long-term, or HEAL, Initiative is conducting interdisciplinary research to end the opioid epidemic. The National Institute of Aging supports research on the health and well-being of older Americans and, through its Alzheimer's Disease Education and Referral Center, provides information on age-related cognitive changes and neurodegenerative disease. The Accelerating Medicines Partnerships combines contributions from both private and public sectors to streamline collaboration between the NIH, FDA, life science companies, and non-profit organizations working to develop treatments for Alzheimer's, Type 2 diabetes, rheumatoid arthritis, lupus, and Parkinson's disease. The NIH also invests in educating and training America's future scientists and medical innovators by sponsoring training grants and fellowships for biomedical- and health-focused graduate and medical students, postdoctoral researchers, and young investigators.

THE ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH

Research!America is grateful to members on both sides of the aisle for providing \$1 billion in FY22 to stand up this new agency. We support the goal of developing ARPA-H into an entity that supports high risk, high reward public-private R&D, and we support an FY23 funding allocation of \$5 billion for ARPA-H that complements but does not supplant funding for the NIH.

By funding transformative high-risk, high-reward research, ARPA-H has the potential to drive biomedical and health breakthroughs—ranging from molecular to societal—to revolutionize treatments for all patients. This health innovation incubator, modeled after DARPA and ARPA-E, will empower the public and private sector to pursue transformative, cross-disease R&D advances. We believe ARPA-H can bring about progress that saves millions of lives around the globe while significantly strengthening U.S. competitiveness in the global economic arena.

THE CENTERS FOR DISEASE CONTROL AND PREVENTION

The threats posed by COVID-19, Ebola, Zika, dengue fever, influenza, the opioid epidemic, measles outbreaks, and other emerging health threats have demonstrated the critical role the CDC plays in protecting Americans. They have also revealed the enormity of challenges the agency faces as it works to safeguard American lives. To protect our Nation, CDC scientists must be on the ground fighting public health challenges wherever and whenever they occur. We recommend an allocation of at least \$11 billion for the CDC in FY23, an increase of \$2.6 billion over FY22, to carry out its crucially important responsibilities.

The CDC is tasked with protecting and advancing Americans' health. Over the past 70 years it has worked diligently to thwart deadly outbreaks, costly pandemics, and debilitating disease. The CDC also plays a key role in research that leads to life-saving vaccines, bolsters our Nation's response to the opioid crisis, and improves health tracking and data analytics.

The CDC's work has benefited Americans in a myriad of ways. For example, the CDC has successfully eliminated the endemic spread of rubella within the United States; played a lead role in addressing the growing threat of antibiotic resistance; dramatically reduced the incidence of child lead poisoning; addressed disparities in health and health care; tracked and contained dangerous pandemics and epidemics; reduced deaths from motor vehicle accidents; and expanded newborn hearing and other screening tests,

THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ is the lead Federal agency responsible for ensuring medical progress translates into better patient care. This investment improves the care received by patients and saves taxpayer dollars. We recommend the subcommittee allocate \$500 million for the AHRQ in FY23, a 30% increase over FY22.

AHRQ has a proven track record in using evidence-based approaches to improve health care delivery. Using AHRQ's research and how-to tools, the U.S. health care system prevented 1.3 million errors, saved 50,000 lives, and avoided \$12 billion in wasteful spending from 2010 to 2013. For example, AHRQ-funded research has contributed to infection control strategies in long-term care facilities by identifying methicillin-resistant *Staphylococcus aureus* (MRSA) in these facilities. AHRQ-funded research has played a pivotal role in reducing hospital-acquired infections by nearly 1 million from 2014–2017. It has made important contributions to patient-centered outcomes research (PCOR) by investing in PCOR method training grants, including PCOR application in opioid use disorder, and by promoting the implementation of PCOR in clinical decision making.

We appreciate your consideration of our funding requests and thank you for your stewardship over these critically important Federal spending priorities. Please call on us if we can be of any assistance. Contact: Sheila Murphy, Senior Policy and Advocacy Officer, Research!America, smurphy@researchamerica.org.

Sincerely,

[This statement was submitted by Mary Woolley, President and CEO, 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) 2023 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 chil-

dren, 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 standard 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 medication; a class of medication used when all other drug classes have failed due to augmentation, inadequate efficacy, or adverse side-effects. Research and clinical experience indicate 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.

FY 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 2023 to bring NIH's budget up to \$49 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 \$6,000,000 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, even though 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 opioid therapy 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 agita-

tion, 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 72 hour psychiatric hold and sent me to a psychiatric 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 anti-depressant, 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 THE ROTARY FOUNDATION

Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee: Rotary appreciates the opportunity to encourage continuation of funding for FY 2023 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),¹ 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 \$276 million for the polio eradication activities of the CDC to capitalize on the historic opportunity of unprecedented low levels of endemic polio virus transmission which is simultaneously threatened by the diversion of critical resources toward the COVID-19 pandemic. These funds will support the GPEI's immediate priority of stopping all form of polio virus transmission through procurement of vaccines, including the recently introduced novel oral polio vaccine, a new tool that is being rolled out to accelerate control of circulating vaccine derived polio. These funds will also provide vital support for surveillance activities which provide confidence in both the presence and absence of polio virus transmission.

The 300,000 members of Rotary clubs in the U.S. appreciate the United States' generous support and longstanding leadership toward a polio free world. Rotary, including matching funds from the Gates Foundation, has contributed more than \$2.4 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 U.S. leadership will help achieve a polio free world and ensure the continued global health contribution of polio eradication infrastructure and resources.

UNPRECEDENTED PROGRESS PRESENTS THE BEST OPPORTUNITY WE HAVE EVER HAD TO ACHIEVE ERADICATION

Since the launch of the GPEI in 1988, eradication efforts have led to more than a 99.9 percent decrease in cases. Thanks to this committee's support, 20 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 2021, for the first time in history, there were no cases of wild polio virus in the entire world for more than 7 months. In addition, Pakistan didn't record a new case of wild polio virus for over a year. Wild poliovirus polio incidence hit an all-time low in 2021 with only five cases recorded in the two remaining endemic countries of Pakistan and Afghanistan- a 96 percent reduction from 2020.

¹The Global Polio Eradication Initiative (GPEI) is a partnership led by Rotary International, the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Bill and Melinda Gates Foundation, and Gavi, the Vaccine Alliance.

Outbreaks of circulating vaccine derived polio virus (CVDPV) which affected more than 20 countries in 2020 are being brought under control with fewer cases in fewer places in 2021 as compared to 2020 (638 cases in 22 countries for 2021 vs 1087 cases in 26 countries in 2020). The novel oral polio vaccine type 2 (nOPV2) is also being introduced to accelerate progress in bringing these outbreaks under control.

Despite this progress, the GPEI and countries it supports face significant challenges. In February 2022, a 3-year-old girl from Malawi was confirmed as having contracted the first case of wild polio in Africa since 2016. The virus that infected the child in Malawi was of Pakistani origin underscoring the fact that as long as polio exists anywhere, it is a threat everywhere. Fortunately, the case in Malawi does not change Africa's status as a region certified free from wild poliovirus because the virus originated in Pakistan and is considered to be an imported case as opposed to locally circulating/endemic virus. In April 2022, Pakistan reported its first cases of wild poliovirus (WPV1) in nearly 15 months. The ongoing COVID-19 pandemic continues to hamper the efforts of countries to sustain high levels of population immunity which poses increased risk for outbreaks at a time of unprecedented constraints on human and financial resources on the ground and from the global community. Conflict and instability also jeopardize progress, hampering efforts to organize and conduct polio eradication activities. These challenges threaten thirty years of progress and the cumulative U.S. investment of U.S. \$4.2 billion which has brought us to the threshold of a polio free world.

This combination of progress in the midst of ongoing challenges underscores the urgency of continued focus to protect the vulnerable gains made toward polio eradication as the COVID-19 pandemic continues to disrupt polio immunization and eradication activities; and 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.

Essential technical capacity and program management expertise: CDC directly contributes to polio eradication activities and is also used to build in-country capacity. This includes the international assignment of technical staff on direct 2-year assignments to WHO and UNICEF to assist polio-endemic and polio-reinfected priority countries. CDC's Stop Transmission of Polio (STOP) members 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 2021, STOP has trained and deployed more than 2,200 public health professionals to work on polio surveillance, data management, campaign planning and implementation, program management, and communications in high-risk countries. STOP also provided support to 42 countries on responding to COVID-19 in 2020-2021.

Vital Country-level Capacity: In Pakistan, CDC supported 81 National Stop the Transmission of Polio (NSTOP) officers for the Expanded Program on Immunization (EPI), and data usage and risk assessment officers distributed in 66 very high, high, and medium risk communities in 3 provinces, and 10 managers/officers to support the National Ministry of Health.

FISCAL YEAR 2023 BUDGET REQUEST

Rotary respectfully requests \$276 million in FY 2023 for the polio eradication activities of CDC. These funds will ensure that CDC provides technical and management expertise in polio endemic, outbreak and at-risk countries; builds country level capacity to build population immunity to prevent future outbreaks as well as capacity to quickly identify and respond to outbreaks.

Increased funding is needed to address three specific areas critical to protecting existing progress and capitalizing on the window of opportunity to stopping transmission of all polio viruses: Outbreak Response, Surveillance and Vaccine Procurement.

Outbreak Response

Increased funding is needed to maximize the effectiveness of outbreak response campaigns and fully leverage the use of nOPV2 through improvements in response planning, execution and monitoring to ensure rapid, high-quality activities including those which:

- utilize and expand existing in country government coordination mechanisms to establish polio control rooms, enabling the use of real-time data for decision-making and an incident management structure to streamline emergency operations;
- accelerate emergency outbreak response through the establishment of incident command structures at global, regional and country level to guide and direct outbreak response;
- digitize the entire outbreak response, from planning to campaign monitoring and utilizing an evidence-based approach for clear assessments of response coverage and quality, including age- and sex disaggregated monitoring data; and
- ensure a stronger role for women in outbreak response operations through increased participation in outbreak response oversight, management, supervision and delivery.

Surveillance

Additional funding will support the expansion of surveillance activities which provide confidence in both the presence and absence of polio virus transmission, and specifically to:

- implement a new direct detection strategy and augment investment in lab infrastructure and data information management to increase regional and country capacity to detect and respond to outbreaks and improve the quality and timeliness of surveillance, and
- expand active surveillance, enhance the use of community-based surveillance in hard to reach areas; and expand use of environmental surveillance.

Vaccine Procurement

Additional funds will support procurement of vaccines, including the recently introduced novel oral polio vaccine (nOPV2), a tool that is being rolled out to accelerate control of circulating vaccine derived polio. Twenty-five countries are already qualified to use this vaccine, 12 have already conducted campaigns and up to forty countries are preparing for use of this vaccine.

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 U.S. \$417 million of the more than U.S. \$2.4 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 priorities from the community level to the National 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. Investing in polio eradication now may cumulatively save an estimated \$33.1 billion by 2100 in the form of reduced costs of surveillance and vaccination. The costs to control polio at today's low levels, plus costs to treat the survivors, would be over U.S. \$1 billion per year for decades to come. Without investment now, by 2032 the world would be spending more to control the virus. Polio eradication is a cost-effective public health investment with permanent benefits. As many as 200,000 children could be paralyzed annually in the next decade if the world fails to capitalize on the more than \$19 billion already invested in eradication. Success will ensure that the investment made by the U.S., Rotary International, and many other countries and entities, is protected in perpetuity.

PREPARED STATEMENT OF THE RYAN WHITE MEDICAL PROVIDERS COALITION

Chairwoman Murray, Ranking Member Blunt, and members of the subcommittee, my name is Dr. Jehan Budak and I serve as the Assistant Medical Director and as an HIV primary care physician for the Madison Clinic at Harborview Medical Center in Seattle, Washington. I am pleased to submit testimony on behalf of the Ryan White Medical Providers Coalition (RWMP), for which I serve as a Steering Committee member. RWMP 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) in the Department of Health and Human Services.

First, I would like to thank the subcommittee for increasing FY22 funding for several of the Ryan White Program parts that support access to HIV care and treatment, as well as increasing funding for the Ending the HIV Epidemic (EHE) initiative at both the HIV/AIDS Bureau and the Bureau of Primary Health Care at HRSA. These increases will help ensure access to effective, comprehensive HIV care and treatment through the Ryan White Program nationwide as well as support target EHE initiative 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. Increasing funding for the Ryan White Program parts in FY23 would help jurisdictions nationwide continue to deliver comprehensive, effective HIV care and treatment as well as engage and retain new patients in a challenging environment impacted by rising care and workforce costs. To sustain and expand these critical services, I request \$231 million (a 12 percent or \$25.5 million increase) in FY23 for Ryan White Part C, which supports approximately 350 HIV medical clinics nationwide.

RWMP also requests additional resources for the EHE initiative to expand access to HIV prevention, care, and treatment, including \$462.3 million for HRSA's EHE program. This funding would include \$290 million for the Ryan White Program EHE initiative to provide additional HIV care and treatment, as well as \$172.3 million for the Bureau of Primary Health Care EHE initiative 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 FY23 budget request.

It is important that increases for Ryan White Part C and for the EHE initiative be new, additional funding and not a repurposing of current resources. The additional pressure on the medical and public health infrastructure in the wake of the COVID-19 pandemic, 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 health infrastructure and medical clinics serving people with HIV. Ryan White clinics were critical to responding to COVID-19 and many Ryan White medical providers were pulled in as leaders of the pandemic response in their jurisdictions. This worked well as these providers are infectious diseases experts with significant experience caring for vulnerable populations. These same providers also have been key to addressing the overdose crisis in their regions as well as increasing viral hepatitis and sexually transmitted infections, all which intersect with the domestic HIV epidemic.

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 as well as the escalating overdose crisis. Part C

clinics have helped people living with HIV by sustaining access to health care and medication through telehealth and other services, such as case management and transportation; by enrolling new patients who have lost health insurance as a result of economic disruption; and by providing overdose prevention and behavioral health care to patients living with HIV and mental health and/or substance use disorders.

Madison Clinic at Harborview Medical Center in Washington State 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 over 3,000 individuals with HIV, most with complex medical and psychosocial needs. Approximately 30 percent of our population is Black or African American (Seattle overall has 7 percent Black representation), 15 percent is Latinx, and 10 percent is Asian, Pacific Islander, or Native American. 47 percent 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 percent 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. Alarming, 12 percent of patients lack permanent housing, and many patients were negatively impacted by the intersection of housing instability; the opioid and other drug crisis 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 to approximately 500 individuals at risk for HIV. 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 provide incentivized, drop-in 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 is infectious, so identifying, engaging, and retaining individuals with HIV in effective care and treatment saves lives and benefits public health by stopping HIV transmission when individuals are virally suppressed.

In 2020, 89.4 percent of Ryan White patients were virally suppressed—a 28.6 percent increase in the program-wide viral suppression rate since 2010. In 2021, 92.8 percent of Madison Clinic patients were virally suppressed in spite of the complex challenges presented by the COVID-19 pandemic. The Ryan White Part C program's comprehensive services engage and keep people in HIV care and treatment. For example, 98 percent of HIV patients are on antiretroviral therapy at Madison Clinic. Early, reliable access to HIV care and treatment helps patients living with HIV live healthy and productive lives and is more cost effective.

Part C Clinics are on the Frontlines of the Opioid Crisis 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 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 \$310 million for CDC to provide surveillance, response, and other HIV prevention services as part of the EHE initiative, as well as \$150 million for CDC to address the infectious diseases consequences of the opioid and other drug 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 and other drug epidemics and that informed the treatment and prevention of COVID-19.

Thank you for your time and consideration of these requests, and please do not 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 Jehan Budak, MD, Assistant Medical Director, Madison HIV Clinic at the Harborview Medical Center in Seattle, Washington.]

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 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 \$102 million in FY22. 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 \$200 million for the REO program in FY23.

Authorized by section 169 of the 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,¹ making workforce development services essential for long-term employment and reentry success. In light of the costs of the criminal legal system at the

¹ 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>.

State, local, and Federal levels, the REO program is crucial to incubating community-based models of successful reentry through employment.

REO is the only Federal program that focuses specifically on workforce development and employment for people with records. As the economy recovers and workforce needs continue to evolve and change, it is essential to ensure that the significant number of people with criminal legal histories has the reentry supports and workforce training needed to achieve gainful employment and long-term reentry success. Developing this pool of trained, talented, and motivated workers also will help fill the workforce gaps employers currently face, especially in sectors with critical worker shortages. For these reasons, Congress should significantly expand the program in FY23 to \$200 million.

EMPLOYMENT REDUCES RECIDIVISM AND IMPROVES REENTRY OUTCOMES

1 in 3 adults in the United States has a criminal record that interferes with their ability to find a job.² 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.³ 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.

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 obtain sustained employment. This holistic approach has rendered outstanding results for both 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 works closely with employers to identify what types of trained employees are needed. In December 2021, the National Federation of Independent Business (NFIB) reported that 60 percent of businesses overall (and 95 percent 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, 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 FY23 to \$200 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 percent of participants obtained employment—15 percent higher than the grant's employment target. Given the success of this cohort of participants, T2W was expanded to include a second cohort who did even

²“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>.

³Visher, C., Debus, S., & Yahner, J. *Employment After Prison: A Longitudinal Study of Releasees in Three States*. Washington, DC: Urban Institute (2008).

better with an employment rate of 78 percent—30 percent 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 percent recidivism rate, and its second participant cohort had a 9 percent recidivism rate — 75 percent and 80 percent lower respectively than the National recidivism rate of 44 percent.⁴

Safer's REO grant for their Advancing Careers & Employment program also saw great outcomes with 577 enrolled clients. The ACE program provided workforce development, education, trauma-informed case management, and occupational training to adults (25 and older) who had been released from incarceration within 180 days or who were currently under supervision. Of the enrolled clients 93 percent developed an employment plan and 60 percent completed job training in the areas of carpentry, commercial driving, IT, hospitality, and solar panel installation.

Program evaluation has shown that such success is related to the comprehensive service model that REO 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 recent study found that in Illinois the average cost associated with just one recidivism event is \$151,662. Another study found that individuals who were employed and earning higher wages after release were less likely to return to prison within the first year. 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 REO AS A REENTRY AND WORKFORCE DEVELOPMENT PROGRAMS WILL HELP ENSURE A MORE EQUITABLE ECONOMIC RECOVERY

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. Reentry and workforce development programs, such as REO, are critical to ensuring a more equitable economic recovery for people with criminal legal histories, especially Black people and people of color who are disparately impacted by the criminal legal system.

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 \$200 million to the REO program in FY23.

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 at Kevin.Brown@saferfoundation.org or Jenny Collier at colliercollective.org.

[This statement was submitted by Kevin Brown, Director of Policy, Advocacy, and Legislative Affairs, Safer Foundation.]

⁴Durose, 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.

PREPARED STATEMENT OF SAVE THE CHILDREN

Chairwoman Murray, Ranking Member Blunt, and honorable Members of the subcommittee, thank you for the opportunity to provide testimony on behalf of Save the Children about the critical investments in the Departments of Health and Human Services and Education to ensure robust investment in early childhood education programs and to support unaccompanied children seeking safety and security in the U.S. In the United States and around the world, Save the Children works every day to give children a healthy start in life, the opportunity to learn and protecting children in crisis. We do whatever it takes for children—every day and in times of crisis—transforming their lives and the future we share. We urge the subcommittee to support robust appropriations for the Department of Health and Human Services, specifically the Office of Refugee Resettlement and the programs of Head Start/Early Head Start, Child Care and Development Block Grants, and Preschool Development Grants, as well as the Department of Education programs—21st Century Community Learning Centers and Promise Neighborhoods.

ADMINISTRATION FOR CHILDREN AND FAMILIES

*Child Care and Development Block Grant (CCDBG)**Request: \$12.3 billion for the Child Care and Development Block Grant.*

Families continue to struggle to afford child-care and childcare providers operate on razor thin margins. Despite significant investments in recent years, fewer than 1 in 7 eligible families received a subsidy under CCDBG. The much-needed relief provided by the American Rescue Plan has been essential to keep the child care sector afloat, and these temporary funds must be supplemented with an expansion to the base CCDBG budget. States face significant pressures on their existing CCDBG and child care relief funds: they must use a portion of CCDBG funds for quality improvement, as well as implementing new health and safety requirements, increasing payment rates, serving more children, and expanding eligibility.

An additional \$6.17 billion is needed—for a total of \$12.3 billion—to avoid damaging funding cliffs, and support States in making targeted investments to their child care systems aligned with longer-term recovery needs.

*Head Start and Early Head Start**Request: \$15.4 billion for Head Start and Early Head Start.*

Head Start and Early Head Start are key to providing and expanding comprehensive early care and education to our poorest children. At the current level of funding, Head Start serves less than half of eligible preschoolers, and Early Head Start only serves approximately one in 10 eligible infants and toddlers. During the pandemic the remarkable Head Start staff across the country have stepped up in order to maintain quality programming by modifying both their in-home and in-person early education programs. Without increased funds, the realities of a competitive market will require programs to choose between cutting access for children or underpaying and risk losing experienced and skilled staff.

An additional investment of \$4.4 billion—for a total of \$15.4 billion—is needed for Head Start and Early Head Start in order to maintain the high-quality early education opportunities the program provides. Specifically, \$1 billion is needed for expansion of Early Head Start and Early Head Start-Child Care Partnerships, \$596 million to sustain the workforce through a cost-of-living adjustment, \$2.5 billion for workforce compensation realignment, \$262 million to provide flexibility to address local quality improvement priorities, including facilities, and \$10 million to help develop the most effective and appropriate staff for American Indian/Alaska Native programs.

*Preschool Development Grants (PDG)**Request: \$500 million for Preschool Development Grants Birth through Five (PDG B-5) program.*

Expanded investments in Preschool Development Grants will enable more children to take advantage of early learning opportunities that encourage their learning and growth and will support efforts to further strengthen the quality of these programs. Research has demonstrated that high-quality early education has long-term benefits for children, especially low-income children, which far exceed the costs. And yet, despite the proven benefits of high-quality early education in general and the PDG program in particular, funding constraints mean that only 28 of the 46 planning grant recipients have received renewal grants.

An additional \$210 million is needed—a total of \$500 million—for Preschool Development Grants to allow state and territories to increase the quality and efficiency

of existing early learning programs and systems, while thinking strategically about how to optimize Federal and State funding streams. Through PDG B-5, Congress has the unique opportunity to foster state-led early learning initiatives, which is particularly necessary as States continue to recover from the pandemic.

OFFICE OF REFUGEE RESETTLEMENT (ORR)

Pilot Grant Program for Federally Funded Respite / Welcoming Centers

Request: \$50 million for the Grant Program for the humanitarian reception of individuals and families who have been released from DHS custody.

In order to create a more humane processing system at our Southern border, the department should establish an ORR-administered Non-Custodial Migrant Shelter Grant Program to support the establishment and operation of shelters by non-profit, non-governmental organizations at the border for families and single adults released from DHS custody. These welcome centers would be run by local community and faith based nonprofit organizations where families and adults can receive legal orientations and other services, reducing time in CBP custody. The funds for this program shall provide humanitarian assistance to individuals and families encountered and released by DHS, including basic medical care, psychosocial support, orientation to legal responsibilities and rights, referrals to community-based case management services at destination cities, and facilitation of onward travel.

Increased Funding for Legal Services, Child Advocates, and Post-Release Services

Request: \$400,000,000 for the provision of legal services for all unaccompanied children in the UC program, \$12 million for the appointment of a Child Advocates, and \$250 million shall remain available to ensure rapid access to and high quality of post-release services.

Unaccompanied children are uniquely vulnerable and face daunting challenges in the immigration system. Many unaccompanied children have valid claims for relief from deportation owing to past or feared harm, abuse, abandonment, neglect, or human trafficking; and all children have a right to a fair hearing in immigration court. Services provided by qualified and independent legal counsel to unaccompanied children increase the efficiency and effectiveness of immigration proceedings and significantly reduce the failure-to-appear rate of children who are released from HHS custody. Along these lines, independent Child Advocates appointed pursuant to the TVPRA provide a vital resource to the most vulnerable unaccompanied and separated children in Federal custody and to Federal agencies charged with their care, release and safe repatriation. While the additional funding recently appropriated for family reunification services has helped, there continue to be significant gaps in adequate home study and post-release service provision.

Creation of Ombudsperson Within HHS to Advocate for the Rights of Immigrant Children

Request: \$10 for the creation of the Office of Ombudsperson within HHS to provide independent child-welfare focused recommendations to ORR and the Secretary regarding the care of unaccompanied children.

Save the Children supports the creation of the Office of the Ombudsperson for Immigrant Children in Federal Custody to advocate for the quick, safe, and efficient release of immigrant children from government custody whenever possible, including the right to review placement decisions. Additionally, the Ombudsperson shall have access to facilities data, reviews, and recommendations of the HHS Office of Inspector General, in order to investigate systemic issues or improvements of facilities or grantees. Other longstanding problems-such as lagging reunifications or inappropriate placements in restrictive settings-also merit additional scrutiny and escalation mechanisms, as children and sponsors are often left with little to no recourse to bring their concerns to bear. The office would support Congress' long-standing view that family separation and detention are generally not in a child's best interest and, in cases in which detention or government custody is required, ensure that immigrant children are only detained or held in government custody in the least restrictive setting. In particular, this office would help mitigate and promptly address conditions that adversely impact children's safety, health, and wellbeing.

Restrictions on Use of Unlicensed Facilities

Request: None of the funds made available under the heading “Department of Health and Human Services-Administration for Children and Families-Refugee and Entrant Assistance” may be used to house unaccompanied children in any facility that is not State-licensed or any proposed facility ineligible for state licensure for the care of unaccompanied children.

State licensing is an essential and irreplaceable guardrail to ensure the safety of children in government custody. When the number of children arriving at the border increased during 2021, the Biden Administration opened new unlicensed facilities called “emergency intake sites” to quickly transfer children from Customs and Border Protection custody. These emergency intake sites were opened and have been operating without adherence to legal standards or ORR policies regarding services and safeguards, leading multiple whistleblowers to speak out against deplorable conditions for children. State actions like those taken by Texas and Florida to strip ORR facilities of state licenses are concerning, as they leave facilities without an independent oversight and monitoring mechanism to ensure the safety and well-being of children.¹ It is critical that ORR continues to challenge these state decisions through litigation while also proactively working with other States to expand its licensed capacity of family- and community-based settings. Congress must ensure that ORR is prepared for fluctuating numbers of arrivals at the border by expanding its system of State-licensed facilities that are compliant with the Flores Settlement and implementing policies that ensure children’s safe and prompt release from custody; it is never acceptable to deprioritize child welfare.

DEPARTMENT OF EDUCATION APPROPRIATIONS

21st Century Community Learning Centers (CCLC)

Request: \$1.789 billion for 21st Century Community Learning Centers.

Every day 11.3 million children are alone after school and are unsupervised for an average of seven hours per week. Parents of more than 19.4 million youth say their children would participate in an afterschool program if one were available in their community. Programs like CCLC help working families, keep young people safe during the hours after school when juvenile crime peaks, and improve academic achievement. Without funding for afterschool and summer learning programs, students will lose out on essential learning opportunities that help them prepare for school, college and careers, and can make up for time lost during the pandemic. The pandemic has shown how important robust afterschool and summer learning programs are to working families and our most vulnerable students, and how vital resources are to support these programs to ensure they are available and effective for the children who need them.

Promise Neighborhoods

Request: \$118 million for Promise Neighborhoods.

The Promise Neighborhoods program supports the implementation of innovative strategies that improve outcomes for children in the Nation’s most distressed communities. To do so, communities must build a continuum of supports for children, from cradle to career. This holistic approach to improving the educational achievement of low-income students ensures sustainable, community-driven changes and interventions.² Since its creation in 2010, this innovative program has proven a to be strategic investment in high-needs communities, funding communities with demonstrated success as well as new communities who create plans for change. This funding would allow for expansion of existing grants and new implementation grants, full funding for extension grants, and the creation of new capacity-building grants to strengthen communities’ ability to deliver critical services to children and families while also scaling city and regional investment strategies.

CONCLUSION

On behalf of Save the Children, and our advocates across the country, I want to thank the subcommittee for its continued leadership and bipartisan work on these programs. I ask that you continue to make a robust investment in children in FY23, increasing access to opportunity, and ensuring a more prosperous America for generations to come.

¹ <https://www.texastribune.org/2021/08/10/texas-child-migrant-facilities-licenses/>.

² <https://www.brookings.edu/research/the-harlem-childrens-zone-promise-neighborhoods-and-the-broader-bolder-approach-to-education/>.

[This statement was submitted by Christy Gleason, Vice President of Policy, Advocacy, and Campaigns, Save the Children.]

PREPARED STATEMENT OF THE SEATTLE INDIAN HEALTH BOARD

Chair Murray, Ranking 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, of Latino descent, and third generation in my family living outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Organizations (UIO) nationwide. I have had the privilege of serving SIHB for 6 years and have been providing congressional testimonials for the past 4 years. I am honored to have the opportunity to submit my testimony today requesting: the permanent authorization of 100 percent Federal Medical Assistance Percentage (FMAP) for UIOs; encouraging behavioral health parity and integration through workforce development initiatives across the U.S. Department of Health and Human Services (HHS) and Health Resource and Services Administration (HRSA); modifying the Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) tool; increasing access to traditional health services through the Centers for Medicare and Medicaid Services (CMS); and increasing administrative time under the Indian Health Service (IHS) Loan Repayment Program. Addressing these key issues can advance the health of urban American Indian and Alaska Native (AI/AN) population.

SIHB is an Indian Health Service (IHS)-designated UIO and a HRSA 330 Federally Qualified Health Center, which serves nearly 5,000 AI/AN living in the Greater Seattle Area in Washington state. Nationwide, UIOs operate 74 health facilities in 22 States and offer services to over 5.4 million AI/AN people in select urban areas. As a culturally attuned service provider, we offer direct medical, dental, traditional health, behavioral health services, and a variety of social support services on issues of gender-based violence, youth development, and homelessness. We are part of the Indian healthcare system and honor our responsibilities to work with our Tribal partners to serve all Tribal people, wherever they may reside.

We are home to a Tribal public health authority, Urban Indian Health Institute (UIHI), 1 of 12 Tribal Epidemiology Centers (TEC) in the country and the only TEC with a national purview-serving both rural and urban AI/AN's. For over 20 years, UIHI has managed public health information systems, managed disease prevention and control programs, communicated vital health information and resources, responded to public health emergencies, and coordinate these activities with other public health authorities and UIO's nationwide. Due to a lack of access to disease surveillance data, UIHI released the only AI/AN COVID-19 Data Dashboard,¹ providing critical disease surveillance data to the 45 UIO service areas ensuring AI/AN communities have access to culturally informed data collection, research, and evaluation.

Extend 100 percent Federal Medical Assistance Percentage (FMAP)

The American Rescue Plan act of 2021 temporarily extended 100 percent Federal Medical Assistance Percentage (FMAP) to UIOs. For Washington state, the 2-year temporary extension has resulted in \$18 million in Federal cost savings that will be captured in the Indian Health Improvement Reinvestment Account. The investment account will be able to expand its funding to activities, programming, and initiatives that improve the health of AI/AN people across the State of Washington.

The permanent extension of 100 percent FMAP to UIOs upholds the political status of Tribal citizens to ensure Federal dollars provide Medicaid-coverage to urban AI/AN Medicaid beneficiaries. Permanent extension of 100 percent FMAP reduces State Medicaid expenditures, honors Federal trust and treaty responsibility to AI/AN people and creates innovative healthcare delivery and systems changes to address social determinants of health experienced in AI/AN communities.

Encourage Behavioral Health Parity and Integration

We request HHS improve partnerships and invest resources with the Indian healthcare system to support recruitment and retention of health care professionals to support health integration, consumer demand, and identify need. A HRSA report found significant shortages of psychiatrists, psychologists, social workers, school counselors, and therapists across the country resulting in severe workforce deficits

¹Urban Indian Health Institute (April 2022) COVID-19 Data Dashboard. Retrieved from: <https://www.uihi.org/covid-19-data-dashboard/>.

for Indian County.² For Washington state, HRSA has identified our area as having a Mental Health Professional Shortage Area, with only 16.8 percent of mental health needs being met.³

We ask that HHS encourage behavioral health parity and integration by supporting initiatives to dual credential our providers to support vacancies. We request HHS mirror the Veterans Benefits Administration (VBA) dual certification process to support our providers. As AI/AN people are disproportionately represented in poor behavioral health outcomes, including higher rates of behavioral health conditions such as mental health, substance use, or suicide,⁴ it is necessary for HHS to invest in behavioral health parity through workforce developments for Indian healthcare clinics.

To address the workforce shortage of the Indian healthcare system as a whole, we support the National Tribal Budget Formulation Workgroup Recommendations, which includes \$1 billion to the Indian healthcare workforce development program to recruit and retain health professionals to address chronic and pervasive health care provider shortages. In addition, we ask that HHS advocate for, prioritize, and support workforce development incentives at IHS, SAMHSA, and HRSA.

Increase Partnerships and Resources to Address Provider Shortages

As previously mentioned, we recommend HRSA support investments into the Indian healthcare system through workforce development and supporting dual credentialing of providers to address our workforce deficits and meet the needs of Indian Country.

In order to ameliorate the significant vacancy rates for the Indian healthcare system, and address challenges to filling the vacancies in our facilities, SIHB has a strong workforce development program which includes 6 family medicine residents, 6 public health interns, and 4 Master of Social Work program students. Of our 6 family residents, 4 identify as AI/AN and recent graduation rates show 80 percent of our previous residents go on to work in communities of color and 50 percent go on to work in Native communities. These types of training programs increase AI/AN representation in provider positions.

As we develop the next generation of Indian Health Care Providers, we must ensure that barriers for American Indian and Alaska Native providers are eliminated, and we must increase leadership and management opportunities for all Indian Health Care Providers in the LRP program. We recommend that IHS modify LRP program requirements to allow providers additional administrative time. Additionally, HRSA investments can support vacancies, salary comparison, incentives, training programs, and dual credentialing needed to support recruitment and retention of AI/AN representation in the healthcare workforce.

Mandate CMS Reimbursement for Traditional Health Services

We request CMS support the integration of Traditional health services as reimbursable services to improve access to quality health services for AI/AN populations. Improved access to Traditional health services support equity-based health care initiatives that are outcome-oriented, patient-centered, and support primary and preventative healthcare services.

In 2021, SIHB secured a SAMHSA grant to launch a Traditional Indian Medicine (TIM) pilot that will code Traditional health services into our Electronic Health Records (EHR) system and will replicate reimbursable services. UIHI will provide evaluation on the pilot to document the health benefits of integrating Traditional Practitioners as part of our wraparound services. SIHB has uniquely integrated our Traditional Practitioners into our clinical and social services teams to provide over 39,000 encounters through assessments, counseling, hospital visits, and group services. In March 2023, SIHB will release a report documenting our methods to credential Traditional Practitioners, code Traditional health services into EHR, replicate reimbursable billing, and health outcomes from this pilot.

²U.S. Department of Health and Human Services—Health Resources and Services Administration. (2016). National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013–2025. Retrieved from: <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf>.

³KFF. (2021). Mental Health Care Health Professional Shortage Areas (HPSA). Retrieved from: <https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴U.S. Department of Health and Human Services—Office of Minority Health. (2021). Mental and Behavioral Health—American Indians/Alaska Natives. Retrieved from: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=39>.

The pilot will demonstrate how integrating traditional services in relatives' (patients) primary and preventative care can support and improve health outcomes of our relatives. Traditional health services can complement Western healthcare to support culturally attuned care for AI/AN people and BIPOC communities across the Nation. We will utilize our success story to advocate for Traditional health services being a standard practice across healthcare systems in the Nation to advance health equity by supporting outcome-oriented, patient-centered, and primary and preventative healthcare services.

Modify the GPRA Tools for Low-Barrier and Culturally Attuned Services

The GPRA Modernization Act of 2010 modified the GPRA tool to better serve the needs of providers. Twelve years later, we desperately need the GPRA tool to be re-modified to meet the modern needs of providers. The Administration, Congress, and local elected officials have all announced their efforts to address rising Substance Use Disorder (SUD) rates. However, the GPRA tool continues to be a burden to SUD access and treatment for our relatives due to the trauma triggering questionnaire. Additionally, the GPRA tool places a strain on our providers to meet required quotas. To ensure continued funding for our critical services, providers must commit their time and resources to fulfilling the requirements of the GPRA tool despite it not informing multidisciplinary teams of local clinics.

Today, the GPRA performance tool is burdensome to patients and providers. From providers in the Indian healthcare system, we have heard the GPRA tool is trauma triggering for patients, time intensive for patients and providers, and collects data that is solely beneficial for the Federal Government. The GPRA tool must be modified to be patient-centric, consider the time of our patients and providers, and avoid collecting unnecessary data that does not benefit local clinics. For example, UIHI and our medical division, are recipients of GRPA funds and certain questions related to behavioral health do not benefit our clinical team or research division.

We request HHS and SAMHSA modify the GPRA tool to be culturally attuned and low barrier to support the needs of our relatives. Additionally, we request HHS and SAMHSA modify the tool with the input of providers, patients, and Native experts to shorten the screening tool, ensure it is patient-centered, holds validity, administratively considerate, and informs providers of the immediate and long-term care of relatives.

Increase Administrative Time under the IHS Loan Repayment Program (LRP)

IHS has notified me amending the Loan Repayment Program (LRP) structure is a legislative fix that must be addressed by Congress. As the Indian healthcare system is severely understaffed, we must continue to implement unique initiatives to support our providers, which includes amending the IHS LRP to increase administrative time.

Under the current IHS LRP structure, medical providers are limited to 20 percent of FTE allocated to administrative time. While direct clinical care training is essential to the development of healthcare providers, we must acknowledge that administrative time is an opportunity to develop skillsets in leadership and operations management. I believe this amendment will support providers in the Indian healthcare system.

[This statement was submitted by Esther Lucero (Diné), MPP, President & CEO, Seattle Indian Health Board.]

PREPARED STATEMENT OF THE SEX EDUCATION COALITION

Dear Chairwoman Murray and Ranking Member Blunt,

As we honor Sex Education for All month this May, the undersigned 55 organizations, committed to supporting the sexual and reproductive health and rights of young people, request your support for fiscal year (FY) 2023 funding that helps to ensure the health of our Nation's youth. We urge you to protect the integrity of the Teen Pregnancy Prevention Program (TPPP) and increase support for the Centers for Disease Control and Prevention's (CDC) school-based HIV and STI prevention efforts. We also encourage the elimination of the abstinence-only "sexual risk avoidance" competitive grant program.

In the wake of numerous attacks on a young person's right to evidence-based, accurate information and services, young people face increased barriers, it is all the more critical that Congress address the resulting persistent inequity and health disparities. While a young person's health and wellbeing is about more than just the absence of disease, or in the case of sexual health, the absence of HIV and other

STIs, unintended pregnancy, or sexual violence, the adolescent data on these points alone, remain largely unchanged and alarming in recent years.

You have likely seen some of these statistics: young people under the age of 25 account for more than 1 in 5 new HIV infections;¹ half of the nearly 20 million estimated new STI cases each year in the U.S. occur among those aged 15–24;² 75 percent of pregnancies among young people ages 15–19 are unintended compared to an overall unintended pregnancy rate of 45 percent across all age groups;³ and 7 percent of high school students reported being sexually assaulted by a partner.⁴

Marginalized young people, such as young people of color, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) young people, and young people with differing abilities, face disproportionate indicators of a lack of systemic support for their sexual health. Lesbian, gay, and bisexual high school students, for example, are more than twice as likely as their heterosexual peers to experience partner violence, be sexually assaulted by a partner, or be forced to have sex.⁵ Further, 35 percent of transgender students report experiencing bullying at school, and the same percentage have attempted suicide.⁶

This data continues to highlight the importance of additional resources to better meet the needs of young people, particularly as the availability and quality of sexual health information and sexuality education varies drastically across the country. Less than 43 percent of all high schools and only 18 percent of middle schools in the U.S. provide education on all of the 20 topics the CDC has deemed essential to ensuring sexual health.⁷

Fortunately, research has shown us how we can better assist young people in leading healthy lives. Access to medically accurate programs that include sexual health information beyond abstinence works to promote adolescent health. These programs help young people determine if and when to have sex, teach them how to use condoms and contraception when they do so, and reduce unintended pregnancies.⁸ Programs that are inclusive of LGBTQ+ youth and LGBTQ+-related resources ultimately promote academic achievement and overall health.⁹ Equipping young people with sexual decision-making and relationship skills results in safer sexual behaviors. Additionally, promoting gender equity reduces physical aggression between intimate partners and improves safer sex practices for all genders.¹⁰

SUPPORT CONGRESSIONAL INTENT AND FUNDING FOR TPPP

Provide \$150 million in programmatic funding and \$6.8 million in evaluation transfer authority to support the continuation of a wide-range of evidence-based and informed community approaches to healthy youth development and unintended pregnancy prevention. Support bill and report language that protects the integrity

¹Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS), HIV among youth, 2017, www.cdc.gov/hiv/group/age/youth/index.html.

²National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC, HHS, Sexually Transmitted Disease Surveillance 2017: STDs in Adolescents and Young Adults, Atlanta: CDC, 2018, <https://www.cdc.gov/std/stats17/adolescents.htm#ref1>.

³Guttmacher Institute, Adolescent sexual and reproductive health in the United States, Fact Sheet, New York: Guttmacher Institute, 2017, www.guttmacher.org/fact-sheet/american-teens-sexual-and-reproductive-health.

⁴Kann L et al., Youth risk behavior surveillance—United States, 2017, Morbidity and Mortality Weekly Report (MMWR), 2018, Vol. 67, No. 8, <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>.

⁵Kann L, Sexual identity, sex of sexual contacts, and health-related behaviors among students in grades 9–12—United States and selected States, 2015, MMWR, 2016, Vol. 65, No. 9, www.cdc.gov/mmwr/indss_2016.html.⁶ Johns MM et al., Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017, <https://www.cdc.gov/mmwr/volumes/68/wr/mm6803a3.htm>.

⁶Johns MM et al., Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017, <https://www.cdc.gov/mmwr/volumes/68/wr/mm6803a3.htm>.

⁷Centers for Disease Control and Prevention. School Health Profiles 2018: Characteristics of Health Programs Among Secondary Schools. Atlanta: Centers for Disease Control and Prevention; 2019.

Secura GM et al., Provision of no-cost, long-acting contraception and teenage pregnancy, New England Journal of Medicine, 2014.

⁸371(14):1316–1323; Community Preventive Services Task Force, HIV/AIDS, other STIs, and teen pregnancy: group-based comprehensive risk reduction interventions for adolescents, 2012, www.thecommunityguide.org/hiv/riskreduction.html.

⁹Schalet AT et al., Invited commentary: broadening the evidence for adolescent sexual and reproductive health and education in the United States, Journal of Youth and Adolescence, 2014, 43(10):1595–1610, <http://link.springer.com/article/10.1007/s10964-014-0178-8>.

¹⁰Ibid.

of the program, which has been subject to unlawful attacks by the Trump administration.

TPPP was established in 2010 to support community-driven, evidence-based or informed, medically accurate, and age-appropriate approaches to preventing pregnancy among adolescents, involving parents, educators, researchers, and providers. In the program's first round of grants, TPPP served over 500,000 young people, trained more than 7,000 professionals, and partnered with more than 3,000 community-based organizations. In the second round of grants, 84 organizations in 33 States, the District of Columbia, and the Marshall Islands were awarded funds to replicate evidence-based programs in communities with the most need; conduct rigorous evaluation of new and innovative approaches to prevent unintended pregnancy among teens; or build capacity to support implementation of evidence-based programs.¹¹

Beginning in 2017, The Trump Administration sought to eliminate and undermine the integrity of the TPPP Program, including by proposing the elimination of the program in the annual President's budget, attempting early termination of ongoing projects, and awarding Tier 1 funding to organizations implementing abstinence-only "sexual risk avoidance" programs. Prior to the Trump Administration's attacks, the second program round was on track to reach 1.2 million young people. Courts have ruled that these attacks were unlawful, as was the April 20, 2018, Tier 1 Funding Opportunity Announcement, which violated TPPP's appropriations language.

This funding would support the work of trained educators and community partnerships, serve young people, and expand the body of evidence available to best meet their needs in alignment with the program's original intent. Further, funding for the Teen Pregnancy Prevention Program and related evidence review and evaluation funding will help to restore evidence-based implementation of grants by supporting adequate technical assistance and high-quality evaluation, reviving the evidence review, allowing grantees to meet the needs of young people in the wake of COVID-19, and serving approximately 125,000 more young people.

In addition, TPPP evaluation funds have been used to examine the efficacy of programs to inform new and innovative adolescent health promotion approaches. The findings from evaluations of the first TPPP grant cycle contributed to the body of evidence that guides educators in making program decisions and highlighted the importance of continued investment in new programs and strategies for various settings and audiences.¹² Learning both what works and what doesn't to support adolescent health is equally important; in building this evidence base and sharing it with communities and educators, TPPP uses a science-based approach to the prevention of unintended pregnancy among young people.

SUPPORT FUNDING FOR CDC'S SCHOOL BASED HIV PREVENTION

Provide \$100 million for CDC's school-based HIV and STI prevention efforts within the Division of Adolescent and School Health (DASH) to enable robust assistance and to States, districts, and schools in their efforts to support student health and to lead research on school health and a range of adolescent health behaviors.

The CDC provides a unique source of support for adolescent health education in our Nation's schools by seeking to promote education, health access, and environments where young people can gain fundamental health knowledge and skills and establish healthy behaviors. Currently, DASH provides funding to 28 school districts across the country to implement school-based HIV and STI prevention programs in schools, integrating substance use prevention, violence prevention, and other public health approaches. The work within DASH expands the research and evidence base of how to best meet the needs of young people, including LGBTQ+ youth, youth of color and disabled youth. Currently, DASH reaches 2 million young people at less than \$10 per student.¹³ With \$100 million in appropriations, DASH could directly reach 20 percent of all 56 million middle and high school students in the Nation, and reach the other 80 percent of young people indirectly through widespread implementation of safe and supportive environments in schools. This funding increase

¹¹OAH, HHS, HHS Office of Adolescent Health Fiscal Year 2016 Annual Report, Rockville, MD: HHS, 2016, www.hhs.gov/ash/oah/sites/default/files/2016-annual-report.pdf.

¹²Margolis AL and Roper YV, Practical experience from the Office of Adolescent Health's large scale implementation of an evidence-based Teen Pregnancy Prevention Program, *Journal of Adolescent Health*, 2014, 54(3):S10–S14, [www.jahonline.org/article/S1054-139X\(13\)00791-X/fulltext](http://www.jahonline.org/article/S1054-139X(13)00791-X/fulltext).

¹³DASH, Centers for Disease Control and Prevention <https://www.cdc.gov/healthyyouth/about/cdc-dash-health-program-impact.htm>.

would allow DASH to fund the 100 largest local education agencies in the country, as well as all 57 State and territorial education agencies.

END ABSTINENCE-ONLY FUNDING

Eliminate funding for the abstinence-only-until-marriage “sexual risk avoidance” competitive grant program, putting an end to harmful programs, regardless of new packaging, that have been proven ineffective at their primary goal of young people delaying sex until marriage.

Despite more than two decades of rigorous research demonstrating that programs with the sole aim of promoting abstinence until marriage are ineffective at this primary goal, over \$2 billion in Federal funding alone has been wasted on this stigmatizing approach. In addition to violating young people’s human rights, federally funded and independent analyses alike have found that youth participating in such programs were no more likely to abstain from premarital sexual activity than those who did not participate in the program.¹⁴ Moreover, regardless of what they are called, abstinence-only programs withhold necessary and lifesaving information that allow young people to make informed and responsible decisions about their own health. These programs have been found to include content that reinforces gender stereotypes, ostracizes and denigrates LGBTQ+ youth, stigmatizes sexually active young people and pregnant or parenting youth, and fails to respect the needs of youth who have experienced sexual abuse or assault.¹⁵ Rather than supporting the needs of young people, abstinence-only programs undermine opportunities to empower youth to make informed decisions about their health and wellbeing.

Young people deserve access to the information, education, and resources they need to make healthy decisions about their lives. Significantly more can, and needs to, be done to support the sexual health education of our Nation’s youth. Supporting these requests in the FY 2023 funding is an essential step in the right direction.

Thank you for your consideration of our request to support the health and wellbeing of young people.

Sincerely,

AAUW IL
 Advocates for Youth
 AIDS Alliance for Women, Infants, Children, Youth & Families
 AIDS Foundation Chicago
 AIDS United
 American Academy of HIV Medicine
 American Sexual Health Association
 APLA Health
 Black Women for Wellness
 Caracole
 Catholics for Choice
 Center for Reproductive Rights
 CHLP
 EducateUS
 Equality California
 ETR
 EyesOpenIowa
 Families USA
 Girls Inc.
 Girls Inc. of Omaha
 Healthy Teen Network
 HIV+ Hepatitis Policy Institute
 If/When/How: Lawyering for Reproductive Justice
 Ipas Partners for Reproductive Justice
 Jacobs Institute of Women’s Health
 Michigan Organization on Adolescent Sexual Health (MOASH)
 NARAL Pro-Choice America
 NASTAD
 National Family Planning & Reproductive Health Association
 National Health Law Program
 National Institute for Reproductive Health
 National Partnership for Women & Families
 National Women’s Law Center
 North Carolina AIDS Action Network
 North Dakota Women’s Network
 Planned Parenthood Action Fund of New Jersey
 Planned Parenthood Federation of America

Positive Women's Network-USA
 Power to Decide
 Reproductive Health Access Project
 SIECUS: Sex Ed for Social Change
 Silver State Equality
 The AIDS Institute

PREPARED STATEMENT OF SHEPHERD FOUNDATION

Thank you for the opportunity to submit this testimony in support of increasing funding for rare cancer research and for utilization of molecular diagnostics in cancer care. These issues are deeply personal for me. While undergoing Navy SEAL selection training at age 27, I collapsed, and upon subsequent examination, was diagnosed with a rare cancer called adenoid cystic carcinoma (ACC). I quickly discovered that the options I had for treatment were extremely limited. While I was able to get my tumor surgically removed, my disease is very likely to return. I will have no choices for treatment beyond more surgery, radiation, chemotherapy that is ineffective in treating ACC, and other treatments which have not been proven to work for this cancer.

I found that I was not alone in facing this dire situation—the lack of treatment options is the unfortunate reality for most rare cancer patients. Frustrated at these shortcomings in “modern” medicine, I started a rare-cancer focused biotech company called SHEPHERD Therapeutics and an associated nonprofit. We may be the only pan rare-cancer focused organization in the world. I am extremely proud of the work our team has accomplished. SHEPHERD is comprised of patients and caregivers, those who have lost loved ones to rare cancers, and those who are still fighting. Our mission centers on ensuring that cancer patients have the treatments and diagnostics they need to survive. To achieve this mission, funding for cancer research must be robust and include directed funding streams for rare cancers and those cancers currently without therapies. We believe one of the best ways to accomplish these goals is the study of commonalities across subsets of cancer to bring forth platform solutions that can save lives near term. The use of broad-spectrum diagnostics, new technologies such as AI, and precision medicine including molecular diagnostics will ensure patients have access to the most effective treatments, reduce the use of costly and ineffective therapies, and enable physicians to select targeted treatments that improve outcomes.

From our research, we know 380 out of the 400 forms of cancer meet the most conservative estimate of what constitutes a rare cancer, the American Cancer Society's metric of fewer than six new diagnoses per 100,000 people per year. Rare cancers account for over 550,000 new diagnoses each year—almost 1 in 3 new patients. Not only are all pediatric cancers and primary brain cancers rare, but so are the majority of cancers experienced by service members. Almost 70 percent of the more than 60 forms of cancer that disproportionately affect those who have served our country are rare forms, and only 25 of them have an FDA approved targeted therapy. Many of those cancers are linked to service-related exposures, such as asbestos, burn pits, radiation and Agent Orange. Evidence suggests that even children of veterans who were exposed to Agent Orange may have an increased risk of certain cancers, like acute myeloid leukemia, according to the National Academy of Sciences.

Beyond the pervasive impact of rare cancer, the lack of treatments is abominable. Over 100 cancers are not even mentioned in the NCCN treatment guidelines. The vast majority of new cancer patients—over 80 percent—who lack an FDA-approved targeted therapy for their cancer, are rare cancer patients. In other words, 182 cancers lacked even one FDA-approved targeted therapy, and 181 of them were rare cancers, as of February 2019. That means that in 2019 almost 200,000 new rare cancer patients faced their diagnosis without a modern treatment. Part of the challenge is the lack of development due to insufficient financial incentives to develop rare cancer therapies. This is in part due to a dearth of clinical trials that include rare cancer patients. SHEPHERD's analysis of all cancer clinical trials between 2012 and 2016 showed that approximately 75 percent of all trials did not include even one rare cancer by name. Only 13 percent of all rare cancers were specifically named as a focus of a phase III clinical trial in those 5 years. More than four times as much money in that time frame was spent on non-rare cancer trials than on trials which included a rare cancer. Clinical trials are expensive to run, and pharmaceutical companies are unlikely to choose to run a clinical trial in a small indication with few patients when a drug will work for a large population, even if that population already has dozens of drugs available for use, and even if that drug is a “me too” therapy which provides little benefit over the current standard of care.

Most companies decide that the cost of drug development cannot be justified by the potential market for a rare cancer like mine, ACC, which has around 1,200 new patients a year.

Fortunately, in the last few years, the FDA has encouraged new trial designs that allow trials to be run that target the molecular drivers of a cancer, allowing all patients whose tumors exhibit that genomic trait to potentially be included in the trial, regardless of their specific diagnosis. More good news: This approach can reach hundreds of thousands of additional patients right now via the utilization of molecular diagnostics. These tests can identify the presence of specific genomic alterations in a tumor that can be treated with an FDA-approved therapy today. Unfortunately, most patients are never even offered the option to receive these tests. Though broad spectrum molecular diagnostics cost less than a single round of chemotherapy, they are not reimbursed by CMS until the cancer has metastasized or reoccurred. In the absence of these tests, patients who lack a standard of care are most frequently put on generic chemotherapy protocols that are highly toxic and have very low odds for success.

The incorporation of molecular diagnostics into the standard of care protocol for cancer patients would improve treatment outcomes, reduce the use of costly and ineffective drugs, and increase the availability of data related to little-studied cancers like mine. Providing molecular diagnostics to patients at the time of cancer diagnosis, and especially to rare cancer patients, is the single most powerful tool currently available to improve outcomes and advance the science of oncology care. Underutilization of these readily available technologies due to lack of awareness or lack of insurance coverage needlessly puts the lives of cancer patients—including patients with my cancer—at risk. Moreover, failure to provide CMS coverage of molecular diagnostics is not just an issue of adequate care, it is also an issue of equity. The majority of cancer patients are treated in community hospitals that are unable to pay for diagnostics out of pocket on behalf of patients. Patients treated at large NCI care centers and academic hospitals, in contrast, more frequently conduct and cover the costs of these tests. Surely, we can all agree that a patient's specific diagnosis, geographic location, income level, or form of insurance should not dictate the quality of their cancer care or their odds of survival.

I respectfully request that you make the commitment in the FY 2023 Labor, Health and Human Services, and Education Appropriations bill to changing the system to properly address rare cancer and help all cancer patients. This would require a substantial increase in Federal spending on rare cancers (following the well-established six new diagnoses per 100,000 people per year definition) and prioritize research, data sharing, and translational development for cancers that lack an FDA approved targeted therapy. Additionally, these changes must strive to greatly increase the utilization of molecular diagnostics at both diagnosis and recurrence to ensure that patients are receiving appropriate therapies. Synergistic efforts to close the rare cancer equity gap would also encompass the following: (1) CMS and private insurance coverage of molecular diagnostics for all cancer patients at the time of diagnosis and when the cancer reoccurs (2) Education on the use and interpretation of molecular diagnostics for oncology care providers, and (3) Establishment of more clinical trials that specifically include rare cancers, either as an indication or via mutational target inclusion criteria.

Behind the statistics there are over half a million Americans who at this moment do not know that during the course of this year they will be diagnosed with a cancer for which there is frequently no treatment beyond what their parents or even their grandparents would have been offered. Science sees no second-class citizens, only patients in need of help. We ask Congress to do the same and take the necessary steps to make cancer a thing of the past. Thank you.

[This statement was submitted by David Hysong, Founder & Chairman of the Board, SHEPHERD Foundation.]

PREPARED STATEMENT OF THE SLEEP RESEARCH SOCIETY
FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

—The sleep community joins the broader research community in requesting \$49 billion in discretionary funding for the National Institutes of Health (NIH), an increase of \$3.5 billion over FY 2022. Sleep impacts nearly every system of the body and various disease processes, please provide proportional funding in-

creases for all NIH Institutes and Centers to further support sleep, circadian, and sleep disorders research activities.

—Please provide distinct, additional funding to further support and implement the new Advanced Research Projects Agency for Health (ARPA-H).

—The sleep community joins the broader public health community in requesting \$11 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 emerging CDC Chronic Disease Education and Awareness (CDEA) program with \$6 million, an increase of \$3 million over FY 2022, 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 2023 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 2022 appropriations, particularly for increasing funding for the new CDC Chronic Disease Education & Awareness Program, which is now supporting a 3-year cooperative agreement on obstructive sleep apnea and can support additional public health projects related to healthy sleep. Please maintain the commitments to NIH, CDC, and the CDEA program and increase funding as you and your colleagues work on appropriations for FY 2023.

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 psychology, neuroanatomy, pharmacology, cardiology, immunology, metabolism, genomics, 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

Sleep research activities at NIH and across the government are coordinated through the National Center on Sleep Disorders Research (NCSDR). Recently, NCSDR released its next 5-year plan for sleep research and welcomed a dynamic new Director, Dr. Marishka Brown.

As a result of sustained investment in NIH and the scientific opportunities in the field of sleep research, the research portfolio has doubled in size from \$233 million in FY 2014 to \$470 million today. This support has led to significant advancements in basic science, including the 2017 Nobel Prize in Medicine. However, research gaps remain in individual sleep disorders, such as narcolepsy, restless legs syndrome, and Kleine Levin syndrome, and patients lack innovative treatments, biomarkers, and new diagnostic tools. Team-based science and translational research is now needed to build on the momentum in sleep research and secure progress that benefits patients and the healthcare system. To effectively and comprehensively move sleep research forward in accordance with the goals of the new research plan, the community recommends support for a sleep research network at NIH.

Sleep Research Network

The sleep/circadian health sciences field requests the establishment of a Sleep Research Network that would allow for rapid assembly of research investigators and support. This will facilitate a prompt response to opportunities for multi-center clinical trials that address key unmet public health needs pertaining to sleep health and sleep disorders. Our members have the expertise necessary to implement a network across key domains including; data informatics, recommended measurement survey tools and technologies, site initiation/quality control, protocol assessment, and commercial/industry partnerships. Research networks like this can encourage development in emerging priority areas via conferences, pilots, educational activities, diversity/inclusion and public education/community engagement with the ultimate goal of accelerating transformative research and intervention to reduce risks and improve treatments.

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.

NIH Sleep Research Plan

To recognize NIH for its leadership on sleep research and to ensure ongoing support for advancing sleep research activities, the community asks for inclusion of the following report language for the National Heart, Lung, and Blood Institute at NIH.

Sleep Research Plan.—The Committee commends the National Center on Sleep Disorders Research for the release of the NIH Sleep Research Plan. The Committee requests information on the resources and assistance NCSDR will need to fully implement the plan and advance stated goals. The Committee supports the use of infrastructure capable of conducting multi-center sleep network studies and clinical trials related to the Sleep Research Plan.

Sleep Health and Health Equity

Sleep is a critical component of efforts to promote health equity and address health disparities. To raise awareness of ongoing efforts and to encourage emerging activities, the community asks for inclusion of the following report language for the National Institute of Health, National Institute on Minority Health and Health Disparities.

Sleep Health and Health Disparities.—The Committee applauds ongoing and emerging efforts by the NIMHD to advance health equity and address health disparities, including cross-institute initiatives and the initiatives identified by the recent Minority Health and Health Disparities Research Framework. The Committee notes the disproportionate impact of sleep deficiencies among populations that experience health disparities in the United States, including American Indians/Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians and other Pacific Islanders, sexual and gender minorities, the socioeconomically disadvantaged; and those living in underserved rural areas. The Committee encourages further work in and collaboration with community stakeholders on the issue of sleep health disparities.

CDC Chronic Disease Education & Awareness Program

Thank you for establishing the CDC CDEA program in FY 2021 by providing an initial investment of \$1.5 million and then doubling that investment to \$3 million for FY 2022. With the initial round of funding, CDC is now supporting four meritorious 3-year cooperative agreements in psoriasis, hearing loss, lymphedema, and sleep apnea. With additional funding for FY 2022, there is an expectation that CDC will fund another round cooperative agreements in critical public health areas. To ensure that there can be another competition to meet the growing demand for this important program for the third year, please provide \$6 million in funding for FY 2023. Further, the community asks that report language for this program encourage the participation of rare conditions in the CDC process and ensure that broader categories, such as sleep health, can be supported along with the current project on sleep apnea.

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.

BRITTANY'S STORY

One February afternoon during Brittany Matthews' senior year of high school, she awoke on her bedroom floor to her mom frantically screaming at her for skipping school for the 20th time that year. Brittany hadn't moved from the spot on the floor where she was doing her makeup at 7 am when her mom left for work. However, Brittany was confused because just a few minutes before this, she had thought she actually was at school and this "hypnopompic hallucination" experience felt just as real as now finding herself still at home. When the school informed Brittany's parents that she needed to go to court for her truancy issues and was not likely to graduate on time, Brittany was sent to live with her dad, who thought he could "straighten her out." That was one of the last straws in a sequence of events that finally led Brittany to receiving a diagnosis of narcolepsy at age 19, which was about 12 years after she began experiencing symptoms at the young age of 7. Narcolepsy is a misunderstood and under-diagnosed chronic neurological disorder affecting the brain's ability to regulate the sleep/wake cycle with a prevalence of 1 in 2,000 people worldwide. During the 5 years that followed, Brittany struggled in every aspect of her life until eventually finding a more effective treatment regimen, which allowed her to re-consider her dream of finishing college. Two years ago, Brittany graduated with her Bachelor of Science degree at the age of 26. Now, she is working full-time and is in the process of applying for graduate school programs for speech language pathology. Despite the progress she has made, Brittany still grapples daily with excessive daytime sleepiness, as well as cataplexy (sudden muscle weakness brought on by emotions). Advancements in research, treatments, and awareness are critical to improve the lives of those living with narcolepsy and other sleep disorders.

[This statement was submitted by Namni Goel, PhD, President-Elect, Sleep Research Society, Project Sleep, and the stakeholder community.]

PREPARED STATEMENT OF THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT

As the voice of all things work, workers and the workplace, SHRM is the foremost expert, convener and thought leader on issues impacting today's evolving workplaces. One such issue is employee mental health and wellness. This year, Congress has an opportunity to make a modest change that will have a significant impact in combating the mental health crisis across the Nation.

To accomplish this, we urge the inclusion of Committee Report language that will accompany the FY 2023 Department of Labor, Health and Human Services (LHHS) and Related Agencies' Appropriations bill to enable grant recipients under the Community Mental Health Block Grant (MHBG) program overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA) to aid in workplace mental health.

As the country continues to recover and adapt to new norms in our daily lives and how we work, workplaces and employers are a critical nexus to improve mental health in America. Congress should take meaningful steps to bolster SAMHSA's mission and reduce the impact of substance abuse and mental illness should extend into our workplaces. Adding explicit language that workplace-based programs are eligible for funding through MHBG is a critical first step.

Burnout, exhaustion and hopelessness are more common among workers than ever before, and pandemic-related stresses are chipping away at productivity. As

millions of Americans return to physical worksites or adjust to hybrid and fully remote work environments, mental health issues will continue to mount. Employers are leading the charge to improve mental health in the United States and are poised to do more for the workforce with access to the necessary resources. The mental health crisis is multi-faceted and requires commitment from Congress and the private sector to address this pressing issue.

The proposed report language will not require additional funding or increases to current allocations to SAMHSA, but it will allow for programs to address workplace mental health and wellness. Throughout the pandemic, organizations have relied heavily on their human resources (HR) professionals as the primary function and stakeholder in guiding employees and employers. These professionals proved themselves invaluable by providing the necessary leadership, empathy and human touch to keep workers connected while adapting to the pandemic and evolving needs of the workforce. The infrastructure is in place for effective workplace mental health programs and resources. The inclusion of this report language would ensure that this framework is well-utilized to meet the evolving needs of the Nation's workforce. The proposed language addition to the Committee Report is provided below:

The Committee notes that undiagnosed and untreated mental illnesses among America's workforce results in increased absenteeism, lowered productivity at work, higher turnover, and other factors that affect productivity. According to the Society for Human Resource Management (SHRM) Foundation, this lack of productivity amounts to an estimated loss of \$23 billion every year in the United States. The Committee believes that workforce mental health is an important part of ensuring the overall mental health of our larger communities. To address workforce mental health in the community context, the Committee sees value in SAMHSA encouraging the use of Community Mental Health Block Grant (MHBG) funds for this purpose. Therefore, the Committee directs SAMHSA to issue guidance to State agencies receiving MHBG funds to encourage public and nonprofit organizations to use a portion of their MHBG funds to implement evidence-based programs designed to educate and aid employers in providing mental health assistance to their employees to reduce the stigma and encourage the treatment of mental health illness in the workplace.

In April 2022, the SHRM Foundation released a report on mental health in the workplace. The report found that the extent of America's mental health crisis is alarming. Tens of millions of U.S. workers are experiencing mental health issues and are less productive because of it, inundating organizations with a vast array of new challenges. Mental health issues such as burnout and stress are hampering short-term productivity and long-term business growth.

Without mental health resources, employees will keep struggling to add value to their organizations. Employers that fail to offer mental health benefits to their workers will struggle to stay afloat. Hundreds of billions of dollars are at stake. In many ways, the U.S. economy-not to mention public health-hangs in the balance.

We cannot afford to wait, as the following statistics demonstrate:

- The World Health Organization estimates that the global economy has lost \$1 trillion due to anxiety and depression alone.
- 41 percent of HR professionals believe their organization does not currently offer enough support for employees' mental health care.
- Nearly 78 percent of organizations currently offer workplace mental health resources or plan to offer such resources in the next year.
- 94 percent of HR professionals believe organizations can improve the health of employees by offering mental health programs. They point to increased productivity, employee retention and attracting new talent as additional reasons to support mental health.

The United States will continue to grapple with the ongoing effects of the pandemic for an unknown period. Congress must continue to be proactive in supporting its constituent communities, as it has throughout the pandemic. Granting SAMHSA the ability to issue workplace mental health grants is the right place to start. Thank you for considering our request.

PREPARED STATEMENT OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

The Society for Maternal-Fetal Medicine (SMFM) is pleased to submit testimony in support of the pivotal work of the Department of Health and Human Services (HHS) to optimize the health of birthing people and infants. 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 fiscal

year (FY) 2023. Specifically, SMFM urges the Committee to provide at least the following in base program level funding:

- \$49.048 billion for the NIH, with at least \$1.816 billion of that funding to support the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD);
- \$11 billion for the CDC, including \$164 million for the Safe Motherhood Initiative, \$100 million for the Surveillance for Emerging Threats to Moms and Babies initiative, and \$210 million for the National Center for Health Statistics (NCHS);
- \$9.8 billion for the HRSA, including \$1 billion 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 5,500 individuals, the core of SMFM's membership is comprised of maternal-fetal medicine (MFM) subspecialists. MFM subspecialists are obstetricians with additional training in caring for individuals experiencing high-risk 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 infants.

HHS SECRETARY

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. 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 HHS Secretary in 2020. Since that time, various agencies across HHS have taken steps to implement PRGLAC recommendation, but there has been no coordinated effort across HHS. This disjointed implementation lends itself to potential duplication and missed opportunities. As such, SMFM recommends that Congress provide \$200,000 in FY 2023 for the creation of an HHS advisory committee to monitor and report on implementation of PRGLAC recommendations.

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 mothers have access to necessary medications.

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.

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.

Maternal Mortality: 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 2020 was 23.8 deaths per 100,000 live births, and racial disparities persisted with a maternal mortality rate of 55.3 deaths per 100,000 live births among non-Hispanic black women compared to 19.1 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 meet the President's budget request by providing at least \$164 million for this work.

Emerging Threats Initiative: 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.

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 \$1 billion 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.

¹Waitzman 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.

²Hoyert DL. Maternal mortality rates in the United States, 2020. NCHS Health E-Stats. 2022. Available at <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm>.

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 2023, 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 Murray, Ranking Member Blunt, and members of the subcommittee, on behalf of the Society for Neuroscience (SfN), we are honored 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 \$49 billion, a \$4 billion increase over FY22, in funding for the NIH for FY23, including the full release of funding for the NIH Innovation Account for 21st Century Cures programs and \$680 million for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. As both a researcher and a Professor in the Department of Biology at Brandeis University, I understand the critical importance of Federal funding for neuroscience research in the United States. My own research identified the ability of brain circuits to “tune themselves” to maintain the appropriate level of excitability, which is critical for healthy brain function.

My research group, supported by NIH funding, made fundamental discoveries in how neurons self-adjust their excitability, making it easier or harder to send electrical messages to other neurons. Over the past two decades, we have unearthed a family of mechanisms that allow for this unique flexibility called “homeostatic plasticity,” so neurons can change the rate they send messages and protect communication in the face of outside disturbances. Our work has many wide-reaching implications: We are studying how learning and memory suffer when these mechanisms malfunction; We are exploring how being awake or asleep affects these mechanisms; and we are investigating how States of being too excitable or not excitable enough contribute to disorders like epilepsy and autism spectrum disorder. Basic research, like my own, is paramount to understanding the brain at a level deep enough to develop treatments and interventions for diseases and disorders.

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 6 years. Growing the NIH budget over \$9 billion in that period is exactly the 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 the 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 America's research and development 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. Industry typically does not fund research on this important first step given the long-term path of basic science and pressure for shorter-term return on investments. Congressional investment in basic science is irreplaceable on the pathway for development of drugs, biologics, devices, and other treatments for brain-related diseases and disorders.

For example, in January 2022, NIH launched Phase 1 of Neuromod Prize to increase the development of neuromodulation therapies. Neuromodulation treatments act directly on peripheral nerves to improve organ function and have the potential to treat a variety of conditions, including heart failure. The Neuromod Prize is part of the SPARC (Stimulating Peripheral Activity to Relieve Conditions) NIH initiative. With SPARC, NIH will combine early-stage research and clinical applications to provide targeted treatments for multiple organ functions.

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 Initiative 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 is 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 FY23. Some recent exciting advancements in NIH funded neuroscience research include the following:

COVID-19 AND ITS IMPACT ON ADOLESCENT MENTAL HEALTH & DRUG USE

Since March 2020, Covid-19 has had a profound impact on our lives, physically and mentally. Adolescence is a challenging transition period, and researchers recognized the need to determine the impact of the pandemic on early adolescent's mental health. Using data from the Adolescent Brain Cognitive Development (ABCD) study, researchers fitted machine learning models that considered factors for adolescent psychological distress and emotional wellbeing during the Covid-19 pandemic. Factors that predicted adolescent psychological distress during the pandemic included being female, pre-pandemic internalizing symptoms, and sleep problems. They also found healthy habits (exercise, better sleep) and social support reduced detrimental effects of the pandemic on adolescent mental health. This study stresses the importance of mental health in vulnerable populations to complement investigations into the physical manifestations of the pandemic.

While adolescent mental health challenges have increased during the pandemic, adolescent drug use significantly decreased in 2021 since the start of the Covid-19 pandemic. These results come from the Monitoring the Future survey, funded by the National Institute of Drug Abuse. Since 1975, the Monitoring the Future has recorded drug and alcohol intake of adolescents across the United States at three time periods: lifetime, past year, and past month use. Findings from the survey show 10th and 12th graders alcohol, marijuana, nicotine, and illicit drug use decreased significantly from 2020 to 2021. This decrease was the largest 1-year decrease recorded in the Monitoring the Future survey since 1975. The results taken from the survey demonstrate how the pandemic has impacted drug use in adolescents. It will be interesting to see how adolescent drug use changes from 2021–2022, with the continuation of the pandemic.

CONGRESS & NIH MUST SUPPORT ACCESS TO MODELS NECESSARY FOR NEUROSCIENCE DISCOVERY

SfN urges the Committee to appropriate funding for biomedical research without restriction on the use of animal models. 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 pri-

mates 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 well-regulated research can continue.

FUNDING IN REGULAR ORDER

SfN joins the biomedical research community supporting an increase in NIH funding to at least \$49 billion for existing NIH institutes and centers, a \$4 billion increase over FY22. 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 new grants and to fully fund continuation 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 its 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 your strong support of biomedical research.

[This statement was submitted by Gina Turrigiano, PhD, President, Society for Neuroscience.]

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN’S HEALTH RESEARCH

The Society for Women’s Health Research (SWHR)—a more than 30-year-old national nonprofit with a mission of promoting research on biological sex differences in disease and improving women’s health through science, policy, and education—is pleased to submit testimony outlining SWHR’s funding requests for fiscal year (FY) 2023. While SWHR believes that all Federal research is complementary and thus supports robust funding across all Federal research and public health agencies, we specifically urge appropriators in FY 2023 to support a program level of at least \$49 billion for the National Institutes of Health (NIH), at least \$62.5 million for the Office of Research on Women’s Health (ORWH) and \$1.816 billion for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).

Biological sex differences influence disease development, progression, and response to treatment, while social determinants of health, including gender, affect disease risk, health care access, and outcomes. Yet, due to years of insufficient research addressing women, we have limited knowledge about women’s health relative to men’s health.

This lack of prioritization, or inattention, to women's health has not only affected our understanding about key aspects of women's health and overlooked a critical portion of the population, but it has also amounted to tremendous money lost for the U.S. economy. Recent research conducted by the RAND Corporation revealed that "even a slight increase in capital invested in basic research into women's health would unleash staggering returns..." The study's simulations, which examined the potential return on investment if NIH were to double the budget for studies specifically assessing the health of women, showed the tremendous opportunity that lies in women's health:

"By doubling the NIH budget for research on coronary artery disease in women from its current \$20 million, we could expect an ROI of 9,500 percent. Studies focused on rheumatoid arthritis in women receive just \$6 million a year. Doubling that would deliver an ROI of 174,000 percent and add \$10.5 billion to our economy over the 30-year timespan."—Chloe Bird, *Fortune*

Robust, sustained funding for Federal research entities that prioritize research into diseases, conditions, and life stages that differently, disproportionately, or solely affect women across the lifespan is critical to achieve health equity for women. The COVID-19 pandemic served as an important reminder that sex and gender differences that exist across diseases (e.g., men are more at risk for worse outcomes 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 vaccinations) and that health disparities are still widespread, with women disproportionately affected by socioeconomic challenges, food insecurity, domestic violence, and mental health concerns related to COVID-19.

To continue building on the progress made and to ensure women's needs are represented in Federal research, SWHR urges Congress to prioritize women's health across the lifespan and women's health research by supporting NIH, ORWH, and NICHD in fiscal Year 2023 funding legislation.

THE NATIONAL INSTITUTES OF HEALTH

The NIH is the premier medical research agency in the United States and the largest source of funding for biomedical and behavioral research in the world. As such, its mission is vital to promote the overall health and well-being of Americans by fostering creative discoveries and innovative research; training and supporting the next generation of researchers to ensure a diverse, strong research pipeline to continue scientific progress; and expanding the scientific and medical knowledge base.

Continued support for the NIH is necessary to drive women's health forward. Across NIH, researchers conduct and support basic, clinical, and translational research on diseases and conditions that impact women across the life stage. Among the NIH initiatives specifically aimed at improving women's health is the Trans-NIH Strategic Plan for Women's Health Research. Released in 2019, the 5-year Strategic Plan laid out broad NIH goals to complement its more targeted women's health programs, advancing women's health research, developing a well-trained biomedical research workforce, and promoting the role of sex and gender influences in research. Initiatives like these—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—will help us achieve consequential progress in making women's health mainstream.

SWHR urges Congress to provide a program level of at least \$49 billion for the NIH, a \$3.5 billion increase in the NIH appropriation plus funding from the 21st Century Cures Act for specific initiatives, in FY 2023. Additionally, SWHR asks that appropriators ensure that any funding for the new Advanced Research Projects Agency for Health (ARPA-H) or other targeted programs like pandemic preparedness supplement this base budget recommendation rather than supplant the foundational investment in NIH. This funding level, which is supported across the public health and scientific research communities, would allow for meaningful growth above inflation in the base budget and would expand NIH's capacity to support promising science in all disciplines (including women's health research) across the agency, keeping the NIH competitive on the world stage.

THE OFFICE OF RESEARCH ON WOMEN'S HEALTH

The biomedical sciences for decades have treated men and women as interchangeable subjects. 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. This approach ignored the impact of sex and gender on human development and disease progression, over-

looking a critical slice of the population and leaving untapped important areas of scientific opportunity.

As the NIH hub 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 on programs, such as the Specialized Centers of Research Excellence, or SCORE, 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.

SWHR recommends that Congress provides \$62.5 million in funding for ORWH in FY 2023. This increase will allow ORWH to build upon its existing programs, take steps in realizing a vision where sex and gender are integrated into research and where women receive personalized, evidence-based prevention and treatment, and continue its efforts coordinating and elevating women's health research across NIH.

THE EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

The NICHD, founded to investigate human development throughout the life process, also provides a home for women's health research in areas across reproductive sciences and maternal health, including infertility, pregnancy, and menopause. The Institute's research portfolio is critical for addressing pressing public health issues, such as pregnancy outcomes, gynecological health issues, such as uterine fibroids and endometriosis, and the environmental, behavioral, and social factors that shape women's health.

Among NICHD's myriad contributions to women's health research is its work with respect to pregnant and lactating individuals. Nearly 94 percent of women take at least one medicine during pregnancy, and 50 percent take at least one medication during the postpartum period. Yet, pregnant and lactating women are often excluded from 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.

As part of its efforts to support these populations is NICHD's Maternal and Pediatric Precision in Therapeutics (MPRINT) Hub, which will serve as a national resource for expertise in maternal and pediatric therapeutics to conduct and foster therapeutics-focused research in obstetrics, lactation, and pediatrics while enhancing inclusion of people with disabilities. The MPRINT Hub will aggregate, present, and expand the available knowledge, tools, and expertise in maternal and pediatric therapeutics to the broader research, regulatory science, and drug development communities.

SWHR calls on Congress to provide at least \$1.816 billion for NICHD in fiscal Year 2023 so the Institute can continue driving advancements in women's reproductive health and funding research and training activities that help address some of the Nation's leading public health issues.

SWHR appreciates the opportunity to submit this testimony and thanks the subcommittee of considering our requests of a program level of at least \$49 billion for NIH, at least \$62.5 million for ORWH and \$1.816 billion for NICHD. We look forward to working with you to ensure the highest possible support for Federal research agencies in FY 2023. If you have questions or need any additional information, please contact SWHR President and CEO Kathryn G. Schubert at kathryn@swhr.org.

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. Enclosed are our report language recommendations to encourage the National Cancer Institute to prioritize research activities to address endometrial cancer disparities in people of color. 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, who include physicians, nurses, and other advanced practice providers, represent the entire oncology team dedicated to the treatment and care of patients with gynecologic cancers. The SGO's strategic goals include advancing the preven-

tion, 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 to support research aimed at improving outcomes for diverse patient populations.

Endometrial cancer is the most common gynecologic cancer in the United States, and the fourth most common malignancy among American women, behind breast, lung, and colorectal cancers. According to the American Cancer Society, the incidence and mortality rate of uterine corpus cancers, over 90 percent of which arise from the endometrium, is rising. In 2012, there were an estimated 47,000 cases of uterine cancer and 8,000 deaths. This has increased by more than 140 percent over the last 10 years, with 65,950 expected new cases and 12,550 expected deaths in 2022.¹ While the majority of other cancers have seen improvement in survival rates, survival rates for endometrial cancer have worsened annually since 2010. Greater prevalence of key risk factors, such as obesity and delayed childbearing may be contributing to the increased incidence of endometrial cancer, but do not explain the worsening mortality.

Endometrial cancer was previously thought to be more common in White women, however as of 2007, the incidence of endometrial cancers in Black women surpassed that of White women and continues to increase each year.² The majority of endometrial cancers are the result of obesity, making this one of the only preventable cancers. Additionally, some of the distressing disparity between lower survival and outcomes for women who have endometrial cancer is missed opportunities at early detection. Bleeding, often accompanied by debilitating menstrual pain, is a symptom that allows early detection, but is sometimes misdiagnosed as fibroids, uterine cysts, or perimenopause. Unfortunately, fewer than 70 percent of endometrial cancers are now diagnosed while still confined to the uterus.³ Thirty-eight percent (38 percent) of endometrial cancers are diagnosed at advanced stages in Black women compared to 25 percent in White women.⁴

Additionally, black women are less likely to receive evidenced based care. Moreover, disparities exist regarding social determinants of health, access to genetic testing, preventive services, and other aspects of care for patients with endometrial cancer. These disparities are creating enormous inequities in outcomes and survivorship in our health care system, particularly for endometrial cancer. Black women are more likely to be diagnosed with aggressive subtypes of endometrial cancer and the mortality and 5-year survival rates are much worse for black women than white women. The five-year survival rate in black women is 63 percent compared to an 84 percent 5-year survival rate in white women.⁵ Black women are two times more likely to die from this disease compared to White women.⁶

Disparities in endometrial cancer outcomes may be furthered by inequities in access to appropriate screening, genetic testing, and preventive services. Identifying actionable targets to mitigate disparities in early detection and receipt of timely, guideline-concordant care remain critical to improving endometrial cancer outcomes among underserved populations. Research is critically needed to help understand barriers to care; elucidate differences in tumor biology; discover new approaches to screening, prevention, and treatment; and promote wider implementation of known strategies to facilitate optimal treatments to improve survival for all patients with endometrial cancer.

Therefore, the SGO urges the subcommittee to adopt the following report language on endometrial cancer in the report accompanying the Fiscal Year 2023 Labor-HHS-Education appropriations bill.

¹American Cancer Society. Cancer Facts & Figures 2022. Atlanta: American Cancer Society; 2022. file:///C:/Users/mjc92028/Downloads/cancer-facts-and-figures-2012.pdf; American Cancer Society. Cancer Facts & Figures 2022. Atlanta: American Cancer Society; 2022. <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf>.

²National Cancer Institute. Surveillance, Epidemiology, and End Results Program. Cancer Stat Facts: Uterine Cancer. Available at: <https://seer.cancer.gov/statfacts/html/corp.html>. Last queried February 13, 2020.

³Memorial Sloan-Kettering Cancer Center, Stages of Uterine (Endometrial) cancer. <https://www.mskcc.org/cancer-care/type/uterine-endometrial/diagnosis/stages>.

⁴American Cancer Society. Cancer Facts & Figures 2022. Atlanta: American Cancer Society; 2022. <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf>.

⁵American Cancer Society. Cancer Facts & Figures 2022. Atlanta: American Cancer Society; 2022. <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf>.

⁶Giaquinto Obstet & Gynecol Feb 2022.

National Cancer Institute

Endometrial Cancer.—The Committee remains concerned about the significant disparities in mortality rates for endometrial cancer that adversely impact Black women. The age-adjusted mortality rate for Black women with endometrial cancer is much worse than it is for White women, which is partly attributed to cancer stage at diagnosis. The Committee urges the NCI to conduct research activities that will lead to the development of targeted interventions to improve early diagnosis among Black women with endometrial cancer and improved access to high quality care through innovative community-based outreach methods to increase the enrollment and participation by Black women in clinical trials. The Committee requests an update on NCI's activities regarding endometrial cancer in the fiscal year 2024 Congressional Justification, including progress made in endometrial cancer early diagnosis, survival rates, and clinical trial enrollment by ethnicity.

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 endometrial cancer outcomes and remove barriers to health equity for all underserved women diagnosed with this lethal disease.

PREPARED STATEMENT OF THE SOCIETY OF NUCLEAR MEDICINE AND MOLECULAR IMAGING

Chair Murray, Ranking Member Blunt, 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 at least \$49.048 billion for the National Institutes of Health's base appropriation. This figure represents an increase of \$3.5 billion over FY 2022 plus the release of the 21st Century Cures funds. SNMMI also supports a proportional increase to the National Institute of Biomedical Imaging and Bioengineering (NIBIB), resulting in at least \$458.5 million for FY 2023—a \$33.6 million increase over the FY 2022 enacted level. Further, should the Advanced Research Projects Agency for Health (ARPA-H) or pandemic preparedness efforts progress, funding should be designated separately from NIH's base and should supplement, not supplant, investment in basic research. 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. 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 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.

Improved Imaging and Therapy for Cancer using Molecularly Targeted Radiopharmaceuticals

Major nuclear medicine advances in the fight against prostate cancer have appeared in the news. In the past year, three cancer-targeted radioactive imaging agents (Pylarify®, Illucix®, and Locametz®) received FDA approval and have entered commercial distribution for greatly improved detection of prostate cancer. These radiotracers seek out prostate cancer cells throughout the body, allowing the active foci of cancer to 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. The FDA has also recently approved a companion targeted radiotherapeutic, Pluvicto™ (¹⁷⁷Lu-PSMA-617), for men with late-stage castrate-resistant prostate cancer that had spread. The PSMA part of the drug makes it act like a guided missile or geotag 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 ¹⁷⁷Lu-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 accelerated 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 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 clinical trials and are expected to provide better patient outcomes. Support of that research is critical.

¹Wahl 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.

²Szabo Z, Mena E, Rowe SP, et al. Initial Evaluation of [(18F)JDCFPyL for Prostate-Specific Membrane Antigen (PSMA)-Targeted PET Imaging of Prostate Cancer. *Mol Imaging Biol.* 2015;17:565–574.

³Kratochwil 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.

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

About a year ago, 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® (ipilimumab) in 2011. In the U.S. 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 U.S. 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 pre-select, with imaging, patients who are likely to respond to immune checkpoint inhibitors thus enabling effective therapy earlier and eliminating side effects of futile 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

⁴Meikle 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/abd47f. PMID: 33339012.

⁵<https://www.whatisbiotechnology.org/index.php/timeline/science/immunotherapy/80>.

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 \$49.048 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 SPINA BIFIDA ASSOCIATION OF AMERICA

Shoshana Siegel of Hollywood, Florida

My name is Shoshana Siegel and I'm a 17-year-old, and I was born with Spina Bifida. I have had seven major surgeries in my life beginning at the age of 3 months. These surgeries include neurosurgery to detether my spine and brain surgery due to a related condition called Chiari Malformation. I am hospitalized 4-6 times a year for on-going foot infections that are a result of lack of feeling in my legs. Sometimes children with Spina Bifida are called million-dollar babies; by the time I was 6 months old my medical costs were half a million dollars. At the age of 17, between my surgeries, medications and hospitalizations, we estimate my medical costs are about \$3 million. I am fortunate to have always had private medical insurance through my mom's employers. I am on-track to graduate high school early and want to go into medical science as my career. I would like to be a forensic medical examiner or forensic psychologist. There are instances of people with Spina Bifida suddenly dying in their 40s with no explanation. I want to find out why and help us all live longer.

I'm here today to talk about the importance of funding for the CDC's National Spina Bifida program which funds research and clinics around the country. At the age that I'm at, I have around seven doctors who talk to each other openly through our local children's hospital system. My doctors include wound care specialists, two different neurologists, a neurosurgeon, an orthopedic surgeon, urologist and a primary doctor. Also, I see two mental health specialists to help me navigate life. If all goes well, I can go to these experienced doctors who know about my condition until I'm 20 years old. After I'm 20, I will no longer be able to receive care from these experts or be entitled to this quality care from my experienced and personalized medical team when I have an infection and need to be hospitalized. At 17 one of my doctors is already starting to transition me to an adult doctor for my next surgery which will take place before I am 18. This is not usually how it is done. Typically, a 20-year-old would be solely responsible for seeking doctors who may have experience with my condition and needs and it could take years to find the right fit for my type of Spina Bifida. It is not as easy as googling "spina bifida doctor". Spina Bifida is referred to as a snowflake condition because no two cases are alike. So for me it would be finding doctors who can specifically understand my body, my conditions and work with my other doctors. This is hard to do outside of a medical clinic situation. And there are not many Spina Bifida medical clinics at adult hospitals.

No one with Spina Bifida should have to fight to have basic medical care or be penalized because a condition which was once pediatric is now witnessing its first generation of adults. The medical system must figure out how to keep pace with a growing, aging and surviving Spina Bifida population.

Funding the National Spina Bifida Program at \$11 million would help prevent individuals like myself from falling over the care cliff that happens when a child with Spina Bifida makes the move from a coordinated pediatric system of care into a fragmented and fractured system for adult care. Establishing more adult care clinics

would help individuals transition and provide for coordination among doctors so we could secure employment and enrich our lives.

With the support of my family, I have had excellent medical care my whole life. This care has allowed me to thrive and excel in life. I would like to keep my life on track for success without being consumed by healthcare stress. Thank you for listening to my story and for your support.

Charlotte Mountz of Harpers Ferry, West Virginia

My name is Charlotte Mountz, and I am 18 years old and I have Spina Bifida. I am just like any other young woman, with hopes, dreams, and fears. I love animals and would like to be a zookeeper. Like most other siblings. My younger brother and I will argue about petty things. But one of my greatest concerns is the lack of healthcare for adults with Spina Bifida.

I have grown up going to fantastic pediatric doctors, who know how to treat people with Spina Bifida. However, Spina Bifida used to be thought of as a pediatric condition because kids would not live until adulthood, happily that has changed and we are seeing adults living into their senior years. Unfortunately, the adult healthcare system hasn't caught up. That is why I am writing to you today.

The Spina Bifida community experiences what is called a care cliff, meaning that when a child becomes an adult, they lose their care, and because of the lack of education about care for adults with Spina Bifida, there are a lack of providers, both PCPs, and specialist including, but not limited to, Urologists, Nephrologists, Neurologists, Neurosurgeons, Orthopedics, and more. Access to these providers is necessary for people with Spina Bifida to live happy and healthy.

I would like you to support an increase to \$11 million dollars for the National Spina Bifida Program at the CDC. This increase will allow the NSBP to find more research into care for adults with Spina Bifida so that we can better educate doctors and lessen the care cliff.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROMUSCULAR &
ELECTRODIAGNOSTIC MEDICINE

FISCAL YEAR 2023 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 \$49 billion in discretionary funding, an increase of \$3.5 billion over FY 2022. 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).
 - Please provide distinct, additional funding to support and further implement 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.
 - Please provide the Centers for Disease Control and Prevention (CDC) with \$11 billion to bolster support for public health programs that support patient communities, such as the National Neurologic Conditions Surveillance System.
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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 2023 L-HHS appropriations. First and foremost, thank you for the ongoing investment in medical research, patient care, and healthcare fraud prevention programs. Please maintain this investment and provide further support for FY 2023.

Concerning 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 nearly 6,700 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 impulses 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 2023 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 percent 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).

A case in Alabama earlier this year recently led to a guilty plea. According to the Justice Department, the provider conspired with... a Huntsville-based testing company, to bill insurers millions of dollars for electro-diagnostic testing that its technicians performed, regardless of whether there was a medical need for them. Insurers were then billed using the providers National Provider Identifier (NPI) number, even where they did not conduct the tests, supervise the tests, interpret the test results, or have anything to do with the tests beyond allowing the NPI number to be used for billing purposes. The fraud identified by the FBI for this case alone is \$28 million.

<https://www.justice.gov/usao-ndal/pr/huntsville-doctor-charged-health-care-fraud-conspiracy>.

[This statement was submitted by Peter A. Grant, MD, EDX Fraud and Abuse Consultant for FBI and OIG, AANEM Past-President.]

PREPARED STATEMENT OF TODAY'S STUDENT COALITION

Dear Chairwoman Murray, Ranking Member Blunt, Chairwoman DeLauro, and Ranking Member Cole:

The Today's Student Coalition (TSC) respectfully requests the following funding levels within the Fiscal Year (FY) 2023 Labor, Health and Human Services, Education, and Related Agencies (LHHS) appropriations bill. The TSC—a collective of 34 cross-cutting higher education policy, advocacy, and membership organizations—appreciates the steps that Federal policymakers have taken to support students through the pandemic. Yet, as our Nation looks to turn the corner and begin the process of rebuilding our economy for a post-pandemic world, Federal investments must continue to enhance the capacities of postsecondary institutions while ensuring student access to the support necessary for success in higher education.

As you begin to work on FY 2023 appropriations legislation, the TSC would like to express our support for investments in the key child care, financial aid/support, and campus mental health programs outlined below. As our coalition strives to create a system of higher education that better reflects and supports the needs of to-

day's students, we believe that investments in these programs represent a chance to not merely repair the damage caused by the pandemic, but to provide real educational and economic opportunity to all.

—*Emergency Aid Grants*: Create a permanent Emergency Aid Grant program to provide grants to institutions with the explicit purpose of providing direct student emergency financial aid. This funding would allow institutions to provide direct financial assistance to ensure an emergency cost does not derail a student's ability to complete college, similar to the assistance provided to students through the Higher Education Emergency Relief Fund (HEERF).

An emergency financial aid grant can help students cover any unexpected expenses so these emergencies do not suspend or halt their education. The Coronavirus Aid, Relief, and Economic Security Act and the two other subsequent COVID-19 aid packages provided resources for institutions of higher education to provide financial support in the form of emergency aid grants for students related to the pandemic. This aid enabled millions of students to stay in school despite the increased costs of living through the pandemic in a postsecondary environment. This authority proved that even a relatively small amount of financial aid can ensure students have a chance to stay in school.

—*Pell Grants*: Pell Grants have served as the cornerstone of Federal financial aid for students from low-income backgrounds, providing crucial support for roughly 7 million students each year. We urge Congress to consider a significant increase in the maximum Pell Grant award in both discretionary and mandatory funding—continuing the trajectory towards a full doubling of the maximum award amount in the coming years.

—*Child Care Access Means Parents in School*: Increase funding to \$500 million for the Child Care Access Means Parents in Schools (CCAMPIS)—the amount needed to provide child care support to about six percent of Pell-eligible student parents of children ages 0–5. The CCAMPIS program provides vital support for the participation and success of low-income parents in postsecondary education through the provision of campus-based child care, widely recognized as one of the most important supports for parenting college students. Increasing CCAMPIS funding to \$500 million would ensure that roughly 100,000 more parenting college students receive the child care assistance they need to continue their educational journeys.

—*Garrett Lee Smith Memorial Act Campus Suicide Prevention Grant*: Finally, increase the Garrett Lee Smith Campus Suicide Prevention Grant (GLS CSPG) to \$15 million, as this funding did not receive an increase in the FY 22 package.

In June 2020, data from the CDC showed that more than half of adults aged 18–24 had at least one adverse mental or behavioral health symptom, with more than a quarter considering suicide in the past 30 days. The GLS CSPG provides vital funding in colleges' efforts to not only address the unique needs of students experiencing mental health challenges or contemplating suicide, but support them in reaching their academic goals. As the mental health challenges on college campuses have grown, funding for this important program has become even more critical.

As you consider programmatic funding levels for FY 2023 appropriations, we urge you to reaffirm Congress's historic, bipartisan commitment to postsecondary education and to today's students. Thank you for the consideration of important requests. We look forward to continued work with you to advance programmatic funding that meets the needs of our students and the Nation as a whole.

Sincerely,

THE TODAY'S STUDENTS COALITION

Higher Learning Advocates
Achieving the Dream
Advance Vermont
America Forward
Association of Young Americans
Center for First-generation Student Success
Coalition on Adult Basic Education
Cornell University Student Assembly
Institute for Higher Education Policy
The Jed Foundation
Jobs for the Future
Let's Get Ready

National Association of Student Personnel Administrators
National College Attainment Network
National Skills Coalition
New America Higher Education Program
Student Veterans of America
Swipe Out Hunger
uAspire
University of California Student Association
University Professional and Continuing Education Association
Veterans Education Success
Young Invincibles

PREPARED STATEMENT OF TRIO TALENT SEARCH

"You're so smart. It's too bad you can't go to college," my dad sighed, a sad look on his face. I was a freshman in high school when he said that to me after reviewing my first report card. Up until that point, I hadn't really thought about college. I had assumed I would probably go because that's what people did after high school. I felt shocked by my dad's words; why wouldn't I go? His answer was "money," of course. There was no money for college.

I would soon come to learn that it wasn't just about money. Well-meaning though they were, my parents, who themselves struggled to complete high school and worked blue collar jobs, didn't have any idea of how to help prepare me for college. When it came to grades, it was simply "do your best." If homework was challenging, my mom jokingly reminded me she flunked out of algebra. There would be no SAT prep courses, no private education, no unpaid internships "for the experience." The time I had for extracurricular activities was shared with the 25 hours per week I worked at a pizza shop. I was smart, yes, but that was about all I had in my favor.

While I was in high school, I was informed that I was eligible to participate in a program called TRIO Talent Search (TTS). My ETS advisor, Carolyn, provided me with critical guidance I didn't get anywhere else. I'd had no idea that college applications cost money, but Carolyn helped me get fee waivers and meet application deadlines, schedule campus tours, and jump through all the hoops I had never known existed, and certainly couldn't have figured out on my own. With her help, I was accepted to the University of New Hampshire Honors Program with a partial scholarship.

In my first year of college, my dad experienced a significant mental health crisis that would ultimately lead to his becoming permanently psychiatrically institutionalized. His illness also resulted in a loss of income that ultimately led to foreclosure on our family home during my sophomore year. I took out extra loans to help with the mortgage, but it simply wasn't enough. These family stressors, coupled with my socioeconomic background, often made me feel "other" than my peers, who seemed so carefree by comparison.

As in high school, I worked through college and was fortunate to complete my work-study in TTS's administrative office. During that time, I became familiar with the many services provided by other TRIO programs. My TRIO supervisors and mentors encouraged me to apply for a tutor-counselor position at Upward Bound, another TRIO program that helped low-income, first generation, and ethnic minority students become competitive for college, in part through their intensive summer college preparatory program. I spent the summer before my junior year working as a teaching assistant for classes and providing mentorship, leadership, and individual tutoring to a fantastically bright and funny group of high school students. It was the first meaningful job I could put on my resume—a dramatic departure from Papa Gino's, Subway, and the Getty gas station off of exit 14.

That wasn't the end of what TRIO had to offer. Right before my senior year, an TTS mentor asked me if I had applied for TRIO's McNair Postbaccalaureate Achievement Program. I hadn't because I had never heard of it. Learning about the program, it seemed too good to be true: a summer spent living and conducting funded research on campus, a free GRE prep course, attending research conferences and college tours, personalized mentorship, graduate school application fee waivers, and peer support. I could barely contain my excitement. When I was accepted into the McNair Program, I felt like I had won the lottery, and in a sense, I really had. The summer I spent with McNair was among the most memorable of my life. I am certain that without that experience, their guidance, and the financial assistance, I would not have been competitive in graduate school application pools saturated with high-pedigree students with stunning CVs. Good grades and a passion for learning are simply not enough for success. With their help, I was accepted to The New School's clinical psychology program with a 75 percent tuition scholarship. I graduated with my BA in psychology summa cum laude, first in my class, with the honor of being designated a Dean's Fellow and Class Marshal. I had the privilege of carrying my college banner in our graduation march, which was one of the proudest moments of my life.

I went on to earn my MA and PhD in Clinical Psychology. While at the New School, I served as lab manager for a psychology lab that studied the psychophysiology of complex trauma. In short, we worked to understand how people with a lifetime of traumatic exposure (such as abuse and neglect) experience and manage their emotions. By also including measures of psychobiology, we were able to better understand the biological mechanisms underlying their emotional processes. A highlight of my time in the lab was when I was able to serve as project coordinator for a 5-year, multi-site NIMH-funded grant study on the common factors

underlying various mental health issues, with a focus on the role of trauma in diagnosis and emotional processing. In understanding how people with various mental health concerns process emotional information, we can develop better, more sensitive treatment interventions. My dissertation research, which focused on how people with trauma histories use physical pain to manage emotional distress, has clinical implications in helping patients reduce self-harming behavior while still coping with intense negative emotions. My research also served to de-stigmatize those who engage in self-harm by showing that many people use benign forms of pain to cope with stress. The main findings from this research have been presented at the Society for Affective Science conference, where I won an award for my talk. My results have since been published in *Emotion*, a highly regarded psychology research journal, and have been picked up by two psychology research digests.

During my graduate school years, I also completed 3 years of predoctoral training at the Manhattan VA hospital, where I provided therapy for veterans, including those with PTSD and traumatic brain injuries. After graduating with my PhD *summa cum laude*, I completed 2-year postdoctoral fellowship at NYU Langone's World Trade Center Health Program for first responders to the 9/11 attacks. During my time there, I provided therapy and assessment for first responders, and founded a therapy group for responders with 9/11-related cancers. I also had the opportunity to co-author an integrative mental health treatment manual to help providers meet the unique needs of this population.

After completing this training, I accepted a full-time position at Bellevue Hospital's World Trade Center Health Program for survivors of the 9/11 attacks, where for 2 years I provided psychotherapy to survivors with trauma-related disorders and co-morbid medical conditions, such as cancer. I was given my first faculty appointment as a Clinical Instructor at NYU School of Medicine and continued to pursue and publish my own research. My time in both the responder and survivor World Trade Center Health Programs was humbling and deeply meaningful, fueling my passion to continue helping people thrive in the wake of trauma.

In October 2021, I accepted an Associate Clinical Director position at the Center for Stress, Resilience, and Personal Growth (CSRPG) at Mount Sinai's Icahn School of Medicine. This also came with a promotion to Assistant Professor of Psychiatry at the School of Medicine. CSRPG conducts resilience-building outreach and provides immediately accessible mental health care to front-line healthcare workers at Mount Sinai. In my role, I coordinate all day-to-day clinical operations, conduct outcome research, engage in outreach, provide clinical supervision, and provide individual psychotherapy and resilience-building workshops to healthcare workers. It has been an immense privilege to provide care to those impacted by these chronic traumatic stressors.

As someone who benefited immensely from the mentorship and guidance of others, I feel strongly about carving out time away from therapy and research to give back to students. During my college years, I served as a youth mentor to a troubled middle school student. During my years as lab manager, I helped masters- and doctoral-level students develop and hone their research interests and skills, while also working to build a sense of community within the lab. As a teaching assistant, I provided both group and individualized support to master's students working on their theses. During my time as a postdoctoral fellow, I began supervising psychology trainees on their clinical cases. At Bellevue, I continued to stay active in the training program, providing supervision and mentorship to pre-doctoral psychologists in training on both trauma-related and general outpatient cases. I also led several didactics and seminars throughout the year on how to understand and treat complex trauma cases. Now, I supervise a group of 10 social workers in their clinical work.

The McNair program's naming after an astronaut is apt, because reaching the exit velocity required to ascend out of the working class requires force akin to a rocket engine and jet fuel. Obtaining my PhD (the first in my family) was of course the result of my own hard work—my “engine”, so to speak. But TRIO programs provided the jet fuel and mapped my course, without which I would certainly not be where I am today. I am privileged now to be doing a meaningful job that I love, with only a continued upward ascent ahead of me.

In addition to what TRIO has helped me accomplish, I am also immensely grateful to know that my future children, and their children in turn, will grow up with the knowledge and resources required to pursue their own educations and build fulfilling careers. TRIO helps individuals, yes—and I am one of those lucky ones. But TRIO's impact goes far beyond the individual, radiating outward to the patients I can now treat as a result of their assistance, and far into the future. I am so incredibly grateful for all TRIO has done for me; I would not be where I am today without these programs.

[This statement was submitted by Ashley Doukas, PhD, Alumna, TRIO Talent Search and Ronald E. McNair Postbaccalaureate Achievement.]

PREPARED STATEMENT OF TRIO UPWARD BOUND, MATH & SCIENCE

As a native Missourian, TRIO Upward Bound Math and Science alumna, former Obama Administration staffer, current TRIO Student Support Services (SSS) Director at Washington University in St. Louis, and Jennings City Council Member in St. Louis, MO, I am a true testament to how #TRIOWorks and shapes lives. I have been and educator and public servant for over two decades because of my wonderful TRIO experience.

As a high school student in Upward Bound Math and Science, the TRIO program helped me think about why I wanted to attend college; my advisor assisted me as I navigated college applications and figuring out which path to take. Being in the TRIO family, I was encouraged to not only receive an undergraduate degree from the University of Central Missouri, but also get a master's degree in Teaching, Social Science from Webster University, and to pursue a PhD in Educational Management-Higher Education from Hampton University.

While in the Upward Bound Math and Science program, I was able to cultivate meaningful friendships and met my best friends at the University of Northern Iowa where we attended summer classes through the program. Thanks to Upward Bound Math and Science, most of us attended college and graduated, and some of us went on to attain graduate degrees. Four of us from my TRIO cohort became Obama staffers. One friend who did not immediately attend college, went to and taught at cosmetology school. Because of that persistent spirit that TRIO programs instill in students, I am proud to have witnessed this very friend graduate from the only HBCU in St. Louis this past May 2022. She had the foundation of TRIO Upward Bound Math & Science. My TRIO cohort friend group is full of successful career paths: we have an urban farmer and food justice advocate, a healthcare worker, a CEO of a tech company, an education advocate, and a defense attorney. We all attribute our success to the support of the TRIO program and its advisors along our journeys.

Having the support during my high school years prepared me to attend college. Without the TRIO program, there would not be a Dr. Kimberly Morton or the countless other successful TRIO alumni who have benefited from this wonderful program. As a staffer in the Obama Administration working at the U.S. Department of Education in the office of post-secondary in the TRIO department and then as a current TRIO SSS director, I understand the impact of TRIO on all sides.

From a TRIO Director's lens, how we advise and advocate for our students throughout their college experience, especially during COVID, has been difficult because of mental health challenges among our first-generation, low-income students, and student with disabilities. We are slowly getting back to a new normal, but I think the long-lasting impacts of COVID, physically and mentally, will remain for years to come. We have also provided programming and three courses to assist students with resources on how to navigate WashU, we collaborate with campus partners, corporations, non-profits, and researchers to assist students with thinking about life post-graduation: whether they plan to go to medical school, law school, pursue other graduate degrees, or if they plan to join the workforce. We are setting students up with mentors and internships while providing them with professional development opportunities so that they can be the best versions of themselves when they graduate from the institution.

TRIO needs more funding to provide academic resources and increase staffing so that we can also serve as students' 4-year advisors. My team takes a holistic approach to advising. As 4-year advisors, we know that the students are getting the critical support that they need from first-year to graduation, and beyond. I would like to ask for support for an increase of \$170 million dollars for the FY23 budget because it is essential that we increase programming and provide academic resources and services to match student needs.

It has been a true honor for me to understand the TRIO program, on all levels. Knowing how many lives the program impacts across the country, it would be great if every institution across the country had a TRIO program. We must continue and expand this important work of ensuring that students who are first-generation, low-income, or have disabilities are seen and heard, have the academic support and programming, and advocacy to navigate to graduation and beyond. Our mission is to develop students who go on to have successful careers and become productive citizens who give back to their communities.

[This statement was submitted by Kimberly Morton, PhD, Alumna, TRIO Upward Bound, Math & Science.]

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) 2023 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. We are funded by philanthropic organizations and do not accept government funding and support evidence-based investments that strengthen public health, disease prevention, and health equity. The pandemic has demonstrated the impact of chronic underfunding of public health and prevention. Communities across the country have responded to the pandemic with a depleted public health infrastructure and workforce, while also responding to longstanding issues due to increases in chronic diseases, substance misuse and suicide, health disparities, and environmental health risks. 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 familiar but inefficient pattern of underfunding core public health and then providing significant infusions of emergency funding when a disaster hits. This short-term funding cannot build cross-cutting capacity or strengthen the underlying infrastructure and workforce needed for effective program implementation and emergency response. Now is the time to fix an underfunded system so we can ensure every community has the chance for 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 \$11 billion for the FY 2023 budget, including investing in these effective public health programs:

Emergency Preparedness: The COVID-19 response was hindered in part because the CDC's emergency preparedness funding had been repeatedly cut, reducing essential training and expert personnel. The Public Health Emergency Preparedness (PHEP) cooperative agreement has enabled great strides in our Nation's all-hazards preparedness, but the pandemic has renewed the urgency in expanded investment in domestic health security. Yet, PHEP appropriations has been cut significantly from \$918 million in FY2002 to \$715 million in FY 2022, or 51 percent when accounting for inflation. The PHEP cooperative agreement supports 62 State, local, and territorial recipients to develop and strengthen core public health preparedness capabilities. TFAH recommends at least \$824 million for the PHEP, the level authorized in 2006, to rebuild capacity to respond to an escalating number of emergencies.

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 at HHS, supports the readiness of the healthcare delivery system for emergencies. HPP provides critical funding and technical assistance to health care coalitions (HCCs) across the country to meet the disaster healthcare needs of communities, but funding has been cut drastically from \$515 million in FY2003 to \$296 million in FY 2022. TFAH recommends at least \$474 million for HPP (PHSSEF), the level authorized in 2006, to build capacity for the healthcare system to save lives during disasters.

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. A February 2022 study found that these programs resulted in significant decreases in sexual risk behaviors, violent experiences, and substance use, as well as improvements in mental health and reductions in suicidal thoughts and attempts.¹ During the COVID-19 pandemic, DASH has also leveraged its programs to improve student connections to mental health services during virtual learning. TFAH recommends

¹ Robin L. Timpe Z. Suarez NA, et al. "Local Education Agency Impact on School Environments to Reduce Health Risk Behaviors and Experiences Among High School Students." *Journal of Adolescent Health*, February 2022. <https://www.sciencedirect.com/science/article/abs/pii/S1054139X21004006>. <https://www.liebertpub.com/doi/10.1089/lgbt.2021.0133>.

at least \$100 million for DASH to expand its work to around 25 percent of all U.S. students and enable them to become healthy adults.

Suicide Prevention: The COVID-19 pandemic appears to have heightened the risk for suicide among certain groups, including girls aged 12–17 years,² Black youth,³ and Latino males.⁴ Concerningly, the recent CDC Adolescent Behaviors and Experiences Survey also found that almost 20 percent of youth respondents had seriously considered attempting suicide, and 9 percent actually attempted suicide.⁵ The complex nature of suicide requires a comprehensive program that focuses on disproportionately affected 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 risk. CDC programs consist of multisector partnerships, using data to identify populations of focus and risk and protective factors, rigorous evaluation efforts, and filling gaps through complementary strategies and effective communications. TFAH recommends at least \$40 million to expand innovative prevention activities to at least 25 sites and support State health departments as they expand comprehensive suicide prevention and syndromic surveillance.

Adverse Childhood Experiences: As the number of adverse childhood experiences (ACEs) an individual experiences increases, so does the risk for negative health outcomes such as asthma, diabetes, cancer, substance use, and suicide in adulthood. CDC estimates that 61 percent of adults report having experienced at least one ACE in their lifetime, and the prevention of ACEs could reduce cases of depression in adults by 44 percent and avoid 1.9 million cases of heart disease.⁶ To help address these issues, CDC has worked to build the evidence base by supporting innovative research and evaluation, support surveillance and data innovation, and identify strategies and build capacity and awareness to prevent ACEs across the country.⁷ CDC currently supports six State-level offices, institutes, or departments that are implementing two or more strategies from its Preventing ACEs guidance document, including economic assistance to families, efforts to connect youth to care, and short-term and long-term interventions to reduce harms.⁸ TFAH recommends at least \$15 million to expand surveillance and innovative ACEs prevention activities to additional States.

Obesity and Chronic Disease Prevention: The COVID-19 pandemic has been exacerbated by preventable, chronic health conditions, including obesity. In 2018, 42.4 percent of adults had obesity.⁹ 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.¹⁰ This Division funds State health departments to protect the health of all Americans by promoting healthy eating, active living, and obesity prevention in early care and education facilities, hospitals, schools, 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

²Yard E, Radhakrishnan L, Ballesteros, M, et al. "Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic—United States, January 2019–May 2021." *Morbidity and Mortality Weekly Report*, 70(24):888–894, June 18, 2021. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm>.

³Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. U.S. Surgeon General, December 7, 2021. <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-healthadvisory.pdf>.

⁴Ehlman D, Yard E, et al. "Changes in Suicide Rates—United States, 2019 and 2020." *Morbidity and Mortality Weekly Report*, 71(8):306–312, February 25, 2022. <https://www.cdc.gov/mmwr/volumes/71/wr/mm7108a5.htm>.

⁵Everett Jones S, Ethier K, et al. "Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic—Adolescent Behaviors and Experiences Survey, United States, January–June 2021." *Morbidity and Mortality Weekly Report*, 71(3):16–21, April 1, 2022. https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm?s_cid=su7103a3_w.

⁶Justification of Estimates for Appropriations Committees. Centers for Disease Control and Prevention, 2022. <https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf>.

⁷Adverse Childhood Experiences Prevention Strategy FY2021–FY2024. In Centers for Disease Control and Prevention, September 2020. https://www.cdc.gov/injury/pdfs/priority/ACEs-Strategic-Plan_Final_508.pdf.

⁸Preventing Adverse Childhood Experiences: Data to Action. In Centers for Disease Control and Prevention, updated August 19, 2021. <https://www.cdc.gov/violenceprevention/aces/preventingacedataaction.html>.

⁹State of Obesity 2021. Trust for America's Health. Sept 2021. <https://www.tfah.org/report-details/state-of-obesity-2021/>.

¹⁰J. 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.

enough money to implement its State Physical Activity and Nutrition Programs (SPAN) in 16 States. TFAH recommends at least \$125 million for DNPAO to expand SPAN to all 50 States and territories and build State-level capacity.

Additionally, inequities in social and economic conditions facing people of color and Tribal Nations continue to negatively impact health outcomes. Among the programs that are effective in reducing racial and ethnic health disparities are Racial and Ethnic Approaches to Community Health (REACH) program and Healthy Tribes (previously referred to as Good Health and Wellness in Indian Country). CDC's REACH program, within DNPAO, works in 40 communities across the country by supporting innovative, community-centered approaches to develop and implement evidence-based and culturally tailored programs that reduce health disparities. The REACH program will be going through a re-compete in FY23, and increased funding is needed to meet the overwhelming need for the program, with over 260 approved but unfunded applications. The Healthy Tribes program represents CDC's largest investment in American Indian/Alaska Native health by coordinating three separate programs: the Good Health and Wellness in Indian Country (GHWIC), Tribal Epidemiology Centers for Public Health Infrastructure (TECPHI), and Tribal Practices for Wellness in Indian Country (TPWIC). Healthy Tribes supports holistic approaches to chronic disease prevention while also allowing Tribal leaders to direct public health interventions most effective for their communities. TFAH recommends at least \$102.5 million for the total REACH funding line (CDC), with \$75.5 million directed to REACH and \$27 million for Healthy Tribes.

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,¹¹ contributing to an estimated 80–90 percent of a person's health outcomes.¹² Public health agencies are uniquely situated to build collaborations across sectors, identify SDOH priorities in communities, and promote cost-saving interventions that prevent chronic health conditions. Currently most public health departments lack funding and tools to support such cross-sector efforts and are limited by disease-specific Federal funding. 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 all States and territories. CDC is also building out the evidence-base for these interventions. In a review of existing multi-sector partnerships addressing SDOH, 29 organizations projected a savings of \$566 million over 20 years from saved medical costs and increased productivity levels.¹³

Environmental Health: Not all emergencies are caused by infectious disease. Many occur due to environmental factors. 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,¹⁴ the Tracking Network is a cost-effective program that examines and combats harmful environmental factors. Yet only half the States receive funding. TFAH recommends at least \$54 million for National Environmental Public Health Tracking Network (CDC), which would enable 15 additional States to join the network.

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 public health approaches to healthy aging. 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

¹¹Taylor, 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.

¹²S. Magnan. Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine, Oct 9, 2017. <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>.

¹³CDC, SDOH Evaluation. <https://www.cdc.gov/chronicdisease/programs-impact/sdoh/pdf/GFF-eval-brief-508.pdf>.

¹⁴Return on Investment of Nationwide Health Tracking, Washington, DC: Public Health Foundation, 2001.

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.

[This statement was submitted by J. Nadine Gracia, MD, MSCE, President & CEO, Trust for America's Health.]

PREPARED STATEMENT OF TUBERCULOSIS ROUNDTABLE

Tuberculosis Roundtable (TBR) 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 2023 (FY23) appropriations. As organizations tasked with protecting the country from tuberculosis (TB), TBR members are gravely concerned about the long-term impacts of the COVID-19 pandemic on future TB incidence. These impacts include significant delays in diagnosis with increasingly complicated cases, increases in co-morbidities, the suspension of targeted testing and treatment of latent TB infection, and the diversion of economic and human resources to the COVID-19 response. We respectfully urge you to fund the domestic TB program at CDC at \$225 million for FY23. This funding is vital to recoup lost staff time and resources due to the pandemic, focus on identifying and treating latent TB, respond to emerging outbreaks and challenges, and strengthen national, State, and local efforts to detect, treat, and prevent all forms of TB, including drug-resistant TB.

TB is the world's second most deadly infectious disease, still ranking ahead of HIV/AIDS, killing 1.5 million people annually.¹ In the United States, TB remains a serious problem with all 50 States continuing to report cases every year. According to CDC, there were an estimated 7,860 new cases of TB reported in the United States during 2021, with many States reporting increases over 2020 case counts.² The pandemic severely impacted TB case notifications due to TB program staff being reassigned to work on COVID-19 and patients being unable or unwilling to seek testing and care under stay-at-home orders and similar policies. Many of these delayed diagnoses have resulted in a rebound increase of TB cases nationally, but many remain undiagnosed. As a direct result, staff and clinicians are seeing much more advanced and difficult-to-treat TB, and jurisdictions are seeing increases in TB deaths.

Tuberculosis often starts out as a latent, or asymptomatic, infection which progresses to active and contagious TB disease when the immune system is challenged. Right now in the U.S., there are up to 13 million individuals with an asymptomatic latent TB infection.³ The diagnosis and treatment of individuals with latent TB, who are at high risk of progression to active and contagious TB disease, could prevent an estimated 650,000 to 1,300,000 new cases of active TB as people are treated before they risk transmitting the disease to their families and communities.

Antibiotic resistant bacteria are an immense threat to the health of the world, and drug resistant tuberculosis counts for one-third of all deaths related to antimicrobial resistance globally. Multidrug-resistant TB (MDR-TB) cases are more difficult and expensive to treat and threaten to overwhelm underfunded state TB programs.⁴ Between 2005 and 2020, there were 1,664 cases of MDR-TB and 40 cases of extensively drug-resistant TB (XDR-TB) reported in the United States.⁵ MDR-TB regimens are longer, often with more expensive medications that include more extensive side effects and require more oversight and assistance from healthcare workers. In 2020, CDC estimated that the cost of treating a single patient with MDR-TB in the United States averaged \$182,000, and the average cost of treating a patient with XDR-TB was even higher at \$568,000, compared with \$20,000 to treat a patient with drug-susceptible TB. CDC also estimated that the costs resulting from all forms of TB in the US totaled over \$503 million in 2020. This doesn't

¹World Health Organization. Global tuberculosis report 2021. <https://www.who.int/publications/i/item/9789240037021>.

²U.S. Centers for Disease Control and Prevention. U.S. TB Statistics. Division of TB Elimination. <https://www.cdc.gov/tb/statistics/default.htm>.

³Ibid.

⁴The Economist. A call to action: It's time to end drug-resistant tuberculosis. Economist Intelligence Unit. https://pages.eiu.com/ji-healthcare—2019-healthcare_landing-page-report.html.

⁵U.S. Centers for Disease Control and Prevention. U.S. TB Statistics. Division of TB Elimination. <https://www.cdc.gov/tb/statistics/default.htm>.

begin to address the costs patients and communities face in the form of lost wages and opportunities during their treatment.⁶

Global crises are also heavily impacting TB in the U.S. as we welcome new arrivals from Ukraine, which has one of the highest rates of MDR-TB in the world.⁷ Testing and treatment is largely falling upon State and local health departments to complete, even while they grapple with budget cuts and increasingly overstretched capacity in the wake of COVID-19. TB program staff have expressed their desire to help during this humanitarian crisis, but fear that an upcoming wave of delayed diagnoses from the pandemic coupled with a new population to care for could prove impossible for them to adequately handle.

CDC's Division of TB Elimination (DTBE) also contains a research arm that houses the TB Trials Consortium (TBTC). Recent TBTC studies have led to monumental breakthroughs in shortening and improving treatment for latent TB and drug-susceptible TB disease, and other studies focus on such priorities as pediatric safety and dosage.⁸ Despite TBTC's tremendous value and the dire need for the benefits of its work, funding constraints risk limiting this vital research.

We recognize your commitment to careful consideration of the many domestic, health, labor, and education programs that require assistance in FY23, and thank you for your continued leadership. We urge you to make eliminating TB in the U.S. a top priority for your FY23 appropriations bill by funding CDC's domestic TB program at \$225 million to recover from the COVID-19 pandemic, focus on addressing latent TB, and strengthen national, State and local efforts to identify, treat, and prevent TB.

PREPARED STATEMENT OF THE TUSKEGEE UNIVERSITY COLLEGE OF
VETERINARY MEDICINE

SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

Health Resources and Services Administration:

- \$1.51 billion for the Health Resources and Services Administration (HRSA) Title VII health professions and Title VIII nursing workforce development programs.
- \$47.42 million for HRSA's Minority Centers of Excellence
- \$47.95 million for HRSA's Health Careers Opportunity Program.
- \$2 million for HRSA's Minority Faculty Loan Repayment Program.
- \$67 million for HRSA's Scholarships for Disadvantaged Students (SDS).

Centers for Disease Control and Prevention

- \$74 million for the Racial and Ethnic Approaches to Community Health (REACH) Program

National Institutes of Health

- \$49 billion for the National Institutes of Health
- \$1 billion for the National Institute on Minority Health and Health Disparities (NIMHD).
- \$300 million for the Research Centers at Minority Institutions (RCMI)
- \$200 million in new, annual research funding dedicated specifically targeted at enabling historically black health professions schools to support research that reverses health status disparities among minority Americans.
- \$100 million for NIH's Extramural Research Facilities program
- \$50 million to reinvigorate the NIMHD's Research Endowment Program (REP)

Office of the Secretary

- \$72 million for the Office of Minority Health at the Department of Health and Human Services.
- \$5 billion in new funding designated for Historically Black Health Professions Institutions for the improvement and development of health care infrastructure.

⁶vi Ibid.

⁷World Health Organization. Global tuberculosis report 2021. <https://www.who.int/publications/i/item/9789240037021>.

⁸U.S. Centers for Disease Control and Prevention. Tuberculosis Trials Consortium. Division of TB Elimination. <https://www.cdc.gov/tb/topic/research/tbtc/default.htm>.

Department of Education

—\$100 million for the Strengthening Historically Black Graduate Institutions (HBGI) Program.

Community Project Funding / Congressional Directed Spending Request (HRSA)

—\$10 million for the Development of a Center for Food Animal Health, Food Safety, and Food Defense in TUCVM

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. Ruby Perry, Dean and Professor of Veterinary Radiology at the College of Veterinary Medicine at Tuskegee University. Since its inception in 1945, Tuskegee University College of Veterinary Medicine (TUCVM) has educated more than 70 percent of the Nation's African American veterinarians, and is recognized as the most diverse of all veterinary schools and colleges in the U.S. The College is the only veterinary medical professional program located on the campus of a historically black college or university (HBCU) in the U.S.

The pandemic has pulled back the curtain on what TUCVM and other Historically Black Graduate Institutions (HBGIs) and HBCUs 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 minority health and disparities. To achieve this we know that it will require the steadfast leadership of health equity champions. We stand ready to work with you and your colleagues to facilitate these efforts.

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.
- 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 U.S. are disproportionately suffering from COVID-19 unfortunately was not a tremendous surprise to those of us who regularly monitor and understand health status disparities in this nation. There are well-known health status challenges faced daily by Black Americans and minority health care providers, it also represents a surrogate for the glaring lack of health infrastructure in medically under-served communities. At TUCVM and other HBGI institutions, we have long been and remain committed to addressing these very same disparities in whatever way that we can, with an eye first and foremost towards the communities with the greatest need across our country.

Ironically, as a result of their mission focus the financial models of historically black health professions schools are uniquely disadvantaged compared to most of their peer institutions. Unlike subspecialty-oriented, research-intensive institutions—with higher margin clinical services, an integrated hospital system, substantial research enterprises, sizeable endowments, and a critical mass of wealthy donors—these institutions are faced with an unprecedented set of adverse factors that challenge their financial viability. Consequently, they are disproportionately dependent on the various Federal programs that support their core purpose.

Specifically, these programs include: the Title VII Health Professions Training Programs administered by the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS); the Research Centers at Minority Institutions (RCMI), the Extramural Research Facilities; the Re-

search 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).

President Biden recently signed the John Lewis NIMHD Research Endowment Revitalization Act to revitalize this important initiative, and it is our expectation that NIMHD will act swiftly to reinvigorate the research endowment program so minority-serving institutions can participate in this competitive opportunity to build their research endowments in a manner consistent with the statutory goal of assisting them in achieving a research endowment that is comparable to the endowments of other schools in their health professions discipline. The NIMHD Research Endowment Program (REP) allows academic institutions to build research infrastructure and recruit, train, and maintain a diverse faculty and student body. Robust funding would allow active and former NIMHD Centers of Excellence to continue their historic focus on research to close the gap between the burden of illness and premature mortality experienced more commonly by communities of color, as well as other medically underserved populations. It would also help improve access to grants to fund research projects, as well as hire staff and provide scholarships for students who come from underserved communities. To ensure successful implementation, we are asking for the Committee to allocate robust funding to NIMHD for this program.

In addition to the recommendations referenced above, TUCVM has submitted a community project funding/congressionally directed spending request for Development of a Center for Food Animal Health, Food Safety, and Food Defense in TUCVM. We are working with key members of Congress to advance this request and ensure its success. Development of a Center for Food Animal Health, Food Safety, and Food Defense in the TUCVM will position Tuskegee University to play a more vital role in supporting Alabama's Agriculture, and to serve its students and farmers in the black-belt region of the State of Alabama more effectively and efficiently. The center would enhance TUCVM's ability to facilitate teaching, research, and service to benefit students, researchers, and the local community, play a pivotal role in assisting the State of Alabama's poultry and fish farmers in adopting modern herd health practices to not only increase production and profits but also to ensure safety of poultry and fish products, and initiate new strategies to encourage DVM students to consider careers in Food Animal Production, Food Animal practice and research to combat the current shortage of food animal veterinarians.

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, veterinarians, 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 College of Veterinary Medicine at Tuskegee University.

[This statement was submitted by Ruby L. Perry, DVM, PhD, Diplomate-ACVR, Dean & Professor of Veterinary Radiology, College of Veterinary Medicine, Tuskegee University.]

PREPARED STATEMENT OF THE U.S. HEREDITARY ANGIOEDEMA ASSOCIATION

SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

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- Provide the National Institutes of Health (NIH) with at least a \$3.5 billion increase in discretionary funding for FY 2023 to bring overall agency funding up to a minimum of \$49 billion annually.
 - Continue to support committee recommendations that encourage advancement and expansion of the hereditary angioedema research portfolio at NIH, as well as research efforts focused on rare conditions more broadly, through timely.
 - Please provide proportional funding increases for NIH's various Institutes and Centers, most notably given the research portfolio; the National Institute of

- Allergy and Infectious Diseases (NIAID), the National Centers for Advancing Translational Sciences (NCATS, which houses the Office of Rare Diseases Research), and the National Heart, Lung, and Blood Institute (NHLBI)
- Provide the Centers for Disease Control and Prevention (CDC) with at least a \$2.55 billion increase in discretionary funding for FY23 to bring overall agency funding up to a minimum of \$11 billion annually.
 - Encourage the Centers for Medicare and Medicaid Services (CMS) to prevent discrimination in health coverage by ensuring rare disease patients do not face arbitrary restrictions when seeking charitable assistance to maintain access to life-sustaining care and therapy when they have no other options, and to prevent from being steered into Federal need-based or illness-based programs that they would not otherwise qualify for while properly managing their illness (building on committee recommendations included in previous fiscal years).

Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to present the views of the U.S. Hereditary Angioedema Association (U.S. HAEA) on funding and related policy items for NIH, CDC, and CMS during consideration of appropriations for FY 2023. First and foremost, thank you for supporting these programs in FY 2022. It is our hope that this invest will continue for FY 2023 to ensure that meaningful progress can continue in specific, promising areas.

ABOUT U.S. HAEA

U.S. HAEA is a patient-driven organization comprised of affected individuals and their families. In this regard, we would primarily like to recognize this subcommittee for its leadership and commitment to providing medical research and public health programs with notable funding increases for FY 2020. This investment will have a tangible positive impact for patients by significantly improving scientific inquiry and public health activities.

U.S. HAEA is a non-profit patient advocacy organization dedicated to serving the estimated 6,000 HAE sufferers in the U.S. We provide a support network and a wide range of personalized services for patients and their families. We are also committed to advancing clinical research designed to improve the lives of HAE patients and ultimately find a cure.

ABOUT HEREDITARY ANGIOEDEMA

Hereditary angioedema (HAE) is a painful, disfiguring, debilitating, and potentially fatal genetic disease that occurs in about 1 in 30,000 people. Symptoms include episodes of swelling in various body parts including the hands, feet, face and airway. Patients often have bouts of excruciating abdominal pain, nausea and vomiting that is caused by swelling in the intestinal wall. The majority of HAE patients experience their first attack during childhood or adolescence. Approximately one-third of undiagnosed HAE patients are subject to unnecessary exploratory abdominal surgery. About 50 percent of patients with HAE will experience laryngeal edema at some point in their life. This swelling is exceedingly dangerous because it can lead to death by asphyxiation. The historical mortality rate due to laryngeal swelling is 30 percent.

A RESEARCH SUCCESS STORY

There was a time not long ago that HAE was a debilitating, and often life-ending, chronic disease. In addition to the serious health impacts, affected individuals suffered with trauma, anxiety, and PTSD stemming from torturous attacks (and the uncertainty of when the next attack might occur). Due to advancements in medical research, HAE patients now have access to life-altering and life-sustaining medications. Properly medically managing the disease now allows many the freedom to work productively, live independently, and thrive.

While we are appreciative of the scientific progress, much more can be done. There is no cure of HAE and treatment is highly individualized. More needs to be learned about the underlying disease mechanisms and successful treatment often involves personalized care and a customized treatment regimen prepared (using trial and error) by a leading physician expert.

NIH has a modest, but meaningful HAE research portfolio. Recent annual investments will facilitate growth in this portfolio and have led to important new scientific projects. The ongoing research at NIH will lead to a time when HAE patients can move beyond their disease. However, a key question that remains is how much of this investment is going to rare and ultra-rare disease research programs, particu-

larly in-light of the “big ticket” items that are often now the focus of annual research appropriations.

For FY 2023, please include committee recommendations thanking NCATS and NIAID for their leadership on HAE research and asking that they continue to prioritize emerging activities to advance our scientific understanding in this area moving forward.

THE IMPORTANCE OF PROPER HEALTH COVERAGE AND ACCESS

The HAE community first became aware of the fact that the Centers for Medicare and Medicaid Services (CMS) had allowed private insurers offering marketplace plans to deny coverage to individuals receiving charitable assistance in 2015 when more than a dozen HAE patients in Louisiana received notices that their coverage was being cancelled due to the fact someone else had helped them pay their premiums. Since that time, the practice has become pervasive and HAE patients are regularly informed that they will lose coverage if they receive any charitable assistance, that they may be committing fraud, and that they may face legal action if they accept assistance. This dynamic has effectively become a back door to pre-existing condition discrimination that is implemented to steer HAE patients into tax-payer funded healthcare. Moreover, the threat now stretches beyond just marketplace plans (to Medigap plans and COBRA) due to the inability to address this issue when it first began jeopardizing health for patients with no alternatives.

Many HAE patients properly manage their illness when they have proper access to healthcare and treatment. HAE patients would typically not qualify for need-based or health-based government programs due to the life-sustaining nature of their treatment. If, however, proper coverage is lost, an HAE patient may have to endure a life-threatening experience of waiting while they spend down to qualify for Medicaid or become sick enough to apply for disability.

US HAEA has joined with other patient-driven organizations experiencing the harm of current pre-existing condition discrimination facilitated by barriers to charitable assistance and the related practice of a restrictive co-pay accumulator to form the ad hoc group, United for Charitable Assistance (UCA). We join with UCA and all stakeholders in asking this subcommittee to once again highlight these rare-disease challenges for CMS and request the current barriers are resolved to protect patients that have no other reasonable options to maintain coverage.

We thank the subcommittee for including meaningful language in previous fiscal years and recommend language similar to the draft committee recommendations below for FY 2023.

RECOMMENDED REPORT LANGUAGE

CENTERS FOR MEDICARE AND MEDICAID SERVICES

PROGRAM MANAGEMENT

Third-Party Charitable Assistance.—The Committee continues to have concerns about proliferation of policies that block patient to access to premium and copay assistance from qualified independent charities, civic groups, and houses of worship. The continued growth of these restrictions are expanding beyond marketplace plans and into other forms of coverage. These policies can be arbitrarily enforced and too easily leveraged against high-cost rare disease patients with the greatest need for third-party healthcare safety net programs and requirements for continued access to therapies to disrupt or delay essential care. We recognize the administration’s stated commitment to expanding coverage and protecting access for those with complex healthcare needs and direct CMS to provide its current position on the third-party payer rule, any potential or planned actions to address insurance restrictions jeopardizing care for rare disease patients that utilize charitable assistance, and how these plans align with overarching CMS efforts to improve coverage and access for the patient community within 180 days of the enactment of this act.

[This statement was submitted by Anthony J. Castaldo, President and CEO, U.S. Hereditary Angioedema Association.]

PREPARED STATEMENT OF UNITED FOR CHARITABLE ASSISTANCE
SUMMARY OF FISCAL YEAR 2023 APPROPRIATIONS RECOMMENDATIONS

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- 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 continue to support investment in medical research through the National Institutes of Health and public health through the Centers for Disease Control and Prevention to further improve care and health outcomes for patients facing complex illnesses, including providing \$49 billion for NIH (with distinct and additional funding for the Advanced Research Projects Agency for Health) and \$11 billion for CDC.
-

Chairwoman Murray, Ranking Member Blunt, and distinguished member of the subcommittee, thank you for your leadership on health funding and patient care issues. On behalf of the dozens of patient organizations comprising United for Charitable Assistance (UCA), we extend our gratitude and appreciation for the opportunity to provide a critical, patient-centered perspective as you consider FY 2023 appropriations issues that impact healthcare coverage and patient access. Most notably, we urge you to continue to support committee recommendations that feature and emphasize the value and importance of charitable assistance programs that serve patients with no other options, while working with your colleagues to maintain and enhance access to this critical part of the health safety net. Thank you again for this important opportunity. Please consider UCA a resource on these issues moving forward.

ABOUT UNITED FOR CHARITABLE ASSISTANCE

We are an 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). Most 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.

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 assist-

ance 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.

From our experience, there appears to be dangerous misconceptions that alternatives to charitable assistance exist, that manufacturers can bridge gaps by voluntarily offering free product as needed, and that Medicare Part A and hospital emergency rooms can provide a base solution for those in extreme circumstances. The reality is that no alternatives exist, there is no comparable or cost-effective substitute for properly managing an illness, and charitable assistance programs will need to be an integral part of the healthcare safety net for the foreseeable future.

When charitable assistance was started decades ago, it was a benevolent response to real and immediate needs facing the seriously ill. This assistance was intended to protect those with pre-existing conditions, prevent medical bankruptcy, and stop involuntary divorce. These were the same goals shared by the core patient protections advanced by the Affordable Care Act and supported on a bipartisan basis in Congress. These patient protections have been an improvement, but they have not supplanted the need for charitable assistance programs.

CONTEMPORARY EXAMPLES OF CHARITABLE ASSISTANCE CHALLENGES (PATIENT STORIES)

Colleen.—Colleen is a working mother with two young children from Connecticut. Her family has health insurance through her husband's employer. Colleen's family has, relied on a combination of a manufacture co-pay coupon and non-profit assistance to make ends meet. Now, the non-profit they relied on no longer offers support, leaving them with a financial shortfall. To make things worse, their health insurance plan now refuses to apply their co-pay assistance to their deductible and out-of-pocket maximum.

Colleen says, "It is double dipping on the part of the insurance giants, and it is unconscionable. These co-pay cards are meant to take the pressure off very sick, very expensive patients. And instead we're getting hit just as hard, even when we have a co-pay card. We are seriously considering pulling my daughter from her preschool for next year because we just can't absorb all these extra health care costs."

Edith.—Edith is in her 70s and a Medicare recipient from Florida who was diagnosed with a rare, chronic, and life-threatening illness about 5 years ago. She takes two targeted therapies to manage her condition. Recently, the non-profit charity she had relied on stopped offering co-pay assistance.

Edith says, "after [I stopped getting copay assistance], every number that I tried either didn't help with my condition or was out of funds. It was scary there for a while because I don't have that kind of money to be able to pay that every month. If I didn't have the medication I wouldn't be around. I would have passed away." Edith's husband adds, "without her medications she cannot breathe. Without these drugs I would lose my wife in a day."

Irene.—Irene is in her 60s and a former building supervisor from Virginia. She now receives Medicare due to disability. Irene's cost sharing requirements outpace her fixed income.

The non-profit organization that had been assisting Irene with her co-pay recently stopped offering funds. Irene said, "I was a single mom and over the years worked very hard to support myself and my son, but there was never enough to save or put away. My [financial assistance] grant runs out... in 21 days. I don't have a clue as to what to do...Basically, I have exhausted all means of other resources and am mentally preparing myself to die."

FISCAL YEAR 2023 RECOMMENDATIONS

Please support committee recommendations like the language outlined below. Thank you for your time and for your consideration of UCA's input.

RECOMMENDED REPORT LANGUAGE
CENTERS FOR MEDICARE AND MEDICAID SERVICES
PROGRAM MANAGEMENT

Third-Party Charitable Assistance.—The Committee continues to have concerns about proliferation of policies that block patient to access to premium and copay assistance from qualified independent charities, civic groups, and houses of worship. The continued growth of these restrictions are expanding beyond marketplace plans and into other forms of coverage. These policies can be arbitrarily enforced and too easily leveraged against high-cost rare disease patients with the greatest need for third-party healthcare safety net programs and requirements for continued access to therapies to disrupt or delay essential care. We recognize the administration's stated commitment to expanding coverage and protecting access for those with complex healthcare needs and direct CMS to provide its current position on the third-party payer rule, any potential or planned actions to address insurance restrictions jeopardizing care for rare disease patients that utilize charitable assistance, and how these plans align with overarching CMS efforts to improve coverage and access for the patient community within 180 days of the enactment of this act.

PREPARED STATEMENT OF THE URBAN INDIAN HEALTH INSTITUTE

Members of the Senate Committee on Appropriations—Subcommittee on Commerce, Labor, Health and Human Services, Education, and Related Agencies, my name is Abigail Echo-Hawk, and I am an enrolled citizen of the Pawnee Nation of Oklahoma, currently living in an urban Indian community in Seattle, Washington. I am Executive Vice President of the Seattle Indian Health Board (SIHB) and the Director of the Urban Indian Health Institute (UIHI) where I oversee policy, research, data, and evaluation initiatives. I request the subcommittee support efforts with the U.S. Department of Health and Human Services (HHS) to: immediately transfer the Healthy Native Babies Program (HNBP) to the CDC; advocate for improved access and reimbursement of doula services; expand grant edibility from the Administration for Children and Families (ACF) to Urban Indian Organizations (UIO) to address the Missing and Murdered Indigenous Women and People (MMIW) crisis, and; uphold Tribal health authority status of Tribal Epidemiology Centers (TEC). Targeted investments are critical for improving the health of American Indian and Alaska Native (AI/AN) people.

I am an American Indian health researcher with more than 20 years of experience in both academic and non-profit settings. I participate in numerous local, State, and Federal efforts to support AI/AN communities in research, including serving on the Tribal Collaborations Workgroup for the National Institutes of Health (NIH) All of Us precision medicine initiative. I serve as the only Native representative for the NIH Office of AIDs Research Advisory Council. I am a co-author to four groundbreaking research studies on sexual violence and Missing and Murdered Indigenous Women and Girls (MMIWG) where I have called national attention to the institutional barriers in data collection, reporting, and analysis of demographic data that perpetuate violence against AI/AN people. I am a member of the National Academies of Sciences, Engineering, and Medicine (NASEM) Standing Committee for the Centers for Disease Control and Prevention (CDC) Center for Preparedness and Response (SCPR). Additionally, I was a committee member for the NASEM: Framework for Equitable Allocation of COVID-19 Vaccine.¹

ADDRESS BARRIERS TO ACCESSING MATERNAL AND INFANT HEALTH

In alignment with the Administration's Initial Actions to Address the Indigenous Maternal Health Crisis¹ and E.O. 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government and the HHS—Equity Action Plan, we request HHS immediately transfer HNBP to the CDC to respond to the disproportionate maternal and infant mortality in AI/AN populations.

Since 2003, NIH has operated the HNBP to provide culturally attuned programming and trainings to address AI/AN infant health disparities. However, the HNBP's contract expired May 5, 2022. NIH is offering to support the transition of HNBP to another Federal agency. As the only public health campaign for AI/AN

¹The White House. 2021. Biden-Harris Administration Announces Initial Actions to Address the Black and Indigenous Maternal Health Crisis. Retrieved from: <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/13/fact-sheet-biden-harris-administration-announces-initial-actions-to-address-the-black-maternal-health-crisis/>.

maternal and infant health, HNBP aligns with the mission and initiatives of the CDC to reduce rates of sudden unexplained infant death (SUID) in marginalized communities. Currently the budget for HNBP is \$217,000, under 3-year agreements, and funds two full-time employees which will have minimal fiscal impact on the CDC. The HNBP must be moved to the CDC to continue supporting generations of Native families.

In 2018, SUID rates for AI/ANs were the highest among any racial or ethnic population with a rate of 212.1 per 100,000 live births for AI/AN infants which is more than twice the rate for non-Hispanic white infants of 84.9 per 100,000 live births.² In 2020, non-Hispanic AI/AN mothers were nearly three times as likely to receive late or no prenatal care compared to non-Hispanic white mothers³ and the highest rate of infant mortality were among non-Hispanic AI/AN infants born preterm or low birthweight.⁴ HNBP aims to address the high rates of SUID through culturally attuned educational materials, training, outreach events, and stipends awarded to Tribes and Native-led organizations.

TRANSFER THE HEALTHY NATIVE BABIES PROGRAM

To support maternal and infant health, I also request HHS evaluate and consider reimbursement services for doulas. The Centers for Medicaid and Medicare Services (CMS) must increase grant flexibility, provide enhanced technical assistance, and ensure more States fully reimburse doulas and midwives at financially sustainable levels. For Native women, doulas decrease negative childbirth experiences, and support their access to health care providers who understand the unique cultural, social, and economic burden mothers face. In the 2022 Legislative session, Washington state passed legislation to credential doulas and midwives. A competent credentialing system for doulas allows us to continue practicing traditional ways of knowing with their care and expertise being vital to improve health outcomes of our people.

These trends illuminate the need for greater investments and targeted approaches for addressing maternal and infant health for AI/AN populations. UIOs and Native-led organizations must be included in grant eligibility by HHS agencies to continue providing maternal and infant health services related to disease prevention, health promotion, screen for maternal depression, service delivery, research, and healthcare professional education for providers interacting with AI/AN communities.

SUPPORT PUBLIC SAFETY FOR MISSING AND MURDERED INDIGENOUS WOMEN AND PEOPLE

In support of Executive Order (E.O.)14053: Improving Public Safety and Criminal Justice for Native Americans and Addressing the Crisis of Missing or Murdered Indigenous People and the U.S. Government Accountability Office (GAO) report titled Missing or Murdered Indigenous Women: New Efforts are Underway but Opportunities Exist to Improve the Federal Response,⁵ we urge HHS and ACF to expand grant eligibility of the Family Violence Prevention and Services (FVPS) to include UIOs. UIOs are on the front lines of responding to violence, sexual abuse, and human trafficking experienced by urban AI/AN populations. UIOs must be included in FVPS grant eligibility to support our programs, services, and initiatives to support AI/AN individuals, families, and communities affected by violence.

I am grateful for the HHS recently holding a joint consultation in partnership with the Department of Justice and Department of Interior related to the GAO report on MMIWG. I request HHS utilize a multi-pronged approach from all HHS agencies including NIH, Indian Health Service (IHS), and CDC to support research and gender-based violence services to serve survivors, victims, community-based organizations, and families affected MMIWP.

To inform HHS' MMIWP efforts, UIHI has released several recent reports identifying gaps in data collection methods and developing culturally attuned frameworks for gender-based violence programming. In 2021, UIHI released Sacred: Womxn of

² CDC. (2021). Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Data and Statistics. <https://www.cdc.gov/sids/data.htm>.

³ CDC. (2022). Births: Final Data for 2020. National Vital Statistics Reports, 70(17). Table 13. <https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf>.

⁴ CDC 2020. Infant Mortality Statistics from the 2018 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports. Table 2. <https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf>.

⁵ U.S. Government Accountability Office (November 2021). Missing or Murdered Indigenous Women: New Efforts are Underway but Opportunities Exist to Improve the Federal Response Retrieved from: <https://www.gao.gov/products/gao-22-104045>.

Resilience,⁶ the report documented the COVID–19 impact on Native femme-identifying survivors of sexual violence. The report also highlighted the critical need to build relationships between law enforcement, providers, and survivors to provide culturally responsive intervention and prevention services. The report also stresses that gender-based violence prevention, programming, and evaluation be led by experts from the Native community to adequately offer culturally responsive services to individuals impacted by MMIWP.

In 2022, UIHI released *Service as Ceremony: A Journey Toward Healing*⁷ a national study interviewing gender-based violence direct service providers. The report reveals offering culturally attuned holistic programming to address physical, psychological, and spiritual impacts for clients were essential to building resiliency and responding to the spectrum of gender-based violence experienced by individuals impacted by MMIWP. This report makes recommendations to fund TECs conducting research, assure gender-based violence grant funding is non-competitive, multi-year, flexible, and include UIO in grant carve outs.

To support gender-based violence services offered to AI/AN survivors, victims, and families, UIHI provides several encompassing recommendations HHS can implement including providing flexible grants to community-based organizations, investing in research conducted by TECs, investing in educational campaigns related to violence intervention and prevention, and investing in human services to support social determinants of health impacting an individual's safety including housing, education, and access to health services.

HONOR PUBLIC HEALTH AUTHORITY STATUS OF TRIBAL EPIDEMIOLOGY CENTERS

I recently provided feedback for the GAO report *Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access*⁸ highlighting necessary actions to be taken by HHS to improve TEC's access to Federal public health data. Despite HHS being required to share public health data with TECs, TECs continue to experience barriers to accessing data, thus limiting available information on AI/AN populations. The report recommends HHS: develop a policy clarifying HHS data available to TECs as required by Federal law; encourage the CDC Director develop written guidance for TECs on how to request data as well as document agency procedures on reviewing TECs data requests; encourage the IHS Director to develop written guidance for TECs on how to request data, and; encourage the IHS Director to develop and document agency procedures on reviewing TEC data requests.

Additionally, several HHS agencies, including the CDC and IHS, have failed to recognize the public health authority of TECs and thereby ignore or reject data requests by TECs. UIHI has been denied access to national and regional data, data collected through the National Notifiable Disease Surveillance System (NNDSS), National Violent Death Reporting System (NVDRS), and other COVID–19 surveillance data. Failure to grant TECs data access perpetuates systemic health inequities in AI/AN communities by limiting the public health surveillance and epidemiological data collected by governmental agencies.

All HHS agencies must ensure data sharing requirements with TECs uphold Congressional intent and recommendations by the GAO report. TECs inform decision-making by Tribes, Tribal organizations, UIOs, government agencies, and public health agencies to ensure equitable distribution of resources and to inform robust policies, planning, and programming to address social determinants of health experienced in Indian Country.

[This statement was submitted by Abigail Echo-Hawk, MA, Director, Urban Indian Health Institute.]

PREPARED STATEMENT OF VENTUREWELL

On behalf of VentureWell, we thank the subcommittee for its support of the National Institutes of Health (NIH). VentureWell strongly believes that robust invest-

⁶Urban Indian Health Institute. (September 2020). *Sacred: Womxn of Resilience*. www.uihi.org/download/supporting-the-sacred-womxn-of-resilience/?wpdmdl=18261&refresh=6217b40a4ce3e1645720586.

⁷Urban Indian Health Institute. (February 17, 2022). *Service as Ceremony: A Journey Toward Healing*. www.uihi.org/download/service-as-ceremony-a-journey-toward-healing/?wpdmdl=19563&refresh=621d39d2458ae1646082514XX.

⁸U.S. Government Accountability (March 2022). *Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access*. Retrieved from: <https://www.gao.gov/products/gao-22-104698#:text=Also%2C%20GAO%20was%20asked%20to,documentation%20of%20TECs%20data%20requests>.

ments in scientific research are crucial for sustained economic growth and technological innovation. VentureWell encourages the subcommittee to provide at least \$49 billion for the NIH base budget in FY 2023, with any additional funding for the new Advanced Research Projects Agency for Health (ARPA-H) to supplement, not supplant, core investments in the NIH base budget. VentureWell also asks the subcommittee to encourage increased support at NIH for programs like the Rapid Acceleration of Diagnostics (RADx) initiative that focus on commercialization and innovation.

ABOUT VENTUREWELL

VentureWell is a global nonprofit organization with more than two decades of experience supporting early-stage science and technology innovators, helping them to bring inventions or discoveries from lab to market in order to offer innovative technological solutions to pressing challenges. VentureWell's training programs are distinguished by the quality of instruction and mentorship provided by our staff and large network of experts in areas such as technology commercialization, intellectual property, global supply chains, and financing. VentureWell is an active partner in the U.S. innovation ecosystem, providing grants, training, and support to early-stage science and technology innovators, startups, and entrepreneurship educators. Our programming has helped bring groundbreaking technological advancements to millions of people across the U.S. and in more than 90 countries, in fields including biotechnology, healthcare, information and communications technology, sustainable energy and materials, and other sectors critical to people and the planet.

Since our founding more than 26 years ago, VentureWell has supported over 12,000 innovators, resulting in more than 2,700 ventures that have raised over \$2.2 billion in follow on investment. Ongoing programs include entrepreneurship grants and training programs focused on innovation and commercialization; faculty grants to researchers and instructors focused on integrating innovation and entrepreneurship teaching in higher education; and competitive national award competitions focused on innovation, design, and commercialization. A core component of our work is partnering with Federal agencies to accelerate the impact and scale of innovation programs and initiatives. Among other NIH collaborations, VentureWell has notably worked to launch the agency's I-Corps program since 2014, the Design by Biomedical Undergraduate Teams (DEBUT) competition with the National Institute of Biomedical Imaging and Bioengineering (NIBIB) since 2016, the NIH Technology Accelerator Challenge (NTAC) for sickle cell diagnostics (2019) and maternal health (2022), and the Rapid Acceleration of Diagnostics (RADx) initiative to speed innovation in the development, commercialization, and implementation of technologies for COVID-19 testing starting in 2020.

FROM INVENTION TO PRODUCT: THE COMMERCIALIZATION ECOSYSTEM

Innovation and entrepreneurship in science and technology is a key driver of economic development in the United States. Our country's ability to transform breakthroughs from basic research into consumer products and scalable businesses has led to enormous benefits for society, including new cures for diseases, better communication and information sharing technology, and safer food and transportation. In recent years, U.S. leadership in science and technology on the world stage—and by extension our National security and global economic leadership—has been threatened as other countries increase their own investments in this area. Our country can address this challenge by increasing Federal investments in agencies like NIH and programs that close key gaps in the pipeline for developing and commercializing new technologies. The U.S. commercialization ecosystem would benefit from comprehensive support for early-stage researchers to translate their ideas into products, to grow the pipeline of entrepreneurial talent in the U.S., and from the reduction of barriers that block the progress of individuals or organizations to commercializing innovations.¹ VentureWell partners with Federal agencies to address these needs by supporting the ventures, individuals, and ecosystems that drive American innovation.

OPPORTUNITIES FOR INNOVATION AT THE NATIONAL INSTITUTES OF HEALTH

Biological sciences and clinical medicine are key areas of research and development linked to entrepreneurial activity. New therapeutics, medical devices, and other health-related technologies have enormously high potential benefits yet relatively long and complex development timelines, making support for venture devel-

¹ <https://www.dayoneproject.org/ideas/closing-critical-gaps>.

opment in this sector a crucial component of bringing products to market quickly and efficiently. Given its position as the top funder for biomedical research in the U.S., NIH plays a major role in fostering more effective and efficient translation of basic scientific discoveries into treatments and therapeutics. Not only does NIH support the fundamental research that underpins most clinical and commercial advances in biomedical research, the agency also funds a portfolio of venture acceleration programs specifically aimed at encouraging entrepreneurship and innovation at all career stages. Our organization has played a key role in NIH's I-Corps program, an intensive start-up training program for academic researchers and students that teaches participants how to evaluate commercialization potential and develop a business model. Our organization also administers the Design by Biomedical Undergraduate Teams (DEBUT) challenge in partnership with the National Institute of Biomedical Imaging and Bioengineering (NIBIB). This competition challenges teams of undergraduate students to solve real-world problems in health care by applying their analytical and design skills towards the development of a new product. VentureWell also partners with the National Institute of Biomedical Imaging and Bioengineering (NIBIB) to help improve maternal health around the world through the NIH Technology Accelerator Challenge for Maternal Health (NTAC: Maternal Health). This challenge seeks to spur and reward the development of prototypes for low-cost, point-of-care molecular, cellular, and/or metabolic sensing and diagnostic technologies to guide rapid clinical decision-making, improve patient outcomes, and ultimately prevent maternal morbidity and mortality. VentureWell thanks the subcommittee for its ongoing support for these programs and encourages continued strong funding for these initiatives at NIH in FY 2023.

To truly capitalize on all the talent and potential in the U.S. entrepreneurial workforce, we believe that diversity, equity, and inclusion must be reflected throughout all Federal efforts in this area. We must remove systemic barriers that limit the participation of underrepresented groups in innovation and entrepreneurial activities and ensure that pathways for commercialization are open to all innovators regardless of their racial, ethnic, gender, or socioeconomic background. VentureWell is committed to supporting a diverse workforce of researchers, faculty, entrepreneurs, and innovators whose voices and ventures have been underestimated and under-resourced, and encourages the subcommittee to ensure that equity is reflected throughout all innovation programs funded by NIH.

DIVERSITY, EQUITY, AND INCLUSION IN INNOVATION & ENTREPRENEURSHIP

In 2019, VentureWell commissioned a national study around broadening participation in the higher education innovation and entrepreneurship ecosystem. Informed by this study, our Advancing Equity: Dynamic Strategies for Authentic Engagement in Innovation and Entrepreneurship report presents a blueprint for university-based entrepreneurship centers that strive to increase diversity, equity, and inclusion (DEI) practices. We co-developed with researchers, faculty, and center directors, a series of resources for advancing the DEI tools and best practices specific to science and technology commercialization and training, and our report Advancing Equity: Navigating New Terrain, demonstrates ways to apply this blueprint at higher education institutions around the country. We continue to provide resources to academic, industry, and network partners as part of our Advancing Equity webinar series. VentureWell fully supports NIH's efforts to broadening participation in biomedical research supports the NIH UNITE initiative to address structural racism and promote racial equity and inclusion at NIH and within the larger biomedical research enterprise.

THE RADX MODEL: COVID AND BEYOND

The RADx Initiative was officially launched in April 2020 with a \$500 million investment through emergency appropriations from Congress to speed innovation in the development, commercialization, and implementation of technologies for COVID-19 testing. RADx leveraged the infrastructure developed through NIBIB's Point-of-Care Technologies Research Network (POCTRN)—created by NIH in 2007—to quickly bring COVID-19 testing technologies to market. Previous investments made by Congress in this innovation infrastructure at NIH were critical to RADx's ability to bring new diagnostic technologies to the American people in record time.

VentureWell has worked alongside NIH on the RADx program since its inception, providing infrastructure support and coordination services, clinical evaluation services through contract research organizations, and performing important administrative roles including government compliance, security testing on platforms, payment processing, sub-contracting to third parties, and procurement standards. In 2 years,

VentureWell engaged 869 experts, contracted with 337 vendors/companies/service providers, issued 201 software licenses, funded 140 RADx projects, and have received 44 FDA authorizations. RADx-supported companies have increased COVID-19 testing capacity across the United States by 1.9 billion tests and condensed the typical multi-year tech commercialization process into approximately 6 months. Tests developed through RADx, with support from VentureWell, have enabled the U.S. to begin to recover from the public health and economic devastation brought on by COVID-19. VentureWell has continued to support NIH through the RADx initiative by providing online educational tools like the whentotest.org Covid-19 calculator, supporting the analysis of test performance through variant modeling and analytical testing, and working in close collaboration with the Food and Drug Administration (FDA) to establish the Independent Test Assessment Program (ITAP) in order to accelerate regulatory review and availability of high-quality, accurate, and reliable over-the-counter COVID-19 tests.

We believe that the RADx approach—a nimble and systematic but aggressive strategy—should be applied in the development and evaluation of diagnostic tools in other therapeutic areas where innovative diagnostics and surveillance technologies are much needed. This includes applications ranging from HIV to maternal health. To prepare for future pandemics and diseases that threaten the public health of the population, we must continue to promote the use of innovative methods with a proven record of success to accelerate the development, commercialization, and implementation of point of care tests for COVID-19, new pathogens, and more. VentureWell encourages the subcommittee to direct NIH to continue support for the RADx program in FY 2023. Sustained investments in RADx will enable NIH—and our country as a whole—to be prepared for future public health threats and will help the United States to maintain its historic role as a global leader in biomedical science and technology.

VentureWell thanks the subcommittee for its ongoing work in advancing biomedical research in the United States and ensuring that our country remains a world leader in science and technology. We urge the subcommittee to continue its commitment to research and development by providing strong funding for NIH in FY 2023, including increased support for programs like RADx that focus on commercialization and innovation. Thank you for your consideration of VentureWell's testimony. For more information about our organization, please see <https://venturewell.org/>.

[This statement was submitted by Phil Weilerstein, President and Chief Executive Officer, VentureWell.]

PREPARED STATEMENT OF THE WAIHA WARRIORS

SUMMARY OF FISCAL YEAR 2023 RECOMMENDATIONS

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- Please provide the National Institutes of Health (NIH) with \$49 billion to facilitate continued growth in rare disease research activities.
 - Please provide proportional increases for the National Institute of Allergy and Infectious Diseases (NIAID), the National Heart, Lung, and Blood Institute (NHLBI), and the National Center for Advancing Translational Sciences (NCATS) to facilitate establishment and advancement of a wAIHA portfolio.
 - Please provide a separate, meaningful increase to advance and adequately support the emerging Advanced Research Projects Agency for Health (ARPA-H).
 - Please provide the Centers for Disease Control and Prevention (CDC) with \$11 billion to support public health efforts.
 - Please systematically increase funding for the Chronic Disease Center at CDC to bring the agencies funding up to \$3.75 billion annually, and please support \$6 million in funding for the line-item CDC Chronic Disease Education and Awareness (CDEA) program to ensure additional cooperative agreements are available for stakeholders.
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Chairwoman Murray, Ranking Member Blunt, and distinguished members of the subcommittee, thank you for the opportunity to present the views of the wAIHA Warriors and the community of individuals impacted by Warm Autoimmune Hemolytic Anemia (wAIHA). First, thank you for the meaningful investment in medical research and public health programs through the FY 2022 omnibus appropriations package. For FY 2023, we join other rare disease organizations and the broader pa-

tient community in asking for a sustained and meaningful investment in NIIH, CDC, and related Federal programs. We also deeply appreciate this opportunity to raise awareness of wAIHA and share the patient experience. Please consider us a resource moving forward. Thank you again.

ABOUT WARM AUTOIMMUNE HEMOLYTIC ANEMIA (WAIHA)

wAIHA is a rare autoimmune disorder in which the immune system creates antibodies that destroy healthy red blood cells. The condition is progressive, potentially fatal, and difficult to address at later stages. It can be idiopathic or occur secondary to another condition. wAIHA can impact anyone and affects men and women equally, though it most commonly affects individuals over 50. Research has led to scientific advancements and potential therapies, but at this time treatment options are extremely limited and consist of (1) steroids and transfusions, (2) immunosuppression and chimeric anti CD20 antibodies, and (3) removal of the spleen. The condition is associated with significant morbidity and mortality, and less than 50 percent of patients remain in remission following front-line treatment.

ABOUT THE WAIHA WARRIORS

The wAIHA Warriors are a patient-driven grassroots organization focused on supporting the community of individuals impacted by wAIHA. Collectively, we use our stories and experiences to raise awareness, advance research, and improve healthcare. We also promote fellowship and engagement among community members to overcome the isolation of wAIHA and work to educate and mobilize healthcare providers to better address this rare disease experience.

PATIENT EXPERIENCE; ERIC, NEW YORK

In February 2011 I had a bad flu just before Super Bowl weekend. I was well enough to attend a Super Bowl party but remember not feeling myself. A few weeks later I had my regular annual physical with my internist. We were away celebrating a friend's 50th birthday, sitting at the pool, when my internist called and told me that my blood work was totally out of kilter (he used the term "pancytopenia"). My wife, Liz, who is a pediatrician, was nervous and just like when our kids were little, I only got nervous when she got nervous. I was very lucky that one of my closest friends is a Hematologist/Oncologist. The next day I went to see him, he set me up for all sorts of scans and bone marrow biopsies and we were off trying to figure out what it was and was not.

Over the next few months he became confident that I did not have any sort of acute blood cancer. I still did not feel myself (I was tired, not hungry, not sleeping well, and not in a good mood). Most the blood tests became normal except for the hemoglobin/hematocrit. My spleen was very large. My friend thought I had AIHA (but my Coombs tests, which are typically what seal the AIHA diagnosis) were negative. Over the summer, I had one Coombs that was barely positive. In August 2011, my hemoglobin was going down and I had a blood transfusion.

In September 2011, my friend/hematologist wanted me to get another opinion, so he referred me to another hematologist who is more of a "benign hematologist" as they are known—don't typically treat blood cancers. She confirmed the diagnosis of AIHA. She began me on prednisone and I felt a little better.

My friend/hematologist thought that if I had a splenectomy (which was thought to be the primary treatment option back then) I might be "cured" and I would not have to be on chronic prednisone the rest of my life. I had the surgery In February 2012. It was a very difficult few days in the hospital followed by about 3 weeks of recovery at home. But after that, I felt pretty good. I was on very very low dose of prednisone (less than 5mg per day) and that lasted for a few years.

In June 2015, I got sick again (tired, peeing a lot, not sleeping, could feel my pulse in my temples). The goal then became to find something that was not as harmful as prednisone that could control the hemolysis and my hemaglobin levels. Over the next couple of years, I had a couple of courses of Rituximab, and also tried courses of Azathioprine and Danazol. When I was hemolyzing and my hemaglobin was dropping, I needed to increase the prednisone.

I made an appointment to see a leading physician, Dr. Kuter, in December 2017. He gave me (and my hematologist) the "state of the art" on the treatments available. The next time I had a deep crash of my hemaglobin, in June 2018, we tried one. Shots of Procrit. Those worked quickly and my hemaglobin went as high as it had been since all this started in 2011.

By the middle of 2019, I had another crash and it was time to see what else was out there. I connected with Dr. Irina Murackhovskaya at Einstein/Montefiore who was doing some clinical trials for AIHA drugs. I had to get my hemaglobin below

10 to participate and I needed a positive Coombs test, and we managed that closely. In October 2019 I started the trial and I chose this trial because it was open and I would definitely get the drug (not a placebo).

In early December 2020, I did not feel well. My legs felt like lead weights. Over the next few weeks my prednisone started dropping pretty quickly. By Christmas week, I was feeling as sick as I had felt in a long time. My Hgb dropped below 8, I had a blood transfusion and I increased my prednisone to 60mg per day (the same as the highest I ever had in the past).

During 2021, I felt well. Still working at home. Things started opening up. We started to get out more. That helped a lot. I continued to wean down the prednisone and by the late Fall was on about 7.5 mg per day. My Hgb was pretty stable. My other hemolysis markers were better and stable too.

In early March, my Hgb was 14.2 (highest I can remember and “normal” range on some ranges). All my other hemolysis markers were as good as they had ever been. Had to have another round of primary Evusheld as the CDC changed the recommendation on how much to get for primary round.

I feel good now. Started back to work 3 days a week towards end of March. Did a quick 3 weeks of Breakthrough M2 diet program and went from about 193 lbs. to about 178 lbs. (15 lbs.) in 3 weeks. Things are starting to get back to (post COVID) normal. In April, my Hgb went back down to low 13s but still holding strong as are the other hemolysis markers. Fingers crossed that they will stay good. With Passover, gained back about 5 lbs. but still feeling pretty good.

[This statement was submitted by Karen Jones, Executive Director, wAIHA Warriors.]

PREPARED STATEMENT OF THE WEST VIRGINIA HEAD START ASSOCIATION

Dear Chairman Murray, Ranking Member Blunt, and Members of the subcommittee,

On behalf of the Head Start community nationwide, thank you for this opportunity to share views and perspectives on Fiscal Year 2023 (FY23) funding for Head Start. For 5 years, I have had the distinct pleasure of serving as the executive director of the West Virginia Head Start Association representing 21 programs from the Cheat River to the coal fields. Every day, we diligently work to build early learners and support West Virginia families facing financial hardships and generational poverty who are too often stung by addiction, depression, and economic uncertainty.

While I am extremely proud of how our programs in the Mountain State have weathered a global pandemic, COVID-19 has laid bare a crisis that Head Start program managers had previously been able to sweep under the rug or gloss over: our neglected and underinvested workforce. In the shadow of conflicting and confusing COVID-19 protocols and the rising impact of inflation, Head Start staff are struggling to meet the needs of West Virginia’s most vulnerable children and their families and we need your help. We urge you to take immediate action to help address the spiraling labor situation crippling Head Start and Early Head Start.

At the present time, we have 143 staff openings in West Virginia—significantly higher than normal for this point in the program year. Most of those openings are due to the staffs’ ability to easily find higher wages elsewhere. Local boards of education, which pay more, are regularly recruiting our staff for other positions—bus drivers, teachers’ aides, and lead teachers—in the state pre-K or K-12 public school system. Private sector employers are also drawing away both potential and current employees. For example, Sheetz currently pays \$15 per hour with a \$3,000 sign-on bonus and Wal-Mart’s starting wage is also \$15 per hour.

In West Virginia, the minimum wage is \$8.75. That is the typical starting wage for Head Start staff. Full-time employment at \$8.75 per hour is well below the Federal poverty line, which means many Head Start staff are earning an income so low that their children qualify for Head Start services. With this in mind, it is not surprising workers are choosing other options that better support the wellbeing of their own families.

What is true for West Virginia is also true for Head Start programs nationwide. At a recent National Head Start Association conference, more than 900 staff were surveyed on current workforce conditions. The results were startling: an average of 35 percent of classrooms have been closed this school year and 90 percent of programs had to close a classroom permanently or temporarily due to staffing considerations. Of the programs surveyed, 30 percent was the average number of open and unfilled job slots at local Head Start programs. Closures translate to thousands of children left at home with an older sibling, a relative, or a neighbor while a mom or dad goes to work or school. For wage-based employees, missing one day can be

a huge setback—often only a day’s pay away from homelessness or the ability to purchase groceries. For children, closed or suspended Head Start classrooms translate into critical learning loss in educational basics and missed critical social skills—skills that COVID-19 has already weakened for so many young children.

Conditions are dire. In the survey comments, one respondent wrote: “We are struggling because we can’t get people to apply for teacher positions. We can’t compete with pay with our local school districts. Children’s behaviors have escalated so much and we need so much behavioral support. Staff are getting punched, bit, and kicked by students on a daily basis. We NEED to take care of our staff. Staff are doing two and three jobs to cover for being so short staffed. We need help!!!”

We need help. We need your help.

Head Start programs need dedicated assistance in paying staff a living wage and competing in an increasingly challenging job market. Adequate compensation reduces turnover and stabilizes programs.

But the impact is far greater, given “turnover disrupts child-teacher relationships, which are crucial to children’s developmental outcomes,” according to a recent report from the Federal Reserve Bank of Minneapolis. The report notes: “Head Start participants found that kids who experienced higher teacher turnover during the school year had smaller gains in vocabulary and literacy and higher levels of parent-reported behavior problems than peers who had more continuity with their caregivers (Markowitz 2019).”

With that in mind, the National Head Start Association (NHSA) is recommending an FY23 LHHS-Education Appropriations funding level of \$14.4 billion for Head Start to help do just that. This includes three sizable, but necessary increases to rescue this critical federal-local program.

(1) *\$596 million cost-of-living adjustment (COLA) increase*: Rising inflation is an additional stress point on our workforce and the families we serve. Head Start’s cost of living adjustment for FY22 was 2.3 percent or approximately one-third the rate of inflation. This is not an aberration; historically, salary increases have either been just at inflation (when it is low) or below it (when inflation is high, like this year) resulting in a cumulative and chronic underpayment that leaves the Head Start workforce further behind private sector employers of every kind. The FY23 recommended COLA at a 5.4 percent increase would be an honest, responsible increase even though it is well-below year-over-year inflationary levels.

(2) *\$2.5 billion in annual workforce compensation*: Under current pay constraints, Head Start and Early Head Start can’t compete. Notably, the five West Virginia Head Start grantees that are school boards report no vacant positions likely due to the higher wages they are able to pay. In other words, the workforce crisis facing early childhood education is clearly a solvable problem. Research has clearly shown experienced, well-trained staff are key to achieving the positive outcomes which Head Start has demonstrated over the decades; however, the constant churn of teachers and staff due to low wages—in addition to the significant vacancy rate—threatens Head Start’s record of success. We urge you to take the necessary action to press for passage of \$2.5 billion per year in Head Start workforce compensation realignment. This is a critical first step to addressing the chronic issues that stand in the way of parents’ ability to fully participate in the workforce and children from being prepared for success in school.

(3) *\$262 million for quality improvement funding (QIF) trauma-informed care*: In the aforementioned survey, 56 percent of respondents indicated pay was the leading cause of employee loss. The second highest was work conditions, with 26 percent of respondents indicating both pandemic-related stress and burnout, combined with children presenting complex behavioral and social challenges, create an overwhelming work environment. We agree. Head Start staff need additional resources, training, and counseling support to lead classrooms and children through this incredibly difficult season. We are thankful that Congress has recognized and funded QIF trauma-informed care and welcome this support. Much more needs to be done to support the wholeness and wellness to the children and families we serve as well as the Head Start workforce.

In the weeks ahead, the Head Start community would appreciate Congress’s full embrace of the NHSA FY23 Recommendation of \$14.4 billion and joining in on a singular focus of addressing Head Start workforce issues too long brushed aside. Our teachers, classroom aides, bus drivers, and support staff deserve to earn a living wage. Please take time this month to talk with local Head Start leaders in your community. I am quite sure you will immediately hear the daily struggle to keep and retain quality staff and the desperate need for change. Thank you for your consideration.

[This statement was submitted by Lori Milam, Executive Director, West Virginia Head Start Association.]

PREPARED STATEMENT OF THE WESTERN GOVERNORS' ASSOCIATION

Chair Murray, Ranking Member Blunt, and Members of the subcommittee, the Western Governors' Association (WGA) appreciates the opportunity to provide written testimony on the appropriations and activities of the Federal agencies under the subcommittee's jurisdiction, including the Departments of Labor (DOL), Health and Human Services (HHS), and Education (ED). WGA is an independent organization representing the Governors of the 22 westernmost States and territories. The Association is an instrument of the Governors for bipartisan policy development, information sharing and collective action on issues of critical importance to the western United States.

The COVID-19 pandemic has had widespread effects on the labor market and the health care system in the United States. As the recovery continues, it is critical to align policies, performance metrics, regulations and reporting requirements across Federal workforce, human services, housing and education agencies in order to achieve the best outcomes for program participants.

DOL funding for workforce development through the Workforce Innovation and Opportunity Act (WIOA) supports economic growth and job creation in the States. Western Governors request that the 15 percent reserve for statewide activities be maintained in appropriations under WIOA. This funding allows Governors to be flexible and innovative in addressing state needs. More flexibility under the current WIOA streams is needed to better anticipate coming labor market disruptions and workers who are not traditionally eligible for assistance or as at-risk incumbent workers prepare for displacement. That flexibility should include allowing Governors to fund outreach and marketing of services in an effort to reach more people. Short term and competitive funding for innovative programs is inefficient and creates unintended obstacles for small States with limited grant writing resources.

Western Governors support the expansion of registered apprenticeship programs and encourage Congress to support and incentivize State, local, and industry-led partnerships to create and scale apprenticeship programs through increased appropriations. New Federal investments in apprenticeships should be provided through line-item formula funding and aligned with existing efforts to foster a coherent system with minimal duplication at the Federal, State and local levels.

Western Governors support efforts to increase student access to short-term education and skills training, including through expanding the Pell Grant program to include high-quality short-term training programs leading to industry-recognized credentials. Western Governors support funding high-quality career and technical education (CTE) programs through the Career and Technical Education for the 21st Century Act (Perkins V). Adequate funding of Perkins State Grants is essential to ensure that CTE programs align with statewide visions for education and workforce development. Governors and States are in the best position to determine how to use Federal CTE funding to meet the needs of their economies.

Better linkages between K-12, higher education and the workforce system are needed. Western Governors call for a carveout of Perkins funding directed to the workforce system to support stronger linkages to K-12 and higher education. Further, to address the crisis in youth employment, Western Governors urge an expanded WIOA funding stream for youth, targeted toward youth who are disconnected from school and work, as well as the establishment of a Youth Employment Taskforce to make further recommendations on effective workforce strategies to address the crisis in youth employment. Finally, to ensure that workforce development programs are inclusive of people with disabilities, Congress should provide additional funding and training for States to conduct outreach and education on equal opportunity and nondiscrimination and to link workforce programs with K-12 special education services.

Improvements in state data infrastructure are needed to better support State education and workforce development, including responding to changing labor market demand, improving the effectiveness of policies and programs, and improving the delivery of services. The subcommittee should provide adequate funding to support state Labor Market Information shops and the U.S. Bureau of Labor Statistics. States should receive a greater share of funds under the state-federal cooperative statistics programs. Western Governors also call for significantly greater ongoing funding through the Workforce Information Grants to States to enhance state capacity evidence-based decision making and the production of locally relevant labor market intelligence. Finally, Western Governors recommend that Congress invest long-

term in multi-State data collaboratives and in more voluntary state participation in collaboratives to enable a truly national data infrastructure to emerge.

Building a sufficient cybersecurity workforce is especially important to Western Governors. A skilled cyber workforce is imperative to the protection of critical infrastructure, which includes a vast array of potential targets. These include: the Nation's electric grid; energy resource supply and delivery chains; finance, communications, and election systems; and a panoply of public, private, military and industrial systems. Western Governors request sufficient appropriations for high-quality cybersecurity education and workforce development programs to grow and sustain the cybersecurity workforce, including those that target underrepresented populations, those that include rotational components to retain personnel, and work-based learning opportunities such as apprenticeships. The Governors support increased funding for the CyberCorps: Scholarship for Service program and educational initiatives, including the National Institute of Standards and Technology's Initiative for Cybersecurity Education and the National Centers of Academic Excellence in Cyber Defense. Civilian cybersecurity reserves can also help augment cybersecurity workforce capacity.

Despite efforts by Western Governors to address the shortage of qualified health care workers in our States, significant challenges remain. Governors urge the Federal Government to examine and implement programs to ensure States have an adequate health care workforce—including positions in primary care, behavioral and oral health as well as other in-demand specialties—prepared to serve diverse populations in urban, suburban and rural communities. Understanding that significant disparities remain in access and treatment for many populations, Governors support efforts to increase the diversity and representation in the health care workforce to improve health outcomes for all. Western Governors recognize efforts to support the health care workforce in the American Rescue Plan Act (ARPA, Pub. L. 117–2) and request a continued focus on this important topic. They also encourage the subcommittee to fund new types of personnel, such as community health workers or promotores, in order to further extend the health care team and ensure that patients are connected to resources, and innovation within the behavioral health care workforce to address gaps in the continuum of care professionals.

Americans are facing an alarming increase in adverse mental health conditions, substance misuse, and suicidal ideation, trends that have been exacerbated by the COVID–19 pandemic. Western Governors appreciate the substantial investment in mental and behavioral health services in ARPA and support continued efforts to improve the quality and quantity of these services. They are essential to reducing suicide rates and treating a range of behavioral health conditions, including substance use disorder. The top 10 States with the highest suicide rates are in the West. Western States are also among those with the highest overall rates of substance use disorder, especially for youth between the ages of 12 to 17. Western Governors recognize and support efforts at the Federal, State and local levels to promote the integration of physical and behavioral health services. The Governors encourage Congress and the Administration to support States' integration efforts and encourage health care providers to better incorporate behavioral and physical medicine into their practice of care. The expansion of early intervention, diversion, and community reentry programs aid in such efforts.

COVID–19 has also laid bare the importance of investing in our Nation's public health system. Congress should examine the lessons learned from COVID–19 in collaboration with States, and based on these findings, they request that the subcommittee ensure that States and the Nation have the capability and necessary public health infrastructure investment to effectively confront future public health challenges. The expansion and support of international health surveillance and public health threat detection mechanisms is of critical importance to these efforts as well.

In addition, Western Governors are committed to identifying risks facing high utilizers of health care services and addressing social determinants of health. They encourage the continued support of services and programs, especially those that empower States and local governments to solve persistent economic and social conditions that often hinder health outcomes.

Western Governors recognize that it is an enormous challenge to judiciously balance competing funding needs throughout the Federal Government, and appreciate the difficulty of the decisions this subcommittee must make. The foregoing recommendations are offered in a spirit of cooperation and respect. WGA is prepared to assist you as the subcommittee discharges its critical and challenging responsibilities.

[This statement was submitted by James D. Ogsbury, Executive Director, Western Governors' Association.]

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) 2023 LHHS appropriations bill. As you begin work on FY 2023 appropriations, we respectfully request that you provide at least \$49.048 billion for the National Institutes of Health (NIH). We also request that you consider including our report language on a "Women's Health Research Study" and a "Menopause RCDC" in the report that accompanies the final FY 2023 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, including polycystic ovary syndrome (which affects up to 20 percent of women), endometriosis (which affects up to 12 percent of women), uterine fibroids (which affect up to 40 percent of women), menopause (which affects all women) and cancers of the cervix, uterus and ovary.. As Congress appropriates funding for FY 2023, the WFRC is requesting that Congress provide \$49.048 billion, an increase of \$4.1 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. Almost all of NIH's institutes and centers fund research on women's health; therefore, 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.

SUPPORT FOR THE ADVANCED RESEARCH PROJECTS AGENCY FOR HEALTH

The WFRC supports the creation of an Advanced Research Projects Agency for Health (ARPA-H), which would provide an important opportunity to advance research in women's health if done in a manner that protects and complements the research already being done by NIH. Any funding appropriated to ARPA-H should be in addition to the \$49.048 billion requested for the NIH. Despite the fact NIH has implemented policies related to sex as a biological variable and taken steps to identify women's health topics where additional research is needed, significant gaps remain in our understanding of health conditions unique to or occurring predominantly in women and in the translation of the research conducted on these topics, despite women accounting for over half of the United States population. Unfortunately, the implications of these gaps are clear: our country is currently in the midst of a maternal mortality and severe morbidity crisis; increasing rates of preterm birth; cervical cancer survival rates have stagnated since the mid-1970s; vaginal mesh procedures that were not studied in clinical trials require regulatory action from the FDA;¹ and there are significant gaps in our understanding of women's fertility and hormonal functions.^{2,3}

¹ <https://www.fda.gov/medical-devices/implants-and-prosthetics/urogynecologic-surgical-mesh-implants>.

² MacDorman MF, Declercq E, Cabral H, Morton C. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstet Gynecol*. 2016;128(3):447–55.

³ Jemal A, Ward EM, Johnson CJ, et al. Annual report to the Nation on the status of cancer, 284 1975–2014, featuring survival. *J Natl Cancer Inst*. 2017;109.

There is a strong need for a greater investment in research of these conditions and many others that occur in women's health before, during, and after pregnancy. Often, women's health is not looked at across the lifespan and we fail to appreciate the very long-term consequences of adverse pregnancy progression and outcomes. We believe ARPA-H has the potential to transform women's health research by investing in a more comprehensive approach to translating basic science into cures.

The existing NIH Institutes and Centers play a critical role in improving human health as evidenced by the work done by the agency in the development of effective COVID-19 treatments and vaccines and this work must continue to receive robust, sustained support. As such, funding for ARPA-H must supplement, not substitute, for the research funded by the existing Institutes and Centers. The basic science supported by the agency are the foundation for the transformational work envisioned for ARPA-H. Therefore, WFRC recommends that the same proportional increases in funding provided to the existing NIH institutes and centers be provided to ARPA-H once established. We also support housing ARPA-H outside of the NIH, in order to prevent funding cuts to existing Institutes and Centers.

SUPPORT A STUDY ON WOMEN'S HEALTH RESEARCH

While the National Institutes of Health (NIH) has taken steps to better track and evaluate the funds being spent on women's health research, we remain concerned about the research gaps, what is being funded and what NIH classifies as women's health research as detailed above. To address these concerns, we request the inclusion of report language directing the NIH Director to contract with the National Academy of Science, Engineering, and Medicine (NASEM) to conduct a study on gaps in women's health research, and to provide \$2 million to support this work.

Specifically, we envision the study would be designed to explore the proportion of research on conditions that are more common or unique to women, establish how these conditions are defined, evaluate sex and gender differences and racial health disparities, and determine the appropriate level of funding that is needed to address gaps in women's health research. Historically, there has been an inadequate representation of minority women as both researchers and research participants. There are clear health disparities among conditions that are more common or unique to women, and the NASEM is well suited to conduct this study to explore these gaps, by looking at women's health more comprehensively, across the lifespan.

Accordingly, the WFRC requests the inclusion of the following language in the report accompanying the FY 2023 LHHS Appropriations bill with regards to the NIH Office of the Director:

Women's Health Research Study.—The Committee recognizes persistent gaps remain in the knowledge of women's health. To address these gaps and improve women's health, the Committee includes \$2 million within the National Institutes of Health to contract with the National Academy of Sciences, Engineering, and Medicine (NASEM) to conduct a study on the gaps present in women's health research across all institutes and centers at the NIH. Specifically, the study should be designed to explore the proportion of research on conditions that are more common or unique to women, establish how these conditions are defined and ensure that it captures conditions across the lifespan, evaluate sex and gender differences and racial health disparities, and determine the appropriate level of funding that is needed to address gaps in women's health research at the NIH. The Committee requests the Academies to, not later than 18 months after the date on which the agreement is entered, to submit to Congress a report containing the findings of the study and the recommendations to address research gaps in women's health research, including measurable metrics to ensure that this research is accurately tracked to meet the continuing health needs of women.

SUPPORT FOR AN RCDC ON MENOPAUSE

The RCDC system is a computer-based process that sorts NIH-funded projects into categories of research area, disease, or condition. There is currently no RCDC category for menopause, which is a condition that will impact all women during their lifespan and remains understudied in research. Since menopause is critical to understanding women's health, the WFRC believes NIH should create a RCDC category for this condition so that this research can be tracked and analyzed over time. Furthermore, the creation of an RCDC for menopause will allow for increased access to information and greater transparency of funded research projects related to the study and treatment of menopause.

Therefore, the WFRC respectfully requests that you include the following report language in the report that accompanies the FY 2023 LHHS appropriations bill under the NIH Office of the Director:

Menopause.—The Committee is concerned about the lack of a Research Condition, Disease Categorization (RCDC) category for menopause, which limits the ability to analyze current and future biomedical research being done on menopause. As menopause is a condition that will impact all women and is an important component of understanding women's health across the lifespan, it is critical that the NIH report on and be able to track the intramural and extramural research being done. The Committee requests that the NIH create a RCDC code for menopause.

CONCLUSION

Thank you again for the opportunity to submit testimony to the Committee as you begin your work on the FY 2023 appropriations bills. We look forward to working with you to ensure that there is appropriate funding for women's health research at the NIH, to address gaps in women's health research and to improve health across the lifespan for women.

PREPARED STATEMENT OF THE WOMEN'S HEALTH INNOVATION COALITION

Thank you for the opportunity to comment on the National Institutes of Health (NIH) budget priorities for FY 2023. We provide this testimony in support of increased funding for research grants focused on addressing health diseases and conditions that solely, disproportionately and/or differently impact women within the FY 2023 Labor, Health and Human Services, and Education Appropriations bill.

The Women's Health Innovation Coalition (WHIC) is a group of innovators, investors, clinicians, analysts, and executives with the shared goal of advancing innovation in women's health. We source innovative solutions to address unmet needs in diseases, conditions, and indications that impact the health of women and minorities. Through collaborative advocacy and policy efforts, we are working to drive initiatives that demonstrate women's health is not a niche market and to promote greater gender—relevant data transparency and increased investment in R&D to bring innovations to market that address gaps in care that harm women and minorities and result costly medical expenditures.

We have identified eight areas of health that solely, disproportionately, or differently impact women, requiring further government research investment and better education and awareness among patients and clinicians in order to advance scientific understanding and medical innovations:

CARDIOVASCULAR HEALTH

Cardiovascular disease affects one in 16 women over the age of 20, is responsible for nearly one in five deaths annually for women, and women 55 and under are twice as likely to die from a heart attack than men.¹ Furthermore, women are seven times more likely to be misdiagnosed and discharged in the middle of a heart attack than men, as men and women present with different symptoms during cardiovascular distress and too many physicians continue to be trained to only see signs in white men.² Women with cardiovascular disease are also more likely to report poorer patient experience, lower health-related quality of life, and poorer perception of their health when compared with men.³ This translates to unnecessary costs across the United States healthcare system, as unrecognized and inadequate treatment of cardiovascular diseases will surpass \$1 trillion by 2035.⁴

AUTOIMMUNE AND IMMUNOLOGICAL DISEASES

With 80 percent of all patients diagnosed with autoimmune diseases being women and 100 types of them predominantly affecting women, this area of health must be

¹ Mayo Clinic, October 4, 2019: <https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/heart-disease/art-20046167>.

² Coya Partners, 2020: <https://www.coyapartners.com/blog>.

³ Victor Okunrintemi, Javier Valero-Elizondo, Benjamin Patrick, et. al, "Gender Differences in Patient-Reported Outcomes Among Adults with Atherosclerotic Cardiovascular Disease", December 10, 2018, <https://www.ahajournals.org/doi/10.1161/JAHA.118.010498>.

⁴ RTI International, "Cardiovascular Disease Costs will exceed \$1 Trillion by 2035", February 14, 2017: <https://www.rti.org/news/cardiovascular-disease-costs-will-exceed-1-trillion-2035>.

addressed.⁵ Part of this disparity can be attributed to many autoimmune disorders' tendency to affect women during periods of extreme stress, such as pregnancy, or during period of hormonal change.⁶ There are few treatments available for many autoimmune diseases, which can be uncomfortable, painful and impact a woman's ability to work and care for her family. Autoimmune diseases are also extremely costly, as the National Institutes of Allergy and Infectious Diseases has estimated that the cost of treating autoimmune disease in the U.S. is greater than \$100 billion annually.

ONCOLOGY

Women bear the burden of inequitable oncological treatment options as well as disparities in specific cancers. For example, one in five people who are diagnosed with lung cancer have never smoked, yet non-smoking women are three times more likely to have the disease.⁷ Gender disparities are also pervasive in terms of treatment options, as a recent study showed that the odds of receiving radiation were 60 percent for women and 70 percent for men, and the odds for receiving intensive chemotherapy were 35 percent for women versus 46 percent for men.⁸ In terms of mortality, the ratio of cancer deaths versus non-cancer deaths was 1.92 times higher for women than for men.⁹ Cancers also disproportionately impact minorities and populations with social, environmental, and economic disadvantages that hinder access to healthcare. African American and Caucasian women have similar rates of breast cancer, yet African American women are more likely to die from the disease. Hispanic and African American women also have higher rates of cervical cancer than women of other ethnic groups, with African American women having the highest rates of death from cervical cancer.¹⁰ In addition, ovarian cancer is the only gender-specific cancer with greater than 50 percent mortality rate, and accounts for more deaths than any other cancer of the female reproductive system with Black women having a much higher 5-year mortality rate (62 percent) vs. Caucasian women (54 percent).¹¹

AGING AND BONE HEALTH

A women's risk of bone fracture is equal to her combined risk of breast, uterine, and ovarian cancer, which is four times the rate of men. Of the 10 million Americans with osteoporosis, approximately 80 percent are women and a proximately one in two women over age 50 will break a bone because of osteoporosis.¹² Studies have shown that there are multiple reasons why women are more likely to get osteoporosis than men. Women tend to have smaller and thinner bones, and women's estrogen, a hormone that protects bones, decreases when women reach menopause.¹³ This prevalence of bone diseases is not only dangerous for women but is also extremely costly. The annual cost of osteoporosis-related bone breaks is \$19 billion for patients, their families, and the healthcare system, and is expected to continue to rise.

GYNECOLOGICAL AND SEXUAL HEALTH

Several gynecological conditions women face throughout their lives and especially as they age are often ignored with insufficient diagnostics and treatments. For example, the annual gynecological exam does not screen for ovarian cancer and 1 in 5 women have masses, yet few diagnostics can catch the cancerous tumors during the critical early stages, especially among women of color who are most often diagnosed too late and die sooner. In addition, more than 4,000 women enter menopause

⁵The Prevalence of Autoimmune Disorders in Women: A Narrative Review, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7292717/>.

⁶Angum, Fariha et al. "The Prevalence of Autoimmune Disorders in Women: A Narrative Review," *Cureus* vol. 12,5 e8094. 13 May. 2020, doi:10.7759/cureus.8094.

⁷Brigham and Women's Hospital, "Why Women's Health Can't Wait", 2014, <https://www.brighamandwomens.org/assets/bwh/womens-health/pdfs/connorsreportfinal.pdf>.

⁸Ibid.

⁹Siegel RL, Miller KD, Jemal A. Cancer Statistics, 2017. CA: A Cancer Journal for Clinicians 2017; 67(1):7-30.

¹⁰National Cancer Institute, "Cancer Disparities," <https://www.cancer.gov/about-cancer/understanding/disparities>.

¹¹American Cancer Society, <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdf>.

¹²<https://www.nof.org/preventing-fractures/general-facts/what-women-need-to-know/>.

¹³National Osteoporosis Foundation "What Women Need to Know" <https://www.nof.org/preventing-fractures/general-facts/what-women-need-to-know/>.

every day in the U.S., but only one in five OB/GYN residency programs provide menopause training to support them and nearly 80 percent of medical residents admit that they feel “barely comfortable” discussing or treating menopause.¹⁴ Also, 84 percent of women experience menopause symptoms, and more than one in 10 (12 percent) say their symptoms can be severe or debilitating. Yet menopause is understudied and misunderstood by physicians and researchers alike with few treatments available for the impact on women that is so severe, many stay home or retire early when they are otherwise in the prime of their career. Most do not understand when symptoms are ignored or misdiagnosed during menopause years, they can lead to severe complications, preventable death, and avoidable and costly medical expenditures. These conditions cost the U.S. healthcare system four times the costs of their non-symptomatic peers. Globally, menopause-related productivity losses can amount to more than \$150 billion a year and if costs to the healthcare system are included, the total price tag of menopause could be higher than \$810 billion.¹⁵

REPRODUCTIVE HEALTH

Disparities in maternal and reproductive health are also a major concern in the U.S. Studies document decades-long racial and ethnic disparities in several areas of reproductive health, including contraceptive use, care for sexually transmitted infections and the human papillomavirus (HPV) vaccination among younger women aged 18 to 25 years, as well as reproductive cancers, preterm deliveries, and maternal morbidity and mortality in all age groups.¹⁶ Most women lack sufficient resources, information and access to care related to perinatal mood and anxiety disorders (PMADs), the number one complication resulting from pregnancy and childbirth. Half of perinatal women with a diagnosis of depression do not get the medical treatment that they need, resulting in poor patient outcomes and increased societal costs. The total annual societal costs incurred by PMADs, including maternal productivity loss (such as loss of work productivity and missing work), greater use of public sector services (such as welfare and Medicaid), and higher health care costs due to worsened maternal and child health, was \$14.2 billion in 2017. This equates to \$4.7 billion in productivity losses, \$2.9 billion in maternal health expenditures, \$3.3 billion in preterm births, and \$1.6 billion in child behavioral and developmental disorder spending.¹⁷ These staggering costs and the devastating effects for mothers who suffer from PMADs must be discussed and addressed.

COGNITIVE AND BRAIN HEALTH

Cognitive and brain function is another health area in which significant disparities exist between men and women. Two-thirds of Alzheimer’s patients over 65 are women and two-thirds of caregivers are women.¹⁸ Moreover, despite clear biological differences in cognitive function, women are not proportionately represented throughout the research process, and female-specific cognitive diseases are not proportionately funded. In medical research for anxiety disorders, 90 percent of animal subjects are male, though women are twice as likely to be diagnosed with anxiety in their lifetime.¹⁹ Although two-thirds of Alzheimer’s patients are women 66 percent of animals used in Alzheimer’s research are male or of an “unspecified gender,” which are mostly male. There is also a stark disparity in funding allocation, as just 12 percent of the National Institutes of Health (NIH)’s 2019 budget of \$2.4 billion for Alzheimer’s disease research went toward projects specifically focused on women. Not only does this hinder innovation, understanding, and treatment of Alzheimer’s disease, it also results in severe economic consequences. If \$300 million had been shifted to the NIH’s Alzheimer’s budget to focus on women’s brain health in that

¹⁴ <https://www.aarp.org>, Note this study also found 84 percent of women say that their menopausal symptoms interfere with their lives, including at work.

¹⁵ Reenita Das, a partner and senior vice president for healthcare and life sciences at consulting firm, Frost & Sullivan, https://apple.news/AkFLvCBgGST6IKWENIXbf_w.

¹⁶ *Obstetrics & Gynecology*: February 2021—Volume 137—Issue 2—p 225–233, doi: 10.1097/AOG.0000000000004224.

¹⁷ Mathematica Policy Research, “Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States”, April 29, 2019, <https://www.mathematica.org/download-media?MediaItemId={E24EE558-B67B-4BF6-80D0-3BC75DB12EB6}>.

¹⁸ Centers for Disease Control and Prevention, <https://www.cdc.gov/aging/caregiving/alzheimer.htm>.

¹⁹ Gender Differences in Anxiety Disorders: Prevalence, Course of Illness, Comorbidity and Burden of Illness, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135672/>.

same year, it would have produced over \$930 million in economic benefits, including quality of life improvements, and reduced medical costs.²⁰

ADVERSE DRUG EVENTS

While recent clinical studies have included more women, for decades, the patients who participated in clinical trials for new drugs skewed heavily male. As a result, many drugs commonly prescribed to this day do not account for gender differences making them ineffective or causing patient harm. Today, most pre-clinical trials continue to exclusively use male mice and male animals even though sex differences are found at the cellular level. Few pre-clinical trials use both sexes to inform the next phase of studies in humans, and even if experiments do include female animals, the subgroup analyses by sex are not reported.²¹ During the next phase of research when the clinical trial includes women, often for the first time, and always at a level far below the actual representation of women in prevalence rates for the disease for which the drug is being developed to treat, this underrepresentation is magnified with greater room for error and ADE occurrence.

RECOMMENDATIONS

With the continued failure to address so many women's health issues, we must increase NIH investment in advancing research in these areas. An analysis of NIH funding patterns found that in nearly three-quarters of the cases where a disease afflicts primarily one gender, the funding pattern favors males, in that either the disease affects more women and is underfunded, or the disease affects more men and is overfunded. Furthermore, the disparity between actual funding and that which is commensurate with burden is nearly twice as large for diseases that favor males versus those that favor females.²² Finally, just 11 percent of NIH research dollars are dedicated to women's health.

Therefore, we ask that Congress increase funding and programmatic investments for the NIH to prioritize all health conditions that solely, disproportionately or differently impact women and minorities. We must improve scientific understanding, investment, research, treatments, diagnostics and awareness for these populations that represent over half the population. We are eager to work with you in this endeavor, find ways to match government funding by incentivizing private investment in this research, and work in a concerted effort to advance the health of women and minorities. Thank you for your consideration.

PREPARED STATEMENT OF THE WORKFORCE INNOVATION AND OPPORTUNITY ACT

The May 21, 2014 Statement of Managers to Accompany the Workforce Innovation and Opportunity Act¹ (WIOA) provides broad intentions to modernize the Nation's workforce development, adult education, and vocational rehabilitation systems through a focus on sector strategies, career pathways, and strategic alignment. WIOA required disaggregated reporting of outcomes by special population as well as participation and performance on key indicators by age, race, ethnicity, and gender. Even though Congress' statement does not once use the word 'equity,' clearly equitable outcomes for community members most in need was at the heart of its intent then and what is needed now.

Our 2022 policy comments are guided by principles of equity, efficiency and quality for youth and adults, responsiveness to providers, and collaboration across all WIOA and relevant other partners. The comments are distilled from quantitative and qualitative research activities undertaken in a comprehensive WIOA landscape analysis project conducted by World Education, Inc., as well as decades of experience in local, State, and Federal adult education and workforce development systems.

2022 WIOA Reauthorization Opportunities

Many of the innovative service designs such as career pathway and apprenticeship programs and equity levers that WIOA codified have yet to be fully utilized,

²⁰ Women's Health Access Matters, "Societal Impact of Research Funding for Women's Health in Alzheimer's Disease and Alzheimer's Disease Related Dementias," April 2021, https://thewhamreport.org/wp-content/uploads/2021/04/TheWHAMReport_ADRD.pdf.

²¹ It is time to integrate sex as a variable in preclinical and clinical studies, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6056479/>.

²² Arthur A Mirin, "Gender Disparity in the Funding of Diseases by the U.S. National Institutes of Health" July 30, 2021, <https://pubmed.ncbi.nlm.nih.gov/33232627/>.

¹ <https://www.help.senate.gov/imo/media/doc/WIOA%20Statement%20of%20Managers.pdf>.

and reauthorization should double-down on implementation of those key levers. In addition to increasing the potential impact of the existing policy, a number of substantive changes would make it easier for WIOA practitioners to partner and provide quality education, training, and other services to their communities.

WIOA's implicit purpose is equity, and we respectfully submit these recommendations to strengthen the joint purpose of an equitable economic recovery and a prosperous future for all America.

Include a Separate Title for Funding America's Job Centers (AJCs), Including Virtual Services

Fund an Equitable Network. A separate title or section within Title I in WIOA should be included to provide for the funding of the AJC network, including brick and mortar as well as virtual infrastructure and certain shared service delivery costs. This direct additional infrastructure funding would solve a longstanding issue and could potentially free up more resources for services. The recommended separate title would describe allowable uses of funding and specify what constitutes fair and reasonable infrastructure costs. These funds would be distributed through the local allocation formula used for Title I and would be administered under a MOU (Memorandum of Understanding) negotiated between the local board and governor. Under this model, the WIOA core programs would have a shared presence in the physical and virtual AJCs, and other partners could opt to co-locate or to provide remote access to services, depending on local needs and available resources.

Amend Deficit-Based Language That Creates Deficit-Based Programming and Leverage Community Stakeholders to Design Strategies

Address the Barrier and Recognize Assets and Experience. WIOA reauthorization needs to address this deficit-based language while maintaining critical reporting on who receives what services and to what impact. One way to do this would be to reframe 'individuals with barriers' to 'individuals CONFRONTING barriers' and to clearly articulate that the public workforce system's role is to support that confrontation with resources needed to overcome barriers. Another way is to rethink eligibility and shift the mindset of fixing individuals with barriers to a system supporting economic opportunity and mobility for those that can benefit from it.

The deficit-based language is also problematic in how it affects the process of designing effective services. Reauthorization should involve a stakeholder consultative process, much like that included in Strengthening Career & Technical Education for the 21st Century Act (Perkins V) in which people confronting the barriers detailed in WIOA priority populations should be involved in designing the services for their communities. Adults in our communities have skills and experiences that can be a powerful starting point for building toward their career aspirations. WIOA needs to leverage job seekers' assets in order to design more effective solutions.

In this process of designing effective services, consideration should be given to "lift up alternatives and approaches to workforce development beyond those focused on jobs, skills, training, and individual worker assets and deficits. Specifically, consider strategy and policy approaches that expand access to our Nation's safety net; address 'digital redlining' and invest in digital access and learning; and support access to high quality jobs and benefits."²

Optimize Alignment of Services, Systems, Resources, and Reporting Across WIOA Core Programs and WIOA Partner Programs

Provide Flexibility. Incorporate authority that would allow Tribal, municipal, county and State governments to request flexibility and grant waivers to pool resources from various WIOA Titles and WIOA Partner Programs to build career pathway systems and programs toward the goal of improved outcomes for low-income youth and adults in the domains of education, training, employment, earnings, health and wellbeing.

Invest in Evidence-Based Program AEFLA Models

IET is Evidence-Based and a Racial Equity Strategy—Create an Integrated Education & Training Funding Stream. The Institute for Education Science (IES) What Works Clearinghouse (WWC) holds the highest standard for rigor in independent education research, seeking to drive education policy less by 'professional wisdom' and more by evidence-based practice. In September, 2020, the National Center for Education Evaluation at IES released an Intervention Report on I-BEST. This gold-standard research identified three randomized control trial studies that meet the WWC criteria, documenting impacts on 45,413 learners in nine States and dem-

² <https://workforce-matters.org/a-racial-equity-framework-for-workforce-development-funders/>.

onstrating statistically significant positive impacts for the career pathway participants versus the control group:

- + 18 positive effects on industry-recognized credential, certificate or license completion;
- + 10 potentially positive effects on short-term employment; and
- Potentially positive effects on short-term earnings.³

Ability to Benefit to Support Adult Dual Enrollment in IET. The Ability to Benefit (ATB) student financial aid provision in the Higher Education Act (HEA) provides underserved students access to accelerated and integrated high school and college credentials through adult dual enrollment. When creating IET with HEA Title IV-eligible student financial aid, Ability to Benefit (ATB) is the obvious choice. However, ATB is poorly understood and massively underutilized, in no small part due to the fluctuation of legislative approval.

Integrated Education and Training works and it works to motivate persistence with individuals WIOA is meant to serve. A reauthorized WIOA Title II AEFLA needs to directly invest in Integrated Education & Training with dedicated funds for this evidence-based strategy and clear guidance on utilizing the Ability to Benefit provision of the Higher Education Act within an adult dual enrollment strategy. Pell grants are critical for adults both for immediate tuition needs and to offset the opportunity costs of being an adult student with living expense funding.

Fund Remote and Blended Programs and Make Digital Skill Development an Allowable Activity and Fund Use. Remote learning programs require additional funds to purchase, maintain and replace devices, software licenses, technology navigators, and remote classroom aides. Emerging COVID-19 based research suggests that those costs are 12 percent-22 percent higher than straightforward in-person delivery. This is the time to invest in them and take adult education fully into the 21st century and beyond. There is a strong foundation to build on and scale up. World Education's EdTech Center has been documenting these models and specific best practices and providing free professional development to providers.

In addition, amend WIOA to make digital capability/literacy an allowable activity and fund use in the same way ABE, ASE, ESOL, and Integrated English Language and Citizenship services are. Amend the definition of Measurable Skill Gain to include documented digital skills.

Fund Career Navigators

Fund A Navigation System. Provide direct funding through WIOA for career navigators including 2.5 percent of that funding for navigator preparation, professional development, and support. Provide approximately \$4 billion annually in new Federal funding to make coaching available to 20 million unemployed and low-wage workers within the workforce system, community colleges, and community-based organizations. This could be done via the following mechanisms:

- Additional funding for Wagner-Peyser (WIOA Title III) to expand access to career coaching for the newly-unemployed;
- Increased funding for WIOA Titles I, II, and IV to create coaching positions at the AJCs and other workforce service providers;
- Ensure career navigation is articulated as an AEFLA service and make the use of funds for this purpose allowable;
- Update the Reemployment Services and Eligibility Assessment program to encourage more access to high-quality career navigators for unemployment insurance recipients; and
- Funding delivered through WIOA for States to provide career and digital navigator funding to community-based organizations, labor-management partnerships and for eligible institutions in partnership with employers and labor unions to offer career navigation/coaching supports at places of work and community colleges, with a focus on underserved communities. Clarify that some of this funding can go to providers of direct online navigation services, as well as to non-profit providers of navigator professional development and supports.

Improve data collection on career navigation services across all WIOA titles, and evaluate the provision of career navigation services through the AJC network, including assessing the extent to which these services can help reduce equity gaps in employment and earnings results.

Additionally, Digital Navigator initiatives⁴ are providing valuable just-in-time digital skill building to adults for career and wider community needs, but these ef-

³ (2020, September). Integrated Basic Education Skills and Training (I-BEST). Retrieved from <https://ies.ed.gov/ncee/wwc/InterventionReport/706>.

⁴ <https://digitalus.org/digital-navigators/>.

forts would benefit from direct connection to and investment from the public work-force system.

Respectfully.

[This statement was submitted by Priyanka Sharma, Vice President, priyanka__sharma@worlded.org and Judy Mortrude, Senior Technical Advisor, judy__mortrude@worlded.org.]

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