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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2024

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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

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NOTE: Under committee rules, Ms. Granger, as chairwoman of the full committee, and Ms. DeLauro, as ranking minority member of the full committee, are authorized to sit as members of all subcommittees.

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PART 1

	Page
Members' Day	**1**
Testimony of Interested Individuals and Organizations	**9**
Department of Health and Social Services	**147**
Addressing the Challenges of Rural America	**287**
United States Department of Education	**399**
Centers for Disease Control and Prevention, Administration for Strategic Preparedness and Response, and National Institutes of Health	**475**
Provider Relief Fund and Healthcare Workforce Shortages	**553**

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2024

WEDNESDAY, MARCH 8, 2023.

MEMBERS' DAY

Mr. ADERHOLT. Well, good morning, welcome. It is my pleasure to welcome everybody to the Subcommittee on Labor, Health and Human Services, and Education for our Members Day, and we are looking forward to taking testimony from Members of Congress this morning.

This is an opportunity for any Member of the House to come before the panel and draw our attention to any particular issues of importance in both their district as well as across the Nation. And I look forward to hearing from our colleagues as they talk about some of the challenges they see and how this subcommittee can help address some of those challenges.

Before we begin, I would like to turn to the ranking member and the former chair of this committee for any remarks that she may have, so, Ranking Member DeLauro, you have the mic.

Ms. DELAURO. Thank you. Thank you so much, Mr. Chairman, and thanks for hosting Member Day, and congratulations on your first hearing as chairman of the subcommittee.

And I want to welcome Representative Landsman for joining us, and thank you for joining us this morning.

It is important for this subcommittee to gather input from Members as we begin the 2024 appropriations process. The subcommittee's bill is the largest of all of the nondefense appropriations bills.

In 2023, Labor HHS that we passed and enacted in December, we supported middle-class and working families, helped to lift up vulnerable Americans, prepare the Nation for future crises.

The achievements were possible with and because of the input—input of our colleagues provided throughout the process, including through Community Project Funding Requests.

Because of the positive impact of the projects, these continue to have in our communities, and I would just say—the chairman has heard me say this before—I am saddened that the majority has chosen to exclude Labor–H from the process going forward.

I think we should be really building on where we have gone in the last couple of years, and we ought to not decrease availability of resources that have benefited our communities.

I also want to mention a worry that I have about a reported proposal by my colleagues on the other side of the aisle to cap the

2024 discretionary spending at the 2022 level. The cuts would be detrimental to the American people, to our economy, and essential government functions that our constituents rely on.

But as we begin the 2024 appropriations process, we look forward to receiving the President's budget request. It really is critical that we work together to not lose ground on the progress we made in recent years.

As we begin to draft the bill, it is important to continue to hear from our colleagues about their constituents' priorities, their priorities, as we put the bill together, because it is that input that really creates the bills at the end of the process. So thanks very much, and I yield back, Mr. Chairman.

Mr. ADERHOLT. Thank you, and we will go ahead and get started. I would like to recognize our first witness who is Representative Landsman, and we welcome you and look forward to your testimony.

WEDNESDAY, MARCH 8, 2023.

WITNESS

HON. GREG LANDSMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. LANDSMAN. Well, thank you, Mr. Chair and Ranking Member, I appreciate this opportunity to all the members of the subcommittee. I am a former teacher. My parents were teachers. I did child education advocacy most of my career and helped pass an effort in Cincinnati called the Preschool Promise, which provides 2 years of quality preschool for 3- and 4-year-olds.

And it is made a huge difference in terms of the number of our children that are showing up prepared, and who ultimately are reading successfully at end of third grade. These are children that will ultimately go on to graduate and do good things.

So I wanted to provide some testimony on the way in which I think this Congress should approach investing in education, and that is, to shift the way we think about it to brain development. And so that our investments don't look like they do now, which really follow the K–12, to some extent, higher ed cycle.

The vast majority of our spending begins when 90 percent of brain development has occurred. So we invest in kids when they get to kindergarten significantly—some would argue, including myself, that we should do more—and we don't do as much in those early years when the vast majority of brain development is occurring.

And so, my argument is to shift that, and my testimony is just that, that we ought to start thinking about our investments in education the way in which brain development occurs.

So that would mean that we would invest significantly in prenatal care, that every expecting mother, because the vast—you know, a good chunk of brain development happens prenatally, that every single mother has access to high quality prenatal care, that they get it, that when they come home, they come home to a stable, safe house.

So we are investing in housing stability, paid family leave, so that connection between the parent and the child is made. That helps with brain development, that we invest in high quality childcare, that helps with brain development, and preschool. All of that helps in brain development.

If we make that shift where the vast majority of our spending on children is happening as brain development is occurring, we will see incredible results for children, for our schools. They will show up prepared. They will be doing better reading, as it relates to math.

Across the board, our schools will get better. We will graduate way, way more students, and they will go on to do great things in college, career training, and be huge parts of our economy.

And so that is what I hope to compel us to do, is to think about education differently and to invest in education as it relates to brain development and follow that trajectory which would have us investing significantly in prenatal care, childcare, housing, preschool, et cetera.

And with that, I yield back, and thank you again for the opportunity.

[The information follows:]

TESTIMONY BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

Congressman Greg Landsman (OH-01)
March 8, 2023

Member Day

Thank you, Mr. Chair and Ranking Member. I appreciate this opportunity, to all the members of this subcommittee.

I am a former teacher, my parents were teachers, I did child education advocacy most of my career. I helped pass an effort in Cincinnati called the Preschool Promise, which provides 2 years of quality preschool for three- and four-year-olds.

It has made a huge difference in terms of the number of our children that are showing up prepared, and who ultimately are reading successfully at the end of third grade. These are children that will ultimately go on to graduate and do good things.

So, I wanted to provide some testimony on the way in which I think this Congress should approach investing in education. We have to shift the way we think about it to brain development, and so that our investments don't look like they do now, which really follow the K-12 to higher Ed cycle.

The vast majority of our spending begins when 90% of brain development has occurred. Now, we invest in kids when they get to kindergarten significantly, some would argue, including myself, that we should do more. But we don't do as much in those early years when the vast majority of brain development is occurring.

My argument is to shift that, and my testimony is just that. We ought to start thinking about our investments in education the way in which brain development occurs. That would mean that we would invest significantly in prenatal care, so that every expecting mother, because a good chunk of brain development happens prenatally, that every single mother has access to quality prenatal care. That when they come home, they come home to a stable, safe house, by investing in housing stability. We have to invest in paid family leave so that connection between the parent and the child is made. That helps with brain development. That we invest in high quality childcare. That helps with brain development. And with preschool. All of that helps with brain development.

If we make that shift, where the vast majority of spending on children is happening as brain development is occurring, we will see incredible results for children and for our schools. They will show up prepared to read, to do math across the board. Our schools will get better, we will

graduate way, way more students and they will go on to do great things in college and career training and help grow our economy.

So, that is what I hope to compel us to do. To think about education differently and to invest in education as it relates to brain development and follow that trajectory. Prenatal care, childcare, housing, preschool, et cetera. And with that I yield back.

Thank you again for the opportunity.

Mr. ADERHOLT. Yeah, I had a quick question. You mentioned being an educator, as your parents were. Were you an early childhood educator or?

Mr. LANDSMAN. No, sir. Thank you for asking. Career was sort of two parts. One was, I was a classroom teacher in high school, but then was—I led an education advocacy group called the Strive Partnership, which is now a national group that looks at data and then uses data to say, Okay, what works, how do we best invest in children? And that got me very involved, for the better part of a decade, in early childhood.

In these first 5 years when 90 percent of brain development occurs in these early years, kids who have everything they need in those early years, they show up to kindergarten—and most States have an assessment—they do great on that assessment.

They know their numbers, they know their shapes, they behave the way you are supposed to behave in a classroom, and so they learn and they do great. Kids who don't show up because they didn't have any of those things, they struggle, and very few of them ever get back on track.

Mr. ADERHOLT. Okay. Ranking Member.

Ms. DELAURO. I would just say that I think there are enough studies and so much data that reflect what you have been saying, is that it is critical. Those early years is when kids are—they are absorbing. They are like little sponges.

Mr. LANDSMAN. Yes.

Ms. DELAURO. They take all this information. And we can't afford to lose that time because you never get it back. It has its impact really on the future and on their future. So the investments in early childhood education, and as I say, we don't need any more studies, to be quite honest with you. We have enough data on early childhood, and the advantages of early childhood education for kids and how positive it is.

So I encourage you to continue down this road. It is very critically important, and, you know, we have started to try to address that issue, and we need to continue to build on it. So thanks very, very much for being here.

Mr. LANDSMAN. Thank you very much.

Mr. ADERHOLT. Yeah, thank you. Let me see if any of our other members have any questions or comments.

Okay. Well, thank you, Mr. Landsman, for being here and for your testimony, and we look forward to working with you.

Mr. LANDSMAN. Thank you. Thank you for doing this.

Mr. ADERHOLT. All right. Thank you.

Mr. LANDSMAN. I think it is a wonderful thing. Thank you.

Mr. ADERHOLT. All right. Well, I don't think we have anybody on the list right now. We did have another member that was going to speak but was under the weather and was not able to be here.

But we will take written testimony for anybody who wants to submit that to the committee, and so—do you have anything you want to say before we adjourn?

Ms. DELAURO. No. I think that this is, you know, being able to deal with written testimony would be great.

Mr. ADERHOLT. Yeah. Well, we will do that because I know this is a Wednesday that is a very busy day for members and multiple

hearings going on. So I know it is sort of crazy, so we look forward to getting any written testimony that may want to be submitted.

So with that, we are adjourned.

THURSDAY, MARCH 23, 2023.

TESTIMONY OF INTERESTED INDIVIDUALS AND ORGANIZATIONS

COLLEGE OF SOUTHERN MARYLAND

WITNESS

YOLANDA WILSON, PH.D., PRESIDENT, COLLEGE OF SOUTHERN MARYLAND

Mr. ADERHOLT. Well, good morning, everyone. It is good to have everyone here, having a nice roomful of witnesses and guests here for our committee on public witnesses today. And of course, we are here at the Subcommittee for the Labor, Health and Human Services Subcommittee of Appropriations.

I am Robert Aderholt, honored to be chairing this subcommittee. And let me just say from the onset that we will probably have members that will be coming in and out during the hearing this morning. It is that time of year when all the subcommittees are having their hearings, and so they are all happening at one time. And so members are shuffling between subcommittees to come in and hear. So I know that some will be coming and going. So just bear in mind that is part of that time of year where we are.

But this is our public witness day. It is, of course, an opportunity for members of the public to come before this panel and draw our attention to the issues that you deem important and that you want to stress to us. And we welcome that.

I look forward to hearing from all of our public witnesses that will be sharing with us today, as we learn about some of the challenges that you face and what this subcommittee can do to try to be of assistance.

Before we would begin, I will just remind everybody that we need to adhere to a 5–minute rule this morning, as we do have a lot of witnesses that will be coming before us and testifying, to make sure that we hear from everyone before we have to adjourn or a vote is called.

For our witnesses, the 5-minute clock will count down on the microphone box that is going to be in front of you. You will have 1 minute remaining when the yellow light comes on, and at that point, start wrapping up your testimony. And then, remember, your full testimony will be able to appear in the hearing record.

So before we begin, I would like to turn to my ranking member and, of course, former chair for many years of this subcommittee for any remarks, Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman, for hosting today's public witness hearing.

And as you pointed out, this really is a highlight of the hearing schedule that we are engaged in. And really are so important helping us to craft the legislation as we go forward.

I welcome all of you today, want to express our sincere gratitude, appreciation to all of you and to those who sent in written testimonies for the record. It is your experiences and your testimonies are invaluable to us and to the subcommittee's bill.

It is one of the most important—today's hearing is one of the most important things that this subcommittee does. The work that we do together to fund the programs and services in this bill impacts every single American at every stage of their lives.

In the 2023 Labor, Health, Human Services, and Education bill, we passed that in December, but we made critical investments in programs and services that our communities rely on. We created and we sustained better-paying American jobs by strengthening job training, apprenticeship programs, worker protection. We increased funding for the National Labor Relations Board for the first time since 2010.

We invested in high-poverty schools, students with disabilities, postsecondary education. We supported middle class and working families with increased funding for childcare, Head Start, preschool grants.

We strengthened lifesaving biomedical research with increased funding for the National Institutes of Health, and we bolstered America's public health infrastructure through the Centers for Disease Control and Prevention and our State and local governments. And we tackled our Nation's most urgent health crises, including opioid misuse, mental health, and maternal mortality.

Our achievements of the past few years were possible because of the input like advocates like yourselves that you provided us throughout the process. So it is critical that we, in fact, work together so that we do not lose ground on this progress.

I will intimate to you that I am worried about House Republicans' reported proposal to cap the domestic spending for the 2024 budget at the 2022 level. The cuts would be detrimental to the American people—my view—our economy, essential Government functions that our constituents rely on.

So as we draft the 2024 bill using the President's budget request as a starting point and with direct input from stakeholders, including all of you, we will continue to fight for the programs that transform the lives of Americans all across this country, the programs that working and middle class families rely on.

Looking forward to your testimony, and again, thank you so much for being here this morning.

Mr. Chairman, I thank you, and I yield back.

Mr. ADERHOLT. Thank you, Ranking Member DeLauro.

And I would like to now recognize the gentleman from Maryland, Mr. Hoyer, for an introduction.

Mr. HOYER. Well, thank you very much, Mr. Chairman.

There we go. Thank you very much, Mr. Chairman, for this courtesy, and I am very, very pleased to introduce Dr. Yolanda Wilson, a friend of mine who represents the College of Southern Maryland as its president. And she is relatively new to our college, but not relatively new to community colleges, which, as a member of the

State Senate in Maryland, I was very pleased to have an opportunity back in the '70s to be one of the leaders in the community college effort. And I thank her for being here.

Dr. Wilson received, Mr. Chairman, both her bachelor's degree and master's degree from the University of Maryland at College Park, and she earned a doctorate in education with a focus on adult and community college education at North Carolina State. She spent 23 years working as a professor and senior administrator in community colleges in both North and South Carolina.

Just this year, she started an historic tenure, as I said, as president of the College of Southern Maryland. From the American Association for Women in Community Colleges to the Middle States Commission on Higher Education, a number of outside organizations have also sought her expertise. Dr. Wilson understands the impact that these schools can have on the lives of their students and on communities across the country.

As someone who has long advocated, as I said, for greater Federal investment in skills training and workforce development as part of my Make It in America agenda, I am eager to hear her perspective. And I want to welcome her to this committee.

Thank you, Mr. Chairman.

Mr. ADERHOLT. Please.

Dr. WILSON. Thank you for the opportunity, for your support to reform student aid for community college students specifically through Workforce Pell Grants for students in short-term programs. We must not overlook the critical role of community colleges in today's conversations about college affordability, both in helping our students to achieve their educational needs, as well as helping our communities thrive.

As favorably reported by the American Association of Community Colleges, President Biden's budget proposal showcases a commitment to the Nation's community colleges and their millions of students. Particularly significant are the proposed funding allocations for the Department of Education and Department of Labor that provides resources for community college programs.

Today, I direct your attention to additional funding to support much needed increases to the Pell Grant maximum and to further expand Workforce Pell Grants for students in short-term programs. Let us first consider who are our students. The rich diversity of our community college students cannot be neatly categorized.

AACC reports that of the Nation's 10.3 million community college students, 4.1 million are considered noncredit or workforce development students. And of the students in credit-bearing programs, 65 percent—or roughly 4 million students—attend part time.

Some of our students are considered dual enrolled, completing high school requirements while getting a head start on their higher education. Many are returning adults, balancing full-time employment with raising a family, all while taking one or two classes and studying 6 to 10 hours a week. And others are the underemployed who are working to gain the necessary licensures and credentials to boost their employability and stay current in their chosen profession.

When we say college affordability, we are inclined to think of ensuring higher education is accessible and affordable for the tradi-

tional age full-time student on their path to a bachelor's degree. But for the part-time student or the student gaining workplace licensures, what does college affordability look like for them?

The conversation about workforce Pell is a game-changer because it removes financial burdens for part-time and skilled trade students who seek our high-quality, short-term workforce development programs.

In February, during the Association of Community College Trustees National Legislative Summit, we heard about efforts at the Federal level to expand Pell Grants for workforce development students. I have vigorously championed this wider net and the implications not only with our Members of Congress and our Maryland State delegation, but also with our county commissioners.

During COVID, our county commissioners supported 1,798 credit students in continuing their education. And of those recipients, almost a third have now graduated. When you consider that 87 percent of our graduates remain in our region, the local economic impact by our students is significant.

In fact, Emsi calculated the total impact of CSM alumni, both credit and noncredit, at $196,000,000 in added income just in 2019 alone. That is the equivalent of supporting 2,822 jobs. But imagine this impact by extending support to workforce development students, enabling employers to more quickly meet their workforce and pipeline needs.

Support of Workforce Pell Grants for students in short-term programs is critical. This will establish Pell Grant eligibility for shorter-term programs, accompanied by rigorous and relevant quality standards. Many students cannot participate in these programs because of their cost. Community colleges support lowering the threshold for Pell Grant eligibility, which would increase access to these programs.

Our joint efforts to grow our trade programs and noncredit certifications are more important today than ever. In Maryland alone, our 16 community colleges annually provide customized training to more than 1,000 Maryland businesses and organizations, upgrading the skills of close to 100,000 employees.

In summary, you have it in your power to ensure all students have accessible, affordable education. On behalf of community college students everywhere, I ask your support for expanding Workforce Pell. With this, all community college students are better situated to be successful, and in turn, our families and our communities grow stronger.

[The information follows:]

U.S. House Appropriations Committee

Labor, Health and Human Services, Education, and Related Agencies Subcommittee

Thursday, March 23, 2023

Submitted by Dr. Yolanda S. Wilson, President, College of Southern Maryland

Thank you for the opportunity to advocate for your support to reform student aid for community college students, specifically through Workforce Pell Grants for Students in Short-Term Programs and Investing in Basic Needs Supports for Students. We must not overlook the critical role of community colleges in today's conversations about college affordability, both in helping our students to achieve their educational needs as well as helping our communities thrive. As favorably reported by the American Association of Community Colleges (AACC), President Biden's budget proposal showcases a commitment to the nation's community colleges and their millions of students. Particularly significant are the proposed funding allocations for the Department of Education and the Department of Labor that provide resources for community college-specific programs. Today I direct your attention to additional funding for the Department of Education to support much-needed increases to the Pell Grant maximum and for the Department of Labor to increase the capacity of community colleges to provide skills training and education and further expand registered apprenticeships across business sectors.

I recognize the powerful impact of community colleges. I have worked 23 years as a professor and senior administrator for South Carolina and North Carolina community colleges, and now as a community college president in Maryland. I have focused my work on creating a student-ready college culture, mitigating institutional barriers to access, retention, and completion, and strategically focusing on programming and policies that support all students to

success. At the recent national Achieving the Dream Conference, peers from more than 300 community colleges shared and learned evidence-based strategies to improve access, support momentum, create upward mobility, and foster community impact. Throughout the conference, some of our community college students, proudly referred to as Dream Scholars, used the power of 'I am' statements to share their unique backgrounds, obstacles they have faced, and the transformational impact that their community colleges have had on their lives. As members of my community college's team reflected on these statements, we were inspired by students who face unimaginable obstacles but speak boldly about how they are actively achieving their dream.

Who are our students? The rich diversity of our community college students cannot be neatly categorized. AACC reports that of the nation's 10.3 million community college students, 4.1 million are considered non-credit or workforce development students. Of those students in credit-bearing programs, 65 percent, or roughly 4 million students, attend part time. Some are considered dual-enrolled, completing high school requirements while getting a head start on their higher education. Many are returning adults, balancing full-time employment, raising and caring for a family, all while taking one or two classes that require studying 6 to10 hours a week. And they are the under-employed who are working to gain the necessary licensures and credentials to boost their employability and stay current in their chosen profession.

When we say college affordability, we are inclined to think of ensuring higher education is accessible and affordable for the traditional-age, full-time student on their path to a bachelor's degree that leaves them with a debt that is manageable upon graduating and pursuing a career. But for the working/part-time student, or the student gaining workplace licensures and stackable credentials, or the under-employed who has little access for financial assistance, what does college affordability look like for them? The conversation about Workforce Pell is a game-

changer for community college students because it removes financial burdens for part-time and skilled trade students who seek our high-quality, short-term workforce development programs.

In February during the Association of Community College Trustees (ACCT) National Legislative Summit, we heard about efforts at the federal level to expand Pell grants for workforce development students. Since then, I have vigorously championed this wider net at the federal level with our Congressman and Senators. I have discussed the implications with our Maryland State Delegation and more meaningfully at the local level in adapting it similarly to the Boards of County Commissioners Cares Scholarships that we successfully launched in our three counties during Covid. That effort supported 1,798 credit students in continuing their education during the pandemic, and of those recipients, almost a third have now graduated. When you consider that 87 percent of our community college graduates remain in our region, it is clear the local economic impact by our students is significant. Now, imagine this impact by extending similar support to Workforce Development students in achieving credentials. Further, imagine the impact for employers to more quickly meet their workforce and pipeline needs.

Support of Workforce Pell Grants for Students in Short-Term Programs is critical. This will establish Pell Grant eligibility for shorter-term programs, accompanied by rigorous and relevant quality standards. Currently, programs must be two-thirds of a year to be eligible for Pell Grants. This excludes many community college workforce-oriented programs that greatly benefit both students and local businesses. Many students cannot participate in these programs because of their cost. Community colleges support lowering the threshold for Pell Grant eligibility to 150 clock hours, as in the JOBS Act and the PELL Act, which would increase access to these programs.

I like to describe the partnership between community colleges, the community we serve, and our business partners with the premise of '*Live. Train. Remain.*' Our joint efforts to grow our trade programs and non-credit certifications and stackable credentials are more important today than ever before. In Maryland alone, our 16 community colleges annually provide customized training to more than 1,000 Maryland businesses and organizations, upgrading the skills of close to 100,000 employees. Each of the nation's community colleges are their community's most significant 'connector and convener,' because that is exactly what community colleges do. We connect students from where they are coming from, to where they are going to – whether that is a new career or transferring to another college.

Community college students also have a great need for wrap-around services. Throughout my interactions with students, the most frequent obstacles they identify are food insecurity, transportation, and childcare. At my college now, we are exploring a new job description for a Basic Needs Coordinator. The staff member who assumes this role will help students identify wrap-around services to address their housing and food insecurities, transportation issues, textbook costs, and other critical needs to get timely services from both the College of Southern Maryland and our community resource partners. I see this person serving as a resource connector who will approach students' needs compassionately and holistically to provide answers and guide students to the resources and support they require to be successful.

This local need reflects what is on the ACCT National Legislative Agenda to Invest in Basic Needs Supports for Students with policies to support students by providing greater access to basic needs services. Title IV assistance is rarely generous enough to cover all necessities such as food, housing, transportation, childcare, and medical expenses for many community college students. Therefore, the basic needs of the whole student can be addressed by increasing the

capacity of community colleges to connect students with supportive services to help them persist and succeed in postsecondary education. The promising new Basic Needs and Postsecondary Student Success programs tackle some of these issues, and Title IV student aid programs can be better integrated with income-maintenance programs by strengthening existing federal programs, including the Supplemental Nutrition Assistance Program (SNAP), to meet students' true needs.

In summary, by addressing college affordability at the community college level, you have it in your power to ensure all students have accessible, affordable education. On behalf of all community college students everywhere, current and future, I ask your support for Expanding Workforce Pell to cast a wider net of support for these students, and for Investing in Basic Needs Supports for Students. With this, all our community college students – whether full-time or part-time, credit or workforce – are better situated to be successful. In turn their families and our communities—in essence, all of us as a country—grow stronger in achieving our dreams and in improving the economic and social mobility of our communities.

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Mr. HOYER. Wow. [Laughter.]
One second to go.
Mr. ADERHOLT. Yes, impressive.
Mr. HOYER. I will tell you what. How about that?
Mr. ADERHOLT. Thank you for your testimony.
And like I said, anything else you would like to submit for the record, please feel free to, and we look forward to working with you. And thanks for being here today.
I would like to go on to the next guest that will be speaking to us will be Mr. Michael Kutcher with the Cerebral Palsy Foundation. And so we would welcome you to the subcommittee today and look forward to your testimony.

THURSDAY, MARCH 23, 2023.

CEREBRAL PALSY FOUNDATION

WITNESS

MICHAEL KUTCHER, CEREBRAL PALSY AND DISABILITY ADVOCATE, CEREBRAL PALSY FOUNDATION

Mr. KUTCHER. Chairman Aderholt, Ranking Member DeLauro, and distinguished members of the committee, thank you for allowing me to speak during National Cerebral Palsy Awareness Month on behalf of the more than 1 million Americans and 17 million-plus people worldwide living with cerebral palsy.
My name is Michael Kutcher, and I was born with cerebral palsy, the most common lifelong physical disability, and the obviously more charismatic twin brother of actor Ashton Kutcher. [Laughter.]
Mr. KUTCHER. I am here as an advocate for the Cerebral Palsy Foundation, and with me is Cynthia Frisina, senior vice president of the Cerebral Palsy Foundation, a mother of a daughter with CP and the creator of National Cerebral Palsy Awareness Day.
I know you have seen my submitted testimony with facts and figures, and I want to emphasize the fact that there is zero Federal dedicated cerebral palsy funding, which directly affects me and makes me personally feel that I do not matter. Even more importantly, I am speaking on behalf of the other 1 million Americans who live with cerebral palsy and also feel that they do not matter either, especially those who do not have a voice to speak for themselves.
Today, we ask Congress to take all steps necessary to establish baseline Federal cerebral palsy research investment and a national cerebral palsy research initiative. It is surprising that so little progress has been made in the understanding of CP over the last 45 years since I was born. With your leadership, we can invoke change.
My story, and millions more like it, highlights the current reality that even in 2023, there is no consensus of best practices for a person with cerebral palsy. High-risk babies with brain injuries, and often, cases are shockingly still being discharged from the hospital with little more than a "wait and see" attitude. It is tragic that there is not an aggressive protocol in place from the minute a brain injury in a baby or toddler is suspected. There should be.

It is also important to point out that the estimated lifetime care and medical costs for all Americans with CP born in the year 2000 alone will cover—will total over $12,500,000,000. Right now, because of lack of research funding, there is actually no evidence-based best healthcare practices and treatments for CP throughout a life span.

We can't let this continue to happen to other children and adults with CP. And the great thing is, we don't have to. Please wipe the image you have of what cerebral palsy is and know that change is possible. Outcomes can be improved. Lifelong healthcare costs of 10,000 babies born each year with CP can be reduced. Quality of life for more than 1 million Americans and their families will be better.

It has been very difficult as an adult with the most common lifelong physical disability to understand why there hasn't been more Federal research support that would lead to better treatments, standards of care, and understanding of cerebral palsy across a life span.

Mr. Chairman, Ranking Member DeLauro, thank you and the subcommittee for allowing me to testify today. I hope to see in my lifetime more research, treatments, and better quality of life for people with cerebral palsy. Your leadership will improve more than 1 million American lives.

Thank you for your support and attention to this urgent public health issue. We would be happy to provide any additional information and answer any questions.

Thank you very much.

[The information follows:]



Michael Kutcher
Advocate
Cerebral Palsy Foundation
March 20, 2023

Chairman Aderholt, Ranking Member DeLauro, and Distinguished Members of the Committee:

Thank you for allowing me to speak during *National Cerebral Palsy Awareness Month 2023* on behalf of the more than 1,000,000 Americans and 17,000,000+ people worldwide living with Cerebral Palsy (CP). My name is Michael Kutcher, and I was born with Cerebral Palsy. I am also an advocate for the Cerebral Palsy Foundation, the largest cerebral palsy nonprofit organization in the US, as well as a businessperson, father, and public speaker. With me is Cynthia Frisina, senior vice president of the Cerebral Palsy Foundation, a mother of a daughter with CP and the creator of National Cerebral Palsy Awareness Month, and Day which is March 25th.

Today we ask Congress to take all steps necessary to establish baseline federal cerebral palsy research investment and a National Cerebral Palsy Research Initiative. We thank the Committee for the $2 million re-establishing cerebral palsy surveillance in at least two sites of the existing Centers for Disease Control and Prevention Autism & Developmental Disabilities Network (ADDM). This funding will help better understand the prevalence of CP and restore the intent of the ADDM Network to track major developmental disorders. We request continuing support for this vital public health intiative. We also request the Committee direct $2 million to the Centers for Disease Control and Prevention to establish a Cerebral Palsy Research program focused on the diagnosis, treatment, prevention, health care and societal costs of CP, and track the number of people diagnosed with CP in the United States across the lifespan. In addition, we also request National Institutes of Health (NIH) to continue to prioritize and invest in research on cerebral palsy (CP) including the establishment of a Cerebral Palsy Notice of Special Interest (NOSI) to significantly strengthen and accelerate CP research priorities across the lifespan. While some progress has been made in the understanding of CP over the last forty years, large gaps remain that must be addressed to improve outcomes and treatment for the CP population and their families.

CEREBRAL PALSY FOUNDATION
DISCOVERY FOR DISABILITY

Cerebral Palsy (CP), the most common lifelong physical disability of all, is a devastating group of disorders, disrupting a person's ability to move, sit, stand, walk, talk and use their hands. Despite the large number of Americans impacted by cerebral palsy, and the number of years the cerebral palsy community has advocated for federal research, the dollar amount of dedicated federal funding has remained sadly zero.

I'd like to emphasize that despite the 1,000,000 plus Americans impacted by Cerebral Palsy, there is currently ZERO dedicated public research funding for it at NIH or CDC. There is currently no existing federal strategy to address the most prevalent lifelong physical disability. We request your support in changing this.

CP is caused by a non-progressive early injury to the developing brain and the severity can vary widely. More than 10,000 babies are diagnosed with Cerebral Palsy each year. In most cases the specific cause is unknown. Some people with cerebral palsy like me have difficulties with balance, walking and fine motor skills, while others are fighting uncontrollable movements, rigid limbs, and are unable to speak or swallow. *75% of people with CP have additional conditions*, including epilepsy, autism, hearing and vision impairments, communication problems, and chronic pain.

The reason I am here today began 45 years ago when I was born as a smaller, unexpected twin of my brother, actor Christopher "Ashton" Kutcher. My mother didn't know she was having twins until our arrival. I was tiny and fighting for life. As a baby and toddler, I missed many developmental milestones struggling with motor skills, vision, hearing and using my hands. When I was finally diagnosed with Cerebral Palsy close to kindergarten age, I had missed a key window of opportunity for early intervention. We were told to wait and hope for the best. *Like the majority of others who have received a CP diagnosis, the cause of my Cerebral Palsy remains unknown.* 45 years later a late diagnosis and few answers is still sadly the case for many families.

My story, and hundreds of thousands more like it, highlights the current reality that, even in 2023, there is no consensus of "Best Practices" for a person with CP -- at diagnosis, or through their life span. High risk babies with brain injuries in most cases, are shockingly STILL being discharged with little more than a *"wait and see"* attitude - despite recognition of the importance of the first few years of every baby's life when the

brain grows rapidly with exuberant neuroplasticity and realistic hope for significant recovery exists. It is tragic there is not an aggressive protocol in place from the minute a brain injury in a baby or toddler is suspected. There should be.

It is estimated that lifetime care and medical costs for all Americans with CP exceeds $1.5MM per person more than someone who does not have CP - causing financial devastation in the struggle to afford care and treatment not covered by insurance. Government programs, like Medicaid, bear much of this cost. Lifetime care costs for those born with CP in 2000 alone will total over $12.5 billion. Investing in CP research funding, with the goal of preventing and minimizing the impact of CP, would dramatically reduce the staggering costs and lifelong human suffering.

Of note, the U.S. lags behind other countries like Australia and most of Europe in CP research funding translating to improved early diagnosis and care *(Source: Hagberg et al: CP Alliance).*

Some risk factors for cerebral palsy include maternal infection, perinatal stroke, preterm birth, multiple births, lack of oxygen, and genetic factors. But for almost half of babies with cerebral palsy, no direct risk factors have yet been identified.

What we do know is that the brain injury does not progress in CP. And with the right treatment, function can improve for people. In reality, being able to move is absolutely critical to all of baby learning and it has a lifelong impact. That's why the earlier treatment can begin the better the long-term outcome.

Cerebral palsy has a profound lifetime consequence for a child's ability to participate in family life, their community, access educational and get a job. A baby with CP becomes an adult with CP, which is why research across the lifespan is so critically important.

Right now, because of lack of research funding, there's really no consensus for best healthcare practices and treatments for CP throughout the lifespan.

We can't let this continue to happen to other children and adults with CP.



And the great thing is - we don't have to. Please wipe the image you may have had in the past of what cerebral palsy was and know that change IS possible. If we invest in research that will lead to better outcomes, there are now tools to help detect cerebral palsy and its consequences as early as possible. Outcomes CAN be improved. Lifelong healthcare costs for 10,000 babies each year CAN be reduced. Quality of life for more than 1,000,000 Americans and their families WILL be better.

We're so fortunate to live in the US with some of the best researchers and healthcare professionals. We can easily improve outcomes for people with CP, the way others across the world have done, and our country has done with other disorders and diseases, by investing in research.

But honestly, this is not going to happen in the US unless the right kind of research is funded to help researchers translate the best and newest findings into healthcare practice for lasting change. Without funding, it could take 20 years between when a new treatment is being discovered and then it's being used regularly into practice. We know this from other conditions, and we know it about Cerebral Palsy. People with cerebral palsy have already been waiting too long for a meaningful improvement in their treatments and their quality of care.

It's important to know that researchers are starting to design new interventions for cerebral palsy. Some of these starting within months of a baby's birth. And these interventions will change how an adult with CP will use their hands, walk, talk, see, hear, and have a fighting chance to make their own difference in the world.

It's been very difficult as an adult with the most common, lifelong physical disability of all to understand why there hasn't been more federal research support, and frankly interest, that would lead to better treatments, standards of care and understanding of cerebral palsy across the lifespan. Why has this condition been so overlooked when it comes to research and healthcare innovation? Now that I'm an adult, I've discovered another obstacle. There are very few doctors who understand adults with cerebral palsy, and they do not have protocols in place to treat our issues and special considerations. In fact, many adults with cerebral palsy resort to seeking care at children's hospitals, if at all.

CEREBRAL PALSY FOUNDATION
DISCOVERY FOR DISABILITY

Currently, there are very few research studies or clinical trials for adults with cerebral palsy. This needs to change.

Mr. Chairman, Ranking Member DeLauro, thank you and the Subcommittee, for your leadership in supporting the CDC's research into birth defects and developmental disabilities and for allowing me to testify today. We also thank the Committee for your ongoing support of NIH research into brain development and injury.

I hope to see in my lifetime, more research treatments and better quality of life for people with cerebral palsy. I don't want another generation of children to unnecessarily have to go through late diagnosis, delayed treatment, and an uncertain future. All because basic research isn't being funded and conducted, and too few doctors are familiar with cerebral palsy. On behalf of the Cerebral Palsy Foundation and the cerebral palsy community, I respectfully ask you to dedicate funding for cerebral palsy research. Your support will improve more than 1,000,000 American lives. Thank you for your support and attention to this urgent public health issue.

Cynthia Frisina and I would be happy to provide any additional information and answer any questions. Please email Cynthia.Frisina@yourcpf.org.

CDC Funded Disorders	U.S. Population	FY 2022 CDC Budget
Autism/ASD	1 in 44	$23,100,000
Fetal Alcohol Syndrome	1 in 1,000	$11,000,000
Hemophilia	1 in 5,000 males	$8,600,000
Spina Bifida	1 in 2,500	$7,500,000
Congenital Heart	40,000 babies each year	$7,250,000
Cooley's Anemia	Fewer than 1,000 cases	$2,100,000
Fragile X	1 in 11,000 females	$2,000,000
Cerebral Palsy	**1 in 345 children**	**$0**

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Ms. DELAURO. Thank you.

Mr. ADERHOLT. Thank you very much. We appreciate your testimony here today, and thank you for the work that you do. And we look forward to how we can work with you and with the Cerebral Palsy Foundation.

And again, we appreciate your testimony, and all the best. Thank you.

[Discussion off the record.]

Mr. ADERHOLT. All right. Next I would like to recognize the ranking member for introducing our next guest.

Ms. DELAURO. Well, isn't this a pleasure, Jared? Listen, just really a very, very warm welcome.

If I might say just to the two prior, I want to say thank you because we won't have time for questions with everybody. But thank you for the courage of speaking up on various issues like cerebral palsy and really the plea for what we do for community colleges, what we do for Pell, what we do for giving people opportunity.

But it doesn't go unheard. It doesn't go unnoticed about what we should do, and thank you for letting us know that there is zero research for CP.

But I want to, as I say, a very, very warm welcome to a former staffer. But Jared was on the Appropriations Committee and a fount of knowledge on all issues that deal with education, et cetera, and it was my honor to be able to work with him when he served with us.

I became chair of the committee in 2019. He joined the subcommittee staff. He handled all of the higher education portfolio, as well as job training, employment services, those efforts under the Department of Labor. And during his time on the subcommittee staff, he helped to pass three omnibus appropriations bills, five emergency supplementals to respond to COVID in 2020, as well as the American Rescue Plan in 2021.

He moved in 2021 to the Center for American Progress to become the Senior Director for Higher Education. And prior to his time on Labor-HHS Subcommittee, he served as senior policy adviser at the Department of Education. He was the lead higher education staffer on the House Committee on Education and Workforce.

Earned a law degree at Temple University, master's from the University of Delaware.

Welcome back, my dear friend. And this is, I think, your first time on the other side of the dais. So it is great to see you, and you know that you are always welcome in this committee.

Thank you, Jared.

Mr. ADERHOLT. Thank you.

Please, we would love to hear your testimony, and thank you again for being here.

THURSDAY, MARCH 23, 2023.

CENTER FOR AMERICAN PROGRESS

WITNESS

JARED C. BASS, SENIOR DIRECTOR FOR HIGHER EDUCATION, CENTER FOR AMERICAN PROGRESS

Mr. BASS. Thank you. Mr. Chairman, Ranking Member DeLauro, and other members of the subcommittee, it is my pleasure to testify before you today about the needs for student aid administration funding for the Department of Education.

And Ranking Member DeLauro, thank you so much for that introduction.

Each year, the Department of Education processes millions of Federal financial aid applications, providing families with access to billions in Federal financial assistance. These crucial Government services provide access to billions in Federal financial assistance, and these crucial Government services provide educational economic opportunities for students throughout the United States, both Democrat and Republican alike.

Through these programs, we train presidents and politicians, CEOs and small business owners, scientists and engineers, school teachers, medical professionals, and much more. Many of us in this room would not be where we are today without these services, myself included.

The student aid administration account is crucial to the operation of these services, and when funding for this account is limited, so, too, are the services that rely on it. For this reason, I ask that the Labor-H Subcommittee consider the following.

First, provide additional resources to support the operation of the Federal financial aid programs. Second, change how funding is appropriated for the account, including dedicated funding for program integrity activities. And third, consider using supplemental appropriations or CR anomalies.

For fiscal year 2024, the Department of Education is requesting $2,650,000,000, an increase of nearly $620,000,000 over fiscal year 2023. The Department needs these additional resources to meet pressing demands. After a 3-year student loan payment pause, borrowers will be returning to repayment later this year. In addition, the Department is on the verge of modifying the existing student loan servicing environment in meaningful ways.

Resources are also vital to the implementation of the FUTURE Act and the FAFSA Simplification Act, key pieces of bipartisan legislation that will fundamentally change the operation of the Federal financial aid programs and require modernizing legacy systems at the Department.

While student aid administration fund has been leveled before, the Department was not faced with the same set of circumstances. If this account does not receive adequate funding, the consequences could be dire. Already, the Department will miss an October 1 target for the release of the FAFSA this year, and it is not clear what other delays might be in store.

To overcome any remaining political obstacles associated with this account this year, the committee could include set-asides for specific functions and operations. For example, below the top line, the subcommittee can include funding specifically for IT modernization, student loan servicing improvements, and other services. Set-asides are used throughout the Labor-H bill, and this new change would help the Department prioritize how funding within the account should be used.

In addition, the committee should prioritize funding for activities that will reduce costs, which is one of the main functions of the Office for Federal Student Aid. For example, dedicated funding for program integrity activities helps weed out fraud, waste, and abuse within Government programs.

For that reason, Congress provides dedicated funding and a cap adjustment for program integrity activities under Social Security Administration in the Labor-H bill. This dedicated funding will produce net savings of $41,000,000,000 over 10 years for SSA.

Given the contractual complexity of FSA's work, it may be helpful to consider making advance appropriations for this account as well. This way, the Department will have advance notice of what resources may be available for the upcoming year. Advance funding may also help to overcome political challenges associated with this account.

Lastly, the committee should consider other vehicles for funding student aid administration. Even if additional funding is provided in fiscal year 2024, those funds may come too late and may not help the Department meet pressing demands. Therefore, the committee should strongly consider using any supplemental appropriations opportunities that may arise this year to provide necessary funding for student aid administration.

The committee should also consider including an anomaly for student aid administration funding if any continuing resolutions arise later this year as well. Anomalies have been provided for student aid administration before. For example, when mandatory funding for student aid administration was set to expire, the Appropriations Committee stepped in to ensure that adequate discretionary funding was provided under both short-term and full-year continuing resolutions. This critical funding ensured that students and their families could still apply for and receive Pell Grants, loans, and other forms of assistance.

We are in a defining moment for higher education. And while the challenges confronting the Federal student aid programs and their administration may seem insurmountable, there is no other committee better suited to addressing these challenges than the Labor-H Subcommittee. From personal experience, I know that the Appropriations Committee will and can ensure that this moment defines the American higher education system for the better, not the worse.

I look forward to working with the Appropriations Committee to ensure that the integrity of the Federal student aid programs is preserved.

Thank you.

[The information follows:]

CAP

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FY 2024 Public Witness Hearing Testimony

Jared C. Bass, Esq.
Senior Director, Higher Education
Center for American Progress

Mr. Chairman, Ranking Member DeLauro, and other Members of the subcommittee, it is my pleasure to testify before you today about Student Aid Administration funding for the Department of Education.

Each year, the Department of Education processes millions of federal financial aid applications, providing families with access to billions in federal financial assistance. For fiscal year 2022, the Department processed 17 million applications and provided approximately $111.6 billion in federal student aid.[1] In addition, the Department manages nearly $1.6 trillion in outstanding federal student loan debt for more than 43 million Americans.[2]

These crucial government services provide educational and economic opportunities for students throughout the United States–both Democrat and Republican alike. Through these programs, we train presidents and politicians, CEOs and small business owners, scientists and engineers, school teachers, medical professionals, and much more. Many of us in this room would not be where we are today without these services–myself included.

The Student Aid Administration account is crucial to the operation of these services. And when funding for this account is limited, so too are the services and opportunities that depend on it. For this reason, I ask that the Labor-H subcommittee consider the following:

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[1] U.S. Department of Education, Office of Federal Student Aid, "Fiscal Year 2022 Annual Report," (Washington, D.C.: 2022), available at https://fsaconferences.ed.gov/conferences/library/2022/annualreport/FY2022FSAAnnualReport.pdf.

[2] U.S. Department of Education, Office of Federal Student Aid, "Federal Student Aid Portfolio Summary," (Washington, D.C.), available at https://studentaid.gov/sites/default/files/fsawg/datacenter/library/PortfolioSummary.xls (last accessed March 2023).

1. Provide additional resources to support the operation of the federal financial aid programs;
2. Change how funding is appropriated for the account, including dedicated funding for program integrity activities;
3. Consider using supplemental appropriations or CR anomalies for funding prior to the enactment of the fiscal year 2024 Labor-H bill.

1. Provide additional resources to support the operation of the federal financial aid

For fiscal year 2023, Student Aid Administration received level funding. For fiscal year 2024, the Department of Education is requesting $2.65 billion, an increase of $620.1 million over last year. The Department needs these additional resources to meet pressing demands.

After a three-year student loan payment pause, borrowers will be returning to repayment later this year. This will be a major undertaking for the Department, requiring planning and widespread communication with borrowers, student loan servicers, and other stakeholders. In addition, the Department is on the verge of modifying the existing student loan servicing environment in meaningful ways. This new era, known as the Unified Servicing and Data Solution (USDS), has the potential to improve the quality of student loan servicing. Resources are also vital for the implementation of the FUTURE Act and the FAFSA Simplification Act– key pieces of bipartisan legislation that will fundamentally change the operation of the federal financial aid programs and require modernizing legacy systems at the Department.

While Student Aid Administration has been level funded before, the Department was not faced with the same set of circumstances. If this account does not receive adequate funding, the

consequences could be dire. Already, the Department seems likely to miss an October 1 target for the release of the FAFSA this year,[3] and it is not clear what other delays might be in store.

2. Change how funding for Student Aid Administration is appropriated

Currently, the Labor-H bill provides a lump sum appropriation for Student Aid Administration with little direction on how funding should be used for various activities. To overcome any remaining political obstacles associated with this account, the Committee could include set-asides for specific functions and operations and then make necessary increases. For example, below the topline, the subcommittee could include funding specifically for IT modernization, student loan servicing improvements, contracts, services, and salaries and expenses. Set-asides are used throughout the Labor-H bill; and while the Committee already provides some guidance to the Department in the funding tables that accompany the Labor-H bill (breaking-out activities by "salaries and expenses" and "servicing activities") this new change would provide further specificity in the text of the bill and help the Department prioritize how funding within the account should be used.

In addition, the Committee should prioritize funding for activities that will reduce costs– one of the main functions of the office for Federal Student Aid.[4] For example, dedicated funding for program integrity activities helps weed out fraud, waste, and abuse within government programs. For that reason, Congress provides dedicated funding and a cap adjustment for program integrity activities under "Social Security Administration" (SSA) in the Labor-H bill.

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[3] Danielle Douglas-Gabriel, "Education Dept. May Miss Oct. 1 Deadline for Redesigned FAFSA Form," *The Washington Post*, February 7, 2023, available at https://www.washingtonpost.com/education/2023/02/07/fafsa-redesigned-application-october-deadline/.

[4] Legal Information Institute, "20 U.S. Code § 1018 - Performance-Based Organization for delivery of Federal student financial assistance," available at https://www.law.cornell.edu/uscode/text/20/1018#:~:text=There%20is%20established%20in%20the%20Department%20a%20Performance-Based,of%20this%20chapter%2C%20as%20specified%20in%20subsection%20%28b%29 (last accessed March 2023).

According to the SSA's FY24 Congressional Justification, this dedicated funding will produce net savings of $41 billion over 10 years.[5] While the Department already uses some Student Aid Administration funding for oversight activities, given the size and scope of the programs it administers, more could be done to reduce costs.

The Labor-H bill also carries a cap adjustment for reemployment services in Title I. These services help unemployment compensation claimants get back on their feet in a timely manner. In its Congressional Justification for this year, the Department of Labor estimates that "the 10-year net savings for the program are $1.022 billion."[6]

Similar services could be provided to help struggling student loan borrowers get back on their feet, especially those who qualify for $0 monthly loan payments. This could come in the form of career or job placement services or through partnership with the Department of Labor. Funding could also be used to provide better oversight of the schools that saddle borrowers with debt without adequate job prospects to repay their loans. These activities could reduce costs for the federal financial aid programs.

With regard to set-asides, it's possible that the Department may need more funding in one set-aside area over another after the Labor-H bill is enacted. Under this new model, the Department would still retain reprogramming authority to make necessary adjustments. And the reprogramming notice requirement included in the Labor-H bill would ensure full transparency and oversight by the Appropriations Committee. Such notices would also provide the Committee with more clarity as to how funds are being used in real-time.

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[5]Social Security Administration, "Limitation on Administrative Expenses," (Washington, D.C.), available at https://www.ssa.gov/budget/assets/materials/2024/2024LAE.pdf (last accessed March 2023).
[6] U.S. Department of Labor, "State Unemployment Insurance and Employment Service Operations," (Washington, D.C.), available at https://www.dol.gov/sites/dolgov/files/general/budget/2023/CBJ-2023-V1-07.pdf (last accessed March 2023).

Given the contractual complexity of FSA's work–such as procurements for various services and functions–it may be helpful to consider making advance appropriations for this account as well. This way, the Department will have advance notice of what resources may be available for the upcoming fiscal year. Advance funding may also help to overcome political challenges associated with this account. This is one of the major reasons the Corporation for Public Broadcasting account includes a two-year advance appropriation–although a one-year advance may be more appropriate for this account and is quite common across the Labor-H bill.

3. Consider using supplemental appropriations or CR anomalies

Lastly, the Committee should consider other vehicles for funding Student Aid Administration. Even if additional funding is provided in FY24, those funds may come too late and may not help the Department meet pressing demands. Therefore, the Committee should strongly consider using any supplemental appropriation opportunities that may arise this year to provide necessary funding for Student Aid Administration. The Committee should also consider including an anomaly for Student Aid Administration funding if any continuing resolutions arise later this year as well. Anomalies have been provided for Student Aid Administration before. For example, when mandatory funding for Student Aid Administration was set to expire, the Appropriations Committee ensured that adequate discretionary funding was provided under both short-term and full-year continuing resolutions. This critical funding ensured that the students and their families could still apply for and receive Pell grants, loans, and other forms of assistance.

Conclusion

We are in a defining moment for higher education. And while the challenges confronting the federal student aid programs and their administration may seem intractable, there is no other committee better suited to addressing these challenges than the Labor-H subcommittee. From experience, I know that the Appropriations Committee will ensure that this moment defines the American higher education system for the better, not the worse.

I look forward to working with the Appropriations Committee to ensure that the integrity of the federal financial aid programs is preserved. Thank you.

Mr. ADERHOLT. Thank you, Mr. Bass, for your testimony.

And certainly, we understand the importance of higher education and funding. So we want to do what we can. So we look forward to working with you.

Thanks so much.

Mr. BASS. Thank you.

Mr. ADERHOLT. At this time, I would like to recognize our member from the great State of Kansas, Mr. LaTurner, for an introduction.

Mr. LATURNER. Thank you, Mr. Chairman. I appreciate it.

Good morning, Katie. So glad you are here today.

I am pleased to introduce Katie Hoff. She is an eight-time world champion, three-time world record holder, current American record holder, and two-time Olympian, competing in both Athens and Beijing, where she earned three Olympic medals in swimming. She has also twice won the United States Olympic Committee honor of Sportsman of the Year.

Hailed as "the female Michael Phelps," she withstood tremendous pressure and emerged after years of hard work with valuable lessons learned on what it takes to succeed and power through bitter disappointment.

In 2014, Katie's career took a turn while she was making a comeback for the 2016 Rio Olympic games. Katie was diagnosed with a pulmonary embolism in her right lung, a diagnosis that ended her career. Since then, Katie has dedicated herself to advocacy with the National Blood Clot Alliance.

In addition to her advocacy work, she is a best-selling author and an entrepreneur who works with aspiring young athletes all over the world.

Katie, thank you for being here with us this morning, and I look forward to your testimony.

Mr. ADERHOLT. Welcome, Ms. Anderson, and we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

NATIONAL BLOOD CLOT ALLIANCE

WITNESS

KATIE HOFF ANDERSON, OLYMPIC MEDALIST AND PULMONARY EMBOLISM SURVIVOR, NATIONAL BLOOD CLOT ALLIANCE

Ms. ANDERSON. Chair Aderholt and Ranking Member DeLauro, thank you so much for holding this hearing and for the opportunity to ask Congress to provide $5,000,000 in funding to the Centers for Disease Control and Prevention to improve awareness and education——

Oh. I will start over.

Chair Aderholt and Ranking Member DeLauro, thank you for holding this hearing and for the opportunity to ask Congress to provide $5,000,000 in funding to the Centers for Disease Control and Prevention to improve awareness and education among the general public and healthcare professionals about life-threatening blood clots.

My name is Katie Hoff. I am a two-time Olympian, three-time Olympic finalist, eight-time world champion, and pulmonary embolism survivor.

Swimming was my whole life. But I didn't get to end my career on my own terms. While training for my comeback for the 2016 Rio Olympic Games, I began to feel tightness in my chest. The tightness progressed to a severe pain in my right rib, which felt like a Samurai sword in my ribs. Even laying on my back and sleeping was super painful, but I continued to push through the pain because my doctors were unable to identify any serious medical condition.

Like many Americans, I had no idea what a pulmonary embolism even was. Actually, only about 6 percent of Americans know what a blood clot is, and this lack of awareness among patients and healthcare providers leads to preventable deaths.

There are two types of blood clots, pulmonary embolism, or PE, and deep vein thrombosis, known as DVT. Every year, 1 million Americans will develop blood clots, and more than 100,000 people die from them. Blood clots can affect anyone, regardless of age, ethnicity, race, or level of physical fitness.

It took 7 weeks for doctors to diagnose me with a pulmonary embolism. During that time, I continued to jump in the pool, unaware that I was in a life-or-death situation. I sought help from a variety of healthcare professionals, trying out every single remedy made available to me. I was desperate for answers because this undiagnosed condition affected my ability to race and engage in my life's passion and livelihood.

Looking back, I can now identify some of the early onset signs. However, most Americans lack the knowledge to recognize these signs and advocate for themselves. In the time that I was seeking diagnosis, I felt like I was going crazy. Doctors thought I was fine because I was a young, seemingly healthy athlete.

The mental toll of suffering from a blood clot is something that has actually continued to affect my life. To this day, I experience a trigger response when I get super out of breath, and I have an emotional breakdown and start crying. My husband also carries the burden of constantly looking for small signs that might be an indicator of a new blood clot.

Even after my diagnosis, I felt isolated because I barely knew anyone who had suffered a clot or anyone who had bounced back from a clot, something that I was unable to do. I honestly felt like a freak.

Sharing stories and being able to talk to fellow survivors is so important to helping people move through the experience of having a blood clot. If patients and healthcare providers have a better understanding about blood clots, the next person like me who suffers from one won't have to suffer alone. Not only will patients be able to advocate for themselves, but so will their loved ones.

Raising awareness is key to prevention, diagnosis, and treatment. I truly believe that my condition would not have been as serious if I and my healthcare providers had the knowledge about blood clots to diagnose me earlier.

In 2017, I joined the National Blood Clot Alliance, a patient-led health advocacy organization, as an ambassador, hoping that by

sharing my story, I could raise awareness about the signs, symptoms, and treatment options for blood clots. The NBCA works closely with the CDC and receives funding to create programs designed to build awareness and educate both the public and healthcare providers about the risks of blood clots.

Despite the significant toll of blood clots on patients and the healthcare system—an estimated $10,000,000,000—the Federal Government allocates few resources to the issue. It is for this reason that I urge Congress to direct CDC to provide $5,000,000 in funding to its public health approach to blood disorders and to budget and develop a comprehensive nationwide blood clot education and awareness campaign for the public and support for education and training on the signs and symptoms of blood clots for healthcare professionals.

My life changed overnight when I developed a blood clot, and if I had the knowledge that I do now about blood clots, I could have spared myself weeks of agony as I chased a diagnosis. I appreciate your leadership and commitment to prevent deaths due to blood clots by providing dedicated funding.

Thank you.

[The information follows:]

Testimony by Katie Hoff, Former Olympic Swimmer & Ambassador for the Sports & Wellness Institute, National Blood Clot Alliance (NBCA)
U.S. House of Representatives Labor-HHS Appropriations Subcommittee
Public Witness Hearing
March 23, 2023

Chair Aderholt and Ranking Member DeLauro, thank you for holding this hearing, and for the opportunity to ask that Congress provide $5 million in funding to the Centers for Disease Control and Prevention (CDC) improve awareness and education among the general public and health care professionals about life-threatening blood clots. My name is Katie Hoff, and I am a two time Olympian, three-time Olympic medalist, eight-time world champion swimmer, and a pulmonary embolism survivor.

Swimming was my whole life, but I didn't get to end my career on my own terms. While training for my comeback for the 2016 Olympic Games in Rio, I began to feel a tightness in my chest. The tightness progressed to severe pain that felt like someone was stabbing me in the ribs with a samurai sword. Even laying on my back and sleeping was painful, but I continued to push through the pain because my doctors were unable to identify any serious medical condition.

Like many Americans, I didn't even know what a pulmonary embolism was. Only 6 percent of Americans know what a blood clot is, and this lack of awareness among patients and health care providers leads to preventable deaths. There are two types of blood clot, Pulmonary Embolism or PE, and Deep Vein Thrombosis known as DVT. Each year, 1 million Americans will develop blood clots, and more than 100,000 people will die from them. Blood clots can affect anyone, regardless of age, ethnicity, race, or level of physical fitness.

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variety of health care professionals, trying out every remedy made available to me. I was desperate for answers because this undiagnosed condition affected my ability to race and to engage in my life's passion.

Looking back, I can now identify some of the early onset signs; however, most Americans lack the knowledge to recognize these signs and advocate for themselves. In the time that I was seeking a diagnosis, I felt like I was going crazy. Doctors thought that I was fine because I was a young, seemingly healthy, athlete.

The mental toll of suffering from a blood clot is something that has continued to affect my life. To this day, I experience a trigger response when I get out of breath and start crying. My husband also carries the burden of constantly looking out for small signs that might be an indicator of a new blood clot. Even after my diagnosis, I felt isolated because I barely knew of anyone who had suffered a blood clot, and those who had seemed to have bounced back, something I was unable to do. I felt like a freak. Sharing stories and being able to talk to fellow survivors is so important to helping people move through the experience of having a blood clot.

If patients and health care providers have a better understanding about blood clots, then the next person like me who suffers from one won't have to suffer alone. Not only will patients be able to advocate for themselves, but so will their loved ones. Raising awareness is key to prevention, diagnosis, and treatment. I truly believe that my condition would not have been as serious if I and my care providers had the knowledge about blood clots to diagnose me earlier.

In 2017, I joined the National Blood Clot Alliance, a patient-led, health advocacy organization, as an ambassador, hoping that by sharing my story I could raise awareness about the signs, symptoms, and treatment options available for blood clots. The NBCA works closely with the

CDC and receives funding to create programs designed to build awareness and educate both the public and health care providers about the risks of blood clots.

Despite the significant toll of blood clots on patients and the health care system – an estimated $10 billion – the federal government allocates few resources to the issue. It is for this reason, that I urge Congress to direct CDC to provide $5 million in its Public Health Approach to Blood Disorders budget to develop a comprehensive, nationwide blood clot education and awareness campaign for the public and support education and training on the signs and symptoms of blood clots for health care professionals.

My life changed overnight when I developed a blood clot, and if I had the knowledge that I do now about blood clots, I could have spared myself weeks of agony as I chased a diagnosis. I appreciate your leadership and commitment to prevent deaths due to blood clots by providing dedicated funding.

Mr. HOYER. Mr. Chairman.

Mr. ADERHOLT. Yes.

Mr. HOYER. From now on, I am going to refer to Michael Phelps as "the female Katie Hoff." [Laughter.] [Applause.]

Mr. ADERHOLT. Okay. Thank you. Well said.

Thank you for being here, and we appreciate your testimony and learning about blood clots. And we look forward to trying to work with you and helping make a cure for that.

So next I would like to recognize Amanda Peel Crowley, and she is, of course, a passionate advocate, but also she is representing PANDAS.

And so I am going to let you describe PANDAS a little more because it is a mouthful. So we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

NATIONAL ALLIANCE FOR PANS/PANDAS ACTION (NAPPA)

WITNESS

AMANDA PEEL CROWLEY, FOUNDING MEMBER, NATIONAL ALLIANCE FOR PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME AND PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCUS

Ms. CROWLEY. Mr. Chairman, it is an honor to appear before the committee today on behalf of NAPPA, the National Alliance for PANS/PANDAS Action.

I am grateful to be able to give a voice here on Capitol Hill to families across the country who have had their lives turned upside down by these terrible illnesses.

We are asking you to provide $5,000,000 in your fiscal 2024 report under the Department of Health and Human Services for childhood post-infectious neuroimmune disorders. These include PANS and PANDAS, conditions where an infection causes the immune system to "go rogue," leading to inflammation and life-altering effects on the brain. The time is now to help parents like us who have watched helplessly for months, sometimes years, as our children lose everything that they once loved.

Imagine for a moment that your happy, playful, 7-year-old boy goes to bed one night and wakes up a completely different child, terrified to be alone, unable to leave his room, and exploding into uncontrollable rages. He writhes in pain on the floor, sometimes for hours, and pleads with you to make it stop. Normal life becomes a nightmare. Leaving the house is so traumatic that he can't attend school or play with friends.

As you desperately seek help over the next few weeks, the pediatrician refers you for a psychiatric evaluation, but the medications prescribed only seem to escalate symptoms. Agonizing months pass as your child cries and tells you he wants to die and attempts to jump off a third-floor balcony.

Now imagine finding out the cause of this unbearable crisis. You meet with a new provider who asks, "Has he been checked for infection?" After tests are run, you discover that these months of devastating symptoms were actually the result of strep throat.

Yes, you heard that correctly. Strep throat and other common infections, including flu and now COVID–19, can lead to behavioral and neurological symptoms that leave a child unrecognizable and destroy families' lives in the process.

PANS and PANDAS are neuroimmune conditions that develop after infection. With the right screening and diagnostic tools, they are highly treatable. But sadly, many children and adolescents are missed. Undiagnosed and untreated kids can lose critical years of learning, and they are especially vulnerable to chronic mental illness and disability that can follow them into adulthood.

When young people are diagnosed with PANS or PANDAS, they often still face lack of access to care. Families have to travel out of State to find providers, pay out of pocket for treatment, and find specialized schools for their children. The social, emotional, and financial costs to families are enormous.

Dedicated scientists and clinicians are working to find novel biomarkers and treatments for PANS and PANDAS, but they cannot do this groundbreaking work alone. With funding, research can change outcomes for young people, something our patient community desperately needs.

I have heard hundreds of heartbreaking stories from families impacted by PANS and PANDAS, of children who experience physical symptoms such as debilitating joint pain and stomach issues and have even lost the ability to walk. Teens with frightening compulsions who pull out every hair on their heads.

Children with such an irrational fear of food that they become severely anorexic and have to be placed on feeding tubes. Adolescents who are wracked with impulsive feelings and thoughts of self-harm, and the unimaginable has happened. They have lost their lives.

I share the next difficult story on behalf of one of NAPPA's founding members. Her daughter Louisa thrived academically and socially. She was a straight A student who aspired to become a doctor. The day that Louisa became ill was her last day at school, and she suffered horrific symptoms for 2 ½ years.

Louisa's severe illness could have been treated far more easily had her original strep infection and OCD symptoms been recognized. Tragically, Louisa lost her battle with PANDAS at age 13.

Her parents want young people to have access to early diagnosis and treatment. They donated Louisa's brain to a PANS and PANDAS research center at Georgetown University, and they have fought tirelessly to share the message that training the medical community, increasing vital research, and ensuring that all young people are routinely screened for PANS and PANDAS will save lives.

My son Will is advocating with me today. We are here to ask for your help. Let us show Will how Congress can take action and partner with us, work with NIH, and be a force for change to finally make progress on PANS and PANDAS research. America's youth deserve the best that our healthcare system has to offer, not a lifetime of pain and symptom management.

A funding commitment from Congress will help PANS and PANDAS families achieve a dream that we know is in reach—a healthy, happy future for all.

Thank you.
[The information follows:]

STATEMENT ON CHILDHOOD POST-INFECTIOUS NEUROIMMUNE DISORDERS

AMANDA PEEL CROWLEY
FOUNDING MEMBER
NATIONAL ALLIANCE FOR PANS/PANDAS ACTION (NAPPA)

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

MARCH 23, 2023

Mr. Chairman,

It is an honor to provide testimony to the Subcommittee on behalf 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). PANS and PANDAS are Childhood Post-Infectious Neuroimmune Disorders (CPINDs). We are requesting support for report language with $5,000,000 in program funding through the Department of Health and Human Services for PANS and PANDAS in the fiscal year 2024 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. This has brought attention to PANS and PANDAS, helping to stimulate the award of a few research grants. 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, or NAPPA, and co-founder of the Mending Minds Foundation. I started these organizations with other parent advocates to drive much-needed

research and awareness and, in the past five years, I have met hundreds of families impacted by these horrific illnesses.

I would like to share several devastating stories that are all too common for families affected by PANS/PANDAS.

Imagine that your happy, playful seven-year-old boy goes to bed one night and wakes up a completely different child, terrified to be alone, unable to leave his room, and exploding into uncontrollable rages. He writhes in pain on the floor, sometimes for hours, and pleads with you to "make it stop!" Normal life becomes a nightmare. Leaving the house is so traumatic that he cannot attend school or play with friends. As you desperately seek help over the next few weeks, the pediatrician refers you to mental health services and a psychiatric evaluation, but the medications prescribed for anxiety and agitation only seem to escalate his symptoms. Agonizing months pass as he cries and tells you he wants to die and attempts to jump off a third floor balcony.

Now imagine finding out the cause of this unbearable and sustained crisis. You meet with a new provider who asks if he has been checked for infection. After tests are run, you discover that these months of horrific symptoms were actually the result of strep throat. Yes, that is correct: strep throat and other common infections including flu, and now Covid-19, can lead to behavioral and neurological symptoms that leave a child unrecognizable and destroy families' lives in the process.

NAPPA and the many families across the US impacted by PANS/PANDAS urge Congress to help. NIH must take action to further study how to identify and treat PANS and PANDAS, conditions where the immune system "goes rogue" and sets off a devastating post-

infectious inflammatory process. The time is now to help parents like us who have watched helplessly for months, sometimes years, as our children lose everything they once loved.

PANDAS, a neuropsychiatric disorder associated with streptococcus, is similar to rheumatic fever in that it can develop if strep infections are not treated quickly or adequately. The infection-fighting immune system becomes misguided, instead attacking normal cells in the body. PANS is an umbrella term for a neuropsychiatric syndrome that follows any infection, including flu, pneumonia, and Covid-19. If identified early, PANS and PANDAS are treatable with immune modulating therapies and anti-inflammatories. With the right screening and diagnostic tools, children can respond to treatment quickly.

But sadly, many children are missed. In PANS and PANDAS, mood and behavior changes are so prominent that they often overshadow debilitating physical and neurological symptoms. For these young people, ruling out a medical condition as the cause of psychiatric symptoms is especially critical. Undiagnosed and untreated kids lose months or years of learning and critical stages of development. They are especially vulnerable to chronic mental illness and disability that can follow them into adulthood. Psychiatric hospitals do not currently test for or treat medical illnesses, so children can remain in limbo without care appropriate for their condition, resulting in further deterioration. In contrast, when the underlying process is recognized and treated, they can better respond to all therapies, medical and psychological.

I have heard hundreds of tragic stories from families impacted by PANS and PANDAS, of children who experience neurological symptoms such as loss of the ability to walk and bedwetting, physical symptoms such as debilitating joint pain and gastrointestinal issues, and agonizing compulsions like pulling out every hair on their head. Some children have such an irrational fear of eating food and contamination that they become severely anorexic and have to

be placed on feeding tubes. Families often have to travel out of state to find providers, pay out of pocket for treatments, and find specialized schools for their children. The social, emotional, and financial costs for families are enormous.

There is one story that is very difficult to tell, but that lawmakers need to hear to truly comprehend the horrors of these illnesses and understand that lives are on the line.

Louisa thrived academically and socially until age 11 when her life deteriorated abruptly and severely overnight. Prior to her dramatic and horrific onset of PANDAS, she was 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, and she suffered terribly for two and a half years until her untimely death. Upon Louisa's initial hospitalization at a major children's hospital, her strep infection and OCD symptoms went unrecognized for weeks; until she was finally swabbed for strep after discharge by her pediatrician.

As a result, Louisa developed a severe and complex case of PANDAS. She was later hospitalized multiple times and developed other conditions triggered by her initial strep infection. She suffered from extreme mood swings and aggression. For over a year, she had terrible insomnia with an inverted sleep cycle. Her night-time waking hours were spent on obsessive and compulsive disorder rituals accompanied by intrusive fears. She sometimes did not sleep for days. Louisa's severe illness could have been treated far more easily had her original strep infection and OCD symptoms been recognized.

Her parents want young people to have access to early diagnosis and treatment. They donated Louisa's brain to Georgetown University's PANS/PANDAS and Other Neuroimmune Disorders (POND) brain bank. With the support of NAPPA, they have fought tirelessly to share

the message that educating and training the medical community, increasing vital research, and ensuring that all children are routinely screened for PANS and PANDAS will save lives.

We are at a critical point in history. We are in the midst of a staggering youth mental health crisis that has worsened since the pandemic began. Suicide is a leading cause of death in young people beginning at age ten. Children and adolescents with PANS and PANDAS are especially at risk due to their high degree of impulsivity and intrusive thoughts of self-harm. Many young people have lost their lives from PANS and PANDAS as a result of impulsive acts.

Research has shown the indisputable link between infections and neuropsychiatric symptoms in susceptible individuals. Recent major breakthroughs have transformed our understanding of the effects of infection on the body and brain by showing that a segment of people with psychiatric symptoms have an underlying infectious, immune, and/or inflammatory process. Ruling out medical conditions and identifying highly treatable illnesses such as PANS and PANDAS can change and even save lives. Across the US, dedicated scientists and clinicians are doing groundbreaking work to find biomarkers and new treatments, but they need your support.

A $5 million commitment from Congress and NIH to dedicate funding to PANS and PANDAS will contribute to a paradigm shift in research, medicine, and mental health care. 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 a dream that we know is in reach—a healthy, happy future for all.

Mr. ADERHOLT. Thank you for your testimony and for sharing with this subcommittee a little bit about some of the issues that this is very devastating.

And thank you for bringing Will. He is a great advocate. So glad you had brought him today for us.

And so, again, we look forward to working with you and how we can be of assistance from this subcommittee. And again, thank you for your testimony.

Next I would like to recognize Mr. Kevin Longino, CEO of the National Kidney Foundation.

Mr. Longino, we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

NATIONAL KIDNEY FOUNDATION

WITNESS

KEVIN LONGINO, CHIEF EXECUTIVE OFFICER, NATIONAL KIDNEY FOUNDATION

Mr. LONGINO. Thank you, Mr. Chairman. Thank you, Congresswoman DeLauro, for allowing us to speak, for me to speak.

My name is Kevin Longino. I am the CEO of the National Kidney Foundation. I am also a kidney transplant recipient. I am one of the few that has been afforded a kidney transplant, given the long waitlist.

Thank you for the opportunity to testify about the incredible burden of kidney disease, chronic kidney disease, and the need to shift our Federal approach from one that currently pays for kidney disease to the tune of $136,000,000,000 a year to one that emphasizes kidney health.

More than 80 million adult Americans are at risk for kidney disease. A lot of the factors are diabetes, hypertension, and other risk factors. Approximately 38 million adults have chronic kidney disease, also called CKD, and an alarming 90 percent of these individuals are unaware. They have not even been diagnosed.

Many find out when it has reached more advanced stages. Often, in the worst case, they find out in an emergency room, and at that point, it is really too late to do an intervention. It is too late to slow progression. It is too late to oftentimes save the kidneys, and it is too late to even save their lives in many cases.

And the costs of kidney disease are astronomical, as I just noted. One in four Medicare dollars are spent on individuals with chronic kidney disease, a condition that usually presents with an avalanche of comorbidities—diabetes, hypertension, and the big one, cardiovascular disease.

You may be surprised to learn that 40 percent of patients with Stage 3 CKD die of cardiovascular disease before they ever get a chance to progress to kidney failure. And so for the lucky few that live long enough to experience kidney failure, dialysis is even more expensive. Patients with ESRD make up only 1 percent of Medicare beneficiaries, but they account for more than 6 percent of Medicare cost.

This amounts to over $51,000,000,000 annually. I will say that again. One percent of Medicare beneficiaries account for more than

6 percent of Medicare costs, and this is $51,000,000,000 annually. And what is equally alarming is that acknowledging that 60 percent of kidney failure is preventable.

So from a patient and a taxpayer perspective, what really makes these costs so tough to stomach is that we invest pennies in kidney-related research and prevention activities. We spend approximately $80,000 per year per patient with kidney failure, and we spend $26,000 per year treating people with CKD. But we only spend $19 per year on prevention, on research, and innovation.

Moreover, investment in kidney research at NIH has lagged behind that of other institutes. While NIH overall has received averages totaling 4.6 percent per year, funding for kidney disease has lagged at 3.3 percent. So this is bad economics, or it is bad business, or it is bad policy, no matter how you look at it.

But I wanted to share with you how things could be different if we invested just a bit more in early diagnosis, treatment, and management of CKD. In 2019, the National Kidney Foundation and CareFirst BlueCross BlueShield partnered on an effort to improve CKD diagnosis and treatment in the primary care setting. By increasing testing of at-risk patients and introducing modest interventions, such as medical nutrition therapy or increasing nephrology services, we were able to reduce ER visits, hospitalizations, and readmissions.

The SAVINGS WERE FANTASTIC. We averaged $206 per member per month, or $408 per member per month, depending on whether you were Stage 3 or Stage 5.

And thanks to a competitive grant from the CDC, and in collaboration with the National Association for Chronic Disease Directors, local Federally Qualified Health Centers, and other stakeholders, in 2022 NKA was able to further test the theory through CKD Intercept. CKD Intercept is our population health approach to transform CKD testing, prevention, diagnosis, risk stratification, management, and referral to nephrology.

While this program is still in its early stages, we have already increased CKD screening and intervention by almost 30 percent. So increased investment in these preventive activities will allow us to replicate this program in high-risk communities across the country.

So for the cost of treating 50 dialysis patients per year, we can instead invest in programs that have proven they can slow disease progression and reduce costs in thousands of patients. This low-cost investment not only yields high returns financially, but improves quality of life for countless individuals.

In closing, I would like to point out that in 2023 is the 50th year anniversary of the Medicare ESRD benefits. As we consider where we want to go over the next 50 years, I would urge Congress to invest in a future where 60 percent of kidney failure is prevented, where dialysis is necessary only in emergency cases, and where every patient that has kidney failure can access a transplant or some other advanced therapy.

To do that, we strongly urge you to preserve and increase our investment in kidney-related research at NIH, prevention at CDC, and in innovative initiatives like KidneyX.

Thank you for your thoughtful and responsible consideration of this request.

[The information follows:]

TESTIMONY OF THE NATIONAL KIDNEY FOUNDATION

KEVIN LONGINO, CEO

BEFORE THE HOUSE COMMITTEE ON APPROPRIATIONS

SUBCOMMITTEE ON LABOR, HHS, EDUCATION, AND RELATED AGENCIES

IN SUPPORT OF FY 2024 FUNDING FOR CDC AND NIDDK

March 23, 2023

I am Kevin Longino, CEO of the National Kidney Foundation (NKF). I am also a kidney transplant recipient. I appreciate the invitation to appear before the Subcommittee to highlight the significant burden that chronic kidney disease (CKD) places on patients, families and caregivers, society, and our nation's health care system.

NKF respectfully requests that the Chronic Kidney Disease Initiative at the Centers for Disease Control and Prevention (CDC) be increased to $15 million over the next five years. We further request 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. NKF appreciates the committee's past support for CKD related programs at the Centers for Disease Control and Prevention (CDC) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). These investments represent a shift in the government's strategy from one that pays for kidney disease to one that emphasizes kidney health. By investing in CKD awareness, prevention, detection, and management, we can reduce the burden of kidney disease, improve quality of life, and reduce health care spending.

Kidney disease affects 38 million adults in the U.S. and beneficiaries with a kidney disease diagnosis costs Medicare $136 billion annually. Another 80 million adults, or 1 in 3, in the U.S. are at risk for developing CKD because they have diabetes, hypertension, a family history of chronic kidney disease, or other risk factors. Unfortunately, in primary care settings, 90% of kidney disease is undiagnosed and patients receive no nephrology care prior to their kidney failure, including as many as 40% whose kidney disease is advanced (stage 4 or stage 5). By the time most kidney disease is diagnosed—at an advanced and costly stage—treatment choices are limited to transplant or dialysis.

While dialysis replaces kidney function for more than 550,000 patients, it is not a cure for kidney failure. The five-year survival rate is only 35% - half that of the survival rate for all cancers. According to the U.S. Renal Data System, patients ages 66-74 had a four-fold higher likelihood of mortality compared to individuals with cancer or stroke and a three-fold higher mortality rate compared to individuals with heart failure or a heart attack.

In addition to kidney failure, CKD contributes to and accelerates several other conditions, notably cardiovascular disease (CVD). The risk of heart failure, atrial fibrillation, stroke, and coronary heart disease is approximately double in patients with CKD, resulting in a mortality rate for Medicare beneficiaries with CKD that is twice that of beneficiaries without CKD.

Patient quality of life is also significantly affected by kidney disease. Individuals with kidney failure often experience cognitive challenges, depression, infection, dietary restrictions, anemia, fatigue, bone loss, and other factors and the hospitalization rate for Medicare kidney patients is 2.4 times higher than for Medicare beneficiaries without CKD.

The cost of kidney disease and kidney failure is astronomical. Medicare spends an estimated $136 billion annually, nearly 25% of Medicare expenditures, on the care of people with a kidney disease diagnosis. Individuals with kidney *failure* represent 1% of Medicare beneficiaries but comprise 6% 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 also characterized by stark racial, ethnic, and socioeconomic inequalities. People of African American, Hispanic, American Indian or Alaska Native, Asian American, or Native Hawaiian or Pacific Islander descent are all at increased risk for developing the disease. For example, Blacks/African American people comprise 13% of the U.S. population but represent 35% of those with kidney failure, treated with dialysis, or kidney transplantation. 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 or a deceased donor compared to White patients with kidney failure. White patients are 3 times more likely to receive a living donor kidney compared to Black patients and 1.7 times greater than that of Hispanics. In 2020, Blacks comprised 12% of living donor recipients while Whites comprised 64%.

Alarming as some of these statistics may be, there is significant hope for individuals facing a CKD diagnosis. Simple interventions can improve kidney and CVD outcomes, like medical nutrition therapy, blood pressure control, diabetes control, and common, affordable drugs such as statin-based therapies. Further, a new class of drugs, sodium-glucose co-transporter-2 (SGLT-2) inhibitors and non-steroidal Mineralocorticoid Receptor Antagonists (nsMRAs) show extraordinary efficacy at attenuating risk of dialysis and CVD, particularly heart failure in

patients with diabetes and CKD, as well as in patients with CKD without diabetes. Observational studies have shown multidisciplinary care that may include a dietitian, pharmacist and nephrologist is also associated with improved outcomes for the T2D with CKD population.

Implementing targeted therapies can significantly improve patient outcomes by slowing the progression of CKD to kidney failure and reducing risk for CVD, and death, especially for at-risk communities. Successful CKD management, however, hinges on patient access to timely awareness, diagnosis, and management.

The CDC Chronic Kidney Disease Initiative plays a critical role in assuring timely diagnosis and management of CKD. As a result of an FY 2022 increase in funding, NKF and the National Association of Chronic Disease Directors partnered on the *CKD Intercept,* an initiative to increase public awareness, educate clinical professionals, and expand health system capacity to diagnose and manage CKD in primary care settings. Implemented in partnership with local health systems, federally qualified health centers, public health departments, community organizations, and other stakeholders the program is tailored to the community's needs. While the initiative is still in its early stages, it is already demonstrating strong results, with participating partners experiencing a 28 percent increase in CDK testing.

NKF hopes to replicate and accelerate deployment of this model with partners across the country. Preserving the current funding level would allow these activities to continue in two to five states. Growing the program to serve all fifty states would require a sustained investment of approximately $15 million.

With regard to biomedical research, in 2021, NKF released a Research Roadmap that highlighted where additional funding could bridge existing deficits in CKD detection and management, reduce incidence and disparities, improve outcomes, and lower healthcare costs. Our roadmap was the culmination of input from nephrology leaders and from kidney patients, family members and caregivers, and living kidney donors.

Despite CKD's impact on patients and Medicare, NIH funding for kidney disease research is only about $700 million annually. FY 2021 funding for NIDDK increased by less than 1% and the FY 2022 increase was 3.4%. From FY 2017-2021, NIH monetary support for kidney research increased at half the rate of NIH funding overall. As a result, innovation in kidney research and treatment has lagged that of other diseases. We appreciate the 4.4% increase for NIDDK in FY 2023 and request continued increases in funding to accelerate new therapies that have the potential to provide cost savings to Medicare. We request a percentage increase for kidney research proportional to or greater than that of NIH overall.

NKF is very appreciative of the Committee's direction to NIDDK in FY2023 to prioritize research into the adoption of new equations for estimating the Glomerular Filtration Rate that do not include race as a modifier. We also recognize the Committee's encouragement for NIDDK to provide additional investments in CKD clinical trials, including diversity of participants, and to support the delivery of evidence-based care in under-represented populations.

Thank you again for the opportunity to testify and for your consideration of these important kidney disease activities in Fiscal Year 2024.

Mr. ADERHOLT. Thank you, Mr. Longino. We appreciate your testimony on behalf of the National Kidney Foundation.

And again, we look forward to working with you and how we can—this subcommittee can work to find solutions and cures for kidney disease.

So thanks so much for being here.

Mr. LONGINO. Thank you, sir.

Mr. ADERHOLT. Okay. Next our guest will be Mr. Jonathan Plucker, Professor of Education at Johns Hopkins University School of Education.

So, Mr. Plucker, we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

JOHNS HOPKINS UNIVERSITY SCHOOL OF EDUCATION

WITNESS

JONATHAN PLUCKER, PH.D., PROFESSOR OF EDUCATION, JOHNS HOPKINS UNIVERSITY SCHOOL OF EDUCATION

Dr. PLUCKER. Thank you, Mr. Chairman, Ranking Member DeLauro, and members of the subcommittee. Thank you for inviting me to participate in today's hearing, and thank you for your attention to a topic that has been the focus of my professional career for over 30 years, developing children's talents and advanced skills.

Today, I am specifically speaking to the need to increase funding available to the Jacob K. Javits Gifted and Talented Students Education Program.

My name is Jonathan Plucker. I am a professor at Johns Hopkins School of Education. I am also immediate past president of the National Association for Gifted Children. I would like to state for the record that the opinions expressed here are my own and do not necessarily reflect the views of the Johns Hopkins University and NAGC.

Academic excellence and talent development have strong relationships to economic and cultural growth. Yet ample evidence suggests that U.S. students achieve at advanced levels at significantly lower rates than students in other countries. Regardless of the content area, the percent of students who score in the advanced range tends to be below that of students in economically competitive countries.

For example, in one study, there is evidence that our highest-performing fourth grade students underperform those in South Korea, Japan, England, Taiwan, Australia, and Turkey and perform at the same level as students in Russia in math. Results are similar for eighth grade math. Science performance tends to be better but is middle of the pack among major economic powers.

One reason for this poor performance at advanced levels is the presence of large and growing excellence gaps. These gaps are differences in advanced performance associated with student race, gender, and class. For example, in fourth grade reading, only 3 percent of low-income students score advanced compared to 14 percent of higher-income students.

Studies strongly suggest that much of the excellence gap is caused by students' lack of opportunity for advanced learning. Of

special concern are bright students in both cities and small towns and also talented students with learning challenges whom are often described as being "twice exceptional."

A study reported just last week that students in small towns have among the lowest participation rates for advanced learning opportunities. When students are provided with these opportunities, they thrive. But far too many do not get them.

There is bipartisan concern about these problems, and educators are tackling them across the country. The issue is not a lack of desire to improve advanced outcomes for students. Rather, the issue is lack of resources and inadequate dissemination of strategies for achieving those outcomes.

The Javits Act remains the Federal Government's primary program to promote educational excellence and close excellence gaps, and the program has made a clear, demonstrable difference. Javits projects have changed the way we train teachers to identify talent, created new models for high-quality curriculum, improved strategies that helped teachers meet the wide range of various readiness levels in their classrooms, and designed and evaluated new techniques for helping twice exceptional students develop their academic strengths.

A number of current projects are exploring the degree to which afterschool programs can promote advanced achievement across a range of school and community types. Available evidence overwhelmingly supports the conclusion that the Javits program is fulfilling its original goals, driving innovation in an area critical to the Nation's future well-being. The Javits Act has had an exceptional return on investment for the country's economy, culture, and taxpayers.

I am grateful for the committee's ongoing support and last year's increase in funding. Yet Javits remains underfunded, given its importance to the country's economic growth and security. Even with the committee's generous increase of funding last year, the act only provides less than 30 cents for each of the country's 56 million K–12 students. This prevents the program from holding competitions for cutting-edge demonstration projects on an annual basis or funding a national dissemination center.

Perhaps most importantly, the current size of the program prevents consistent funding opportunities for State dissemination projects. My colleagues doing cutting-edge work in several States, including Alabama, Colorado, and Texas, among others, show evidence of considerable innovation. Additional Javits support would allow those State Departments of Education to significantly increase services for students and educators.

Increasing the funding to $1 per student or $56,000,000 would provide ample resources for all these activities to occur. This investment in our children will pay significant dividends for the United States for years to come by increasing innovation, economic competitiveness, and cultural resources for a generation.

Thank you for your time.

[The information follows:]

Testimony for the Record

Submitted to the

House Committee on Appropriations

Labor, Health and Human Services, Education,

and Related Agencies Subcommittee

for the Public Witness Hearing

March 23, 2023

Jonathan A. Plucker, Ph.D.

Professor of Education, Johns Hopkins University

Chairman Aderholt, Ranking Member DeLauro and members of the Subcommittee, thank you for inviting me to participate in today's hearing and thank you for your attention to a topic that has been the focus of my professional career for over 30 years, developing children's talents and advanced skills. Today I am specifically speaking to the need to increase the funding available to the Jacob K. Javits Gifted and Talented Students Education Program, administered by the Department of Education.

My name is Jonathan Plucker. I am a professor at Johns Hopkins School of Education, where I teach in the gifted education and education policy programs. I am also immediate past-president of the National Association for Gifted Children. I would like to state for the record that the opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University and NAGC.

Lower Rates of Academic Excellence in the U.S.

Academic excellence and talent development have strong relationships to economic and cultural growth. Yet ample evidence suggests that U.S. students achieve at advanced levels at significantly lower rates than students in other countries.

Regardless of the content area or international assessment, the percent of U.S. students who score in the advanced range tends to be below that of students in economically competitive countries. For example, the most recent round of the Trends in International Math and Science Study (TIMSS) provides evidence that our highest performing fourth-grade students underperform those in South Korea, Japan, England, Taiwan, Australia, and Turkey in math and at the same level as students in Russia. Results are similar for eighth grade math. Science performance tends to be better but is middle-of-the-pack among major economic powers.

One reason for this relatively poor performance at advanced levels is the presence of large and growing excellence gaps. These gaps are differences in advanced performance associated with student race, gender, and class. For example, in Grade 4 Math during the last administration of the National Assessment of Educational Progress, only 2% of low-income students scored advanced compared to 13% of higher-income students. In Grade 4 Reading, the corresponding results were 3% versus 14%. These excellence gaps were large before the pandemic and now appear to be even bigger.

Studies strongly suggest that much of the excellence gap is caused by students' lack of opportunity for advanced learning. Ironically, at a time when research points us to dozens of strategies to help students achieve academic excellence, many students simply do not have access to these services.

Of special concern are bright students in both cities and small towns, and also talented students with learning challenges, whom are often described as being "twice exceptional." A study

reported just last week that students in small towns have among the lowest participation rates for advanced learning opportunities. When students are provided with advanced learning opportunities, they thrive; but far too many do not get these opportunities.

There is bipartisan concern about these problems, and educators are tackling them across the country. I work with districts each year to implement strategies that allow all students to develop their talents. The issue is not a lack of desire to improve advanced outcomes for students. Rather, the issue is lack of resources and inadequate dissemination of research-based strategies for achieving those outcomes.

Solving America's Academic Excellence Problem

Javits Has Greatly Advanced Our Knowledge of Advanced Education

The Javits Act remains the federal government's primary program to promote educational excellence and close excellence gaps, and the program has made a clear, demonstrable difference. Javits projects have changed the way we train teachers to identify talent, created and tested new models for high-quality curriculum, improved strategies that help teachers meet the wide range of readiness levels in their classrooms, and designed and evaluated new techniques for helping twice-exceptional students develop their academic strengths, among many other innovations.

In particular, the Javits Act funded projects that helped us design effective interventions for identifying talented students in low-income and rural communities, and high-quality, pre-differentiated curriculum that raises the advanced achievement of students in both the inner-city and small towns. A number of current projects are exploring the degree to which after school programs can promote advanced academic achievement across a range of school and community types.

Many of the funded projects have taken models created in one district and carefully applied them to other districts, such as a project to apply the Young Scholars Model from Fairfax County, Virginia, to low-income students in Connecticut, or a project to apply advances in STEM teaching

and learning to rural schools in Indiana. These application projects are invaluable, in that they help us learn how promising models generalize to other communities and populations of students.

Javits Impact Has Been Felt Across the Country

Furthermore, Javits projects have been implemented from coast-to-coast and border-to-border, helping improve our understanding of how to promote talent development among our country's very diverse communities and stakeholders.

The past few award cycles have resulted in large-scale funded projects from Connecticut to Hawaii, North Carolina and Tennessee to Texas and Arkansas, among several others, including statewide projects in Oklahoma, Maryland, and Minnesota. Many of these projects are STEM-focused or directly address the talents of twice-exceptional students.

The geographic diversity of these projects has been invaluable, allowing us to learn how projects developed, for example, in Washington State or South Carolina can benefit students and families in New York or South Dakota, and vice-versa.

The available evidence overwhelmingly supports the conclusion that the Javits Program is fulfilling its original goals, driving innovation in an area critical to the nation's future well-being. The Javits Act has had an exceptional return on investment for the country's economy, culture, and taxpayers.

Expand Javits to Give Schools and Educators Better Tools and Resources

I am grateful for the Committee's ongoing support of the program and last year's increase in funding. Yet Javits remains underfunded given its importance to the country's economic growth and security. Even with the Committee's generous increase of funding last year, the Act only provides less than 30 cents per each of the country's 56 million K-12 students.

These limited resources prevent the program from holding competitions for cutting-edge demonstration projects on an annual basis or funding a national dissemination/resource center. In

addition, experts have identified a need for much more robust leadership training programs, given that a major roadblock to talent development can be administrative indifference to advanced outcomes. At current funding levels, new initiatives to tackle leadership issues are simply not on the table.

Perhaps most importantly, the size of the program prevents consistent funding opportunities for state dissemination projects. My colleagues doing cutting-edge work in several states could use additional resources to accelerate their activities. For example, in a recent study of state-level policies that promote excellence and shrink excellence gaps, Alabama, Colorado, and Texas, among others, showed evidence of considerable innovation. Additional Javits support would allow those state departments of education to significantly increase services for students and educators.

Increasing the funding to $1 per student, or $56 million, would provide ample resources for all of these activities to occur, greatly increasing our knowledge of how to promote equitable advanced learning and our ability to implement these strategies in every community in the country. This investment in our children will pay significant dividends for the United States for years to come by increasing innovation, economic competitiveness, and cultural resources for a generation.

Thank you and I would be pleased to answer any questions you may have.

Mr. ADERHOLT. Thank you, Professor, for your testimony here this morning. And as I have mentioned with our other guests, we look forward to working with you and how we, this subcommittee, can work with you to try to get some of the funding to try to help some of the issues that you have talked about in education, especially with the gifted.

And so, again, we appreciate you being here.

Dr. PLUCKER. Thank you, sir.

Mr. ADERHOLT. Next I would like to introduce Dr. Brian Persing. He is the medical oncologist and hematologist, and he is here on behalf of the Association for Clinical Oncology.

So, Dr. Persing, we appreciate your being here today and look forward to your testimony.

THURSDAY, MARCH 23, 2023.

ASSOCIATION FOR CLINICAL ONCOLOGY

WITNESS

BRIAN PERSING, M.D., MEDICAL ONCOLOGIST AND HEMATOLOGIST, ASSOCIATION FOR CLINICAL ONCOLOGY

Dr. PERSING. Thank you very much, Chairman Aderholt. And thank you to the committee for the opportunity to testify before you today.

My name is Brian Persing, and as a practicing medical oncologist and hematologist at the University of South Alabama and Mitchell Cancer Institute in Mobile, Alabama, I know firsthand the importance of investing in biomedical research.

I am here representing the Association for Clinical Oncology, the world's leading professional organization representing nearly 45,000 medical oncology professionals. Thank you to each member of this subcommittee for your longstanding bipartisan commitment to the support of federally funded research at the National Institutes of Health and the National Cancer Institute.

ASCO appreciates this opportunity to provide fiscal year 2024 funding recommendations that will continue the scientific progress our patients depend upon. ASCO is requesting $50,924,000,000 for the National Institutes of Health, including $9,988,000,000 for the National Cancer Institute. We are also requesting at least $1,500,000,000 for the Advanced Research Projects Agency for Health, or ARPA–H, supplemental to the NIH base budget.

Finally, ASCO requests $472,400,000 for the Centers for Disease Control and Prevention Division of Cancer Prevention and Control and $63,400,000 within that division for the Cancer Registries Program.

In 2022, the NIH provided $36,680,000,000 in research funding to scientists in all 50 States and the District of Columbia, supported more than 568,000 jobs, and generated $96,840,000,000 in economic activity. Robust growth in NIH-supported foundational research across the country is key to pushing the boundaries of innovation in both public and private sector.

In July of 2022, the NIH celebrated 10 years since the first pediatric patient was treated with CAR T-cell therapy. This is groundbreaking therapy that works by training a patient's own

body to destroy cancer cells. To replicate successes like this and to achieve cures, we must ensure the NIH has the capacity to support fundamental science across the full range of scientific disciplines.

The cancer death rate fell 33 percent in the last 30 years, but it is still, sadly, the second most common cause of death in the United States. Over 1.9 million new cases will be diagnosed and approximately 609,800 people will die this year from cancer.

The NCI is the largest funder of cancer research in the world, but its funding has not kept pace with opportunities for cutting-edge research. Today, only one in seven lifesaving research grants can be funded. Apart from these missed opportunities, we will lose early career investigators who may choose other careers if their grant submissions are not funded, disrupting the workplace pipeline.

The Cancer Moonshot investment is paying off, increasing our understanding of how tumors behave, enhancing treatment, and identifying new approaches to pediatric cancer. We urge Congress to sustain the momentum by reauthorizing and funding the Cancer Moonshot and its infrastructure. With your support, the NCI can achieve its ambitious Moonshot goal of reducing the death rate from cancer by 50 percent in 25 years.

In addition to the work done by the Cancer Moonshot, NIH-funded translational research and clinical trials have significantly improved the standard of care in many diseases. As a practicing oncologist, I have seen the impact this has had on my patients. A few years ago, the NCI funded a trial evaluating cancer genes of women with breast cancer to determine whether patients were likely to benefit from chemotherapy after surgery. It showed that 60 to 70 percent of women were considered low risk and did not require chemotherapy.

One of my patients, a woman in her 40s, had breast cancer and previously would have been given chemotherapy based on the size of her tumor. But thanks to the trial, we learned we could avoid chemotherapy. She was spared significant toxicity and was able to continue a busy life caring for her two teenaged children. Today, she is cancer free and has completed her hormone therapy.

Over the last 40 years, adult trials conducted by the National Clinical Trials Network have extended the lives of patients with cancer by an additional 14.2 million life-years. That amounts to roughly $326 in Federal investment for each life-year added. An increase in the NCI's budget would enable the institute to achieve its goal of doubling patient accruals to clinical trials by giving patients an opportunity to extend their quality of life.

As a complement to trials, clinicians need accessible data to understand cancer at a broader level. The Centers for Disease Control and Prevention Cancer Program play a critical role in prevention, detection, and treatment of cancers.

The human and financial cost of advanced disease and about 50 percent of cancer deaths could be prevented by using existing prevention and early detection strategies supported by the CDC's Division for Cancer Prevention. ASCO joins the cancer community in requesting at least $472,400,000 for the CDC DCPC and $63,400,000 for the CDC's Cancer Registry Program.

We also reiterate our firm belief that the agency's funding should be additive for ARPA–H and not come at the expense of robust predictable funding for the NIH, NCI, and other existing entities.

Thank you again for your continued support of patients living with, surviving, and at risk for cancer through funding these Federal agencies and programs. We look forward to working with you on a fiscal year 2024 budget that advances and accelerates U.S. cancer research and transformative health solutions.

[The information follows:]

Brian Persing, MD

Association for Clinical Oncology

Statement for the Record prepared for:

Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Regarding funding for the National Institutes of Health for FY 2024

March 23, 2023

Thank you, Chairman Aderholt and Ranking Member DeLauro, for the opportunity to testify before you today. As a practicing oncologist and hematologist in Mobile, Alabama, I know first-hand the importance of investing in biomedical research. I am here representing the Association for Clinical Oncology (ASCO), the world's leading professional organization representing nearly 45,000 oncology professionals. Thank you to each member of this subcommittee for your long-standing bipartisan commitment to support federally funded research at the National Institutes of Health (NIH) and National Cancer Institute (NCI). This strong commitment to scientific discovery will speed the development of innovative treatments and sustain our nation's position as the world leader in biomedical research. ASCO appreciates this opportunity to provide fiscal year 2024 funding recommendations that will continue scientific progress our patients depend on:

- $50.924 billion for the **National Institutes of Health**
    - $9.988 billion for the **National Cancer Institute**
- At least $1.5 billion for the **Advanced Research Projects Agency for Health (ARPA-H)**
- $472.4 million for the **Centers for Disease Control and Prevention's (CDC) Division of Cancer Prevention and Control (DCPC)**
    - $63.4 million for the **Cancer Registries Program**

National Institutes of Health In 2022, NIH provided $36.68 billion in research funding to scientists in all 50 states and the District of Columbia, supported more than 568,585 jobs, and generated $96.84 billion in economic activity.[1]

Robust growth in NIH-supported foundational research across the country is key to pushing the boundaries of innovation in both the public and private sector. In July 2022, NIH celebrated 10 years since the first pediatric cancer patient was treated with CAR T-cell therapy. This groundbreaking therapy works by training a patient's own body to destroy cancer cells, treating cancers such as leukemia, lymphoma, and multiple myeloma. NIH research is now focused on expanding this treatment to other cancers. CAR-T is only one example of the revolutionary research NIH can do with sustained, robust federal investments.

To replicate successes like this—and to achieve cures—we must ensure NIH has the capacity to support fundamental science across the full range of scientific disciplines.

National Cancer Institute The cancer death rate fell 33% in the last 30 years. Despite progress in preventing and treating cancer, it is the second most common cause of death in the U.S. In 2023, over 1.9 million new cases will be diagnosed and approximately 609,800 people will die from cancer. Of those new cases, more than 30,000 will be in Alabama. We expect this number to rise as the population ages; 88% of people diagnosed with cancer are 50 years of age or older and 57% are 65 or older.[2]

The NCI is the largest funder of cancer research in the world, but its funding has not kept pace with opportunities for cutting edge research. Between FY2013 – FY2022, R01 and R37 grant applications rose by 45%, but today only 14% percent of life-saving research can be funded. Apart from these missed opportunities, we will lose early career investigators who may choose other careers if their grant submissions are not funded, disrupting the workforce pipeline.

The NCI's Professional Bypass Budget released in 2022 recommended $9.988 billion in FY2024 to fund the multiyear commitment to research and critical goals in the Cancer Moonshot.

The Moonshot investment is paying off, increasing our understanding of how tumors behave, enhancing treatment, and identifying new approaches to pediatric cancer. This progress was enabled by NCI's investment of nearly $1.4 billion in 240 Cancer Moonshot projects across more than 70 cancer science initiatives. Funding for the Cancer Moonshot expires this fiscal year. We urge Congress to sustain this momentum by reauthorizing and funding the Cancer Moonshot and its infrastructure. With your support, the NCI can achieve its ambitious Moonshot goal of reducing the death rate from cancer by at least 50% in 25 years.

In addition to work done by the Cancer Moonshot, NIH-funded translational research and clinical trials have significantly improved the standard of care in many diseases. These efforts have produced 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 therapies unlikely to help them. This is where science becomes practice-changing for patients in America.

As a practicing oncologist, I have seen the impact this has on patients. A few years ago, NCI funded a trial evaluating the cancer genes of women with breast cancer to determine whether patients were likely to benefit from chemotherapy after surgery. It showed that 60 to 70% of women were considered low risk and did not require chemotherapy. One of my patients, a woman in her 40s, had breast cancer and previously would have been given chemotherapy based on the size of her tumor. Thanks to the trial, we learned she could avoid chemotherapy. She was spared significant toxicity and was able to continue a busy life caring for her two teenage children. Today, she is cancer-free and has completed her hormone therapy.

ASCO urges a substantial increase in funding for the National Clinical Trials Network (NCTN) and NCI Community Oncology Research Program (NCORP), which bring trials to the community setting, where a larger, more diverse patient population can participate. The NCORP network now covers 44 states and the District of Columbia.[3]

Over the last 40 years, adult trials conducted by the NCTN have extended the lives of patients with cancer by an estimated 14.2 million life-years. That amounts to roughly $326 in federal investment for each life-year added.[4] An increase in NCI's budget would enable the Institute to achieve its goal of doubling patient accruals to clinical trials, giving more patients the opportunity to extend and improve their quality of life.

Cancer Prevention and Control and Cancer Registries Program As a complement to clinical trials, clinicians need accessible data to understand cancer at a broader level. The Centers for Disease Control and Prevention's (CDC) cancer programs play a critical role in the prevention, detection, and treatment of cancer. The human and financial cost of advanced disease—and about 50% of cancer deaths—could be prevented using existing prevention and early detection strategies supported by CDC's Division of Cancer Prevention and Control (DCPC).

Federal funding for DCPC has remained stagnant for many years. Excluding the DCPC's WISEWOMAN heart disease program funding, the past thirteen years have seen only a 6% increase. That is about $100 million less than if DCPC funding had merely kept up with inflation.

ASCO joins the cancer community in requesting at least $472.4 million for the DCPC, and $63.4 million for the CDC's Cancer Registries Program. Cancer registries are a critical tool, providing surveillance, identifying trends among different patient cohorts, illustrating the benefits of early detection, and showing the impact of treatment advances on outcomes. Funding

the National Program of Cancer Registries at $63.4 million could expand real-time reporting in up to 16 states.

Advanced Research Projects Agency for Health As the Advanced Research Projects Agency for Health (ARPA-H) continues to develop, we urge Congress to establish consistent and appropriate funding to ensure the success of the public-private partnerships necessary to accelerate the more immediate delivery of life-changing solutions.

Providing at least $1.5 billion in FY24, consistent with FY23, will allow the new agency to recruit talent and identify opportunities for the revolutionary solutions that have characterized the agency upon which it is modeled, the Defense Advanced Research Projects Agency (DARPA). We reiterate our firm belief that the agency's funding should be additive and not come at the expense of robust, predictable funding for the NIH, NCI, and other existing research agencies.

Thank you again for your continued support of patients living with, surviving, and at risk of cancer through funding for these federal agencies and programs. We look forward to working with you on an FY24 budget that advances and accelerates U.S. cancer research and transformative health solutions.

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[1] United for Medical Research; https://unitedformedicalresearch.org/annual-economic-report/
[2] American Cancer Society, Cancer Facts and Figures 2023; https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2023/2023-cancer-facts-and-figures.pdf
[3]National Cancer Institute; https://ncorp.cancer.gov/about/
[4] Unger JM, et al. Population, Clinical, and Scientific Impact of National Cancer Institute's National Clinical Trials Network Treatment Studies. J Clin Oncol. 2022 Dec 8:JCO2201826. doi: 10.1200/JCO.22.01826.

Mr. ADERHOLT. Thank you, Dr. Persing. And——

Mr. HOYER. Mr. Chairman.

Mr. ADERHOLT. Oh, yes, please.

Mr. HOYER. I want to make an observation. The payline for extramural grants approval is now in the middle teens, as I understand. I think you cited 14 percent on the NCI.

When I was on this committee the first time, Joe Early was a congressman from Massachusetts, and he very much focused on the payline because experts tell us that at least 3 out of every 10 applications are very good science. But we are now down in the middle teens, and what you pointed out at the beginning, young people who may go into research, as they see this payline reducing, believe there is no future in that basic research. And if we continue that, we are going to lose to the rest of the world, including China.

So your point, I think, is an extraordinarily important one. And Mr. Chairman, we really ought to look at that payline because we are leaving a lot of good science on the table.

A former Governor of my State—famous or infamous, depending upon your perspective—Spiro T. Agnew, once said that the cost of failure far exceeds the price of progress. That is the profound reality of what you are talking about.

Thank you, Mr. Chairman.

Mr. ADERHOLT. Thank you. Ms. DeLauro.

Ms. DELAURO. Mr. Chairman and Dr. Persing, I just want to tell that what we did in the 2022 appropriations bill was an overall increase in terms of NCI for $408,000,000, and $150,000,000 in terms of an increase in the payline. So you are on solid ground with where you are going, and it is an area that continues to be of extreme interest.

And as a cancer survivor, just really can't tell you how much your work at the NCI means and allowing those of us who have been stricken with this illness to be able to survive.

So, we are there. Thanks.

Mr. ADERHOLT. Thank you. Thank you, Dr. Persing.

And as a fellow Alabamian, we welcome you to the subcommittee. But also I had an opportunity to be on your campus a few months ago with your now president Jo Bonner, who we served with here, and who is now president of the University of South Alabama.

So we look forward to working with you, and I think everyone agrees that, of course, all of these diseases that we are hearing about are devastating. But of course, cancer hits so many people and so many families. And so we appreciate your testimony, and we look forward to working with you, and thanks for your testimony.

Okay. Next we will welcome Ms. Dorothea Staursky, and she is with the National Marrow Donor Program, and we look forward to your testimony.

So, welcome.

THURSDAY, MARCH 23, 2023.

NATIONAL MARROW DONOR PROGRAM

WITNESS

DOROTHEA STAURSKY, VOLUNTEER AND BONE MARROW DONOR, NATIONAL MARROW DONOR PROGRAM

Ms. STAURSKY. Thank you.

Chairman Aderholt, Ranking Member DeLauro, and committee members, my name is Dorothea Staursky of Birmingham, Alabama. On behalf of the patients, family members, donors, volunteers, and staff of National Marrow Donor Program, or NMDP, I want to thank you and the members of the committee for your support of the C.W. Bill Young Cell Transplantation Program and respectfully request $35,000,000 for the program in fiscal year 2024.

For over 35 years, Congress and the program have partnered to save lives. By establishing a National Bone Marrow Donor Registry in the mid 1980s, Congress promised patients with blood cancers like leukemia and lymphoma and over 75 other life-threatening diseases that they would have a way to find a lifesaving donor match. Thanks to this partnership, the program has facilitated over 120,000 transplants between an unrelated matched donor and a patient with blood cancer or disorder. This funding will not only save lives but will also improve access to cell therapies for thousands of underserved patients.

I am proud and honored to be testifying today as a two-time NMDP volunteer bone marrow donor. I joined the registry because I saw a social media post about a young Greek-American child who needed a bone marrow transplant to save his life. This social media post encouraged people with Greek heritage, like myself, to sign up for the registry. I learned that ethnic background affects the patient's odds of finding a match.

Thanks to congressional investment, NMDP has successfully developed targeted recruitment efforts, groundbreaking innovation, and continues to remove barriers to transplants.

While patients' lives are changed through this program, my life was also forever altered when I received a call informing me that I had been identified as the best possible match for a patient. I was honestly a little overwhelmed and had so many questions, but NMDP was there to support me.

The procedure itself was painless and easy, and the coordination was seamless. They were a great support system throughout the process. It was both an honor and a great responsibility to have matched with my recipient, Mario, and to offer him hope for a healthier life.

After a full calendar year, we were allowed to connect. I am proud to know I was able to give Mario more time to spend with his family and give his two young children more time and memories with their dad. My donations to Mario have given my life and work new meaning. I continue to be involved by hosting donor registration drives in Alabama, Mississippi, and New York and recently completed my doctoral degree with a dissertation on bone marrow donation.

Professionally, I have a career in hospital administration at the University of Alabama at Birmingham. Every day, I am surrounded by the bravery and strength of our patients, the spirit of our family members and caregivers, and the healing work of our providers. All this time I have Mario front of mind.

Empathy starts with imagination. Throughout my donation journey, I imagined myself, a family member, a friend, or a colleague as a patient waiting for a match so they can live. I feel that it is my personal responsibility to work to ensure that every patient has a suitable donor available.

In the Greek language, the word "philotimo" is a word that lacks a true definition. However, its meaning is great. The roots of the word "philotimo" include "filos," meaning "friend," and "timi" meaning "honor."

Philotimo extends beyond friendship and honor. It encompasses the desire in each of our hearts to do good work for others. This is what we should all aspire to achieve. Being a donor, being an advocate, and supporting the program is a perfect way to show our humanity by doing something out of love and honor for another human being.

This committee knows the meaning of philotimo. More than any other committee in Congress, the programs you support save lives every day, including the C.W. Bill Young Cell Transplantation Program. I humbly request that you continue your support of this program by appropriating $35,000,000 in fiscal year 2024.

Thank you for your time, consideration, and continued support of blood cancer and blood disease patients.

Thank you.

[The information follows:]

Testimony by Dorothea Staursky, Volunteer and Bone Marrow Donor on behalf of

National Marrow Donor Program

Chairman Aderholt, Ranking Member DeLauro and Committee Members, my name is Dorothea Staursky of Birmingham, Alabama. On behalf of the patients, family members, donors, volunteers, and staff of the National Marrow Donor Program® (NMDP) I want to thank you and the members of the Committee for your support of the C.W. Bill Young Cell Transplantation Program (Program) within the Health Resources and Services Administration (HRSA), Health Care Systems account last year. Your partnership with the Program truly saves lives. In Fiscal Year 2024, NMDP respectfully requests $35,000,000 for the C.W. Bill Young Cell Transplantation Program to improve access to cell therapies for thousands of underserved patients.

The Program has been a true public/private partnership between NMDP and Congress for more than 35 years. By establishing a national bone marrow donor registry in the mid-1980s, Congress promised patients with blood cancers, like leukemia and lymphoma and over 75 other life-threatening diseases, that they would have a way to find a life-saving donor. Thanks to this 35-year partnership, the Program has facilitated over 120,000 transplants between a matched, unrelated donor and a patient with blood cancer or disorder.

While patient's lives are changed through this program, my life was also forever altered when I received the call that I was a patient's match. In October 2018, I received a call from an NMDP representative informing me that I had been identified as the best possible match for a patient with a rare blood disease. I am speaking to you now as a two-time cell donor through

the Program, as I donated peripheral blood stem cells (PBSCs) to my recipient in November 2018 and then again to the same recipient in June 2019.

I initially joined the registry because I saw a social media post about a young Greek American child who was suffering from a rare blood disease and needed a bone marrow transplant to save his life. This social media post was encouraging individuals with Greek heritage to sign up for the registry. This was the first time that I learned that ethnic background affects a patient's odds of finding a match. When it comes to matching, a patient's likelihood of finding a matching donor on the registry ranges from 29% to 79%, depending on ethnic background. Thanks to Congressional investment, NMDP has been successful in narrowing that gap, through targeted recruitment efforts, groundbreaking innovation, and assisting patients in navigating barriers to transplant.

My cells were a match for a young man with a wife and two young children. I felt a responsibility and an honor that I matched with my recipient and was able to offer him hope for a healthier life. After a full calendar year, my recipient and I were able to exchange contact information. His name was Mario, and thanks to social media and an online translation platform, we were able to connect and communicate with one another. Unfortunately, shortly after this, I learned that Mario passed away. I am comforted in knowing that I was able to give Mario more time to spend with his family and was able to give his two young children more experiences and memories with their dad.

My PBSC donations to my recipient, Mario, has given my life and work new meaning. I continue to be involved with NMDP. I have hosted donor registration drives in Alabama,

Mississippi, and New York, currently serve as a volunteer Advocacy Ambassador, and recently completed my doctoral degree with a final doctoral project that focused on bone marrow and stem cell donation. Professionally, I have a career in hospital administration in a cancer center in Alabama. Every day, I am surrounded by the bravery and strength of our patients, the spirit of our family members and caregivers, and the healing work of our providers.

Empathy starts with imagination. Throughout my donor journey, from registration to donation to legislative advocacy, I imagined myself, a family member, colleague, or a friend as a patient waiting for a match in order to live. I feel that it is my personal responsibility to never cease my work to ensure that every patient has a suitable match available.

In the Greek language, the word *Philotimo* is a word that lacks a true definition; however, its meaning is great. The roots of the word *Philotimo* include *filos* meaning friend and *timi* meaning honor. *Philotimo* extends beyond friendship and honor. It encompasses the desire in each of our hearts to do good work for others. *Philotimo* is what we should all aspire to achieve. Being a donor, being an advocate, and supporting the Program is a perfect way to show our humanity by doing something out of love and honor for another human being.

This committee knows the meaning of good work. More than any other Committee in Congress, the programs you support save lives every day, such as the Program I am here to speak about today.

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 41 million volunteers worldwide, who stand ready to be a life-saving

bone marrow donor. It also includes more than 800,000 cord blood units through NMDP and international partnerships, 115,000 of which are in the National Cord Blood Inventory, which is also funded by your Committee.

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 adjusting to life after transplant.

Finally, the Stem Cell Therapeutic Outcomes Database is a third program component that helps doctors significantly impact 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 prompt transplants, and treatment of even more blood diseases through transplant.

Our request this year builds upon past funding to clear a pathway for more patients, especially those from minority and geographical distant communities, to be able to access transplant services. The funding we are seeking this year will immediately increase the number of patients who enter the pipeline to receive a bone marrow transplant for a lifesaving cure, by

increasing targeted donor recruitment efforts, expanding early intervention with community referring physicians upon patient diagnosis to accelerate the path to transplant, and propeling innovation to improve outcomes and establish new treatment options to ensure a 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.

The request also builds on a successful pilot program, called HLA Today. HLA Today, a program piloted and funded by NMDP, has shown outstanding early success in targeted outreach to patients diagnosed with a transplant-treatable disease. Alabama was the first in the nation to launch HLA Today in 2019, with Mitchell Cancer Institute at University of South Alabama in Mobile. Since then, the program has grown to 29 states and Puerto Rico. This free program improves the time to transplant through a simple process of providing genetic typing for patients who are newly diagnosed with a condition for which a transplant may be a potential treatment or cure. With increased Congressional support, NMDP aims to expand this program nationwide to improve patient access to treatment options.

Thank you for the opportunity to share my story and most importantly thank you for learning a little bit about my recipient. Your longstanding support for this Program is the hope that people hold onto after receiving their life-threatening diagnosis. On behalf of those who are alive today, those who are currently searching the national registry for their potentially life-saving donor, and for those who will need to look to the Program for help in the future, I urge you to fund the C.W. Bill Young Cell Transplantation Program at $35 million to immediately provide access to therapy at the point of diagnosis for all patients. Thank you.

Mr. HOYER. Amen.

Mr. ADERHOLT. Thank you. Thank you. And again, as a fellow Alabamian, we welcome you here, and glad to have your testimony.

And let me just say that I think everyone here on the dais served with C.W. Bill Young, and he was a great man and, of course, had a vision for this program. And so we appreciate your testimony, and we look forward to working with the National Marrow Donor Program.

And thank you so much again for being here.

Ms. STAURSKY. Thank you so much for having me.

Mr. ADERHOLT. Okay. Our next guest is Ms. Sarah Rittling, who is executive director of the First Five Years Fund.

And Ms. Rittling, we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

FIRST FIVE YEARS FUND

WITNESS

SARAH RITTLING, EXECUTIVE DIRECTOR, FIRST FIVE YEARS FUND

Ms. RITTLING. Good morning.

Mr. ADERHOLT. Good morning.

Ms. RITTLING. Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee——

There we go, sorry.

Good morning. Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify on the need for all children, especially those from low-income families, to have access to affordable, high-quality early learning and care.

My name is Sarah Rittling, and as the executive director of the First Five Years Fund, I am here recommending funding for Child Care and Development Block Grants, CCDBG; Early Head Start and Head Start; the Preschool Development Grants Birth through Five program; and IDEA Part B and C.

I spent the early part of my career on Capitol Hill as counsel to Senator Lamar Alexander before the Senate HELP Committee and, before that, counsel to Representative Mike Castle before the House Committee on Education and the Workforce. Today, at the First Five Years Fund, also known as FFYF, we seek to build on the longstanding bipartisan support at the Federal level to expand access to high-quality early learning and childcare programs.

First and foremost, I want to thank the subcommittee for your bipartisan efforts over many Congresses to strengthen the Birth through Five system in our Nation. I appreciate the support you have shown these programs in the past, which is also why I know no one on this committee needs a primer on the essential role that childcare plays for families, businesses, and the economy.

And you know that for millions of working families and young children, childcare has become either unavailable or unaffordable. Childcare is hard to find. And even when parents can find it, waitlists are long, and costs are high.

This has only gotten worse in recent years as the childcare sector is still down approximately 60,000 jobs from pre-pandemic levels, leaving families with an even smaller supply of care even as nearly all other sectors have completely recovered. And this has an impact on families all across the Nation.

For example, families like the single mom who had to give up her job and stay home because the cost of childcare would eat 75 percent of her take-home pay. Or the parents who have to leave their active toddler with an elderly neighbor because, like nearly two-thirds of all rural families, they live in a childcare desert with little or no options.

We are here to talk about the child who will struggle to catch up with her peers once kindergarten starts because her parents didn't have access to affordable care and early learning options like the Judy Centers that would allow her the ability to develop and thrive.

And finally, the small business owner who had to turn away work or close the restaurant this week because her staff had a hole in the patchwork childcare they rely on and couldn't come in. According to the Bureau of Labor Statistics, employees each year miss work because of childcare challenges. In fact, childcare challenges cause our Nation to lose as much as $122,000,000,000 every year in revenue, earnings, and productivity.

Congress plays a key role in addressing these realities. Federal programs benefit families in all 50 States and every congressional district. Even with the growing support from committed Governors, local elected officials, businesses, and philanthropy, the Federal Government provides the funding to undergird an extremely complex childcare system that we have.

Specifically, these programs are distinct and work together. I will go through them now. Child Care and Development Block Grant, CCDBG, helps parents work while their children receive quality care. States partner with the Federal Government on how to use these funds to best meet the needs of children, parents, and childcare providers in their community.

This block grant focuses assistance on helping low-income working families with young children pay for care. Over the years, some States have also used these to raise payment rates for providers, improve health and safety standards, meet the childcare needs of families working nontraditional hours, and reduce waitlists.

Head Start and Early Head Start deliver comprehensive early learning, health, nutrition, and family support services to families and children from birth through age 5. They are customized and modeled based on the needs of families and their communities, an approach that allows many programs to combine Head Start funding with other Federal and State funds from pre-K childcare or other early care and education services to maximize their impact.

Preschool Development Grants, in a nutshell, is the infrastructure that States—is the money that provides States the ability to build an infrastructure to make these programs talk together. And IDEA, I don't think I need to talk about. The committee is very well versed in that.

Access to high-quality care is critical. We all know this. Thank you for your continued support, and we are ready to assist in any way we can.

[The information follows:]

United States House of Representatives

Appropriations Subcommittee on Labor, Health and Human Services and Education

Testimony of Sarah Rittling, Executive Director, First Five Years Fund

Washington, D.C., March 23, 2003

Chairman Aderholt, Ranking Member DeLauro, and members of the Subcommittee, thank you for the opportunity to testify today on the need for all children, especially those from low-income families, to have access to affordable, high-quality early learning and care.

My name is Sarah Rittling and, as the Executive Director of the First Five Years Fund, I am here today to urge the Committee to provide an additional $4.38 billion for the Child Care and Development Block Grant (CCDBG), an additional $5.47 billion for Head Start, and an additional $185 million for the Preschool Development Grants Birth through Five (PDG B-5) program in the Department of Health and Human Services budget. I am also requesting an additional $392 million for early intervention services provided under IDEA Part C and $82.6 million for preschool special education services under Part B, Section 619 in the budget for the Department of Education. These requests have also been relayed this week to Congress in a letter cosigned by 44 national organizations.

I spent the early part of my career on Capitol Hill as counsel to Sen. Lamar Alexander, R-Tenn., on education policy before the Senate Health, Education Labor and Pensions

Committee. Before that, I served as counsel to Rep. Michael N. Castle, R-Del., on education and labor matters before the House Committee on Education and the Workforce. Today I am the Executive Director of the First Five Years Fund, also knowr as FFYF, which works to build on the long-standing bipartisan support at the federal level to expand access to high-quality early learning and child care programs. This is what brings me here today.

I first want to thank the Subcommittee for your bipartisan efforts to strengthen the child care system in our nation. I appreciate the support you have shown these programs in the past. I know no one on this Committee needs a primer on the essential role that child care plays for families, businesses, and the economy. And you know that, for millions of working families with young children, child care has become either unavailable or unaffordable. Child care is hard to find and, even when parents can find it, wait lists are long and costs are high. This has only gotten worse in recent years, as the child care sector is still down approximately 60,000 jobs from pre-pandemic levels, leaving families with an even smaller supply of care even as nearly all other sectors have completely recovered. And this has an impact on families all across the nation.

- Families like the single mom who had to give up her job at the restaurant and stay home because the cost of child care would eat 75% of her take-home pay.
- Or the parents who have to leave their active toddler with an elderly neighbor because, like nearly two-thirds of all rural families, they live in a child care desert, with little or no access to available child care or early learning options.

- Today, we're here to talk about the child who will struggle to catch up with her peers once kindergarten starts because her parents didn't have access to affordable, quality early care where she could learn, develop and thrive.
- And finally, we're here to talk about the small business owner who had to turn away work or close the restaurant this week because staff had a hole in the patchwork child care they rely on and couldn't come in. According to the Bureau for Labor Statistics, hundreds of thousands of employees each year miss work because of child care challenges. In fact, child care challenges cause our nation to lose as much as $122 billion every year in revenue, earnings, and productivity.

Congress plays a key role in addressing these realities. Federal programs benefit families in all fifty states and every Congressional district. Even with the growing support from committed governors, local elected officials, businesses, and philanthropy, the federal government provides the vast majority of public funding for the extremely complicated child care system we have in this country. But, today, these programs still only reach a fraction of the families in your district who are eligible and need child care.

Child Care and Development Block Grant (CCDBG): CCDBG helps parents work while their children receive quality care. States partner with the federal government on how to use these funds to best meet the needs of children, parents, and child care providers in their communities. This block grant focuses assistance on helping low-income, working families with young children pay for care and, over the past few years, some states have also used CCDBG funds to raise payment rates for providers, improve health and safety standards, meet the child care needs of families working nontraditional hours, and reduce waitlists. The program is designed to support families

who are working or in school, with an income below 85% of the state median income (though states can set income eligibility below that ceiling). However, at current funding levels, the program only reaches around 14% of eligible children and families.

Head Start and Early Head Start: Head Start and Early Head Start deliver comprehensive early learning, health, nutrition, and family support services to families and children from birth to age five who are most in need. These programs customize services and program models based on the needs of families in their specific communities, an approach that allows many programs to combine Head Start funding with other federal and state funds for pre-K, child care, or other early care and education services to maximize their impact. The program is designed to reach children in families making below the federal poverty line - which is less than $30,000 for a family of 4 - or who are categorically eligible because they're homeless, in the foster care system, or also receiving other assistance like SNAP or TANF. With the current funding level, however, Head Start today only reaches about a third of eligible children aged 3-5 while Early Head Start only reaches 11% of those aged 3 and under.

Preschool Development Grants Birth-Five: In a nutshell, with Preschool Development Grants the federal government supports states' ability to build an essential early learning infrastructure. It's about strategy; states use this funding to create more effective, efficient programs by collaborating across multiple systems and agencies. For example, states have used these funds to coordinate funding across programs, build better data analysis, foster parental choice in care, or bolster the early learning workforce. This all strengthens programs and lays the foundation to make high quality early education available to even more working families. These grants have been

incredibly impactful, with nearly every governor across the country applying for funds and 42 states currently benefiting from the program. Additional federal funding would help ensure all states can build a strong infrastructure of early learning and care for children and families.

Individuals with Disabilities Education Act: IDEA ensures states and public agencies can provide early intervention, special education, and other related services to more than 7 million eligible children and youth with disabilities across the country, including infants and toddlers. Programs for young children with disabilities play a significant role in early childhood education and development. Ensuring that young children have access to early interventions during this fundamental period for learning, behavior, and health means that children will get the appropriate services and supports they need to be equipped for success in school and even mitigate the need for more extensive services later in childhood. This funding is essential in making sure that young children with disabilities are ready to learn when they enter school.

CONCLUSION: Access to a high-quality child care and early education helps children enter kindergarten ready to learn, and offers working families greater opportunities and a pathway out of poverty. This Subcommittee has historically been incredibly supportive and I appreciate the opportunity to testify today on behalf of additional investments in our federal early learning and child care programs. We stand ready to assist in any way.

Sarah Rittling, Executive Director, First Five Years Fund

srittling@ffyf.org

Ms. DELAURO. Mr. Chairman.

Mr. ADERHOLT. Wonderful. Yes. Ms. DeLauro.

Ms. DELAURO. Thank you.

I want to just applaud your testimony, but I also want to let you know that there are two sides to this, and this is what we were able to do last year in 2023. With regard to Child Care and Development Block Grant, it was $1,800,000,000. Head Start funding, $960,000,000. Preschool Development Grants, $25,000,000. Grants to States, $850,000,000. And grants for infants and families, $43,000,000.

So this is what we have done. But I also want to just say one other thing. And I say this to all of my colleagues here on both sides of the aisle, and there is only some who want to apply the 2022 budget numbers for 2024. And with Head Start, if we did Head Start at the 2022 level, you are going to lose 170,000 slots for children. If there is a 22 percent reduction, it is 200,000 slots.

Low-income kids are not going to be able to get the opportunity to be educated. Childcare, if you fund at the 2022 level, 105,000 childcare slots eliminated. 105,000 kids are eliminated from the program.

So these are serious. And I say this to my colleagues on both sides of the aisle because I know my colleagues. When we passed the 2022 bill, we passed it. It has to be bipartisan, and it has to be the House and the Senate. So these were investments that were made. So I ask you to be mindful, and I obviously was talking to my colleagues about what is necessary for us to do. And I implore your advocacy on this issue, and I thank you for your testimony.

Mr. ADERHOLT. Mr. Hoyer.

Mr. HOYER. Thank you, Mr. Chairman.

I want to follow up, first of all, and say that there is no greater advocate for children in this Congress than Rosa DeLauro. I would like to think I am in the ballpark with her, but she is an amazing person.

The American Rescue Plan that passed dedicated $38,000,000,000 to childcare. I visited a childcare center in Charles County, Maryland, in my district on Monday. And the director of that runs three childcare centers in and around Charles County. But for the American Rescue Plan, she would have had to shut down during the pandemic all three centers. That would have been some 200 slots that were not available for childcare.

Childcare is a huge challenge in our country, and early childhood education is—you mentioned the Judy Centers, and I mentioned it earlier. There are now 69. There will be 100 in the next 2 years. They are going to add, so we will have 100 Judy Centers. They are essentially 3- and 4-year-olds, but less than that as well. Infants as well.

I quoted Ted Agnew. Let me quote somebody else from Maryland, born a slave on the Eastern Shore of Maryland, Frederick Douglass. And a profound quote that he made, "It is easier to build strong children than it is to repair broken men."

That is what this is about. And Ms. DeLauro used this is an investment committee. It is not a spending committee, an investment committee, and there is a difference. And investing in our young children is as good an investment as any country will ever make.

Thank you.

Mr. ADERHOLT. Thank you.

Thank you, Ms. Rittling, for your testimony, and we appreciate your testimony regarding the children like you mentioned that all need affordable, high-quality healthcare.

I will just say we are impressed with your resume, that you mentioned you worked for Senator Lamar Alexander in the other body, and we were impressed with that. But we were even more impressed when I see in your resume that you worked for Mike Castle here in the House of Representatives. So we all served with Mike, and he was a great Member. So we appreciate your testimony.

Mr. HOYER. All of us share that view.

Mr. ADERHOLT. Thank you.

Our next guest, another Alabamian. We are glad to have Ms. Amy Templeton here today, who is president and CEO of McWane Science Center.

And Ms. Templeton, we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

AMERICAN ALLIANCE OF MUSEUMS

WITNESS

AMY TEMPLETON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MCWANE SCIENCE CENTER, ON BEHALF OF AMERICAN ALLIANCE OF MUSEUMS

Ms. TEMPLETON. Thank you. It is always nice to see another friendly Southerner. Yes.

Mr. ADERHOLT. Thank you.

Ms. DELAURO. I am going next Friday to Birmingham. Does that make me——

[Laughter.]

Mr. ADERHOLT. You are. You are. You will get the certificate when you get there.

Ms. TEMPLETON. Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify today.

My name is Amy Templeton, and I am president and CEO with the McWane Science Center in Birmingham, testifying on behalf of the American Alliance of Museums. I urge you to provide the Office of Museum Services within the Institute of Museum and Library Services with at least $65,500,000 for fiscal year 2024, a much-needed increase of at least $10,000,000 accounting for inflation and public need for museum services.

In light of museums being banned from this year's House Community Project Funding, which we strongly oppose, increasing funding for competitive grants for museums is all the more critical. IMLS is the primary Federal agency responsible for helping museums connect people to information and ideas. Its Office of Museum Services supports all types of museums, from art museums to zoos, by awarding grants to help them better serve their communities.

Museums are economic engines and job creators. According to "Museums as Economic Engines: A National Report," pre-pandemic

U.S. museums supported more than 726,000 jobs and contributed $50,000,000,000 to the U.S. economy each year. For example, the total financial impact that museums have on the economy of Alabama is $473,000,000, including 9,410 jobs. For Connecticut, it is an $834,000,000 impact, supporting 10,229 jobs.

In fiscal year 2022, OMS received 716 applications, requesting nearly $109,000,000. But current funding has allowed the agency to fund only a small fraction of the highly rated grant applications it receives. $65,500,000 would allow OMS to increase its grant capacity for museums, funds which museums need as they continue to emerge from the pandemic and redouble efforts to serve their communities.

In 2019, my science center received an OMS grant in the amount of $134,000 to strength science engagement experiences within our museum. It led to the development of new programs and exhibits that allow our visitors to learn more and to apply that new knowledge to their own everyday experiences.

In 2021, we received an OMS grant in the amount of $222,000 for the planning and design of a new exhibit that encourages visitors to learn STEM principles through the lens of popular music. We believe this exhibit will help us broaden and diversify our audiences, providing greater exposure to STEM among people of color, older teens, and young adults. The planning activities that were supported by OMS have allowed us to progress on this project to the point where private funds are now being committed, forming a true public-private partnership.

Also in 2021, McWane Science Center received an OMS grant through the American Rescue Plan in the amount of $36,000 to support educational initiatives for the 2021–2022 school year. Initiatives included school-based outreach programs, virtual programming, teacher workshops that served 300 early childhood educators, and STEM kits for a variety of grade levels that teachers can check out for use in their classrooms.

These OMS grants and many others like them to museums all across the country make a transforming impact on American museums and the teachers, students, and families they serve.

I want to express the museum feels gratitude for the $55,500,000 funding for OMS in fiscal year 2023, and we applaud the 136 bipartisan representatives who wrote to you in support of OMS funding. This small program provides a vital investment.

For the record, I also would like to endorse the upcoming written testimony on this issue of the Association of Science and Technology Centers, the Association of Science Museum Directors, and the Association of Children's Museums.

In closing, I highlight recent national public opinion polling that shows that 95 percent of American voters would approve of lawmakers who support museums, and 96 percent want Federal funding for museums to be maintained or increased. Museums have a profound positive impact on society and are essential community infrastructure.

Thank you again for this opportunity to testify today.

[The information follows:]



Testimony of Amy Templeton, President & CEO, McWane Science Center,
on behalf of the American Alliance of Museums
to the House Appropriations Subcommittee
on Labor, Health and Human Services, Education and Related Agencies
in support of the IMLS Office of Museum Services
March 23, 2023

Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to submit this testimony. My name is Amy Templeton, and I am President and CEO of the McWane Science Center in Birmingham, Alabama, testifying on behalf of the American Alliance of Museums (AAM). I urge you to provide the Office of Museum Services (OMS) within the Institute of Museum and Library Services (IMLS) with at least $65.5 million for fiscal year (FY) 2024, a much-needed increase of at least $10 million accounting for inflation and public need for museum services. In light of museums being banned from this year's House Community Project Funding, which we strongly oppose, increasing funding for competitive grants for museums is all the more critical.

AAM—representing more than 35,000 individual museum professionals and volunteers, museums of all types, and corporate partners serving the museum field—stands for the broad scope of the museum community.

I want to express the museum field's gratitude for the $55.5 million in funding for OMS in FY 2023, and we applaud the bipartisan group of 136 Representatives who wrote to you in support of OMS funding.

During the COVID-19 pandemic, OMS provided critical leadership to the museum community. Its Communities for Immunity partnership is working to boost COVID-19 vaccine confidence and access in communities across the country.

Museums are a robust and diverse business sector, including African American museums, aquariums, arboreta, art museums, botanic gardens, children's museums, culturally-specific museums, historic sites, historical societies, history museums, maritime museums, military museums, natural history museums, planetariums, presidential libraries, public gardens, railway museums, science and technology centers, and zoos.

Museums are economic engines and job creators: According to *Museums as Economic Engines: A National Report*, pre-pandemic U.S. museums supported more than 726,000 jobs and contributed $50 billion to the U.S. economy per year, including significant impact on individual states. For example, the total financial impact that museums have on the economy in the state of Alabama is $473 million, including 9,410 jobs. For Connecticut, it is a $834 million impact supporting 10,229 jobs. Nationally, museums spend more than $2 billion yearly on education activities and the typical museum devotes 75% of its education budget to K-12 students.

IMLS is the primary federal agency responsible for helping museums connect people to information and ideas. The IMLS FY 2022-2026 Strategic Plan frames how the agency envisions meeting the essential information, education, research, economic, cultural, and civic needs of the American public. OMS supports all types of museums by awarding grants that help them better serve their communities. OMS awards grants in every state to help museums digitize, enhance, and preserve collections; provide teacher professional development; and create innovative, cross-cultural, and multi-disciplinary programs and exhibits for schools and the public. Congress reauthorized IMLS at the end of 2018, with wide bipartisan support. OMS grants to museums are highly competitive and decided through a rigorous peer-review process. In addition to the dollar-

for-dollar match generally required of museums, grants often spur more giving by private foundations and individual donors.

In FY 2022, Congress provided $268 million to IMLS, of which $47.6 million was directed to the Office of Museum Services. With this funding, OMS provided 280 grants totaling $44.6 million to museums and related organizations in 49 states. By leveraging significant private, state, and local funding, OMS grants amplify a small federal investment for maximum impact in the community. There is high demand for funding from the IMLS Office of Museum Services. In FY 2022 OMS received 716 applications requesting more than $109 million, but current funding has allowed the agency to fund only a small fraction of the highly rated grant applications it receives. $65.5 million in FY 2024 funding would allow OMS to increase its grant capacity for museums, funds which museums will need to help recover from the pandemic and continue to serve their communities. This funding increase would still be greatly shy of the high demand of $109 million in highly rated grant applications the agency received in FY 2022.

The pandemic has inflicted profound damage on US museums, the vast majority of which are 501(c)(3) nonprofit charitable organizations. The museum field will take years to recover to pre-pandemic levels of staffing, revenue, and attendance. Thanks to several federal relief programs, far fewer museums than initially expected are in danger of permanent closure and tens of thousands of jobs were saved. While federal relief funding has provided critical lifelines, museums are still struggling to return to pre-pandemic levels of support. Despite the tremendous financial and psychological stress caused by the pandemic, museum professionals demonstrated the critical role museums play in our country's infrastructure and deepened their social impact in their communities. Museums are essential community infrastructure.

Here are examples from the McWane Science Center of how OMS helps museums better serve the public: In 2019, McWane received a grant in the amount of $134,452 to strengthen the science engagement experiences within our museum. The grant allowed our education staff and core volunteers to become Certified Interpretive Guides through the National Association of Interpretation, and to create a novel and defined science engagement framework to support visitor interaction and learning. The grant led to a complete reformatting of our engagement and interpretation activities and the development of new programs and exhibitions to allow our visitors to learn more and relate that new knowledge to their own everyday experiences.

In 2021, we received an OMS grant in the amount of $221,740 for the planning and design of a new permanent exhibit and education program called "Dropping Science" that encourages visitors to use STEM principles for creative and expressive interactions inspired by the hip-hop cultural movement. There is an enormous amount of STEM in hip-hop, including math in the rhythms and beats, and technology and engineering in the manipulation of electronic devices to create new musical instruments. In addition to teaching STEM principles, we believe this exhibit will help to broaden and diversify our audiences, providing greater exposure to STEM among underrepresented science center visitors, including people of color and older teens and young adults. The planning of this exhibit has facilitated multiple community conversations and partnerships, including an advisory group of local hip-hop artists and producers, and collaboration with organizations that are using hip-hop as a basis for educational programs in schools and community centers.

This grant is an excellent example of how OMS supports and encourages exploration and development of new ideas and creative innovations. Funding was provided for the planning of exhibit content, development of a formal evaluation plan, exhibit prototyping, and a final exhibit

design plan. These elements are crucial in bringing projects from an idea to a reality, but they are often hard to fund through the private sector. The activities supported by OMS have allowed us to progress to a point where private funds are now being committed, forming a true public/private partnership that will benefit our museum and the community we serve.

Also in 2021, McWane Science Center received an OMS grant through the American Rescue Plan in the amount of $35,567 to support educational initiatives for the 2021-2022 school year. Initiatives included developing and implementing school-based outreach programs, virtual programming, teacher workshops, and classroom resources. This funding enabled us to deliver outreach programs to more than 12,000 children. We also created and presented professional development programs for early childhood teachers from pre-K to early elementary school, serving nearly 300 teachers during the school year. This funding was also used to develop STEM kits for a variety of grade levels that can be checked out by teachers and used in their classrooms. The grant helped us use lessons learned during the pandemic to fully develop an expanded educational delivery model, including digital programming as a staple in addition to in-person services.

These OMS grants, and many others like them made to museums across the country, make a transforming impact on American museums and the teachers, students, and families they serve.

In closing, I highlight recent national public opinion polling that shows that 95% of voters would approve of lawmakers who acted to support museums and 96% want federal funding for museums to be maintained or increased. Museums have a profound positive impact on society. If I can provide any additional information, I would be delighted to do so. Thank you again for the opportunity to submit this testimony.

Mr. ADERHOLT. Thank you.

Ms. DELAURO. Mr. Chairman.

Mr. ADERHOLT. Yes. Ms. DeLauro.

Ms. DELAURO. I want to thank you, and we were very happy to make the increase in the museum services in the last budget. And I thank you for mentioning that.

I, too, am saddened by the fact that museums are not eligible to apply for Community Project Funding because it is a real need. But in addition to everything that you have said about museums, I think fundamentally they really are the home of our humanity and are the soul of this country and what our history is about and what direction we want to go in, et cetera.

And to shortchange museums I think it just is overall error, and really, this country and the people of this nation, knowing something about its history, about its current, present, and about its future.

Thank you.

Ms. TEMPLETON. Thank you.

Mr. ADERHOLT. We do appreciate you being here, and certainly, McWane Science Center is a great asset for the State of Alabama. Thank you for your work there and especially this morning, for being here for the American Alliance of Museums, and we look forward to working with you and with these grant programs.

And thank you for being here, and look forward to working with you in the future.

Ms. TEMPLETON. Thank you so much.

Mr. ADERHOLT. Thank you.

Our next guest is Mr. Paul Schroeder. He is Vice President for Impact and Outreach with the American Printing House for the Blind.

Mr. Schroeder, we welcome you to the subcommittee today, and we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

AMERICAN PRINTING HOUSE FOR THE BLIND

WITNESS

PAUL W. SCHROEDER, VICE PRESIDENT FOR IMPACT AND OUTREACH, AMERICAN PRINTING HOUSE FOR THE BLIND

Mr. SCHROEDER. Good morning. Mr. Chairman, Ranking Member DeLauro, members of the subcommittee, thank you so much for the—oh, we didn't hit the button. See, we are already off to a bad start.

Mr. ADERHOLT. You are good. You are good.

Mr. SCHROEDER. They said it was the light button, I don't know.

I do feel compelled, Mr. Chairman, since Alabama has come up several times, that I have been invited in May to come down to Talladega.

Mr. ADERHOLT. Oh, my.

Mr. SCHROEDER. I am not racing, just clarify that. I get to be the commencement speaker at the Alabama Institute for the Deaf and Blind and very privileged to have that honor.

Mr. ADERHOLT. Congratulations.

Mr. SCHROEDER. Look forward to going through your district——
Mr. ADERHOLT. Yes, thank you.
Mr. SCHROEDER [continuing]. On our way there.
Mr. ADERHOLT. Yes, absolutely.
Mr. SCHROEDER. I am here to talk about the American Printing House for the Blind and thank the subcommittee for your support for the APH over the many years that we have been at our work. With the support of Congress and the Department of Education, it has been our privilege to provide textbooks, tools, and technologies for the tens of thousands of students who are blind or low vision throughout the United States.

Mr. Chairman, we have been at this for a little while, too. We have been doing this since 1879 with Federal support. So we are very privileged to have had that opportunity.

My focus this morning is on a piece of Braille technology that here is with me at the table. I will hold it up briefly and hope to not drop it. That is a beta technology that is going to transform educational opportunities for blind students.

We also hope, by the way, to be able to, working with Congress, expand the successful assistive technology training program that was inaugurated a few years back with the help of the Subcommittee on Appropriations for Labor–H.

Braille is indispensable for those of us who are blind. It is a key success factor in employment and successful education. Braille textbooks are a key part of that. But I have to tell you, Mr. Chairman, members of the subcommittee, Braille textbooks are extraordinarily expensive and difficult to produce. They are very difficult to ship. And for the schools and students who work with them, they are also very difficult to manage.

A lot of that has to do with the size and storage. We have got a picture that I think some of you have been handed, but I will also give you another example. A popular biology textbook that we produced in Braille takes up 47 volumes, each of them about 3 inches thick and 4 pounds in weight.

So to do the math, that is about 12 feet of books at 190 pounds. I think that is more than most backpacks will accommodate. So that is what our students are contending with.

We have decided at APH that we needed to tackle this head on, and we needed to create a device that would allow books to be available to blind students in an efficient way, in a cost-effective way, and in an immediate way. So that 190 pounds of books—12 feet of books—the picture that, if you have had a chance to look at it——

Mr. ADERHOLT. Yes, we have.

Mr. SCHROEDER [continuing]. The math book is taller than the young student who is using that book, they will all fit on this device. And every other book that that student would need pretty much throughout their school program will fit on this device.

With this "Monarch," as we have come to call it, our students are going to be able to explore the building blocks of life and the expansiveness of our universe. I am going to just hold up, for those of you who can see it, that could be the universe. It actually happens to be a boron atom, for those of you who didn't do the chemistry real fast. [Laughter.]

Mr. SCHROEDER. It has got five protons, six neutrons, and a lot of electron shells. When I say the "building blocks of life," this is what I mean. Our students will be able to have access to that material in a timely fashion, something we have never been able to do before.

Just 6 months ago, I couldn't have presented this technology to you. It is a beta technology. But thanks to the work and the support from the fiscal 2023 appropriations legislation, we were able to do the research and are in the process of doing the training for our teachers so that they will be able to help their blind students learn this new technology.

But who is kidding who? The blind students will be teaching the teachers. There is no question about that.

Mr. Chairman, we are doing this in partnership with experienced organizations. Humanware, a company with long experience developing assistive technology, is part of this effort, and the National Federation of the Blind, the advocacy organization that works so hard on behalf of individuals who are blind or visually impaired, is part of the effort. This is a device that features multiple lines of Braille and tactile graphics on the same surface.

I am holding another device that is the current state of the art in Braille. It has one line of cells, of 20 cells in this case. Mr. Chairman, I do not think that many of you would tolerate a laptop monitor or a smartphone with one line of Braille, and I am sure you would not want to read a book on a monitor or a smartphone with just one line of text and no pictures.

Blind students are resilient. We have—and I say "we" because I was a blind student. We have had to learn many times without sufficient materials for the task at hand.

What we are hoping is that the committee will be able to make an investment, as we have asked for in the request for $53,000,000 this year—$10,000,000 over 2023—an investment to put this technology into the hands of our students. Give them a chance to learn, to explore and, frankly, thinking of it as the monarch, to let their imaginations fly.

Thank you very much for the opportunity. If there are any questions, I would be happy to take them.

[The information follows:]

Testimony

American Printing House for the Blind

Before the U.S. House of Representatives

Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Paul Schroeder

Vice President, Impact and Outreach

American Printing House for the Blind

March 23, 2023

For over 140 years, the American Printing House for the Blind (APH) has received federal funding to support "manufacturing and furnishing books and other materials specifically adapted for instruction" to serve the tens of thousands of blind students throughout the United States. This federal mandate was established in 1879 when Congress passed the Act to Promote the Education of the Blind. This Act designates APH as the official supplier of educational materials in all educational settings, for students in the U.S. who meet the definition of blindness and are learning at less than college level. For FY 2024, APH requests at least $53.4 million, a $10 million increase over FY23, to accelerate initial production and distribution of game-changing braille technology that will level the learning playing field for blind or low vision students.

Thank you for the opportunity to testify before the Labor, Health and Human Services, Education and Related Agencies Subcommittee today. I also want to thank you for the longstanding support the subcommittee has provided to the American

Printing House for the Blind (APH). I am especially grateful to Chairman Aderholt, Ranking Member DeLauro, subcommittee members and staff for the most recent increase the subcommittee provided to APH in the FY 2023 spending bill enacted last year. Today, I plan to provide an overview of how APH is utilizing these resources and outline our request for FY 2024.

As the world's largest nonprofit organization creating accessible learning experiences through educational, workplace, and independent living products for people who are blind and low vision, APH has excelled in researching, designing, and manufacturing a wide range of materials, tools, and technologies. APH currently offers over 600 products, many incorporating universal design, which means they are designed to be usable by everyone, to ensure students who are blind or low vision, often with other disabilities, can participate fully across the educational environment. From essentials like textbooks in braille or large print to accessible learning tools tactile maps and models, the federal investment in education and opportunity for students who are blind has fostered groundbreaking improvements in instructional material, technology, and practices. APH has ensured that these opportunities were put into the hands of students who are blind or who have low vision. APH has also significantly expanding training resources and hopes to add additional regional partners to enhance assistive technology training for teachers, parents, and students throughout the United States.

Fluency in reading and writing braille is a key component to educational and employment success for individuals who are blind and APH has been at the forefront of the evolution and advances in the use and production of braille. However, braille

textbooks are expensive and time-consuming to produce, challenging to ship, and immensely difficult for school districts and students to manage and store due to their size.

In FY 2024, APH is prepared to release The Monarch, game-changing braille technology that will transform access to education for blind students. This technology successfully builds on the research supported in the FY 23 appropriations legislation.

The development of the Monarch, a multi-line electronic braille and tactile graphic display, is a landmark achievement for blind students who will finally have a truly modern, electronic reading device that will support full participation and inclusion in the education environment and set them up for lifelong success.

Until the advent of the Monarch, there have been few significant advancements in portable electronic braille technology. Currently available electronic braille devices provide only one line of refreshable braille cells. In contrast, the Monarch is capable of rendering 10 lines of braille and tactile graphics, text, and pictures on the same surface. With a built-in web browser, books will be transmitted within minutes over an Internet connection, removing the time-consuming barriers involved in producing and shipping braille textbooks. This new device will dramatically increase opportunities for blind or low vision students to engage in STEM education by providing access to complicated charts and graphs and educational apps such as a scientific graphic calculator, along with enhanced capabilities to read and write computer programming. In addition, APH is working to ensure that the Monarch also includes tools to provide access to material created by classroom teachers which remains a significant accessibility challenge for blind students today. Because state and national exams have also been challenging to

make accessible for braille readers, APH is working with major educational testing companies to enable this new device to be used in an exam mode, dramatically improving current testing approaches for blind students. To maximize the success of this effort, APH is partnering with Humanware, a leading developer of assistive technology, and the National Federation of the Blind, a highly effective advocacy organization of blind individuals.

While traditional paper braille books will continue to be an essential option for instruction, APH is committed to ensuring that students who are blind have access to technological innovations, like The Monarch, designed to support efficient and more immediate access to braille textbooks and classroom content, including graphics. In short, the Monarch transforms educational opportunities, classroom experience, and expands the world of learning for blind and low-vision students with immediacy not previously possible.

APH is honored to carry out the Act to Promote the Education of the Blind. The federal investment ensures that students whose needs might otherwise be overlooked or unmet are afforded opportunities to be fully included in our nation's schools. APH partners with key stakeholders, including state education agencies, to ensure that materials are provided to eligible students throughout the United States. The federal appropriation is critical in ensuring that these students have the opportunity to understand the building blocks of life or the design of the universe through the use of tactile models, share their thoughts through braille or the use of adapted communications devices, or express their imagination with accessible tools to create compelling art. The appropriation, overseen by this Subcommittee, makes this possible,

and the staff of the American Printing House for the Blind is proud and humbled to be the instrument that brings educational opportunities to fruition. Thank you for your ongoing support, and I look forward to answering any questions you may have

Mr. ADERHOLT. Well, thank you. I appreciate, Mr. Schroeder, your testimony and your demonstration here of the Monarch, and it is fascinating to learn about the technology.

And any questions or comments?

Ms. DELAURO. I just want to make the point. Thank you for mentioning that we did increase the funding for the printing for the blind in the 2023 appropriations. But there was also language included to support the device, and we tried to deal with both the device and funding for the device.

Also you said blind students are resilient. You certainly are, certainly are courageous. And thank you very, very much. That is just outstanding.

Mr. SCHROEDER. Thank you, Ranking Member. We have put it to good use, and thank you for this.

Mr. ADERHOLT. I do have a quick question. With the Monarch that you are talking about, how long has it been available?

Mr. SCHROEDER. So this is a beta unit that is about a month old, and I will tell you that all of the technology people at APH were very frightened when they put it in my hands. [Laughter.]

Mr. SCHROEDER. Because I am not a technologist, but I have done my best.

Mr. ADERHOLT. But this, the vision is that it would be in the hands of every blind student that wants to learn?

Mr. SCHROEDER. We are hoping beginning in school year 2024. So toward the end of the fiscal year 2024, to be able to start putting these devices into the hands of blind students, yes.

And that is the purpose of the request is to make sure that this device that is going to be more expensive than the Braille devices we currently have, such as this one that I also have with me, that this device will be able to be available to students, and that State education agencies and schools will be able to start making them available to their students.

Ms. DELAURO. So the request that you're making is for the funding for the device itself and the ability to get it out to wherever it is needed and so forth, so we can get it out the door.

Mr. SCHROEDER. That is correct.

Ms. DELAURO. That is right.

Mr. SCHROEDER. That is correct. Thank you.

Mr. HOYER. Mr. Chairman.

Mr. ADERHOLT. Yes.

Mr. HOYER. I know I keep talking. I apologize for that.

Mr. ADERHOLT. No.

Mr. HOYER. But I was a sponsor, as you know, of the Americans with Disabilities Act. This is what is called in the act a "reasonable accommodation," and we have all experienced it. That is why the elevator tells you what floor it is rather than you are seeing it necessarily. That is why the elevator now has Braille so that a blind person can see it. It is a reasonable accommodation to make sure that people can be included fully.

And you talk about capacity of that technology, I am always amazed, Mr. Schroeder—and I am holding up my iPhone. I am always amazed at the capacity. At some point in time during my life, which has been a long time, it is going to run out of capacity. But it sure hasn't, and I have been using it a long time.

And this is a wonderful, wonderful device to make sure that we include everybody in the opportunities that America and the world has to offer. So thank you very much for bringing this to our attention.

Mr. SCHROEDER. Mr. Hoyer, if I may, I want to thank you for your sponsorship of the Americans with Disabilities Act. I was with you on the day of the signing, got a chance to meet you for the first time. And I am told I look a lot older now, but you don't look any different to me. So——

[Laughter.]

Ms. DELAURO. You are terrific. Wow.

Mr. HOYER. You know, people say to me——

[Applause.]

Mr. HOYER. I love that, but it is people say to me, say, boy, you don't look any older. And when I first met you, I said, you know, the good news is as I get older, my friends gets older and their eyesight gets worse. In your case, it is absolute. But thank you very much.

Mr. ADERHOLT. Well, thank you, Mr. Schroeder. We do appreciate your testimony and look forward to—this subcommittee working with how we can try to help facilitate this program. And again, your testimony is very, very helpful.

Thank you.

Mr. HOYER. Good job.

Mr. ADERHOLT. All right. Well, our next guest is Dr. Anne Zink, M.D., president and chief medical officer, Association of State and Territorial Health Officials and the Alaska Department of Health.

Dr. Zink, we welcome you to the subcommittee and look forward to hearing from you.

THURSDAY, MARCH 23, 2023.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS AND ALASKA DEPARTMENT OF HEALTH

WITNESS

ANNE ZINK, M.D., FACEP, PRESIDENT AND CHIEF MEDICAL OFFICER, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS AND ALASKA DEPARTMENT OF HEALTH

Dr. ZINK. Great. Thank you so much, Chair Aderholt, as well as Ranking Member DeLauro, as well to distinguished members of this committee, not only for the opportunity to appear before you today, but really for all of your tremendous support for public health.

I come to you, as mentioned, as the president of the Association for State and Territorial Health Officers, but as also mentioned, I am the chief medical officer for the State of Alaska, a practicing emergency medicine physician, and a mom to two wonderful girls.

Healthy economies are built with healthy people, and that is why the choice before you today is not a choice on spending, as mentioned, but a choice on investment—investing in public health, investing in the future of this great country, and investing in our children.

I chose emergency medicine because I love the honor of working with people in their greatest moments of need, and we have heard many of them today. A teenager found in her room, vomiting after an attempted overdose, parents desperate for help, a child rushed by bystanders seizing after they were hit by a car on their way to school, or a gentleman with crushing chest pain whose heart stopped but was able to go home a couple days later with his family, thanks to a great team, amazing medical interventions, and some luck.

However, I soon realized that my patients—if I had to care for my patients, I needed to care about health policy. Patients are my why. Public health is the how.

The school counseling that may have allowed that teen to get help before the overdose, the safe routes to school that separated the child from the road, or the diabetes and hypertension management that might have mitigated the heart attack. Not to mention being able to eat food when I go to a restaurant or having clean water when I go home at night.

Emergency medicine is the seawall of our healthcare system, and it is buckling under the weight of a lack of sustained investment in public health. People are boarding for days, weeks, even months in our emergency department, presenting sicker with unchecked or chronic diseases, and we are seeing rising numbers of patients with mental health crises and re-emerging infectious diseases like syphilis, a disease I never saw in my training and now regularly see, as well as chicken pox, tuberculosis, measles. The vast majority of injuries and illness I see every day could be prevented or reduced by investment in public health and primary care.

Good public health is a lot like the daily habit of diet and exercise. It doesn't always come easy. It is hard to prioritize with many other demands, but—and it is often invisible in the daily news cycle, but it pays dividends in the long run.

The Association for State and Territorial Health Officers represents all 50 States and the territories. We manage many of the programs that you have heard about today, and we are united in our consensus that public health funding should be flexible and sustained.

The funding requests for core public health work are detailed in my written testimony and cover a broad range of efforts, numerous Federal agencies from CDC to ASPR to HRSA. However, there are three funding asks I want to bring your attention to specifically within the CDC budget.

The first is $1,000,000,000 for the public health infrastructure and capacity. The second, $153,000,000 for social determinants of health. And a third, $340,000,000 for data modernization.

First, public health infrastructure and capacity. The challenges in Alaska are very different than that in D.C. or Ohio, and the people that we serve are more than one specific disease. But that is often how the funding comes to us. We are so grateful for this committee's creation and support of this program, which is disease agnostic, as well as flexible, allowing us to meet the critical needs and fill the gaps in our communities.

Second funding for social determinants of health. Well, this may include housing and employment, education, transportation, and so

much more. It is important to remember that 80 percent of our health is determined by things outside of the healthcare system. And this funding is not meant to solve all of these larger challenges, but it is to coordinate with agencies and partners to add to the body of knowledge how to maximize the impact of our limited resources and improve health, regardless of geography, race, or gender.

And finally, the dire need for increased funding for data modernization. Our data systems are overstretched, outdated, and often siloed. Our lives, as mentioned with your phone, are enhanced by the daily use of data. Our weather forecasts, money securely transferred one place to another, or our driving routes that take into account a recent accident on our way home.

Yet in healthcare, I look for the most recent public health alerts taped to the bathroom walls of our breakroom. I can't access medication lists or vaccine records when I am trying to care for a patient, and my team in Alaska had to use the National Guard to enter data into different datasets and then manually match them to understand and respond to a global pandemic.

We appreciate the subcommittee, the funding for CDC Data Modernization, DMI, but we need robust, sustained, and yearly funding so that public health can support the patients that you have heard about, to support providers, and to support policymakers.

As a nation, we have made tremendous stride in life expectancy with clean water and sewer. We have built upon that success with revolutions in diagnostic and therapeutic medicine. But our success is slipping. The U.S. has an average life expectancy falling to the lowest of all developed nations, yet we spend more per capita. Our funding depends and our future depends on stable, well-funded public health infrastructure integrated with healthcare.

So thank you to this committee, to the Members of Congress for your time, and we look forward to the success of previous bipartisan agreements to increase the resources for the Nation's public health system in fiscal year 2024.

[The information follows:]

Testimony by Anne Zink, MD, FACEP
President, Association of State and Territorial Health Officials
For the House Appropriations Subcommittee on Labor,
Health and Human Services, Education, and Related Agencies
U.S. Department of Health and Human Services
March 23, 2023

On behalf of the Association of State and Territorial Health Officials (ASTHO), I respectfully submit this testimony on FY24 appropriations for the U.S. Department of Health and Human Services (HHS). ASTHO is the 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 **$11.58 billion for the Centers for Disease Control and Prevention (CDC), $1 billion for Public Health Infrastructure and Capacity, $153 million for Social Determinants of Health, $340 million for data modernization efforts, $1 billion for the Public Health Emergency Preparedness Cooperative Agreement (PHEP), and $175 million for the Preventive Health and Health Services Block Grant (Prevent Block Grant).** Under the Assistant Secretary for Preparedness and Response (ASPR), ASTHO requests **$500 million for the Hospital Preparedness Program (HPP)**. Additionally, we ask for **$10.5 billion in discretionary funding for the Health Resources and Services Administration (HRSA)**.

We are incredibly grateful to Congress for providing resources both via emergency supplemental funding and increased discretionary investments to support the past three years of a herculean global pandemic response effort. It is important to keep in mind that, as a former state health official once eloquently stated, "The US public health system is not a singular entity but a decentralized uneven patchwork of federal agencies and state, local, tribal, and territorial public health authorities. As a result, the collaborative endeavor or public health

is only as strong as the weakest link."[1] As Americans move forward, public health officials remain deeply concerned that our country faces significant challenges, including, but not limited to, the ongoing opioid overdose epidemic, mounting health debt, and mental health crises. Thus, in order to meet not only the next public health emergency threat but also address our current challenges, it is critical that Congress invest in a stronger public health system by providing sustained and flexible funding that meets the needs of state, territorial, and local public health departments.

America's state and territorial public health departments work in partnership with CDC toward this goal, and we respectfully request $11.58 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.

We are grateful for the subcommittee's ongoing support for public health infrastructure and capacity by creating a new line item in the FY22 annual appropriations bill, and we respectfully request $1 billion for this program at CDC in FY24. This disease-agnostic, flexible, and sustainable 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, this funding will support agencies in their efforts to invest in a highly trained workforce that can rapidly scale to meet local, regional, or national needs.

[1] https://www.healthaffairs.org/content/forefront/getting-government-work-public-health

State and territorial health agencies are uniquely positioned to lead, develop, and coordinate interventions 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. ASTHO supports providing $153 million in funding to grow capacity within jurisdictions to address SDOH in their communities and also build the evidence based through research, data collection, and surveillance. An increase in funding will support investment in health equity principles, policies, and approaches to better serve members of historically underrepresented and underserved communities.

Along with partner organizations, ASTHO supports the Data: Elemental to Health Campaign. Previously, we called on Congress to provide the first-ever dedicated funding for public health data systems and build a 21st-century public health data superhighway. Thanks to the work of this Subcommittee, Congress answered the call and provided annual funding and necessary infusions of supplemental funding through the CARES Act and the American Rescue Plan for CDC's public health Data Modernization Initiative (DMI). For FY24, we request $340 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.

States utilize the Preventive Health and Health Services Block Grant (Prevent Block Grant) flexible dollars to offset funding gaps in programs that address leading causes of death and disability. In some cases, this grant serves as seed funding for innovative projects that a state or territorial health department wishes to provide to meet otherwise-unfunded community health goals. ASTHO respectfully requests $175 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%, not including adjustments for inflation.

The Public Health Emergency Preparedness Cooperative Agreement (PHEP) at CDC provides vital support for public health preparedness and response. ASTHO requests $1 billion for PHEP to sustain and improve governmental public health programs. Established in the aftermath of the September 11 terrorist attacks, PHEP has been a core public health preparedness program that supports 62 state, local, and territorial public health departments. The pandemic response demonstrated the need to invest in these programs to rebuild and bolster the United States' preparedness response. CDC is currently refreshing its strategy based on lessons learned from COVID-19 to support public health jurisdictions with an updated response framework that prioritizes essential areas for the public to prepare for, respond to, and recover from health threats in the next five year funding cycle beginning in FY24.

Under ASPR, ASTHO is requesting $500 million for the Hospital Preparedness Program (HPP) and the healthcare coalitions that serve communities to operate and coordinate activities across 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. HPP is the only source of federal funding for this work.

Additionally, we request $10.5 billion in discretionary funding for HRSA. HRSA is a strong federal partner of state and territorial public health agencies, and we support HRSA's ongoing efforts to improve maternal and child health, invest in community health centers, and expand efforts to address the challenges with the healthcare workforce. Additional funding will allow HRSA to fill preventive and primary healthcare 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. State and territorial health agencies rely on HRSA programs to promote integration of behavioral health and physical health, address rural health needs, link individuals with HIV/AIDS to healthcare services, and address the pressing problem of maternal mortality, among several other program areas.

Thank you for considering these funding requests. We are excited for the opportunity to work with Congress to address public health challenges and opportunities impacting our nation's health.

Mr. ADERHOLT. Thank you. Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

I think this really is music because I think what we found in the pandemic was that our public health infrastructure collapsed. It collapsed.

Our laboratories, the data wasn't there. CDC was not getting information as to what was happening, and it was catastrophic. So that I really am very, very proud of the work that we have done in this committee, and I am proud to have established—you know, my focus has been on public health infrastructure.

And what we have done is focused in on the point you have made on data marginalization, on that initiative. The capacity of the funding line to be able to do that. And more than half of the increase in the 2023 budget was about allocating the funding to these kind of core activities.

So I want to encourage you to advocate in this area because we need to build on what was done in 2023 without the numbers of—whenever a crisis comes up, we deal with the crisis for the moment. But then we go back to where it was, and all kinds of institutions have said to me, the medical profession said that is very nice that you are going to address—whether it is Ebola, Zika, whatever it is—but then you go away.

What we need to do is to have consistent funding for public health infrastructure. So I know it is your goal. It is as well my goal, and it is this committee's goal as well.

So, thank you.

Dr. ZINK. Thank you so much.

Ms. DELAURO. Thank you very much.

Mr. ADERHOLT. Dr. Zink, thank you for your testimony. We look forward to working with you on these issues.

Next we, of course, have another Alabamian that is coming before our subcommittee, and we have Ms. Felicia Simpson, co-director of the Alabama Expanded Learning Alliance. And not only from Alabama, but from the prestigious Fourth Congressional District of Alabama, Lake Guntersville, which I have the honor to represent.

So, Ms. Simpson, we look forward to your testimony.

THURSDAY, MARCH 23, 2023.

ALABAMA EXPANDED LEARNING ALLIANCE

WITNESS

FELICIA SIMPSON, CO-DIRECTOR, ALABAMA EXPANDED LEARNING ALLIANCE

Ms. SIMPSON. Good morning, Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee.

I am Felicia Simpson, director of the Alabama Expanded Learning Alliance. On behalf of the Afterschool Alliance, afterschool and summer learning programs, and the families they serve, I would like to thank you for the increase in funding for 21st Century Community Learning Centers in the fiscal year 2023.

Today, I ask you to build on that investment in our communities and address the vast unmet need for afterschool and summer

learning by providing $2,090,000,000 for this program for fiscal year 2024.

21st Century Community Learning Centers allow Alabama to serve 18,643 students in afterschool and summer, and it ranges from pre-K to 12th grade. And we serve 1.5 million students across the Nation. These programs serve students in high-poverty and low-performing schools. They are a tremendous support to underserved communities.

They leverage community partnerships and faith-based partnerships. They keep children safe, provide meals, offer engaging hands-on learning experiences, apprenticeships, and mentorships. They improve school attendance, academic achievement, increase graduation rates, and so much more.

In Alabama and across the Nation, for every one child in an afterschool program, there are four more waiting to get in. As a nation, we must to do more to ensure all children have access to high-quality afterschool and summer learning programs.

I would like to note that partnerships at the State level are critical, and we are fortunate to have an exceptional Governor in Kay Ivey, who has committed funding and support in Alabama, which leverages our Federal investment, and a Lieutenant Governor who understands the importance of STEM in afterschool.

Large industries across Alabama are implementing afterschool and summer programming for children of their employees. Research finds productivity decreases in industry after 3:00 p.m. as parents are more concerned about their children arriving home safely or simply being at home unsupervised.

With jobs in STEM driving our economic growth, afterschool gives nearly 6 million students opportunities to explore STEM. However, funding remains a barrier for these rich resources. States can provide grants for only one in three applications for 21st Century funding.

Before the pandemic, 24.6 million parents nationwide were wanting and needing to enroll their children in afterschool. Simply providing level funding or, even worse, a decrease in 21st Century funding will mean fewer programs and fewer students served. Everyone in this room is here because there was a resource, a support system, a mentor, an opportunity which manifested in your life. All of these are offered in afterschool and summer programs.

Allow me to share a story about a man named Phil. He grew up with a single mom and was considered a latchkey kid. In middle school, he found himself at a crucial place. His mom enrolled him in a local afterschool program. And with that program came stability and a safe place during a very turbulent time in his life.

With the help of a high-quality afterschool program, Phil graduated high school, entered the United States Army Reserves, graduated from Birmingham School of Law, and went on to serve the Alabama State Senate. Phil was blessed to have a high-quality afterschool program within his community and blessed with a single mom who rested in those resources. Not all children are so fortunate.

This is why I urge you to increase funding for 21st Century Community Learning Centers by $750,000,000 in fiscal year 2024, to give more young people like Phil opportunities to learn, inspire,

and thrive. Across the Nation, afterschool and summer program is a privilege afforded to few. Now is the time to deem it a nonnegotiable for supporting children and families. You can do this through your support for 21st Century Community Learning Centers.

Thank you for allowing me this opportunity to speak on the importance of high-quality afterschool and summer programming on behalf of children and families. I am sincerely honored to testify before you.

[The information follows:]

Oral Testimony of Felicia Simpson

Alabama Expanded Learning Alliance (AELA), Director

House Appropriations Committee

Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Good morning Chairman Aderholt, Ranking Member DeLauro, and members of the Subcommittee. I am Felicia Simpson, Director of the Alabama Expanded Learning Alliance (AELA). On behalf of the Alabama Expanded Learning Alliance (AELA), the Afterschool Alliance, and afterschool and summer learning programs and the families they serve in Alabama and across the nation, I would like to thank you for increasing funding for the Nita M. Lowey 21st Century Community Learning Centers in Fiscal Year 2023. Today, I ask you to build on that investment in our communities and address the vast unmet need for afterschool and summer learning programs by providing $2.09 billion for the program in Fiscal Year 2024.

The Alabama Expanded Learning Alliance works to ensure Alabama youth, families, and communities have access to high quality out-of-school-time programming that promotes positive development and life-long learning. Our goals include supporting the development and growth of statewide policies that secure the resources needed to sustain new and existing school-based afterschool programs. With the 21st CCLC funding, Alabama serves approximately 18,643 students in 202 communities. Across the nation, we serve approximately 1.5 million students. Through the 21st CCLC initiative, partnerships between local school, community and faith-based organizations provide students in pre-k through 12th grade with a safe and supportive environment where they participate in academic enrichment opportunities, explore

a diverse set of opportunities in STEM and Literacy, participate in internships and fellowships, and earn high school credits through pathways such as Alabama Act 2021-428 mandating that *"the Alabama State Board of Education, each local board of education, and public charter schools shall routinely inform students and their parents of the ability to earn elective credits."* ELOs are defined as approved out-of-classroom learning experiences which provide a student with enrichment opportunities; career readiness or employability skills opportunities, including internships, pre-apprenticeships, and apprenticeship, or any other approved education opportunities. It has become an integral part of Alabama's workforce.

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. With students back at school, 21st CCLC afterschool and summer learning programs are more essential than ever. Programs can leverage community partnerships to keep children safe, fed and offer engaging, hands-on learning experiences which improves school attendance, academic achievement, and increased graduation rates.

According to "America After 3PM," a national household survey of more than 30,000 families released by the Afterschool Alliance in 2020, in Alabama and across the nation, for every one child in an afterschool program, there are 4 more waiting to get into a program. Cost and access to programs, including transportation and overall availability, were deemed the largest barriers.

For those Alabama families participating in programs, 91 percent of parents are satisfied with their child's afterschool program and 81 percent agree afterschool programs provide

young people opportunities to learn important life skills, like the ability to communicate and work collaboratively with other students. More must be done to ensure that all children in Alabama, and nationwide, are able to take part in an afterschool program that keeps them safe, inspires learning, and gives parents peace of mind. I would like to note that partnership at the state level is critical, and we are fortunate to have an exceptional Governor in Kay Ivey, who has committed funding and support in Alabama which leverages our federal investment. Large industries, such a Mazda Toyota in Huntsville AL, are implementing afterschool and summer programming for their employee's children. Research finds productivity decreases in industry after 3PM as parents seem to be more concerned about their children arriving home safely, transitioning to a childcare facility after the school day ends, or attending a local YMCA or Boys and Girls Club program.

Of course, every state has its challenges and successes. A recent survey of more than 1,000 afterschool program providers found that nationally, more than half of providers (53 percent) had a waitlist for their program and 1 in 4 (23%) are operating at reduced capacity. While American Rescue Plan Act 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.

21st Century Community Learning Centers are a lifeline, helping students reconnect, re-engage, and develop the skills they need to be successful in school and in life. They anchor

students to peers and caring adults, and help many discover their passions, be it robotics, gardening, coding or music. Programs are innovative and respond to students' needs. Junior ROTC (JROTC) programs are available through many programs. Further, programs sometimes emphasize physical education and activity to ensure that young people who want to serve in the military can do so. And, as stated earlier, other programs offer students academic credit for learning that happens in afterschool programs. At this moment when so many youth are struggling, afterschool programs provide the trauma-informed care so many need. In Alabama, we are partnering with the Department of Mental Health to ensure staff are trained and understand how to care for children with these challenges and the students are provided with support.

Students and communities absolutely benefit from afterschool programs. Students who regularly participate improved their school attendance, health-related behaviors, and math and reading achievement. Regular participation helped narrow the achievement gap between high- and low-income students in math, improved academic and behavioral outcomes, and reduced school-day absences. With jobs in science, technology, engineering, and math (STEM) driving economic growth, afterschool gives nearly six million students opportunities to explore STEM.

However, funding remains a barrier for these rich experiences. States can provide grants for only 1 in 3 requests for 21st CCLC funding. Across 10 years, $4 billion in local grant requests were denied due to insufficient funding. Before the pandemic, 24.6 million students nationwide were on the afterschool waitlist. As of last fall, data shows that for every child in an afterschool program, four were waiting to get in. Additional funding will also help programs address staffing challenges, which is a major and growing concern. Costs associated with staffing,

transportation, and supplies continue to increase. Thus, level funding or a decrease in 21st CCLC funding will mean fewer programs and fewer students served.

Afterschool and summer learning programs help parents work with less worry knowing that their children are safe and happy while benefitting socially and academically. More afterschool programs are needed to help keep youth in school, help them graduate and prepare for the workforce.

Finally, I want to share a story about a gentleman named Phil. As a child, he grew up with a single mom and was considered a "latchkey kid." In middle school, he found himself at a pivotal point as to his future. His mom enrolled him in a local afterschool program which brought stability and a safe place during a turbulent time in his life. Phil graduated high school, entered into the United States Army Reserves, graduated from Birmingham School of Law and eventually served our state in the Alabama Senate from 2010-2018 representing the 10th district. Currently, he is the policy director for the Alabama Policy Institute, and hosts a conservative radio program, Rightside Radio. Phil was blessed to have a high-quality afterschool program near his school and a single mom who knew about the resources within her community. Not all children are so fortunate.

This is why I urge you to increase funding for 21st Century Community Learning Centers by $750 million in fiscal year 2024 to give more young people, like Phil, opportunities to learn and thrive. Out of School Time programming was once a privilege afforded to few. Now, it has become a non-negotiable for supporting children and families. Thank you for allowing me this opportunity to advocate on behalf of children and families in Alabama and across the nation.

Mr. ADERHOLT. Thank you. Thank you, Ms. Simpson.

And I happen to know Phil, and he is a great individual and a good friend. So I am happy to know that we have a mutual friend there with the former senator.

And we appreciate your testimony. This is an important issue—oh, yes, please?

Ms. DELAURO. I just want to say many, many years ago, I volunteered in the afterschool program at the Conte Community School in New Haven, Connecticut. Taught modern dance and calligraphy. Couldn't do either one of them at the moment here.

So, but this program, 21st Century Learning Centers, is named after Nita Lowey, who was the chair of the Appropriations Subcommittee, who was very, very much committed to the afterschool program, as I am as well. And we were able to deal with an increase, $40,000,000 increase, because we believe in this program.

But I also, again, want to make my colleagues on both sides of the aisle knowledgeable that if we move to a 22 percent cut in the 2024 budget, your request of $750,000,000, what would happen to this program would be a cut of $293,000,000. So we need your advocacy because you are the boots on the ground. You see it. You know its value. And so thank you very, very much for your advocacy.

Mr. ADERHOLT. Thank you, Ms. Simpson. We appreciate your testimony.

Our next guest who will be speaking, giving testimony, will be Mr. Clarke Forsythe, senior counsel, Americans United for Life.

So, Mr. Forsythe, we welcome you here to subcommittee and look forward to your testimony.

THURSDAY, MARCH 23, 2023.

AMERICANS UNITED FOR LIFE

WITNESS

CLARKE FORSYTHE, SENIOR COUNSEL, AMERICANS UNITED FOR LIFE

Mr. FORSYTHE. Chairman Aderholt, Ranking Member DeLauro, members of the committee, I am Clarke Forsythe, and I serve as senior counsel with Americans United for Life.

And I want to thank you for the opportunity to testify today in support of preserving pro-life appropriation riders, including the Hyde Amendment, Title X, the Weldon Amendment, and Medicare Advantage rider. I urge the subcommittee to keep these riders for three main reasons.

Abortion funding aggravates the pressure on women to abort. Given massive Federal deficit, it makes no sense to use tax dollars to pay for elective abortion when private funding is readily available, as made clear in Robin Marty's book in which she documents it State by State.

And tax-funded abortion violates the conscience of millions of American taxpayers, which a bipartisan majority of Members have recognized since 1976. All of the pro-life appropriation riders in the Republican bill that passed the House in 2018 should be preserved.

First, studies have found that coercion or pressure on women to abort plays a role in many abortions. One 2004 study found that 64 percent of women felt pressured by others to have the abortion. And coercion can take many forms, from intimate partner violence to subtle pressure to paying for the abortion.

And early abortion rights advocate Daniel Callahan, a nationally recognized ethicist, recognized that legalized abortion has given men more choice because they now have, as he said, a potent new weapon in the old business of manipulating and abandoning women.

Abortion increases the risk of intimate partner violence. In fact, the prevalence of intimate partner violence is nearly three times greater for women seeking abortion than for women continuing a pregnancy, and that is cited in the ACOG Committee opinion, page 2, in footnote 10 of my written testimony.

Employers may also pressure women to abort. This problem became so obvious to Congress that Congress enacted the Federal Pregnancy Discrimination Act shortly after the Roe decision.

Trafficked women are also at significant risk of coerced abortion. A 2014 study found that 66 trafficked victims had a total of 114 abortions. The victims reported that they often did not freely choose the abortions they had while trafficked.

Coerced abortion has become so widespread in the United States since the Roe decision that at least 20 States have enacted some form of law to protect women from a coerced abortion. Public funding aggravates the pressure women feel to abort by weighting the financial scale in favor of abortion and eliminating a reason they may have against abortion.

Second, given the massive Federal deficit, it makes no sense for Congress to fund elective abortion with tax dollars when more than enough private funding for abortion exists through numerous funders at the State and local level across the country.

And third, funding restrictions are an important safeguard for taxpayers' conscience rights. The most prominent abortion funding restriction is, of course, the Hyde Amendment, which Congress has approved since 1976.

Although Americans hold different views on abortion, polling data has shown a consistent consensus of Americans supporting restrictions on abortions, including public funding restrictions. In fact, in the 2023 Marist poll, 60 percent of Americans said they opposed taxpayer funding of abortion.

A bipartisan majority of Members that has supported abortion funding restrictions for 46 years has understood that funding restrictions are critical to support for other social welfare appropriations. Instead of becoming embroiled in the abortion debate for every single social welfare program, Members have determined to restrict abortion funding, thus facilitating the passage of important social welfare legislation that won't also fund abortion.

And pro-life riders also protect the conscience rights of medical professionals, in addition to taxpayers. The Weldon Amendment, for example, is an anti-discrimination provision that defends the conscientious objection of healthcare professionals, healthcare institutions, healthcare insurance plans that refuse to provide, pay for, or refer for abortion.

So these appropriation riders are essential to protect conscience, and I urge the subcommittee to protect women from another layer of coercion and safeguard the conscientious objection of taxpayers and medical professionals.

Thank you.

[The information follows:]



Americans
United
for Life

Written Testimony of Clarke D. Forsythe, J.D., M.A.
Senior Counsel, Americans United for Life
Submitted to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Committee on Appropriations
March 23, 2023

Dear Chair Aderholt, Ranking Member DeLauro, and Members of the Subcommittee:

My name is Clarke Forsythe, and I serve as Senior Counsel at Americans United for Life ("AUL"). AUL is a national law and policy nonprofit organization, which strives for a world in which everyone is welcomed throughout life and protected in law. Thank you for the opportunity to testify in support of pro-life Health and Human Services appropriations riders, including the Hyde Amendment,[1] Title X abortion funding restrictions,[2] Weldon Amendment,[3] and Medicare Advantage program conscience protections.[4] I urge the Subcommittee to keep these riders for the following reasons.

Publicly-Funded Abortion Increases the Coercion on Women to Abort

Public funding of abortion increases the pressure a woman may already feel to have an abortion. The reality is many women are coerced into having an abortion by either a partner, family member, employer, or sex trafficker, as illustrated by numerous empirical studies.[5] As an example,

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[1] *See* Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, div. H, tit. V, §§ 506–507, ___ Stat. ___, ___ (2022) (restricting the use of federal funds for abortion, except for medical emergencies and cases of rape or incest).
[2] *See id.* div. H, tit. II (prohibiting the use of Title X funds for abortions and requiring "that all pregnancy counseling shall be nondirective").
[3] *See id.* div. H, tit. V, § 507(d) (establishing anti-discrimination protections for medical professionals, facilities and health plans that conscientiously object to "provid[ing], pay[ing] for, provid[ing] coverage of, or refer[ring] for abortions").
[4] *See id.* div. H, tit. II, § 209 (protecting entities' participation in the Medicare Advantage program when they "will not provide, pay for, provide coverage of, or provide referrals for abortion.").
[5] *See, e.g.*, Tim Bradley, *New Michigan Laws Deter and Punish Coerced Abortion*, CHARLOTTE LOZIER INST. (June 20, 2016), https://tinyurl.com/MICoercionBan; Priscilla K. Coleman et al., *Women Who Suffered Emotionally from Abortion: A Qualitative Synthesis of Their Experience*, 22 J. AM. PHYSICIANS & SURGEONS 113, 115 (2017); REPORT OF THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION 20–21 (2005).

a 2004 study found 64% of women felt "pressured by others" to have an abortion.[6] Because coerced abortions have become such a widespread phenomenon since the Supreme Court decided *Roe v. Wade*, at least 20 states have enacted some form of coercive abuse prevention law.[7]

Coercion can take many forms, such as intimate partner violence ("IPV"), force, vocal opposition, subtle pressure, or paying for the woman's abortion. Psychologist Susan Nathanson wrote about the role of her husband's coercion in her decision to abort, who stated, "If you don't choose to abort this child, I will push you to do it."[8] Unfortunately, Nathanson is not alone in her experience as many women suffer reproductive control or IPV when pregnant.

IPV is "abuse or aggression that occurs in a romantic relationship."[9] Abortion increases the risk of IPV.[10] The prevalence of IPV is nearly three times greater for women seeking abortion than for women continuing a pregnancy.[11] Similarly, a study found that one quarter of women of reproductive age have reported experiencing reproductive control.[12] Reproductive control is defined as "actions that interfere with a woman's reproductive intentions."[13]

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[6] Vincent Rue, et al., *Induced Abortion and Traumatic Stress: A Preliminary Comparison of American and Russian Women*, 10 MED. SCI. MONITOR SR5, SR5–16 (2004).

[7] ALA. CODE § 26-23A-4(b)(7) (2014); ARIZ. REV. STAT. § 36-2153(A)(2)(d) (2021); ARK. CODE § 20-16-1705 (2015); CONN. GEN. STAT. § 19a-601(a)(1) (1990); DEL. CODE tit. 24 § 1786 (1995); IDAHO STAT. § 18-615 (2008); IND. CODE § 16-34-6-6 (2022); KAN. STAT. § 65-6709(k) (2017); LA STAT. tit. 40 § 1061.17(C)(1)(j) (2022); ME. STAT. tit. 22 § 1599-A(1) (2019); MICH. COMP. LAWS § 333.17015 (2013); MO. REV. STAT. § 188.027(4) (2019); MONT. CODE § 50-20-106(7) (2009); NEB. REV. STAT. §§ 28-327(1)(d), (4)(a) (2022); N.C. GEN. STAT. § 90-21.91 (2011); N.D. CENT. CODE § 14-02.1-02.1(1)(a) (2022); OHIO REV. CODE ANN. §§ 2317.56(B)(4)(b) (2021), 3701.791(C) (2009); OKLA. STAT. tit. 63 § 1-757.7 (2021); 18 PA. CONS. STAT. § 3206(g) (1992); S.D. CODIFIED LAWS §§ 22-17-14 (2021), 34-23A-56 (2015); TENN. CODE ANN. § 39-15-202(i)(1)(A) (2018); TEX. HEALTH & SAFETY CODE ANN. § 171.012 (2021); UTAH CODE ANN. § 76-7-312 (1974); W. VA. CODE § 16-2I-2 (2021); WIS. STAT. § 253.10(3)(b) (2016).

[8] SUE NATHANSON, SOUL CRISIS: ONE WOMAN'S JOURNEY THROUGH ABORTION TO RENEWAL 28 (1990).

[9] *Preventing Intimate Partner Violence*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 11, 2022), https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html.

[10] COMM. ON HEALTH CARE FOR UNDERSERVED WOMEN, *Reproductive and Sexual Coercion*, Comm. Op. No. 554, at 2 (reaffirmed 2022) (internal citation omitted); Megan Hall et al., *Associations Between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, 11 PLOS MED. 1, 15 (Jan. 2014).

[11] Hall, *supra* note 10, at 15; *see also* Jay G. Silverman et al., *Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict*, 100 AM. J. PUB. HEALTH 1415, 1416 (Aug. 2010).

[12] Sam Rowlands & Susan Walker, *Reproductive Control by Others: Means, Perpetrators and Effects*, 45 BMJ SEXUAL & REPROD. HEALTH 61, 62 (2019).

[13] *Id.*

Coercive abuse can come from parents, family members, or employers as well. Parental pressure to abort is documented in court cases where minors have sought protection from coercive parents. The media has also reported stories of family members and employers forcing women and young girls to abort.[14] Additionally, a 1990 study reported open hostility from program directors to pregnant residents,[15] and female lawyers have testified to experiencing the same pressures in law firms.[16]

Sex trafficking victims are also among the number of women who suffer reproductive control. A 2014 study found that 66 sex trafficking victims had a total of 114 abortions.[17] The sex trafficking victims "reported that they often did not freely choose the abortions they had while being trafficked," with a majority indicating "that one or more of their abortions was at least partly forced upon them."[18]

Appropriating federal funds to cover abortion does anything other than give women a "choice." Rather, public funding of abortion exacerbates the pressure women feel to abort by tilting the economic comparison in favor of abortion. This skews women's decision-making between abortion and childbirth, especially for low-income women. Given the massive federal deficits, it

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[14] *See* Adrienne P. Samuels, *Police Say Maine Couple Kidnapped Daughter, Intent on Forcing Abortion*, BOS. GLOBE (Sept. 18, 2006), http://archive.boston.com/news/local/articles/2006/09/18/police_say_maine_couple_kidnapped_daughter_intent_on_forcing_abortion/; Damon Sims, *Cleveland Man Accused of Beating 16-Year-Old Pregnant Daughter*, CLEVELAND.COM (July 8, 2008), http://blog.cleveland.com/metro/2008/07/cleveland_man_accused_of_beati.html; Associated Press, *Girl, 16, Forced to Drink Turpentine to Induce Abortion*, N.Y. SUN (Sept. 27, 2006), https://www.nysun.com/article/national-girl-16-forced-to-drink-turpentine-to-induce; Welch Suggs, *Former Coach at Berkeley is Accused of Pressuring Assistant to Have an Abortion*, CHRON. HIGHER EDUC. (Sept. 17, 2002), https://www.chronicle.com/article/coach-is-accused-of-urging-assistant-to-have-an-abortion/; Jessica Hopp et al., *Mystics Coach Was Cited in Pregnancy Suit*, WASH. POST (September 16, 2002), https://www.washingtonpost.com/archive/politics/2002/09/16/mystics-coach-was-cited-in-pregnancy-suit/75f3fd03-184c-4292-9264-3ba074460c4c/.

[15] David Shulkin & Merlem Bari, *Letter to the Editor*, 324 N. ENG. J. MED. 630 (1991).

[16] Joan H. Stern, *Female Talent at Lawfirms*, NATL. L. J., Mar. 18, 1991, at 15–16.

[17] Laura J. Lederer & Christopher A. Wetzel, *The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities*, 23 ANNALS HEALTH L. 61, 73 (2014).

[18] *Id.*

makes zero sense for Congress to fund abortion with taxpayer dollars, especially when it violates the conscientious objections of many Americans and when there is already private funding for abortion throughout the country.[19]

Pro-life Appropriations Riders Are Integral Conscience Protections

Pro-life appropriations riders protect the religious, moral, and ethical convictions of taxpayers and medical professionals who conscientiously object to supporting or participating in abortions. Fundamentally, conscientious objections to abortion are refusals to violate human dignity and take a human life.

Funding restrictions are an important safeguard for taxpayers' conscience rights.[20] The most prominent abortion funding restriction is the Hyde Amendment. In introducing his amendment, Congressman Hyde explained, "we who seek to protect that most defenseless and innocent of human lives, the unborn—seek to inhibit the use of Federal funds to pay for and thus encourage abortion as an answer to the human and compelling problem of an unwanted child."[21] Research has credited the Hyde Amendment with saving over 2.4 million unborn lives.[22]

Abortion funding restrictions are critical for social welfare appropriations. "Abortion presents a profound moral issue on which Americans hold sharply conflicting views."[23] Yet, since 2008, polling data has shown "a consistent and clear consensus of Americans who support restrictions on abortion," including funding restrictions.[24] In the 2023 Knights of Columbus-Marist

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[19] ROBIN MARTY, HANDBOOK FOR A POST-ROE AMERICA 66–72, 163–278 (2019) (detailing the National Network of Abortion Funds (NNAF) and listing other abortion funds available in "every state in the nation.").
[20] This is especially important because in virtually all cases, federal courts do not have jurisdiction to hear taxpayer suits to enjoin federal appropriations. *Massachusetts v. Mellon*, 262 U.S. 447, 486–489 (1923).
[21] 122 Cong. Rec. 20,410 (1976) (statement of Rep. Henry Hyde).
[22] Michael J. New, *Addendum to Hyde @ 40: Analyzing the Impact of the Hyde Amendment*, CHARLOTTE LOZIER INST. (July 21, 2020), https://lozierinstitute.org/addendum-to-hyde-40-analyzing-the-impact-of-the-hyde-amendment/.
[23] Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2240 (2022).
[24] *See* Michael Mead, *New 2023 Knights of Columbus-Marist Poll: Post* Roe*, A Majority of Americans Continue to Support Legal Limits on Abortion*, KNIGHTS OF COLUMBUS 1, 2 (Jan. 18, 2023),

Poll, 60% of Americans said they opposed taxpayer funding of abortion.[25] Instead of becoming embroiled in the abortion debate, Congress has determined to restrict the scope of its appropriations, thus facilitating the passage of important social welfare legislation.

Pro-life riders also protect the conscience rights of medical professionals. The Weldon Amendment, for example, is an anti-discrimination provision that defends the conscientious objections of healthcare professionals, institutions, and insurance plans that refuse to "provide, pay for, provide coverage of, or refer for abortions."[26] As Representative David Weldon explained, his amendment "is a continuation of the Hyde policy of conscience protection" and a response to aggressive litigation attempts to infringe on conscience rights.[27] The Weldon Amendment, like other pro-life riders, helps protect "[t]he right of conscience [which] is fundamental to our American freedoms."[28] Thus, pro-life appropriations riders are essential conscience protections.

Conclusion

Pro-life riders are an integral part of the annual appropriations bill. I urge the Subcommittee to maintain the rich legal tradition of protecting women from coercion and safeguarding the conscientious objections of taxpayers and medical professionals.

Sincerely,

Clarke D. Forsythe
Senior Counsel
Americans United for Life

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https://www.kofc.org/en/resources/communications/polls/majority-americans-still-support-abortion-limits.pdf (citation omitted).

[25] *Id.* at 1.

[26] Pub. L. No. 117-328, div. H, tit. V, § 507(d), ___ Stat. ___.

[27] 150 Cong. Rec. H10,090 (referencing, *e.g.*, *Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997) (requiring a nonprofit hospital to perform elective abortions at its facility over the hospital's conscientious objections)).

[28] *Id.*

Mr. ADERHOLT. Thank you, Mr. Forsythe, for your testimony. And we—did you want——

Ms. DELAURO. Yes.

Mr. ADERHOLT. Yes. No, go ahead.

Ms. DELAURO. I will just make a very, very simple statement. Mr. Forsythe, the decision to terminate a pregnancy is a very serious one. It is a very personal one. It is a decision, which women should be allowed to make with their families, with their doctor, with clergy, with the people who may be the closest to them that could help them in what is probably a very difficult time.

I would also say that we need to respect the decisions that women make. We need to trust women. And I understand your position, and I think it is important for us to realize that paramount is the ability for women to make those decisions for their health, for their economic, financial security and stability of their family.

And I trust them. It is about their dignity. It is about the respect that we should make.

And I thank you, Mr. Chairman.

Mr. ADERHOLT. Yes, well, thank you.

And of course, the abortion issue is one that probably divides Congress more than anything else. But I think I appreciate your testimony from the aspect of talking about the public funding aspect, which is something that I think you mentioned 60 percent of Americans disagree with public funding, and no matter how you come down on the issue of abortion, the public funding is in a totally different category.

So thanks for bringing that to our attention, and we look forward to working with you.

Mr. FORSYTHE. Thank you. Chairman, may I respond very briefly?

Mr. ADERHOLT. Yes.

Mr. FORSYTHE. That picture you paint, though, is complicated by the medical literature that shows the many sources of coercion, the intensity of coercion, and the many women affected by coercion. So that needs to be factored in.

Thank you.

Mr. ADERHOLT. Thank you for your testimony.

Next our public hearing guest is Katherine McGuire, chief advocacy officer of the American Psychological Association.

And Ms. McGuire, we appreciate your testimony here today and look forward to it.

THURSDAY, MARCH 23, 2023.

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES

WITNESS

KATHERINE BRUNETT McGUIRE, CHIEF ADVOCACY OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES

Ms. MCGUIRE. Good morning, Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee.

I am representing the American Psychological Association and APA Services, the advocacy arm for the association. APA is the largest organization representing psychology in the United States,

with 146,000 members and our affiliates. We are grateful for this committee's leadership in making bipartisan investments in mental health over the past several years, but more needs to be done.

In my written statement, I point to a number of specific programs and recommended funding levels that we urge you all to consider. Today, I want to spend time talking about the human impact of these programs and why robust funding levels are so vital to ensure a healthier tomorrow.

57.8 million U.S. adults are living with varying levels of mental health concerns. APA data show a population experiencing remarkably high levels of stress and anxiety. Psychologists report that demand for treatment for anxiety and depression remains high.

Practitioners are seeing increased workloads and longer and longer waitlists, which have contributed to higher levels of burnout within the profession. Researchers responsible for ensuring new products are ethically designed, determining the impact of online platforms on children, or testing new treatments are left underfunded.

Most alarming is the increase in the crisis we continue to see in youth mental health. Nationally, nearly 4 million children experienced depression in the last year, while the rate of suicide attempts increased by a disturbing 55 percent.

Educators report increasing numbers of students seeking assistance for mental health issues, and hospitals continue to be overwhelmed by the number of children seeking care for mental health emergencies. Recent CDC data also show that 45 percent of high school students are feeling consistently sad and hopeless, with teen girls and LGBTQ+ students showing disproportionate levels of concerning behaviors, all while they are bombarded by harmful online content.

This is more than a mental health crisis. This is the accumulation of neglect, stigma, and unequal treatment of mental and behavioral health that we must turn the tide against.

To meet these challenges, we need investments in a diverse and robust mental health workforce. The U.S. continues to face a nationwide shortage of mental healthcare providers, including psychologists, with Southern States having even less access to care. That gap of care is most evident in our new mothers, with over 50 percent of women with postpartum depression not receiving any mental health treatment at all.

By 2030, these shortages will worsen significantly, particularly in rural communities. Of the over $15,000,000,000 our country invests annually in the training of physical healthcare professionals, less than 5 percent of that amount is invested in building our mental healthcare workforce.

Funding HRSA's Graduate Psychology Education Program at $30,000,000 and SAMHSA's Minority Fellowship Program at $36,700,000 will help increase our Nation's supply of psychologists trained to provide culturally competent, integrated mental and behavioral healthcare to underserved populations. In addition, we urge Congress to fund the enforcement of mental health parity.

Finally, Congress must also support the treatment and prevention of mental health problems in our Nation's youth. An increase of at least $200,000,000 for youth mental health research at the

National Institute of Mental Health, including $20,000,000 for the study of the mental health impacts of social media, is needed.

This must also include a focus on meeting young people where they are. Schools and colleges are often on the front lines of the youth mental health crisis. They need the resources to deliver comprehensive services that support prevention and early intervention. Additionally, Congress must further invest in programs that promote all evidence-based models of integrated primary and behavioral healthcare, which is especially well suited for the pediatric population.

Much of the recent funding for mental healthcare has been provided on an emergency basis, but we cannot address our Nation's mental health needs solely through crisis response, let alone go back to past funding levels. Instead, Congress must provide consistent, sustainable support to build the mental health workforce and to help champion the role of psychologists in all of our communities.

I thank you again for the opportunity to speak with you today. The American Psychological Association and its members stand ready to find solutions to the critical issues that this committee has authority over.

Thank you.

[The information follows:]

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

American Psychological Association Services, Inc.
Public Witness Written Testimony Submitted March 20, 2023
Katherine B. McGuire, Chief Advocacy Officer
United States House of Representatives
Appropriations Subcommittee on Labor, Health and Human Services, and Education
Fiscal Year 2024 Appropriations

The American Psychological Association Services (APA Services) is the companion organization of the American Psychological Association (APA), which is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

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 Services requests the following funding levels for FY 24 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 Services endorses the Ad Hoc Group's request of at least $50.924 billion for the National Institutes of Health (NIH) in FY 24. We also support the President's request for a $200 million increase for the National Institute of Mental Health (NIMH) to help combat the growing mental health crisis, including $20 million for the study of the mental health impacts of social media. APA Services supports language directing NIMH to collaborate with the National Institute of Child Health and Human Development and the National Institute of Minority Health

and Health Disparities on research in the populations most vulnerable to mental health disorders. APA Services recommends at least $900 million for the Institute of Education Sciences (IES). Finally, APA Services urges the Committee to provide $25 million for gun violence research in FY 24 at NIH and $35 million at the Centers for Disease Control and Prevention (CDC).

Supporting the Psychology Workforce:

The nation's mental and behavioral health workforce must be expanded to meet the growing demand for services. To address this, APA Services supports increased funding for the following programs within HHS' Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA).

Within HRSA, APA Services joins the Mental Health Liaison Group (MHLG) in urging the Committee to provide $30 million for the Graduate Psychology Education Program and $387 million for the Behavioral Health Workforce Education and Training (BHWET) Programs. APA Services joins the Coalition to Stop Opioid Overdoses (CSOO) in requesting the Committee provide $15 million for the Integrated Substance Use Disorder Training Program (ISTP). These programs are increasing training opportunities for doctoral, internship, and post-doctoral residents in integrated settings, specifically for medically underserved populations.

Within SAMHSA, APA Services requests $36.7 million for the Minority Fellowship Program (MFP). This increase will support MFP's dual mission to increase the diversity of the mental health 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:

APA Services joins the MHLG in requesting $1.7 billion for SAMHSA's Community Mental Health Block Grant including a 5% set-aside for prevention and early intervention; $2.7

billion for the Substance Use Prevention, Treatment and Recovery Services Block Grant and $2.0 billion for the State Opioid Response (SOR) Grants in FY 24. APA Services also supports the request for $713.4 million for Opioid Overdose Prevention and Surveillance at CDC. This funding would support the integration of state and local prevention and response efforts, provide support for providers and health systems prevention (including the use of prescription drug monitoring programs as a clinical decision support tool), enhance partnerships with public safety and first responders, and establish and improve linkages to medications for opioid use disorder.

APA Services also supports $160 million for the SAMHSA Minority AIDS Initiative for the National Suicide Prevention Lifeline, $836 million for 988 and Behavioral Health Crisis Services grants, $100 million for the Mobile Mental Health Crisis Response program, $11 million for the Suicide Prevention Resource Center, $28.2 million for the National Strategy on Suicide Prevention (NSSP), $10 million for the 988 Coordinating Office, and $104.9 million for the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant program.

Additionally, we ask the Committee to include $50 million for the State/Tribal Youth Suicide Prevention Program and $12 million for the Campus Suicide Prevention Grant Program. The Committee should also include $150 million through the Department of Education's Fund for the Improvement of Postsecondary Education to address the mental health of college students.

To ensure that K-12 students receive a well-rounded education, access to school-based mental health services, and programs that foster safe and healthy schools, APA Services requests $1.48 billion for Title IV-A, the Student Support and Academic Enrichment Grant, and $244 million for Project AWARE. To increase the number of mental health providers in school settings, APA Services requests $428 million within the Safe Schools National Activities for the

School Based Mental Health Services Professional Demonstration Grant and the School-Based Mental Health Services Grant Programs. APA Services also urges the Committee to include $16.26 billion for Part B (Grants to States) of the Individuals with Disabilities Education Act to provide equitable education for students with disabilities.

APA Services 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 supporting healthy pregnancy at NIH.

Finally, APA Services 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 Services requests $10 million for MHPAEA enforcement, with 10% allocated to the Office of the Solicitor for parity litigation. To support parity act enforcement within HHS, APA Services requests $10 million for CMS's Center for Medicaid and CHIP Services.

Addressing Social Determinants of Health & Social Safety Net:

Within HHS' Administration for Children and Families, APA Services supports $1.7 billion for the Social Services Block Grant. In addition, APA Services urges the Committee to provide $13.1 billion for the Head Start Program, $9 billion for the Child Care and Development Block Grant, $360 million for Preschool Development Grants, and $125 million for CAPTA Title I to support state child abuse prevention and treatment services.

Improving the health of the entire population requires an expansion of where we see interventions occurring across the entire continuum of behavioral health needs and how they ar carried out. Successfully addressing the health inequities caused and exacerbated by the

pandemic requires a fundamental shift in how we approach behavioral health and that is where we bring forth the robust body of psychological science to demonstrate the importance of behavioral health in improving population health.

APA Services is dedicated to a population-health approach to address societal concerns whether in rural areas or communities that are under resourced. As such, APA Services supports the $100 million request for CDC's Social Determinants of Health (SDOH), which will provide tools that support community efforts to improve health. To expand the reach of federal school-based health education, APA Services requests $90 million for the CDC Division of Adolescent and School Health (DASH), to increase access to health services, implement evidence-based sexual health education, and foster supportive environments for young people to learn. APA Services 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.

Finally, APA Services supports $5 million for CDC's Office of Rural Health to address unique rural health care needs, coordinate efforts across CDC's portfolios, tailor scientific and communications resources, and improve public health functions and service delivery. Again, APA Services thanks the Subcommittee for the opportunity to share our FY 24 funding requests and we urge your full consideration.

Mr. ADERHOLT. Thank you, Ms. McGuire.

We appreciate your testimony, and certainly we—I understand that mental health is really a serious issue in this country, and sometimes it is the hidden illness that we don't see so much of the time. So your testimony is very well received.

Ms. DeLauro.

Ms. DELAURO. Yes. I just want to point out—thank you for bringing up the issues around mental health. It was a crisis before the pandemic, and it certainly was exacerbated by that. So it is front and center.

But I want to be mindful of what the application of the 2022 budget numbers to the 2024 budget would mean, a 22 percent reduction in the 988 Suicide Lifeline, cut responses by 900,000. Nearly a million people facing suicidal, mental health, or substance use crisis would be unable to access support and stabilization services.

State Opioid Response, more than 29,000 would lose admission to the opioid use disorder treatment. An estimated 46.3 million Americans age 12 and older had a substance use disorder, 106,000 people died from a drug-related overdose in 2021. And it would really cut back the opportunities for us to be able to provide a well-qualified mental health professional in every school in this Nation in order to deal with the increase of mental health problems that our kids are facing.

And I will just tell you. I have a staff member at the moment who is watching her 12-year-old on a 24-hour basis, going in to see him every hour to make sure that he is all right because he is in danger of suicide.

Serious problem. We can't afford the results of cutting resources, but we need to be increasing these resources.

Thank you for what you are doing in your professional life and for your advocacy.

Mr. ADERHOLT. Thank you, Ms. McGuire. Thank you.

Our final testimony for today will be from Mr. Richard Stern. He is the director of the Grover Hermann Center for Federal Budget at the Heritage Foundation.

And I see from your bio that you also have worked on Capitol Hill. So you are not a stranger to this place, and so we welcome you and look forward to your testimony.

THURSDAY, MARCH 23, 2023.

THE HERITAGE FOUNDATION

WITNESS

RICHARD STERN, DIRECTOR, GROVER M. HERMANN CENTER FOR THE FEDERAL BUDGET, THE HERITAGE FOUNDATION

Mr. STERN. Well, thank you. And thank you for including my testimony in today's proceedings.

So, as many of the witnesses have come here today to ask for more taxpayer funding for this program or that, I have come here today to encourage that we reduce funding levels. I am here today for the 334 million Americans who are suffering with the economic and societal ills caused by over Federal spending, by runaway Federal spending, and overregulation.

It is easy to point to where the Government sends dollars. It is much, much harder to point to the destruction wrought when Government takes that money out of the private sector.

The intrusion of the Federal Government in our economy has likely cost average American households tens of thousands of dollars of annual income. But that income loss isn't about dollars and cents. It is about a loss that is much, much more profound—the loss of innovation, of technological progression, and scientific knowledge, the things that would have extended health and quality of life even further. Things that we can't imagine today that would have come if we had had a more efficient economy, if the Government had not had those burdens.

It is the tragic reality that the Government's intrusion in the economy and its runaway spending has dimmed and denied the futures of hundreds of millions of Americans. And today, Americans face the scourge of inflation. They have seen their mortgage rates spike. They have seen their purchasing power drop.

The Federal budget is set to consume more than a quarter of our economy in just a decade. Almost 82 percent of the debt that we have today has been created just in the last generation, just since 2000. And that debt now stands at $250,000 per American household. The debt is now truly America's second mortgage, and its burdens keep compounding.

And it is not just mandatory spending that has caused this problem. Just since fiscal year 2017, discretionary budget authority has grown 66 percent faster than the overall economy. In fact, the annual level of discretionary spending since then is $604,000,000,000 higher. At the same time, the dollar increase in mandatory healthcare spending has only been $374,000,000,000. Congress' decision annually to add more and more to discretionary spending has actually outpaced even that mandatory spending category.

Every dollar spent by the Government is a dollar that is taken from hard-working Americans, and it is a dollar that is taken out of our economy. It redirects the fruits of the labors of the Americans that earned it, that produced those resources. This destructive crowding out sucks the oxygen out of the room and denies the investments that would lead to more job opportunities, higher wage levels, more innovation and technological growth, and the production of the goods and services that enrich our lives, improve our health, and extend our life spans.

Further, I believe that it is imperative for Congress to use its power of the purse to block overregulation and abuses from the Federal branch. The Founders envisioned that Congress, whose appropriations power was not merely to set funding levels, but it was also there to protect the American people from the abuses of Government regulation and the power of the Government. I would urge this subcommittee to write more limitation provisions into its base text to defund some of these onerous regulations and to prune these abusive behaviors from the executive branch.

If we are to restore America's vitality and our economy, to end the scourge of inflation, to avoid triggering a debt crisis, we must cut the size and the scope of the Federal Government. We must return those resources back to the hard-working Americans that produced it. We must respect their dignity, what they have put into

it. We must believe in their ability to build a better future for us, and we must preserve their rights, their God-given rights that allow us to build—that have built the society that we have today.

Now I have in my written testimony that I submitted a long list of programs that I believe would be good to reduce funding levels for to achieve the things we have talked about here. To highlight just a few of them, so we believe that the Federal job training programs have failed American workers. They have backed unions. They have demonstrated, produced lower wage levels and job stability than private sector programs that they outcompete.

Nearly half of CDC spending, nearly a third of the Health Resources and Services Administration spending is unauthorized. It is largely the work of earmarks and spending that is produced outside of the authorizing committees, stripping those Members of Congress and the authorizing committees of their power to direct how these programs are created.

Further, of course, there is a whole slew of funding that goes to things like the Public Broadcasting Company, that go to the Endowment for Arts and Humanities, that go into education that are not used to help promote Americans' education or to help build lives, but goes to grants to various entities. We would like to see these cut.

And of course, education spending overall, we have among the highest rates of education spending and middling results. This is a classic case of the inefficiency caused by Government intrusion.

Thank you again.

[The information follows:]

Richard Stern

Director, Grover M. Hermann Center for the Federal Budget

The Heritage Foundation

Though many of the witnesses here plan to ask for more taxpayer funding for this program or that one, I am here today to ask that we reduce spending levels. While few benefit from each of the programs listed in my testimony, all 334+ million Americans suffer from the economic ills caused by runaway federal spending and overregulation of our lives.

Americans have faced the scourge of inflation, seen their mortgage rates spike and their purchasing power drop. The domino that began this chain is a spending trajectory that aims to grow the federal budget to a quarter of our economy in a decade. This same reckless fiscal policy has ballooned our debt from $5.75 trillion to $31.46 trillion in just the last 23 years – almost 82% of our national debt was created in less than a generation while tax revenues have been at historic highs as a percentage of our economy. The debt now stands at almost a quarter of a million dollars per family - The federal debt has truly become America's second mortgage.

Every dollar spent by the government is a dollar taken from the hard-working Americans that earned it. Government spending redirects the fruits of the labors of all Americans through the hands of bureaucrats. This destructive crowding out takes the oxygen out of the room, starving the economy of the investments that create job opportunities, grow wage levels, and that allow us to produce the goods and services that enrich our lives.

Though mandatory spending has driven most of this disastrous run up in spending, it is not the only cause. Since FY 2017, the annual level of discretionary budget authority has increased 66% faster than the economy and by $604 billion, far more than even the $374 billion increase in annual federal spending levels on mandatory healthcare programs.

Further, it is imperative that Congress use its power of the purse to block overregulation and executive branch abuses of power. The Founders envisioned Congress' appropriations power as more than merely setting funding levels. They gave Congress the power to protect the American people from the abusive overreach of government.

I urge this subcommittee to write more limitation provisions into the base text of their bill to push back on the reckless regulatory practices of the Biden administration – especially those that threaten rights to life and conscience.

If we are to restore America's economic vitality, end the scourge of inflation, and avoid triggering a debt crisis, we must cut the growth of federal spending and reduce the size, scope, and burden of the federal government. We must honor the dignity and hard work of hundreds of millions of Americans and leave them with the fruits of their labors and protect their freedoms and their other God-given rights.

Below are just a few programs and accounts that would be ripe for reining in spending, as well as proposed deregulation efforts that can be achieved through limitation provisions.

Eliminations and Significant Reductions:

- *Labor - Employment and Training Administration, Training and employment services* - Should be eliminated, especially WIOA and Job Corps. ($4.14 billion in savings)
- *Labor - Job Corps* - Should be eliminated ($1.76 billion in savings)
- *CDC* - Funding should be cut by at least $3 billion. We should reduce funding for diseases receiving disproportionate shares (such as HIV/AIDS, TB), and reduce or eliminate funding for "social" diseases and reduce or eliminate global health funding.
- *National Institutes of Health* - We should reduce funding by at least $20.3 billion, including elimination of the Center for Minority Health and the Center for Complementary and Integrative Health, and defunding of "alternative medicine" throughout the CDC.
- *HHS - Community Services Block Grant* – Funding should be eliminated ($804 million in savings).
- *HHS - Health Resources and Services Administration* - Reduce funding by at least $2.4 billion, including elimination of the anti-life Title X family planning program.
- *HHS - Substance Abuse and Mental Health Services Administration* - Reduce funding by at least $1.6 billion from programs that are duplicative of CDC and HUD efforts.
- *Corp for National and Community Service* - Funding should be eliminated ($1.31 billion in savings).
- *Corp for Public Broadcasting* - Funding should be eliminated ($535 million in savings).
- *Institute of Museum and Library Services* - Funding should be eliminated ($295 million in savings).

- *Endowments of the Arts and Humanities* - Funding should be eliminated ($207 million in savings).
- *Smithsonian Institution* Funding should be reduced by $715 million.
- *Education* - Reduce by at least $20.5 billion from programs focused on giving handouts to state and local governments. (for a complete four and a half page list, please see here)

Excessive Growth – These are programs that have wildly outgrown a FY 2017 inflation adjusted baseline. Excessive growth figures here reflect their portion of spending that is in excess of their enacted FY 2017 inflation adjusted level:

- Child Care and Development Block Grant. Excess growth: $4.68 billion.
- Refugee and Entrant Assistance. Excess growth: $8.66 billion.
- Indian Health Services. Excess growth: $593 million.

Potential Limitation Provisions:

- Maintain the long-standing pro-life appropriations provisions, such as the Hyde, Helms, Smith, Dornan, and Weldon amendments.
- Prohibition on funding being used in contravention of any guidance issued by the Trump administration that allowed states to deny Medicaid funding to entities based on whether they performed abortions.
- Prohibition on funding being used to create or maintain HHS's Reproductive Healthcare Access Task Force.

- Prohibiting funding being used to facilitate the interstate commerce of abortion pills through states with restrictions on such pills.
- Prohibition on funding being used to enforce Biden's Executive Order 14076 to encourage federal agencies to facilitate abortions. - (Rep. Clyde from the 117th Congress H.R. 8835).
- Prohibition on funding being used to require Title X grant recipients to refer people to abortion providers.
- Prohibition on funding being used to reimpose this Obamacare Section 1557's prohibition of discrimination on the basis of "termination of pregnancy" - (Rep. Cline from the 117th Congress H.R. 8702).
- Prohibition on funding being used to lease, or otherwise provide or make available, federal land, buildings, or other assets to entities that perform, or facilitate in any way the performance of abortions.
- Prohibition on funding being used to provide, or facilitate the provision of, transportation or other services that perform, or facilitate in any way the performance of abortions.
- Prohibition on funding being used to make any federal asset available to perform or facilitate in any way the performance of abortions.
- Prohibition on funding being used by the federal government to advertise, or otherwise disseminate information related to, entities that perform, or facilitate in any way the performance of abortions or to advertise, or otherwise disseminate information in any manner that could facilitate in any way the performance of abortions.

Mr. ADERHOLT. Thank you. Would you like to comment?

Ms. DELAURO. Oh, sure. [Laughter.]

Mr. ADERHOLT. Okay. You have the floor.

Ms. DELAURO. Thank you.

And Mr. Stern, really I am delighted that you are here today because I think it really is helpful to listen to and to see the disastrous cuts that are being advocated by the Heritage Foundation. And quite frankly, I plan to cite the proposed cuts in the future.

If people—and I have mentioned some of the folks who would like to see us move back to 2022, what some of those cuts would mean. Now folks will just say, well, maybe that is just DeLauro speaking. No, there is a reality out there, with everyone in this room and beyond whatever networks you have, to understand what is being suggested.

Sometimes the public just doesn't believe that anyone would advocate to eliminate health and education programs, slash billions of dollars from the NIH research, from Head Start, education for low-income communities. But the list goes on, and I am sure you may have a more fulsome, robust list that I would love to get a copy of it, to tell you the truth.

Listen, and to our friend who is here from the Institute of Museum and Library Sciences, Heritage would eliminate, it would—funding would be eliminated. So there is a reality, my friends. Understand and use your voices. Use every ounce of your being in your advocacy to thwart this disastrous effort.

I am proud having served as chair of this committee, and I have served as ranking member in the past of this committee, where and in a bipartisan basis, we have invested in these programs, and we have invested in making opportunity real for people. And this is the subcommittee that has the greatest impact on people's lives, bar none, at every step.

And then for us to sit back and roll back the domestic investments that have been made to benefit the American people, and the stories, the stories are rife with what is happening to people today and where they can begin to get help. I never see anything that says where is the cut? Where is the end to the tax breaks for the richest one-tenth of 1 percent of the people in this Nation?

And to make sure that the biggest corporations are paying their taxes. That is a waste of taxpayer dollars, not the investments that have been made in this subcommittee over the years.

And I will really shout from the rooftop, Mr. Stern, about where you and Heritage would like to take this country.

Thank you, Mr. Chairman.

Mr. STERN. Congresswoman, and we certainly appreciate you doing that. So we will be happy to make the list available.

We make your annual budget available to the public, too, because we believe that the tradeoffs I was talking about are real and important, and it is important that we reduce that burden of Government to promote a better future for Americans.

So happy to make that list available, and we make it available to everybody we can.

Mr. ADERHOLT. Let me just—did you have something to say?

Mr. HOYER. I just want to—when you provide that list, I would like your economist to compute the cost of not investing because I

think all too often, we see this expenditure of money, and we put a dollar figure. You heard me quote Agnew. "The cost of failure far exceeds the price of progress."

NIDCR, which is the dental institute, Dr. Lowe, when I was first on this committee, pointed out that in 1 year, as a result of the investment in dental research in this country—including fluorides—in 1 year, they saved all the money that had been spent since NIDCR was created.

So I am concerned about the fiscal. As you may know, I have been always concerned about the fiscal posture of our country. I think we have to be very careful. I share Ms. DeLauro's feeling that if we all paid our fair share, and we spent money wisely not only on the nondefense discretionary side, but on the defense discretionary.

I don't know, do you have any cuts on the defense?

Mr. STERN. We actually do have. So they are not in the jurisdiction of this committee. So they are not on the list. But we do actually have them that we think would be for efficiencies that you could plug back into better national defense. Yes.

Mr. HOYER. We will be glad to receive those as well.

Mr. STERN. Absolutely.

Mr. HOYER. But——

Mr. STERN. And Congressman, I will say we have scored what you are talking about. From our position, and we are very convinced of it, that investment you are talking about from the Government means a deprival of investment that Americans are doing. It means that Americans are investing less in these things that they would innovate, that they would build.

So that tens of thousands of dollars of lost annual income I was talking about, that is our score on the dangers of when Government steals that investment from hard-working Americans and redirects it the way that bureaucrats want.

Mr. HOYER. Thank you. Mr. Chairman.

Mr. ADERHOLT. Thank you. And let me just say for those of our guests that are here that may not be insiders, so to speak, and may not—I think you have seen what makes this committee a tough job. As no doubt, there is so many needs out there that we can make investment in.

But to Mr. Stern's point, we do have over a $30,000,000,000,000 debt in this country. And to dismiss that completely and act as if it is not an issue I think would be doing a disservice to the American people.

Now that doesn't mean that from my perspective, I think that we need to do smart investing in these things and making sure that things that make a real bang for our buck for the American people. But again, for those of you who may not be on a daily basis, you now see what makes this job hard and what will make my job as chairman of this committee. But I feel like we can work together, and we can come to some solution.

So, thank you——

Mr. HOYER. Before you——

Mr. ADERHOLT. Yes? Yes, sir?

Mr. HOYER. I just want to make a comment because I came in early to talk. The fact that all of you stayed is incredible.

Ms. DELAURO. They do all the time.

Mr. HOYER. That is what I am told. Now when I was first in this—my first incarnation, when I was 30 years younger, that didn't always happen, Mr. Chairman. People would go in and out. Understandably, they testified, and then they left. Seeing Dr. Wilson sitting here the whole time, she started, and she is still here.

But I congratulate you because, as Ms. DeLauro said and as the chairman said, it has given you an opportunity to see how we make choices in a democracy, and it is tough.

Because each one of you has a firsthand knowledge of the issue that you are involved with, whether it is your son or whether it is a more general population, and you need to inform the American people with whom you deal of how these—I have a favorite saying, life is series of tradeoffs. If you do one thing here in the hour, you can't do the other thing during that hour.

And that is what this committee, that is what this Congress, that is what you have elected your representatives to do. But we can do it better to the extent that you are more knowledgeable, and therefore, you can advocate not just to the people who are involved in the interest specifically that you have testified on, but who are trying to figure out how—as a Congress—Republicans, Democrats, liberals, conservatives, and everybody in between make these decisions.

And my experience over the 42, 43 years that I have been here is that almost every Member that we come in contact wants to do the right thing. Whether they are conservative, liberal, Democrats, Republicans, they want to do the right thing. And our democracy's premises, the more you know, the more you communicate to us, the better we are going to do.

Thank you.

Mr. ADERHOLT. Thank you, Mr. Hoyer.

And again, like I said, this is—and thank you for staying around because I think it is important to hear from some of the other issues that you may not be familiar with. You are well familiar with your issue, but some of the other issues. But also to hear about—hear from the Heritage Foundation, which I think is important as well because, obviously, we don't have unlimited resources.

And I would say for all of you who gave out a dollar amount, I said if we had unlimited resources, let us double it. But unfortunately, we don't live in that perfect world.

But we will do the best we can. We look forward to working with you, and we will be following up with any questions.

So thank you, and the hearing is adjourned.

TUESDAY, MARCH 28, 2023.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WITNESS

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

CHAIRMAN'S OPENING STATEMENT

Mr. ADERHOLT. Well, good morning. Good morning, Mr. Secretary. It is a pleasure to have you to the Subcommittee on Labor, Health and Human Services, and Education for our very first budget hearing of the year, which happens to be my first budget hearing as chairman. And we look forward to hearing your testimony today and thank you for being here.

As I have been trying to come up to speed as the new chairman, I have been learning more about the incredible breadth of the programs that are under the jurisdiction there that you oversee from a day-to-day basis. From research that will, hopefully, cure diseases like cancer and Alzheimer's, providing childcare and early learning for the youngest Americans, training our next generation of medical professionals, and administering health insurance for our Nation's poor and aging population, it is clear that your responsibility and your departments are very many.

There are many programs in your budget that I think we all agree are priorities, and we can collectively support. I share your concerns about maintaining our biodefense and preparedness for threats both from abroad and arising from natural means. I support biomedical research that will help cure cancers, dementias, and the other chronic health diseases that cut so many lives short, especially in rural America as well as across the Nation. I support programs that provide quality early education, access to quality healthcare, and programs to help people with disabilities live independent lives on their own terms.

And then, of course, there are other policy areas that I know we will have disagreements on. It is the responsibility of this subcommittee to determine how we can support the most critical programs, identify the investments that will give us the greatest return, and face head on the challenges of limited resources that we have available to us right now.

Unfortunately, hard decisions will have to be made. I look forward, though, to having a discussion with you this morning about the areas of top priority and what they are from your perspective so that we can invest the taxpayer dollars more wisely, given the expected funding constraints.

I must say at the outset that it is disappointing to see that your budget continues to double down on out-of-control Government spending, which only adds to our already-high inflation rates. And

I think we can all agree that inflation is a burden on every American, but it also hurts those on the margins of our society the most.

Taxpayer spending for what many of us feel are partisan priorities like Sexual Gender Minority Research Office within the National Institutes of Health and nearly doubling the funding for the Title X program, which under this administration is making grants to abortion providers, does not seem to be the best use of taxpayer dollars.

In addition, the President's failure to secure our Southern border is resulting in billions of dollars in taxpayer funding—or taxpayer spending, rather, to care for unaccompanied minors who illegally cross our borders to look for work. While border security is the jurisdiction of the Department of Homeland Security, these minors, as you know, are the responsibility of HHS through the Office of Refugee Resettlement.

Sadly, many of them are ending up in dangerous and abusive situations at the hands of so-called sponsors, and your agency is releasing them to these so-called sponsors. Simply put, I think this has to end.

I would also be remiss if I did not point out that many management challenges face you at the helm of HHS. From the continuing problems with administering the Provider Relief Fund to overseeing a public health agency that has almost totally lost the public's trust, there seems to be no shortage of areas in need of some improvement. I hope, as I know many of my colleagues do as well, that we can learn this morning of what you are doing to take positive steps in these areas.

Finally, there are many external challenges facing the Department. Threats to cybersecurity, threats from new and evolving diseases, and the many challenges of poverty and access to care also land on your doorstep. I look forward to hearing your ideas to help combat these areas as well this morning.

I am pleased that you agreed to send an agency witness to our hearing tomorrow on the challenges of what rural America is facing. This is an important topic for many members of this subcommittee, and your agency is responsible for many programs that can help these citizens. We look forward to learning more about them, and I am hopeful that we will continue to hear from your agency in the coming months on other timely topics that will inform our spending decisions.

As a reminder for everybody this morning and to our witnesses, we will go by the 5-minute rule so that everyone will have a chance to get their questions asked and answered, and certainly including myself under the 5-minute rule as well.

RANKING MEMBER OPENING STATEMENT

But before we begin, I would like to yield the floor to our ranking member, who is certainly no stranger to this subcommittee. So the gentlelady from Connecticut, we recognize you for your opening statement.

Ms. DELAURO. Thank you very, very much, Mr. Chairman.

And I want to welcome the Secretary this morning, dear friend, a former colleague—Secretary Becerra—and thank him for testifying today.

Just a shout-out to the Alzheimer's Association here. Love the purple shirts in here, but love the work that you do. Thank you. Thank you.

Well, Mr. Secretary, when you came into office 2 years ago, our Nation was reeling from a painful health and economic crisis, making your job even more critical, but also more difficult. And over the past 2 years, you have made great progress to support working families and the health and the well-being of the American people.

Alongside the administration, this committee made historic investments through the 2022 and 2023 appropriations packages to reverse decades of underinvestment in the programs that American families rely on. We lowered the cost of prescription drugs, supported working families, made healthcare more affordable, strengthened lifesaving biomedical research, bolstered our public health infrastructure, and addressed urgent health needs.

And today, I look forward to discussing HHS' 2024 budget request, which builds on that critical progress. This budget takes important steps to continue tackling our Nation's most pressing health needs and supporting families while making our communities healthier and safer.

An increase of $1,900,000,000 for the Centers for Disease Control and Prevention would bolster our Nation's public health and help State and local public health agencies strengthen their infrastructure, while making strides in maternal and infant health, behavioral health, gun violence prevention. My God, what happened yesterday?

The maternal mortality rate in this Nation, especially among black and brown women, is unacceptable and, frankly, appalling. I thank you for taking steps to continue addressing it.

This is not just about infectious diseases. This budget will also strengthen our public health agencies so we can support food safety, early detection and prevention of cancer, opioid prevention and surveillance. We must be ready for any current and future crisis. We must end the cycle of complacency that leaves us scrambling when a crisis hits.

And with a significant increase for substance abuse and mental health services and the SAMHSA programs, we would provide more mental health services to children, strengthen recovery support services and opioid prevention and treatment, and continue the 988 Suicide and Crisis Lifeline.

American families need our help. This budget acknowledges that reality. Families are facing a childcare crisis. This budget would lower costs, expand affordable early learning programs, with significant increases for Child Care and Development Block Grants, Head Start, and Preschool Development Grants.

And with a significant increase for the Health Resources and Services Administration, the administration is prioritizing innovative ways to support the health of mothers and kids, strengthen community health centers, end the HIV epidemic, and increase access to contraceptive care.

In the wake of the Supreme Court's disastrous decision to strike down Roe v. Wade, we need to support reproductive healthcare, and family planning has become even more pronounced. The President's budget includes an increase of 79 percent for Title X family

planning to provide affordable contraceptive services and healthcare to nearly 2 million low-income women and men across the country.

This program has helped nearly 195 million people over its more than 50-year history, many uninsured. This is a critical bedrock of our public health safety net, and we will never stop fighting for those who depend on it.

I do want to mention my worry that the proposed increase of less than 2 percent for the National Institutes of Health is insufficient and threatens the progress this committee has made through significant sustained investments in biomedical research. The Advanced Research Projects Agency for Health, ARPA–H, would receive an increase of $1,000,000,000, a disproportionate increase, in my view, compared to the small increase at NIH.

SPENDING CUTS

People depend on these programs, which is why I must mention how deeply concerned I am over extreme—some House Republican calls for massive spending cuts and even more extreme calls by some former Republican officials to eliminate so many of the programs that keep families healthy, safe, and prosperous. These cuts would be devastating to children, families, seniors, veterans. We should be doing everything we can to increase access to these programs, not cutting off vital services to the people who need them.

I do not believe that some of my Republican colleagues realize the implications of these cuts. Just let me run through some of the scariest numbers that you shared in your letter to me.

If these cuts were implemented, 200,000 children will lose access to Head Start; 100,000 children lose access to childcare, undermining the early education of our kids and their parents' ability to get to work.

Perhaps even more staggering, amid a mental health and overdose crisis, nearly 1 million people facing a suicidal or mental health crisis would not be able to access support services through the 988 Suicide and Crisis Lifeline. Tens of thousands of people could be refused opioid use disorder treatment, denying them lifesaving healthcare.

An estimated 2 million vulnerable individuals and families, including rural and underserved populations, would lose access to healthcare services through community health centers, like the Fair Haven Community Health Center in New Haven, Connecticut, that I visited last week. And despite the looming rise of food insecurity, nutrition services such as Meals on Wheels would be cut for more than a million seniors.

I would also add that the cuts of this magnitude would dramatically impact the CDC's ability to support State and local health agencies, weaken our public health infrastructure and capacity. More than 70 percent of CDC funds go to public health partners, including our State and local health agencies. Such extreme cuts would be felt all over our Nation, would make our communities much more vulnerable to a public health crisis.

The cuts are unrealistic, unsustainable, and unacceptable. They threaten so much of the progress we have made in recent years. They put people at risk. Like you and President Biden know, in-

vesting in families is how we make our economy stronger and our communities safer. I will never stop fighting these dangerous proposals.

Mr. Secretary, I thank you for your dedication doing the same. I look forward to hearing your testimony.

With that, Mr. Chairman, I yield back.

Mr. ADERHOLT. Thank you, Ms. DeLauro.

And Mr. Secretary, we look forward to your testimony, and you are recognized.

SECRETARY'S OPENING STATEMENT

Secretary BECERRA. Chairman Aderholt, Ranking Member DeLauro, and members of the committee, thank you very much for the invitation.

A lot has happened in the year since I last spoke to this body about the budget. More than 16 million Americans have secured health insurance through the Affordable Care Act marketplaces. That is an all-time high. Altogether, more than 300 million Americans today now carry insurance to cover their healthcare. That is an historic high.

The President's new lower-cost prescription drug law has capped insulin at $35 per month and made preventive vaccines like the flu, COVID, shingles vaccines available for free under Medicare. Moving forward, this new law gives us the right to finally negotiate lower prescription drug prices for Americans.

And to cap it all off, the Biden-Harris administration has safely and effectively executed the largest adult vaccination program in U.S. history, achieving nearly 700 million shots in arms during the COVID pandemic without charge.

The fiscal year 2024 budget proposes $144,000,000,000 in discretionary funding and $1,700,000,000,000 in mandatory funding for HHS. It positions us to tackle the urgent challenges we face, including a growing behavioral health crisis and future public health threats. It also funds operations and mission-critical infrastructure needed to build a healthier America, moving the Nation from an illness care system to a wellness care system.

An illness care system leaves our most vulnerable families behind. A wellness care system invests in providing the full spectrum of healthcare to all Americans.

Illness care allows the price of prescription drugs to skyrocket. Wellness care starts by prescribing fruits, vegetables, and exercise. It treats food as medicine.

Illness care requires you to get a referral by your family physician to see a specialist for mental health services. Wellness care lets you get mental healthcare the minute you walk through the door of your family physician's office.

Illness care forces hard-working Americans to deplete their life savings to be able to qualify for long-term care that they need. Wellness care invests early in long-term care like in-home care, so our older adults and Americans with disabilities can thrive at home and in their communities.

Our budget invests in wellness care. And we invest more than $30,000,000,000 to prepare us for the next COVID or public health

crisis, including $1,000,000,000 to replenish our Nation's Strategic National Stockpile.

On behavioral health, too many of our loved ones are dying from suicide and overdose. So we increase access to crisis care. We grow the behavioral health workforce, and we beef up substance use services. We are also gearing up to handle more than 6 million additional contacts from people who are experiencing a mental health crisis through 988, the three-digit Suicide Prevention Lifeline we stood up last year.

This budget covers 2 million adults left out of Medicaid by their home States and extends tax credits to make their healthcare more affordable for millions of Americans. It would also ensure that expanded postpartum Medicaid coverage for a new mom and her baby is here to stay. The President's budget not only strengthens Medicare for today's seniors, but it protects and strengthens it for the next generation.

We also take care of our family members in this budget, investing $600,000,000,000 in childcare and preschool programs, and $150,000,000,000 to strengthen Medicaid home and community-based services. This budget funds the Cancer Moonshot, ARPA–H. It invests in Title X family planning programs, so essential to so many of our families. It delivers on our commitments made as part of the National Strategy for Hunger, Nutrition, and Health.

It opens more community health centers. And important to me as a former Attorney General, it bolsters our healthcare fraud and abuse detection and enforcement work.

And the President's budget honors our responsibilities to Indian Country, with more than $2,000,000,000 in new resources in 2024. Last year, for the first time, you gave the Indian Health Service advance appropriation, providing the same protection against budget uncertainty that other health services receive. We hope to build on that progress this year.

This budget reflects the President's and our values and commitments. It helps begin the move from a nation focused on illness care to one about wellness care, and most importantly, it ensures health and wellness are within reach for all Americans.

On behalf of the women and men of HHS, we look forward to working with you. Mr. Chairman, I thank you, and I yield back.

[The information follows:]

TESTIMONY OF SECRETARY XAVIER BECERRA
BEFORE THE HOUSE LABOR-HHS-EDUCATION APPROPRIATIONS SUBCOMMITTEE
March 31, 2022

Chair DeLauro, Ranking Member Cole, and Members of the Subcommittee, 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 health care 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, over 215 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 two 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 FY 2023. The FY 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 and treatments reimbursement, with the same soon to follow for vaccinations. 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 FY 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 five 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 health care 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 health care a top priority. The Affordable Care Act (ACA), bolstered 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 health care 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 health care costs for most consumers and increased enrollment to record levels. In fact, consumers saw their average monthly premium fall by 23% 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 health care 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 health care 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 FY 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 FY 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 health care, 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 under-served 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 population growth and pandemic impacts. ACL supports caregivers and advances equitable access to health care, 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 FY 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 FY 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 FY 2023.

To address chronic underinvestment in IHS, the Budget increases funding for each year over ten years, building to $36.7 billion in FY 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 health care 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 ten years to address the nation's behavioral health crisis. In support of the President's call for reforming our mental health care 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 health care 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 health care, 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 FY 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 five 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 FY 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 Heath 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 ten years. The pandemic has unleashed new health care 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 FY 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.

5-MINUTE RULE

Mr. ADERHOLT. Thank you, Mr. Secretary.

Let me start out. And again, I just will remind everybody we will do the 5-minute rule. So we will try to abide by that today. So thank you all for understanding since we have a lot of folks here that want to ask questions.

UNACCOMPANIED MINORS

But Mr. Secretary, it was disheartening to read the widespread reports of unaccompanied teenagers who enter through the Southern border without a parent, and they end up in the hands of human traffickers, and they are forced to work long hours in dangerous jobs. In previous statements, you have compared the Department's work in releasing minors into the U.S. as "an assembly line" and encouraged your staff to expedite the release of children.

In light of these child labor violations, what changes will you be making to ensure that children are placed with suitable sponsors, and what efforts is the administration taking to address the flow of migrants into the U.S. after Title 42 is lifted in May?

Secretary BECERRA. Chairman, thank you for the question, and I hope to explore this with you and members in more detail because I think all of us, whether it is—I have three daughters that I raised. I have worked on immigration issues for the longest time. When I was a Member of Congress along with you, I had one of the largest populations of migrant families.

And so I must tell you that this is very important. Children are children, regardless of where they are from. And so we do everything we can to make sure we protect those children while they are in our custody.

I would say to you that what we have done with regard to the unaccompanied migrant children that come into our custody after Department of Homeland Security transfers them to us—because they are not allowed to keep them by law for more than 72 hours—is we provide them with the care that we can while we are in the process of trying to find a suitable sponsor who can provide care for them while these kids are waiting for their immigration proceedings to move forward.

We in the process look for a responsible sponsor. We vet everyone who is coming through as a potential sponsor, and we don't release that person until they have gone through background checks and can pass those checks. Some of the stories that we are reading, I agree. It is unconscionable that there are companies, there are employers in America who are employing 12- and 13-year-olds to do work that even is dangerous for an adult. We have labor laws against that kind of child labor, and we should take action on that.

But when it comes to the care of those children while they are in our custody, we do the best we can. And because every specialist on childcare will tell you, it is better to have a child in a home instead of in a large Government, federally sponsored congregate care setting, we do what we can to find a responsible sponsor. Usually that means a family member. Close to 90 percent of the cases, it is an immediate family member that we place these kids with.

And so we do everything we can, and we try to do as much follow-up as we can. If you give us more authority and more resources, we could do more. But we will do what we can because kids are kids.

Mr. ADERHOLT. Oh, in light of it with these reports, is there anything that you have been able to try to change to try to combat some of the things we are hearing?

Secretary BECERRA. One of the things that we are doing you may have heard is the Department of Labor and HHS, we are going to try to work a little closer. Because they are working on a number of investigations that might relate to child labor violations, and it may include some migrant kids.

So we are trying to see if they can give us access to some of their preliminary information that they have been collecting in their investigations, clearly keeping it confidential, so we can see if somehow that might pinpoint to us the individuals who may be applying to be sponsors, but really shouldn't if they are engaging in labor law violations.

But we are going to try to work closer in that respect. We are going to try to make use of some of the money that Congress has given us to see if we can do continued post-release follow-up with the kids. We would need some authorities because those children nor their sponsors have any obligation to stay in touch with us once we have released that child.

LIFTING TITLE 42

Mr. ADERHOLT. Can you talk a little bit about the efforts of the administration trying to address the flow of migrants after the Title 42 is lifted in May?

Secretary BECERRA. Yes. And I will try to stay to the unaccompanied migrant kids. That is the jurisdiction we have. I know that the administration has a whole-of-government approach, and the Department of Homeland Security could certainly tell you about the number of efforts that are underway to try to deal with those that are at the border itself.

You are probably reading about reports about how the U.S. has reached an accord with Canada and is looking to reach an accord with Mexico and how we would handle people who were trying to cross the border. That is Department of State. That is Department of Homeland Security.

What I can tell you with regard to HHS is we have done everything we can to make sure that if a child is—without any adult supervision is found at the border, that we are able to ensure that DHS, Department of Homeland Security, will not be in violation of the law by placing that child in what is essentially an adult detention facility not meant for children. And that is where we take on the responsibility to find a decent place to care for that child while we look for a responsible sponsor.

Mr. ADERHOLT. Thank you. Ms. DeLauro.

Ms. DELAURO. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

FUNDING CUTS

A couple of questions. One, there are some in the Republican House majority that are demanding massive funding cuts in the fiscal year 2024 appropriations. It would appear it might be up to 22, 25 percent. It could go higher.

Mr. Secretary, give us an idea about the real impacts of the cuts being proposed with regard to using those 2022 numbers for the 2024 budget. If you could describe the human consequences to children, families, seniors, veterans, and folks across the country?

Secretary BECERRA. Congresswoman, first, I have to thank you for all the work you have done to get us to a point where we had additional resources for programs like Head Start, for childcare, even unaccompanied migrant children.

What we understand is that there is discussion here in the House of trying to keep funding at fiscal year 2022 levels. The Office of Management and Budget, which does the budget calculations for the administration, has asked us to formulate what would happen if we were to have a 22 percent reduction in these discretionary programs at HHS. What we can tell you is that it would lead to some 100,000 slots for childcare being eliminated from our funding opportunity, which means these families, most of these families would not be able to afford other childcare options.

It would mean that there would be a loss of some 200,000 slots for children in the Head Start program. And again, these are for low-income children. So very unlikely that their parents could find a different alternative for preschool support for their kid.

The Indian Health Service, which I just mentioned—Congress did a phenomenal job of making sure we could provide some stability in their health services—it would cut off some 2 million people in some of the most vulnerable communities that we have from access to healthcare. And in Indian health services itself, we would probably see a reduction in inpatient admissions at some of the IHS facilities by some 10,000 inpatient visits and outpatient visits by nearly 4 million.

The Low-income Home Energy Assistance Program, which helped a lot of families survive the winter by being able to afford their energy, the fuel they needed, would see their benefits cut from $529 to about $413 on average. Somewhere in there, $400 to $500. They would lose an ability to have additional help to pay for their energy, their heating needs, cooling needs, in summer and winter.

I could go on. NIH, nutrition services, our behavioral health services. I could go on, but Congresswoman, I don't want to use up all your time.

Ms. DELAURO. Well, thank you. And I would just ask you another question. Have my colleagues on the other side of the aisle made any similar request for information about the impact of the cuts they intend to make? It is kind of a yes or no question, Mr. Secretary.

Secretary BECERRA. I am not aware of a particular request for information on what the impact would be in terms of cuts. I know that we have had dialogue with a number of members.

988 SUICIDE CRISIS LIFELINE

Ms. DELAURO. Okay. Quickly, on the 988 Suicide Crisis Lifeline, Mobile Crisis Response Teams, we increased the funding to $500,000,000 more because this was—we created the Mobile Crisis Response Team so that we could help those who were experiencing a mental health crisis be treated by healthcare professionals rather than law enforcement, and we created a $10,000,000 pilot program and increased it to $20,000,000.

Tell me what kind of success have we had—or talk about the first 9 months of the 988 Suicide and Crisis Lifeline, as well as how the additional funds have ensured that individuals are connected to the proper healthcare service and what you have in mind for the increased expansion of the mobile crisis teams.

Secretary BECERRA. And Congresswoman, for folks who aren't fully familiar with 988—and I hope they will become as familiar with 988 as they are with 911, because 988 is essentially 911 for those who are experiencing a mental health crisis. It used to be you would have to know a 10-digit phone number to be able to call in, and it would be a different phone depending on what region of the country you were in.

And so if you were on the verge of actually committing suicide, and you were deciding to make that final attempt to reach out to someone, if you didn't know the phone number, that would be tough. If you knew the number, but you happened to be in a different part of the country, it might not be the right number.

And so you all had the wisdom of saying let us make this smart. Let us do it the way we do for 911. 988. What we did because it is not a Federal program—it is a State-operated system—is we tried to make sure that the States were ready to go. Because a lot of States are in need of infrastructure support, and COVID made it very difficult for everybody to figure all this out.

So we did the best job we could to tie things together. We essentially were the glue for 988, and I thank all the States that actually stepped up.

Some still have to do a little bit more work, but some have even gone to the point of coming up with a permanent funding stream for 988. The result, July 2022, we launched. Within that first 6 months, we saw a 50 percent increase in the number of people calling.

That is great news. It is also terrible news. It shows you just how many people are calling and asking for help before they make the wrong call. And so we hope we could continue to move forward. That is why we want to do 6 million more additional contacts. We are going to help States, but we hope you will look at our budget and give us that support.

Ms. DELAURO. Thank you.

HHS LETTER ABOUT CUTS

Mr. ADERHOLT. Dr. Harris.

Mr. HARRIS. Thanks very much. Thank you very much, Mr. Secretary, for being here.

First, with regard to your letter about the cuts, it was pretty lazy work, to be honest with you. You just assumed a level cut all across

the agency, which, of course, again that would be pretty lazy work on our part, if that is what we did. But I get it. I get the political point you made.

For instance, you didn't assume that maybe we should ask our State partners under the expanded Medicaid program to just contribute the usual FMAP, and we could raise enough money from the States with that just to, oh, pay for all those—all those programs that you think are so valuable. But I get it. You don't want to ask our State partners to participate.

HHS REMOTE WORK PRACTICES

I am going to ask unanimous consent to show a picture here that I think you have seen before, Mr. Secretary. I think you saw it on the other side of the Capitol. I am just going to ask you because this is, my understanding, a parking lot taken—a picture of a parking lot during business hours in Maryland at the CMS headquarters. Do you have any reason to believe this is not a valid picture?

Secretary BECERRA. Um——

Mr. HARRIS. No, you don't.

Secretary BECERRA [continuing]. I will accept your representation.

Mr. HARRIS. Okay. So maybe you can just very briefly explain why it is empty during normal business hours? Are we really paying employees not to be at work? And specifically, are we paying them locality pay not to be at work? Are we paying them actually perhaps even additional money not to be at work?

Secretary BECERRA. So I can't speak to the photo. I don't know where it comes from or when it was taken. But what I can do is speak to the workforce at HHS. We work full time. We do our best to make sure everyone——

Mr. HARRIS. Mr. Secretary, my question is very specific. The locality pay question. Are you paying workers who are at home additional locality pay when they don't come to work.

Secretary BECERRA. Congressman, thank you for the question.

We can only provide locality pay if someone is eligible for it.

Mr. HARRIS. Okay. So you are. Thank you. All right.

GENDER AFFIRMING CARE

Now, with regards to the President's comments about funding gender-denying mutilation surgery. That is all I can call it because, believe me, I have seen bilateral mastectomies. I have seen "connectomies" for trauma. These are gender-mutilating surgeries.

You really want to pay for that under the CHIP program? Is the President serious? He wants to take our Childhood Health Insurance Program and pay for this?

Secretary BECERRA. I want to be——

Mr. HARRIS. Yes?

Secretary BECERRA. I want to be careful how I answer this because I answer this as Secretary, but I also answer this as a father.

Mr. HARRIS. Sir, I am just asking—be direct. This is a very simple question. Does the President want to use CHIPs money to pay for gender mutilation surgery?

Secretary BECERRA. If it is a simple question, I will tell you the simple answer is we want to make sure that everyone in America has access to the healthcare that they need, whether you are a child or an adult.

Mr. HARRIS. So the answer is yes. So the President perceives and you perceive that that mutilation surgery is what the child needs? Not what the child might want, what the child needs. Is that your testimony today?

Secretary BECERRA. Congressman, my testimony is that, as you know, we cannot provide any dollar, taxpayer dollar for any service that is ineligible under Federal law. But we make sure that if it is eligible under Federal law, we will do everything in our power to make sure that child, that adult gets that care.

Mr. HARRIS. So even in States where that underage surgery is illegal, your position would be that you should be paying for those surgeries?

Secretary BECERRA. We only comply with the law when it comes to the distribution of Federal dollars, and so, therefore, we make sure that any Federal dollar that goes out is to provide the care that medical professionals say that that individual needs.

Mr. HARRIS. I see. Regardless of their age?

Secretary BECERRA. A medical professional has to make a decision, and then that individual would have to make a judgment.

Mr. HARRIS. Even in those States where that would be illegal under State law?

Secretary BECERRA. Congressman, you are asking me to speculate on something that I am not aware of. And so if you could point out where there is an act that is occurring that is against the law, we can talk about that. But at the Federal Government, we spend our money complying with the law.

Mr. HARRIS. Okay. Thank you very much.

NO SURPRISES ACT IMPLEMENTATION

Now just in my remaining time, I am going to ask a little bit about the No Surprises Act implementation because it has been a fiasco. I get it. The insurers are in control at HHS. I fully understand it.

And they have the Department, of course, which has lost the first Texas case. You know you lost it. You didn't even appeal it. I mean, obviously, you were caught dead to rights in really I would say conspiring with the insurance companies about the qualified payment amount and to be used as a benchmark for this No Surprises Act arbitrations.

Now you raised the fee to ask for an arbitration on the part of a physician who feels they are being unfairly treated by an insurance company. A multi, multibillion dollar—these companies make tens of billions of dollars in profit. You raised the fee from $50 to $350.

Now I was in State government before, and let me tell you something. I don't think we ever multiplied a fee by a factor of 7 ever. Yet you all did it. And you have also said that these claims are—too many of the claims are "frivolous" because there is "no cost to file claims." This is before the Senate Finance Committee. This is your testimony there.

Do you still feel that most of those claims are frivolous, and do you also feel that maybe a $350 fee might not be no cost to file claims?

Secretary BECERRA. Congressman, what I would urge you to do is talk to the judges, the arbitrators that have to go through these cases who, by the way, do not get paid for their service unless a claim goes all the way to an outcome. If a claim is frivolous, it does not go to an outcome, and those judges are spending vast amount of their time trying to adjudicate claims.

There are any number—we are receiving exponentially more claims than you ever thought or we ever thought, more than the seven times you are saying that the rate of filing has gone up. We have to somehow make sure that no one thinks it is a free thing, a free ride to just submit a frivolous claim, bog down the system, and prevent the legitimate claims from being adjudicated so people can get paid.

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

Mr. ADERHOLT. Mr. Hoyer.

TELEWORKING

Mr. HOYER. Thank you very much, Mr. Chairman.

First, let me, as a representative of, I presume, a lot of those employees who are working at home, as they are at IBM or Costco—not Costco so much, but technical firms, other firms who are finding it as efficient because they work on computers. And where the computer is located is somewhat irrelevant.

But they are paid locality pay not because of where they park, but because where they live. And if the cost of living is a very high cost of living, they are paid a differential, which the Congress and the President of the United States decided was okay under the Federal Employees Pay Comparability Act, which I introduced in 1990 and which was signed by George Bush. Let me just get that out of the way.

Now, secondly, Mr. Secretary, thank you very much for your testimony. Thank you very much for your letter.

PROGRAM CUTS

I have not heard anybody campaigning in America that says I want to have 200,000 less 3- and 4-year-olds in Head Start, notwithstanding the fact they are eligible. They simply say they want to cut the program.

Nor have I heard anybody saying that they want 105,000 less children cared for while their parents are at work. What they say is they want to just cut childcare.

Nor have I heard anybody say they want 900,000 less responses to people who call on the brink of suicide. Nor have I heard anybody say we want 29,000 less people admitted to opioid crisis programs. I just hear we want to cut.

Nor do I hear that we want to have 2 million of the most vulnerable people in America not have access to healthcare centers. We just want to cut.

Nor on, you mentioned, Indian health—1.6 million less visits, 120,000 less dental visits for Indians who have been shut out in

many respects and whose land we stole from them many years ago. I just hear we want to cut.

Now I could go on ad nauseam, I suppose, on so many different areas. Head Start has, since I served on this committee, almost invariably served about half of those children who were eligible. Why? Because there were not sufficient slots. I think that has a ramification. Because if you don't invest in those children, they become not necessarily taxpayers, but tax takers because they fall behind very quickly.

So, Mr. Secretary, I appreciate the letter that you wrote. It is somewhat—I don't know about it being a lazy letter. I think really the problem with it, it is too accurate a letter. This committee, Mr. Secretary, as you well know, is a people's committee whose actions have an extraordinary impact on the well-being of our people, the education of our children, and the healthcare of our people.

MATERNAL AND CHILD HEALTH

Mr. Secretary, let me ask you a couple of specific questions. First of all, I have been very interested in maternal/child health. We are the richest country on Earth. We perceive ourselves to be a very sophisticated country. I believe that as well.

However, in terms of maternal health, particularly maternal health for minorities, we are not doing well. We are not only not doing well in terms of the wealthiest countries in the world, but we are not doing too well even among those in the middle. Would you explain that and tell me what impact a cutting of this maternal healthcare would have in America?

Secretary BECERRA. Congressman, thank you for the question.

It is hard to believe. When you tell that to most Americans, they won't believe it that we have women dying shortly after birth, after giving birth at rates that would compare with developing countries and, in some cases, worse. We have children, newborns who are dying at rates that would compare to those of developing countries, and in some cases worse. Two to three times worse, especially in our black community. Two or three times worse, especially in our indigenous, our Native American community.

Much of it is a legacy of lack of access. Much of it is difficulty affording the care. Much of it is just neglect. And that is why the President has taken this on with a great deal of fervor. And we are today, for example, offering States a challenge. We, at the Federal level, through Medicaid will make sure that we provide a woman and her new baby access to postpartum care after they deliver not just for 60 days, which is what is traditionally within Medicaid, but for 365 days.

So far, some 30 States have taken us up on that challenge, and the President's budget will make that a permanent part of Medicaid. But so far, there are still 20 States who are unwilling to let the Federal Government pay for the vast majority of the costs in Medicaid for the care, postpartum care for that mother and her baby.

We can do this, and we are going to try really hard. We are also making investments in programs that don't require us to pay a physician. But the doula programs that help a woman as she is getting ready to deliver and help her after delivery, those are very

cost-effective programs that essentially give a woman and her baby access to someone who knows how to care for a woman and her baby.

Mr. HOYER. Thank you, Mr. Secretary.

Mr. ADERHOLT. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

ALZHEIMER'S TREATMENTS

Mr. Secretary, thank you for appearing before us today.

I do also want to honor and acknowledge all the wonderful folks from the Alzheimer's. Thank you for your persistence and all you are doing to try to cure this disease. Thank you.

Mr. Secretary, my first questions are in the realm of Alzheimer's. One in three seniors die from Alzheimer's or a related form of dementia. Members of both parties have expressed concern to this administration regarding the national coverage determination policy and its impact on access to Alzheimer's therapeutics and diagnostics. This new class of Alzheimer's treatments gives families hope that they will have more quality time with their loved ones before the disease takes hold.

The VA and the CMS have had the same trial data made available to them regarding these potentially life-changing Alzheimer's treatments. The VA chose to evaluate the available trial and data in open access, albeit with restrictions to patients. What is holding CMS back from taking a similar approach, sir?

Secretary BECERRA. Congressman, thank you for the question.

And first, I think it is important to talk about how we have made so many advances, and we are getting to the verge of being able to treat conditions like Alzheimer's. And FDA took that step and said that they were moving forward with approval of that Alzheimer's drug, finding it safe and effective. They are still waiting for additional clinical trials to come in with further evidence to find out if their actions can be left with a standard approval, which would be the full approval needed within FDA.

Medicare services are received under the Centers for Medicare and Medicaid Services, and those are treated differently than the way FDA treats the issue of whether a drug should be put on market, as you know. And CMS goes through a different analysis.

What I will note is that CMS did create a coverage path for this new Alzheimer's drug. It is a limited path because CMS is also waiting to receive more evidence of the utility of the medicine, and as soon as FDA collects some of that evidence they are trying to get and gives standard approval, then you will see CMS quickly move as well to try to qualify that drug for coverage within the CMS standard.

You have to remember there are two different standards by two different agencies, but the most important thing is to remember that whether you are at FDA, you are at CMS, or at that dais, or sitting here, all of us know someone who is suffering from dementia, Alzheimer's, and it is incumbent upon us to move as quickly as we can.

Mr. FLEISCHMANN. Thank you, sir. A follow-up to that.

How many times has CMS provided coverage for drugs or therapeutics approved under the FDA's accelerated pathway?

Secretary BECERRA. And so it is not so much that they have provided coverage based on the FDA's approval based on an accelerated pathway, it is that the CMS has gone through its analysis, separate analysis, and made a determination that based on the requirements that Congress has set for CMS by law, that those requirements have been met.

Mr. FLEISCHMANN. Understood.

DOMESTIC MANUFACTURING

I want to switch to my last question on PPE. Mr. Secretary, during the pandemic, a number of companies made a substantial investment toward domestic manufacturing of personal protection equipment. I am aware of one American manufacturer that actually produces 1 gown per second 7 days a week, 24 hours a day, and has engaged with 6-year contract agreements with over 30 U.S. health systems.

My question, Mr. Secretary, is what is being done by HHS to shore up these domestic manufacturers such as this company I have actually alluded to that is doing that? One gown per second they can do in America to avoid our dependence on China or any other outsource.

Secretary BECERRA. And here, the President has tasked us to do everything we can to use domestic manufacturing. We saw what happened when we couldn't find masks during the beginning of COVID. It is crazy that we had to go to places like China to find masks.

And so we are trying to invest in more domestic manufacturing capabilities. The difficulty here is trying to have the resources. We need money to just replenish the Strategic National Stockpile, but we are trying to promote domestic manufacturing. What the manufacturers are looking for is a consistent, a thread of certainty that if they jump in the game, it won't just be because the Federal Government helped this year, but that in 5, 10 years, there is still a market that they can compete in.

And that requires us to make investments up front. We are trying to do some of that, and we are going to use every opportunity we can and every authority we have to try to make domestic manufacturing more possible.

Mr. FLEISCHMANN. Thank you. And I look forward to working with you in that endeavor, Mr. Secretary.

Secretary BECERRA. Absolutely. Absolutely.

Mr. FLEISCHMANN. Mr. Chairman, I will yield back. Thanks.

GOING BACK TO 2022 LEVELS OF FUNDING

Mr. ADERHOLT. Mr. Pocan.

Mr. POCAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here.

I would like to get to a couple subjects. Okay, I am moving mikes. A couple different subjects.

First one, though, I am concerned in listening to the Republican leadership with their talk about going back to 2022 levels of funding, the cuts that that would have. It is the politics of the budget versus the people benefiting the budget. And two programs in particular. One is Meals on Wheels. Senior nutrition, obviously, if you

look at that cut going back to 2022 levels, about an $80,000,000 cut, 1 million less seniors getting meals.

My mom, in her late 80s—she passed away last year—but late 80s was getting Meals on Wheels. They came in. It was someone that she had a chance to see every day. I have delivered Meals on Wheels in multiple communities in my district, and that may be that one little check that some people need. I am really concerned about what those cuts mean.

Also in the State Opioid Response Grant program, the cut there would be about $350,000,000. A lot of us talk about fentanyl. Rightfully so, but more than talk, we need to do something. I think the President is trying to do something.

Can you just talk about very briefly these two areas and what the impact of that kind of a cut would mean?

Secretary BECERRA. Congressman, and like you, I have a mother who depends a lot on some of the services that are out there that we make available. I would say this.

Fentanyl, opioids, there is no doubt that if we don't get ahead of this, we are going to lose loved ones. We have seen that already. And the States are making a yeoman's effort. When I was Attorney General, the States, we were part of an effort to sue many of those manufacturers of opioids to get them to pay for the damage they have committed.

For us to walk back those commitments would make it difficult for a lot of these people who are willing to come in—and opioids are very addictive, but they are willing to come in and try to get off of that stuff. Before we lose them, we should be providing them with the access to the treatment they need. Before they start to use, we should have access to preventive programs that keep them from going there.

And before our children start to use what some other young adult is doing, we have to have the programs in place to help them. And so it would be a travesty to give up on the funding in the fight against opioids and drug addiction.

MEDICARE ADVANTAGE

Mr. POCAN. Thank you. A different subject and one I think that we have written you on and I know we have talked about previously is Medicare Advantage.

I agree with Mr. Harris about the excessive profits insurance companies make. Medicare Advantage in particular is twice as profitable as regular health insurance. These companies are making a killing on this. And yet it has tripled just from 2011 to 2021 from $124,000,000,000 to about $361,000,000,000. A lot of money out there.

Two questions. One, why do we let them use "Medicare" in their name? We don't allow anyone to use U.S. Postal Service Delivery. We don't allow someone to call themselves the U.S. Treasury Investment Fund. Why are we allowing Medicare Advantage, which is private insurance, to be called Medicare?

And secondly, CMS did do some things recently to try to help go after some of the collection of overpayments, which I think virtually every company has done to the U.S. Government. Can you

talk just a little bit about those changes? But name why, and then I would love to hear more.

Secretary BECERRA. Yes, and Congressman, you are bringing up a really important point. Because Americans watch these commercials, and they hear the name "Medicare," and they think, oh, okay, gosh. I got to look at this.

And then when they hear the pitch, the sell pitch, they think, well, I got this great deal with Medicare. I will take it.

You got to look behind the curtain, and that is what we are trying to do by doing additional work to scrub the way that managed care program within the Medicare system works. Because we want to make sure that not just the seniors and disabled folks who are on the Medicare program get their money's worth, but we want taxpayers who are helping pay for some of those Medicare services get their money's worth.

I have to tell you that at this stage, it is hard to believe the amount of money that is being spent lobbying and doing commercials to try to prevent us from being able to do the type of work that any oversight agency should do to get returned to the taxpayers' money that was overpaid. We are going to continue to do it.

Mr. POCAN. And if I could just add, the most recent advertising is assuming your 1 percent increase is cutting Medicare. They are not Medicare. Only Medicare is Medicare. So if we really want to take their advice that we are cutting Medicare, then they shouldn't have Medicare in their name at all.

Secretary BECERRA. Yes.

Mr. POCAN. And I have introduced a bill to do that, but if there is anything the agency can do to go after this false advertising because I know way too many people, seniors in my district, who signed up for this and then can't get actual benefits because they are in a network.

And even my mom was impacted. A nice salesman sold her this. Couldn't get the care she needed because she couldn't get to the facility. The building she lived in, she would have got care if she was on Medicare.

So if they are going to claim this is a cut to Medicare, then let us just allow Medicare to use "Medicare."

I yield back, Mr. Chairman.

Mr. ADERHOLT. Mr. Moolenaar.

PREPARING FOR THE NEXT INFECTIOUS DISEASE

Mr. MOOLENAAR. Thank you, Mr. Chairman.

Mr. Secretary, good to see you, and thanks for being here today.

In your role, you have the responsibility to ensure that the United States is prepared for the next infectious disease outbreak. A critical component of being prepared is ensuring that we are actively conducting, monitoring, and surveillance of these pathogens in both the hospital and community setting. And how will HHS ensure the correct diagnostic testing is being done to quickly identify infectious pathogens?

Secretary BECERRA. That is a great question. And you will understand that I ended up going to law school, not to medical school. So I am going to be as concise in my response as I can be.

We are going to rely on the scientists, the medical professionals, especially those that deal with disease and virus, to give us the best evidence. We were able to generate, create a lifesaving vaccine in record time because we relied on the scientists to give us their best work.

And if we continue to rely on those who have spent their life training and studying this and doing the research, we should be able to move forward. Because some of the discoveries that have been made with the technology and the science that we have are going to allow us to reach Americans with lifesaving treatments and vaccines in ways that we have never seen before.

Mr. MOOLENAAR. Were you surprised, when you mentioned the scientific community, how slowly they recognized natural immunity or infectious-based immunity? Because one of the, I think, tragedies is that people were very slow to recognize the importance and the contribution of infectious-based immunity.

Secretary BECERRA. I don't think it was so much slow, Congressman. I know where you are heading on that. But I would look at it this way. They are saying people are dying in numbers, great numbers from COVID. We don't yet have a direct solution. We shouldn't wait until more people get infected and then survive and create that natural immunity to figure out how to help those who may not be as strong and as fit and won't survive it.

No one wants to see the scenes again of people in hospitals having to use a ventilator who a month ago were walking upright, going to work, and today are barely alive because a mechanical ventilator is doing their breathing for them. And so I think they are trying to get there as quickly as we can, but everyone is aware that you do gain some natural immunity if you survive that virus.

COVID PUBLIC HEALTH EMERGENCY

Mr. MOOLENAAR. Would you agree that the health emergency COVID is over now?

Secretary BECERRA. So I would agree that we are certainly at a different place, and that is why we are pulling down the public health emergency that was declared shortly after COVID started hitting in this country. But if I were to tell you, Congressman, that the news just came out an airliner carrying 250, 300 passengers just crashed in America and everybody perished, you would gasp.

And if I told you it was going to happen tomorrow and the day after that and the day after that, you would say what is going on in the aviation industry? COVID is killing 200 to 300 people a day still. So we still have to protect against it, but it is certainly not what it was before.

Mr. MOOLENAAR. And is there something special about, what is it, May 11th or when the President says the emergency——

Secretary BECERRA. Yes, I get asked——

Mr. MOOLENAAR. I mean, it is kind of like, okay, the weather on May 11th will be what?

Secretary BECERRA. Yes. Fair question. Fair question.

One thing we did was we promised, we made a commitment we would give especially our providers, especially the industries that are working off of the protections and flexibilities that you all gave us. You let us do things like on telehealth that we could otherwise

not do. Rather than just yank back that authority to do those things, we said we will try to give you lead time, 60–day lead time before that public health emergency comes down.

Mr. MOOLENAAR. Okay. I am told the Committee for a Responsible Federal Budget estimates that there is somewhere between $70,000,000,000 and $90,000,000,000 that was going to be spent to address the emergency, the health emergency. Are you familiar with that? Unobligated dollars in Federal agencies directly related to the American Rescue Plan that was supposed to be addressing an emergency?

Secretary BECERRA. I am not familiar with that number. I can give you the accounting of the monies that we have got from the American Rescue Plan and how we have spent it. But I——

Mr. MOOLENAAR. Do you have any unobligated dollars that were designed to be spent during the emergency?

Secretary BECERRA. More than 90 percent of the monies that Congress made available to HHS—I am speaking of HHS—has been obligated. There is about 6 percent of that money that has not been obligated. But if you were to talk to some of the States, some of the providers that are out there, they would say wait a minute. We have got the request in. They just haven't signed on the dotted line. We are expecting some of those funds.

Mr. MOOLENAAR. Right. I just—we have spent a lot of money these last 2 years, over $6,000,000,000,000 on this emergency, and it just seems to me when you have got $70,000,000,000 to $90,000,000,000 still in the Federal Government that was designed to be spent there, and we got a $32,000,000,000,000 debt, and we are concerned about a fiscal cliff, it just seems that spending dollars towards an emergency where there is no longer an emergency would be wasteful.

Secretary BECERRA. Congressman, I can guarantee you that some of the hospitals in your district, some of the providers, some of the manufacturers of that protective equipment would say to you, wait a minute, we are still being asked to prepare some of this stuff. That is what that money that is left is going to be used for.

It is still related to COVID. We may not be in a public health emergency the way we were 3 years ago, but there is still a need for us to protect against——

Mr. MOOLENAAR. But wouldn't those be considered obligated?

Secretary BECERRA. Well, they are—as I said, they are in the pipeline, and you said to be obligated. I wanted to be—I wanted to be honest. Have we signed on the dotted line and said it is now committed? No. But is it in the pipeline to be signed on the dotted line? Yes, it is.

Mr. MOOLENAAR. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. ADERHOLT. Ms. Frankel.

SERIOUS CUTBACKS

Ms. FRANKEL. Thank you.

There is something wrong with our time—oh, there we go. Okay. Good to see you. Thank you for your service.

I want to quickly first just talk about seniors because I have a very big senior population in Palm Beach County. And as I know

you know that Democrats are putting people over politics, especially when it comes to reducing the cost of prescription drugs and putting a cap on insulin to help our seniors.

I am concerned about a potential large cutback that would reduce our efforts in Meals on Wheels, housing for seniors, causing longer waits for Medicare services. So I hope that—and also potentially cutting things like research for Alzheimer's. And thank you folks for being here.

So I hope that we do not do those serious cuts, but I want to change direction a little bit because our distinguished chair raised my ears to it. My ears, maybe I will say that. My concerns when he mentioned potentially cutting Title X. And I would like to ask you this.

Would you explain to everybody what the impact of serious cuts to Title X would mean?

Secretary BECERRA. Congresswoman, let me start by giving you the best advice I got growing up from my mother. She said, "Mi hijo, siempre va a ser major prevenir que remediar." It's always going to be better if you can prevent than remediate.

Family planning is important because it helps a couple, an individual make decisions ahead of the event occurring. And the more we plan out our families, the more we are ready to have them not only come to this Earth, but also go to college, the better off we will be versus trying to remedy what we didn't take care of.

And so family planning, Title X is simply that. It helps families, especially families who don't have a lot of income, be prepared. Do the things that probably you and I, with better incomes, can take care of. And that means going early to get the preventive healthcare services. It means if you are pregnant, going in for service now, not waiting until you deliver.

Ms. FRANKEL. So, and let me just add to that for the folks who don't know what Title X does. I mean, and they are serving millions and millions especially of young people, young adults who have no access to healthcare. There are wellness exams, lifesaving cervical and breast cancer screenings, birth control, contraception education, testing and treatment for sexually transmitted diseases.

Something like this isn't quite a—6 million STD tests per year under Title X, which brings me to another subject. The Republicans are on a mission to ban abortion across this country. And we have seen, unfortunately, State after State, including my home State of Florida, which is about to pretty much ban abortion.

I know you have been looking to see what the impact has been, and I will ask you what have been your findings?

Secretary BECERRA. Well, let me give you one that is, I think, stark. Pregnant women in States with abortion bans are nearly three times more likely to die, regardless of their income or their education, during the process of trying to bring that child into the family. Three times more likely to die.

BIRTH CONTROL ACCESS

Ms. FRANKEL. That is pretty scary. So let me get to another subject because I think we could go on and on with that. And that is getting back to birth control, which I think we should all try to support, if it is voluntary. Correct?

Over a decade ago, the Affordable Care Act promised coverage for birth control with no out-of-pocket cost. Unfortunately, the current guidance allows insurance companies to pick and choose which type of birth control they want to cover, as long as they cover one within each category or method. So insurance company, for example, gets to choose which kind of birth control pill somebody—that they will cover, and this is a problem. And my question to you is whether HHS would consider requiring insurance plans to cover all unique birth control products?

Secretary BECERRA. Congresswoman, we have taken action to make sure no insurance company denies or deprives a woman of the healthcare she is entitled to under the Affordable Care Act, and that includes reproductive. That includes abortion care services, and that, of course, includes birth control services.

And so we have brought in insurance companies. The Department of Labor, Department of Treasury, and Department of Health and Human Services, we asked insurers to come and speak to us because we were receiving reports that they were depriving women of payment for those services, coverage for those services.

We have also brought in pharmacies throughout America to make sure that they know they have to dispense those products as well, and we are going to do everything we can, including regulations, to make sure that we implement the statutory requirements of the Affordable Care Act because everyone in America, regardless of your gender, is entitled to have access to the care that you need for health.

Ms. FRANKEL. Thank you. Mr. Chair, I yield back.

Mr. ADERHOLT. Ms. Letlow.

RURAL HEALTH DISPARITIES

Ms. LETLOW. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here today.

One area of great concern for my constituents—I represent 24 parishes in Louisiana—is the health disparities and access to regular and specialized care in my rural district known as the Delta region along the Mississippi River. Within the Delta, according to the CDC, Louisiana is now the third-highest State in new cancer cases and among the top five for cancer deaths, and there seems to be little progress in slowing the morbidity rates down. This region has far too long been subject to lack of care comparative to its urban peers.

As a member of this subcommittee, I would love to work with HRSA in investing in the health of the nearly 10 million people residing in the Delta region. So my question is this, How is the Department addressing the health disparities, especially around cancer rates, in the Delta region? And how can the Department and this committee work together on developing a regional plan to address these high cancer rates and cultivating a healthcare workforce so individuals living in rural areas can have an earlier diagnosis and adequate treatment?

Secretary BECERRA. Congresswoman, first let me start by saying that I hope you will follow up with this. Carole Johnson is the head of HRSA. I will—after this hearing, I will let her know that you

asked specifically about that. And if it is okay, I will ask her to call you.

Ms. LETLOW. That would be wonderful.

Secretary BECERRA. Yes. Because I think it is important. We are trying to do what we can to reach into communities that have been left behind.

The reason so many people died of COVID is because they didn't have easy access. Chances are you don't have a pharmacy or a medical office within a mile or two of a lot of your residents, a lot of your constituents, and that makes it tougher for them to get connected.

And so we are trying to create—shrink that access gap. And so on top of having Administrator Johnson reach out to you, let me mention a couple of things that we are doing.

We are trying to advance rural health in different ways. We talked a little earlier about the fact that the public health emergency is coming down. We think the telehealth opportunities that came from COVID, where you don't have to leave your home and still have access to a doctor, should continue. And we thank Congress for giving us an extension of those flexibilities, but we need them permanently. And that is where your help will come in handy and your support.

The other thing we are trying to do is ensure that on cancer specifically—because, I mean, how many of us haven't lost someone to cancer? What we are trying to do is improve access to screening. About 9 to 10 million Americans missed their cancer screening tests during COVID because they couldn't go out. We want to get those folks back in because those are the folks who we will catch before it becomes a terminal illness. And so, help us.

One of the things we are trying to do, the First Lady, Dr. Biden, has been aggressive on this in the Cancer Moonshot to say it is not just about coming up with cures. It is about getting people the preventive—my mom, I said it, right? Prevent versus remediate. We want to do those preventive screenings. Help us get to those folks who haven't done the preventive screenings.

MATERIAL HEALTH OUTCOMES

Ms. LETLOW. Thank you. Another area of importance to me is maternal health outcomes. I know you talked about it today, but especially for rural moms.

Louisiana is one of the original recipients of the HRSA Maternal and Child Health State Grant and has used this grant to set up a perinatal psychiatric access line and better train providers throughout the State. However, there is a long way to go in improving postpartum care, which you have already talked about.

I am discouraged that several of the HRSA programs that cover maternal and child health were flat funded again for a third year straight within the President's budget request, despite a huge demand for these grants. Those programs include the Maternal Mental Health Hotline, the Innovation for Maternal Health, and the Screening and Treatment for Maternal Depression.

So while we have seen some improvement based off recent data, Louisiana still has one of the highest maternal mortality rates in the U.S. And the U.S. spends $4,200,000,000,000 on healthcare an-

nually, and we are failing to adequately address the health needs of our moms and our babies. I believe we can and we must do more.

So what steps—I know you have addressed some of them—is HHS taking to address the fact that maternal mental health conditions are the leading cause of maternal mortality in the U.S., and how can the Department and, again, this committee work together on directly assessing those maternal needs? I know you have talked about Medicaid expansion for 365 days. I am particularly interested in RMOMS program and how that works in conjunction.

Secretary BECERRA. Yes. So I think you are going to be talking to Administrator Johnson quite a bit.

Ms. LETLOW. Okay.

Secretary BECERRA. And so we will try to make sure she connects with you on this issue as well. Secondly, I believe—I don't want to misspeak—but I believe your State has adopted the challenge——

Ms. LETLOW. Right.

Secretary BECERRA [continuing]. To move towards 365 days of coverage for a woman postpartum care and also for their child, and so I hope that is the case. Because that is probably the most direct way that we can make sure that your providers, your doctors will get reimbursed for the care that they provide to some of these folks.

The other thing we are doing is some of the programs we are doing that are specific to rural America, you will want to make sure you are talking to Administrator Johnson about those. We will follow up with you because if you want to tackle this in your district, we want to be right there with you.

Ms. LETLOW. Okay, I would love some more information on the RMOMS specifically and how that is helping in rural.

Secretary BECERRA. We will get back to you.

Ms. LETLOW. Okay, thank you for your time.

Secretary BECERRA. Thank you.

Mr. ADERHOLT. Mr. Harder. Mrs. Watson Coleman.

DISPARITIES IN HEALTHCARE ACCESS

Mrs. WATSON COLEMAN. Thank you, Mr. Chairman.

Good to see you, sir, Mr. Secretary. Thank you for your work.

And I want to thank my colleague for raising an issue that I am very concerned about, and that is disparities in access to healthcare, be it maternal mortality, infant morbidity and mortality, or just healthcare in general.

I am particularly concerned about mental health. I had been prompted by just Facebook many years ago to head a special task force on looking at the impact of mental health and suicidal issues with young people, particularly young black youth, and we held a series of hearings.

That hearing and those findings led to a piece of legislation pursuing equity in mental health, but in addition, it came at a time when the whole issue of mental health started exploding in this country because of the pandemic and what was happening. So I want to ask you about mental health issues. The proposals that you all have to deal with mental health, particularly getting treatment and services in the schools and places where young children

are impacted because we recognize that mental health is showing up at very young ages.

I want to know what your kind of budget proposal is right now, and I want to know just how damaging would a 10 percent or a 20 percent or a return to 2022 funding levels have on your ability to deal with this escalating need of mental health in this country?

Secretary BECERRA. Congresswoman, and first, thank you for the work that you have done on this issue of maternal mortality and morbidity, and whether it is in the Louisiana Delta or whether it is in urban areas of New Jersey, women are dying. And it is incredible to believe in this country that women are dying right after giving birth, and their babies oftentimes as well.

On the issue of mental health, this budget, the President's budget invests some $4,000,000,000 in discretionary funding to help meet some of those behavioral health needs that you mentioned. That would include funds to increase access to crisis care services. We are putting more money into the Certified Community Behavioral Health Centers. These, as you know, are the 24/7 crisis centers that many times are not available throughout the country.

You don't have a mental crisis only between the hours of 9:00 to 5:00, and you need to have access to care. And if that center is closed, where do you go? And so these critical care centers are open 24/7 to meet those needs. We are expanding services and access to those kinds of centers.

We are putting in an additional $334,000,000 to ensure capacity of the Suicide Prevention Lifeline, and that would give us a chance to have some 9 million contacts under 988 for fiscal year 2024. That is about 6 million more than we had before. We know the need is there, and so we are going where we know we could make a big difference.

I could go on and on if you would like, but I know your time is limited.

Mrs. WATSON COLEMAN. Well, I know that we are trying very hard to catch up and to be able to in real time deal with the issues. And so I am concerned, I would like to know from someone like you, what would be the impact of the diminishing of those resources either back to the 2022 level of funding, continued flat-funding, 10 or 20 percent cut. What does that mean in terms of saving lives, quality of life, ensuring our children grow up with healthy minds and appreciate living as opposed to thinking that suicide or other damaging things are alternatives to their problems?

Secretary BECERRA. Well, as I mentioned, rather than being able to make all those additional contacts under the 988 program, we would probably, if there were about a 22 percent cut in services at 988, that would likely mean a loss of contact with about 900,000 individuals who are calling at a time of mental health crisis.

That would mean that that 300-and-so additional—330 or so additional dollars in funding for 988 from $500,000,000 to about $836,000,000 would essentially be erased as well. It makes it very difficult to believe we could really reach America.

PROVIDER SHORTAGES

Mrs. WATSON COLEMAN. One of the other issues that we face during this period of time is that we recognize that there aren't the kind of service providers that we need. There aren't enough psychiatrists, psychologists, social workers, other kinds of healthcare workers. And I know that you all have as part of this budget a priority to increase capacity, increase understanding, also recognize compensation levels as well as other things that these workers need in order to be healthy and do their jobs.

What would a 10 or 20 percent cut in what you are proposing result in, in terms of the workforce needs that have been demonstrated that is so direly needed?

Secretary BECERRA. Well, it would not only result in the need to cut or reduce services, but it would probably make it almost impossible to continue forward some of the programs that are out there to try to help increase the size of our workforce. Because we have to essentially move to dedicate whatever money is left after these devastating cuts to actual services.

So, for example, the investments we are making in workforce would probably have to disappear. They would have to be relegated to the need for actual service, and that is a travesty. And we know, for example, in childcare, you could probably make more money if you abandon your work as a childcare worker and go flip burgers at the corner burger stand.

Mrs. WATSON COLEMAN. Thank you.

Thank you, Mr. Chair. I will yield back.

Mr. ADERHOLT. Mr. Clyde.

GENDER AFFIRMING CARE

Mr. CLYDE. Thank you, Chairman Aderholt, for holding this hearing today.

And thank you, Mr. Secretary, for attending.

Secretary BECERRA. Thank you.

Mr. CLYDE. Secretary, under the Department of Health and Human Services, do any taxpayer dollars go toward sex reassignment surgeries or hormone blockers for those attempting to change their birth sex?

Secretary BECERRA. Congressman, we make sure that——

Mr. CLYDE. A simple yes or no will work.

Secretary BECERRA. I am sorry?

Mr. CLYDE. A simple yes or no will be fine.

Secretary BECERRA. Well, I have to make sure it is clear because the services that someone receives at their doctor's office or in a hospital in a particular State may differ from other places, and we must make sure that whatever we do, we are abiding by the law. So we provide resources and support to make sure that any services that are provided fall within Federal guidelines and the Federal law.

Mr. CLYDE. Okay. So, and Federal law allows that. Is that what you are saying?

Secretary BECERRA. Federal law allows a number of services to move forward, and we make sure we monitor to make sure pro-

viders are using their monies that they get from the Federal Government properly.

Mr. CLYDE. Okay. How many taxpayer dollars have gone toward paying for sex reassignment surgeries or hormone blockers since you have assumed office in 2021?

Secretary BECERRA. I could try to take a look to see if we can find that kind of information, but I don't have anything—information on that available with me.

Mr. CLYDE. Okay. The HHS does track the amount of money spent on various treatments?

Secretary BECERRA. Again, it depends because you are talking about 50 States and their different ways, but we do track the money because we have to come back to you to report that it was responsibly——

Mr. CLYDE. Absolutely. I am sure the ladies back here that are supporting Alzheimer's funding would want to know that as well, that you do track the amount of money that is used on various treatments.

Secretary BECERRA. We absolutely track the money that we send out to States and to providers.

Mr. CLYDE. Okay. All right. Have any of these sex reassignment surgeries or hormone blockers been given to children, minors under the age of 18?

Secretary BECERRA. Again, you are asking me a question. We don't actually administer programs directly at HHS. We fund services from States and from providers. So you would have to give me more insight into what you are referring to because——

Mr. CLYDE. So you don't have a restriction on that then?

Secretary BECERRA. Our restriction is by statute, what you all set for our parameters on how we can use the dollars you give us and under what conditions.

TITLE X FAMILY PLANNING

Mr. CLYDE. Okay. According to the Department of Health and Human Services fiscal year 2024 budget, HHS proposes to increase funding for the Title X family planning by 76 percent. This is after the Biden administration repealed the Trump era rule, which, as you know, prohibited the use of Title X funds to perform, promote, refer for, or support abortion as a method of family planning.

Is any money in the 76 percent increase in Title X family planning going towards referrals for abortion services for women?

Secretary BECERRA. The increase in funding—and by the way, Title X has not received an increase in funding in, I think, close to a decade. And obviously, family planning services are more needed than they were 10 years ago. What we do is make sure that the money is spent appropriately under the law and which is provided to those different centers, who provide a number of services, not all of them——

Mr. CLYDE. I am specifically asking about abortion services. Would you please address your answer to that?

Secretary BECERRA. So we would only allow monies to be used in ways that the Federal Government permits, and any grantee of Title X funding understands that they must use Title X dollars in the way that Title X allows.

Mr. CLYDE. Okay, please answer the question.

Secretary BECERRA. Which is?

Mr. CLYDE. Which is—I have said it twice now, all right? Does any money of the 76 percent go towards referrals for abortion services for women? A simple yes or no is fine.

Secretary BECERRA. Again, you are asking me to put myself in the position of those centers throughout the country that provide services.

Mr. CLYDE. Well, I mean, you track what money goes for, right? The services that it goes for?

Secretary BECERRA. Those centers have to make sure they have spent the money according to Federal law.

AUTHORIZATION FOR FEDERAL PROGRAMS

Mr. CLYDE. Okay. All right. Prior to becoming Secretary, you spent many years as a Member of Congress on the Ways and Means Committee, very powerful authorizing committee.

Secretary BECERRA. Great committee.

Mr. CLYDE. Uh-huh.

Secretary BECERRA. This is pretty good, too.

Mr. CLYDE. Do you think unauthorized Federal programs should be funded?

Secretary BECERRA. I am sorry. Say again.

Mr. CLYDE. Do you think unauthorized Federal programs should be funded?

Secretary BECERRA. There is no way within the executive branch that we can spend money that hasn't been allocated for a particular use.

Mr. CLYDE. Authorized.

Secretary BECERRA. If it has been authorized, we can spend it.

Mr. CLYDE. But if it has not been authorized, it can't be spent. Is that what you are telling me?

Secretary BECERRA. We would have to have legal authority to spend it. Otherwise, we couldn't.

Mr. CLYDE. Okay. Do you know when the last time the Title X family planning program was authorized?

Secretary BECERRA. Every year, there is a family planning program that is made available. When you all provide money in the budget, you give us authority to spend money on family planning.

Mr. CLYDE. Well, authorized. Not appropriated, authorized.

Secretary BECERRA. Oh, so now you are trying to—you are being a little technical here.

Mr. CLYDE. No, I am not being technical. It is very, very distinct between authorized and appropriated.

Secretary BECERRA. Congressman——

Mr. CLYDE. From my research, it is——

Secretary BECERRA [continuing]. You sit on the Appropriations Committee.

Mr. CLYDE. Yes, I do. It seems that Title X has not been authorized since 1985. And when it was last authorized was the 98th Congress Public Law 98–512. That would be this one right here.

Secretary BECERRA. Then explain to me why you grant us dollars to spend in those ways.

Mr. CLYDE. I am the one asking the question here, sir, Mr. Secretary.

Secretary BECERRA. Well, I am trying to answer the question. The reality is that we cannot spend money——

Mr. CLYDE. Okay. Over the last 2 years in your tenure as Secretary, why have you not asked for an authorization?

Secretary BECERRA. We would love to have the authorization. Let me see you try to get it through this Congress.

Mr. CLYDE. So you are here today asking for money to fund a program that is currently not authorized?

Secretary BECERRA. This program has existed for decades, and we can only spend money that you allow us to spend on it. Having a fully authorized program is ideal, ideal. Think about the Children's Health Initiative that couldn't get authorization for many years. We still spent money trying to keep our kids healthy.

Mr. CLYDE. So you still spend money on unauthorized programs.

Secretary BECERRA. Only because you grant us the authority, Congressman.

Mr. CLYDE. But you have to ask for it, and I yield back.

Mr. ADERHOLT. Mr. Harder.

ASTHMA PROGRAMS

Mr. HARDER. Thank you so much, Mr. Chairman, and thank you, Ranking Member.

Thank you, Secretary Becerra, for being here.

I know we are talking a lot about the impact of particular cuts. I wanted to focus especially on programs that I think really need to grow to serve the health needs of our community.

As you know, I represent the San Joaquin County in California. Having grown up in Sacramento, you know it well. Been spending a lot of our time in our district, and I know that you understand some of the issues and the health challenges that the Valley faces.

One of those is asthma. I grew up with childhood asthma in my area. My brother did. I know exactly what it is like to make sure that you have to put your inhaler in your backpack before you go to school. We have the highest rates of childhood asthma in the entire Nation. We have asthma-related emergency room visits 300 percent higher than the national average.

Programs like the National Asthma Control Program make a huge difference in areas like mine, and yet I don't think we are funding those programs adequately. The funding was $33,000,000 nationwide for the Asthma Control Program last year. The budget that you are asking for is the same, which is actually, given inflation, a reduction in the type of support that I think families like ours need.

Can you talk about why you are requesting level funding for this program, and what we can do to make sure that asthma and kids with childhood asthma are given the appropriate healthcare they need?

Secretary BECERRA. Congressman, I know you know this issue well, and I thank you for posing the question. And I congratulate you. In fact, I encourage you to do exactly as you are doing, and that means advocating for the folks back home. Because I think a

lot of folks forget that that breadbasket of the world, the Central Valley, also has some of the worst air in the Nation, in the world.

And I thank you for the work that you are doing. A lot of my family lives in your district.

We would love more money to do even more on asthma, and we are grateful for the money you helped us get in the last bill in the omnibus that increased by $3,000,000 the amount of money we had. And if I could answer every Member of Congress' question to say how come you are not committing more, I would need a ton more money.

But what I will tell you is this. You are on the right course, just as the folks that are behind me who are really pushing hard for asthma treatments availability are doing absolutely what they should do. I would hope that you would continue that effort, and I hope that the next time I come, I will say thank you because you were able to secure more money for asthma programs in this country.

Mr. HARDER. Well, thank you for your support on that.

I think what is particular about asthma is that the National Asthma Control Program has proven that every dollar spent on it saves $71 in healthcare costs. It is 71 to 1. I used to spend my career in business before I came to Congress. If I ever saw a 71-to-1 return, I would be doing a very different set of things with my life on a beach somewhere.

Secretary BECERRA. Congressman, I want to introduce you to my mom. I mentioned how she focused me on prevention versus remedy.

Thanks.

Mr. HARDER. Absolutely. And I think that is why this program is so important. But that is only one tool in the toolbox for HHS. What else do you think we could be doing to tackle asthma? And what especially are you focused on, on home-based interventions or self-management education, to make sure that we are focusing on that side of prevention?

Secretary BECERRA. There is no doubt that we need to do a much better job of giving people access early, especially for children, to the type of preventive services that let people detect right away that their child might be suffering from asthma. We have to make sure that in our schools we are making more of those healthcare services available.

That is why at HHS we are trying to move to help schools actually apply to be providers under the Medicaid program, which is difficult. They are not healthcare providers, per se. But if they check enough of the boxes and do the right thing, we could probably get healthcare provided more in our schools, and those schools would get reimbursed for having done that because they can't afford to spend precious education dollars on that.

We are going to do everything we can, as my mom said, to prevent rather than to remediate. Look forward to working with you. But certainly, screening and access to preventive healthcare services for all our families regardless of their income would be crucial.

Mr. HARDER. Thank you. Thank you for your attention on this, and I know you have a lot of heart for my district and our community. So thank you for that.

If you ever want to come and visit your family and then do some public visits and talk about asthma or any of the other issues——

Secretary BECERRA. If that is an invitation, I am there.

Mr. HARDER [continuing]. We would love to have you.

Secretary BECERRA. Okay.

Mr. HARDER. Well, thank you so much.

And with that, I yield back.

Secretary BECERRA. Thank you.

Mr. ADERHOLT. Thank you. Mr. Ciscomani.

UNACCOMPANIED CHILDREN

Mr. CISCOMANI. Thank you, Mr. Chair.

And thank you, Secretary Becerra, for being here with us, and thank you for making time to answer our questions.

I represent Arizona's Sixth Congressional District.

Secretary BECERRA. I know it.

Mr. CISCOMANI. And I hope I can cover two quick areas here on my questions to you, but on the first one, we will be going actually back to what the chairman mentioned at the beginning.

So, on February 27, HHS announced that it will be conducting an audit over the next 4 weeks on the vetting process for potential sponsors of children in the Office of Refugee Resettlement, including the vetting requirements for potential sponsors. It has been 4 weeks since that announcement. When can we expect Congress and this subcommittee also to—when can we—can Congress and the subcommittee expect the results from that audit?

Secretary BECERRA. We will probably be able to check in with you in the coming weeks. One, we are trying to make sure that we are looking closely at the entire process, but we should be able to get back to you pretty soon.

Mr. CISCOMANI. Okay. We are really looking forward to those results.

Also, the Office of Refugee Resettlement also conducted safety and well-being calls with both the sponsor and the child after the child is released from ORR custody. How long after a child is placed with a sponsor family does this call take place?

Secretary BECERRA. Congressman, we try—because we lose jurisdiction over the child once we have placed them with a sponsor, we try to do a check with them within about 30 days to make sure everything is moving forward. And so we reach out to the child. We reach out to the sponsor and hope to hear back from them.

Mr. CISCOMANI. I am trying to get a sense of the nature of the calls. How often do you think the calls actually happen? Do they get answered, or do they go unanswered? Or do you make additional attempts to connect with them? What is the success ratio there?

Secretary BECERRA. Thank you for asking that. You are probing, which is what others haven't done.

We reach out to the child directly. And because the person is a child, a minor, we also reach out to the adult who is responsible for the child. That means the sponsors as well. We make three attempts with the child and with the sponsors to try to reach out to them.

Mr. CISCOMANI. Okay. Appreciate that.

FENTANYL

Let us move on to the second topic I wanted to cover, which is the area of fentanyl. Again, I cover a district that is highly hit by this, and I think I keep saying that regarding fentanyl every State has become a border State in that sense, given the tragedies that we see.

In my county of Pima County, where I live, fentanyl deaths is now the number-one cause of leading death among teenagers. A tragedy for sure. So with my district being on the Southern border, the opiate overall epidemic is a major concern for me. As you know, over 100,000 drug overdose deaths occurred in 2021, and with the flow of fentanyl and other illicit drugs across the Southern border, I expect these numbers to be exponentially higher.

Unfortunately, for 2022, we are definitely seeing again if you are counting the level of numbers that I mentioned. Unfortunately, the administration hasn't released these numbers yet. And as you can imagine, I am actually waiting for results for 2022. When do you think we could have some data and some numbers on the drug overdose poisoning of fentanyl?

Secretary BECERRA. Yes, and I know that the numbers usually lag a little because we have to rely on the States to provide us the information, and we are collecting it as best we can. We know everyone is interested to see where they are doing well and where they are not. We will try to get those out as quickly as we can.

And Congressman, if you want, we can follow up with you if you want a more precise date?

Mr. CISCOMANI. Yes, I would like that, Mr. Secretary. I appreciate that.

The last question I have is around in the same area here. The reports have shown that drug traffickers are now mixing fentanyl with other drugs as well. Xylazine specifically being one of them, which is a veterinary tranquilizer, which increases the effects of fentanyl and makes it deadlier.

Another concern is that this new mixture is not an opioid, so Narcan does not have the same effect on preventing the drug poisoning. How is HHS preparing for more cases like this of drug poisoning involving this mixture, and what is HHS doing to develop Narcan options that can treat these mixtures, especially now that the DEA has seen the mixture in 48 out of the 50 States?

And I got to tell you, small business owners in my district are being trained by local law enforcement on how to distribute Narcan and apply it to people overdosing and poisoning on their own businesses. So this is truly tragic, tragic, and keeps increasing. So what is your response on that?

Secretary BECERRA. Yes, and you have raised something that I think a lot of folks miss. We are asking our men and women in uniform to actually do more than they were trained for in the academy. And they have to because, otherwise, some of these folks are going to die right in front of them.

And so it is crucial that we have access to the types of treatments that can revive you, keep you alive, and provide the training where it is possible.

And so what we are trying to do is make sure that working with law enforcement, we try to make sure that what the evidence proves works and make it more available. Because our laws are still based on 1980s, 1970s, 1990s, and sometimes we don't give access to the kind of treatment—naloxone and other things—that could save a life.

And so we want to make sure we are using best evidence and also making sure that we don't put it on just our law enforcement because sometimes they don't have the access to that information. Sometime they are not trained up on that, but yet they are the first ones to have to respond.

And so we have to understand that this issue of drug use goes way beyond just waiting for that person who is overdosing to try to save them. It is making sure we provide the support, including for our law enforcement officers, so that we can make sure we do this the right way.

Mr. CISCOMANI. Thank you, Secretary.

Madam Chair, I yield back.

Ms. LETLOW [presiding]. Mr. LaTurner, you are recognized for 5 minutes.

Mr. LATURNER. Thank you, Madam Chairwoman.

Welcome.

Secretary BECERRA. Thank you.

PROVIDER RELIEF FUND

Mr. LATURNER. Good to see you today. I want to talk about a few issues related to healthcare access——

Secretary BECERRA. Okay.

Mr. LATURNER [continuing]. Back home in Kansas. First is an issue related to the Provider Relief Fund that I know you have addressed in previous congressional testimony, but I would like to get some additional clarity on it today.

There were several acute care hospitals that opened in 2019 and 2020, including Rock Regional Hospital in Kansas, that received significantly less financial support from your Department than other legacy providers. You have committed in the past to work to help these new providers so that they are not forced to close their doors and move us backwards on access for those who need it most.

However, I am deeply concerned that whatever actions you have taken is not sufficient to date. What specifically has your Department done to help support these new providers?

Secretary BECERRA. And Congressman, let us do this. Administrator Carole Johnson at HRSA is the one who administers that Provider Relief Fund. If you want, we can try to follow up because I am not going to be able to give you a quick, concise answer. So let me keep it at this.

One, when we came in, the formula had already been baked on how to distribute the money from the previous administration. That formula used one aspect, a variable, Medicare reimbursement to sort of drive dollars to those providers. There are a lot of providers—including, of course, a new provider—that won't have a record of having gotten Medicare reimbursement because they are new. So guess what? The formula weighs against them because they can't show that they had large expenses.

When we came in, we decided we don't want to use that formula. We came up with a different formula for what would be the fourth tranche of funding in the Provider Relief Fund. But by then, by the fourth tranche, very little of the money was left. Most of that money had already gone out.

And so chances are the answer for those providers you are talking about is that they didn't qualify because they weren't around to qualify in the first three tranches. We changed the formula, and in the fourth tranche, they probably received something. But because that tranche of money was so small compared to the others, and it had to go around to a lot of folks who were new providers or who got—who didn't get a fair share in the first three tranches, it has become less than some people would have expected.

But to give you specifically for those providers, if you want, we can follow up with Administrator Johnson and her team.

Mr. LATURNER. I certainly understand the issue, but I just want to make clear—and I think you understand this—that even though they didn't have the record under the formula, it is still very much impacted.

Secretary BECERRA. Absolutely.

Mr. LATURNER. And so when you get a new provider, you certainly don't want to see them close their doors.

Secretary BECERRA. Absolutely. Congressman, put yourself in my shoes. Am I supposed to yank back the money that all those providers got before and say we now find a provider that didn't get anything or very little and is worthy, and so, therefore, give me back some of the money we gave you?

Every one of those providers would be coming to your door saying they are about to try to take the money I already used.

Mr. LATURNER. Let us talk about those specifically offline, if we can.

Secretary BECERRA. Sure.

Mr. LATURNER. And we would welcome that conversation.

Secretary BECERRA. Look forward to that.

340B PROGRAM

Mr. LATURNER. HRSA has previously taken some action to ensure proper enforcement of the 340B program when it comes to PBMs, as some safety net providers have reported that PBMs are undermining the intent of the 340B program by effectively pickpocketing the 340B savings that were intended to support those providers and using them to boost their own profits instead.

I believe it is vital that we have more information about the operation of PBMs so that we know how best to address the problems instead of operating in today's opaque reality. Outside of HRSA enforcement of the 340B statute, what is your Department doing specifically to promote additional transparency of PBMs practices?

Secretary BECERRA. And thank you for the question. Look forward to your help on this one.

We are, as you said, trying to create a more transparent operation. We don't want to find that the middlemen are skimming money unnecessarily off the top that should be going to help make drugs, prescription drugs affordable for folks.

And so we are trying to open up, move the curtain, but here is the difficulty and one of the reasons why I can only say so much. We get sued every time we try to have more transparency and more accountability by these middle managers. And so, right now, we have been taken to court on a number of occasions as we try to move forward with regulations that would open up transparency and provide more accountability.

NIH OFFICE OF NUTRITION RESEARCH

Mr. LATURNER. The budget request for the National Institutes of Health includes a $120,000,000 increase for the Office of Nutrition Research——

Secretary BECERRA. Yes.

Mr. LATURNER [continuing]. Within the Office of the Director from a current funding level of just $1,300,000. I can't see any justification for why we need to be providing a 9,000 percent increase for research that can already largely be conducted by other agencies like USDA that will likely result in Kansas farmers being told by D.C. bureaucrats what we can and can't grow.

Could you give us specific examples of what the budget envisions the office doing with an additional $120,000,000?

Secretary BECERRA. Yes. And Congressman, I hope we have an opportunity to discuss this because I hope I can dissuade you in the feelings that you have. Because today in America, you can buy a bag of potato chips with a certain level of salt, and if you were to go to a country in Europe, same bag of potato chips, and you turned around and you looked at the amount of sodium in that bag, you would find that it is about 50 percent, maybe more than that, less salt.

Why a difference? Because our standards don't allow us to go in as quickly to try to provide for the nutrition of Americans. The money that we are including is so we can start to treat nutrition the way we should, as part of health. And that we treat food as we should, as medicine to help people stay healthy.

Mr. LATURNER. My time has expired. Madam Chairwoman, I yield back.

Ms. LETLOW. Mr. Ellzey, you are recognized.

Mr. ELLZEY. Thank you, Madam Chair.

PREPAREDNESS

And first of all, I would like to say thank you to the folks here from the Alzheimer's Association. All of us know somebody who has suffered from this very cruel disease, and I appreciate you being here.

Thank you very much.

And I agree with my friend, Mr. Ciscomani, about the Narcan. And from my perspective, Mr. Secretary, Narcan should be the defibrillator of the modern era. And everywhere there is a defibrillator, we should have 10 Narcan doses—school buses, high schools, aircraft—everywhere across the country. Because it takes a matter of seconds to save it. It is harmless, and we need to be looking at it as a nationwide issue.

Because we are losing wartime numbers of Americans every day, 200 every day, to fentanyl overdoses, and it is extremely important.

Thank you for being here, sir. I have got a couple of quick questions for you.

Number one, let us talk about COVID and the next infectious disease. We need to be prepared both at the community and the local hospital level. How is HHS ensuring that we have quick diagnostic testing done to quickly identify infectious pathogens?

Secretary BECERRA. We continue to work and make investments in the diagnostics. I was asked earlier about the money that was provided to address COVID and how most of that money has been spent, about 94 percent. There is still about 6 percent that remains.

Some of that 6 percent would go precisely to what you just mentioned. Is to make sure we continue to stay prepared. We are able to fund the types of programs, whether it is for treatment or testing, that will be needed. And we want to replenish our Strategic National Stockpile, which was reduced so we could meet this need during the pandemic.

HUMAN TRAFFICKING

Mr. ELLZEY. Thank you, sir.

Shifting gears to human trafficking, it is my belief—and I am from Texas 6. We have three interstates going through my home county, Ellis County just south of Dallas, where we know human beings are being trafficked for the sex trade throughout the United States from the Southern border.

Human trafficking and sex trafficking is evil as modern-day slavery. The number of unaccompanied alien children encountered at the Southwest border has increased over the last 2 years, with over 146,000 in fiscal year 2021, 152,000 in 2022, 37,000 in the first 3 months of fiscal year 2023. Under Federal law, HHS is responsible for ensuring the safety of all unaccompanied alien children referred to HHS by CBP, an entity within DHS, which means ultimately you are responsible for protecting these children through the Office of Refugee Resettlement.

In 2021, HHS and DHS signed an MOA, a Memorandum of Agreement, which replaced a previous 2018 MOA between HHS and DHS, removing some requirements for background checks for potential sponsors of unaccompanied alien children. Specifically, the 2021 MOA removed the requirement that the Office of Refugee Resettlement must provide biographic and biometric data for all adult members of a sponsor's household in order to check the FBI's national and statewide criminal history, child abuse, neglect, and sex offender databases prior to placement of the UAC.

Leaves those children vulnerable, in my mind. I am new to this committee and new to this issue other than knowing that it exists. It seems like it is making it easier for those children to be put at risk than harder.

So my question is, was there a rationale for removing the biographic and biometric data?

Secretary BECERRA. I appreciate the question, Congressman.

And by the way, I appreciate the way you have approached it because I know in your State, you see it every day.

Mr. ELLZEY. Yes, sir.

Secretary BECERRA. I believe what you are referring to is our decision, based on the work with the advocates for these families and for these children, who said if you know there is a parent for which that child can be released in sponsorship, then why would you need to do as vigorous a check as you do generally when you are trying to find out who would be an eligible sponsor?

And we decided that if it is to a parent that the child would be released, who is going to care more about that child than the parent himself or herself? And so because at that point in time that you are referring to, we were getting more kids than we had capacity to absorb, we decided that at least with regard to a child who had a parent waiting to become the sponsor, that we would assume that having done checks, that the people in the household with that parent should be responsible as well.

And so, based on having a parent available, we said that if we could find a parent—and most of the time we can find a parent—that to be able to move that child to a better setting than having them in these congregate care settings where you have got hundreds of kids, we would do something like that. But otherwise, everyone goes through a background check.

Mr. ELLZEY. Thank you for your time, Mr. Secretary.

Secretary BECERRA. Thank you for posting that.

Mr. ELLZEY. My time has expired. I yield back, Madam Chair.

Secretary BECERRA. Thank you, Congressman, for that question.

Ms. LETLOW. Mr. Secretary, we are going to start a second round. Thank you, Mr. Secretary. We are going to start with a second round of questions.

I would like to acknowledge Ranking Member Ms. DeLauro for 5 minutes.

BACKGROUND CHECKS

Ms. DELAURO. Thank you very, very much.

If I can just take a second of my time because I lived through the issue of the background checks. To my colleague Mr. Ellzey, it was found by the prior administration that the expanded background checks did not increase the safety of these children. So it was under the prior administration, under the Trump administration that what they began to do was roll back on the entire household.

Because what they found was that doing the entire household tripled the amount of time that children were in the Government's care. And so it really brought unification to a halt, et cetera.

Secretary BECERRA. Yes.

Ms. DELAURO. So it was the prior administration that rolled back. Be happy to talk to you more about it. Lived through it, and you know, it made good sense what the actions were.

CHILD CARE

Childcare. Speaking of childcare, two questions here.

This is—we know that childcare is essential. It is a crisis. More kids need access to childcare. But the childcare facilities struggle to retain staff. The staff is underpaid, and this is women in disproportionate numbers, women of color, underpaid.

And so, Mr. Secretary, what is included in your 2024 budget to address the staffing shortages and underpaid workforce in childcare and in early childhood education?

I am going to ask my second question at the same time, which is a trick, I know. With the block grant, the Child Care and Development Block Grant, there is a $1,900,000,000 increase we secured for the CCDBG in 2023, and I appreciate and support the $1,000,000,000 increase you are requesting. What does the $1,000,000,000 increase for the block grant mean in terms of the number of additional children that would be able to access childcare? What does it mean for the economy if we are able to expand access to affordable childcare?

Secretary BECERRA. And Congresswoman, I am going to give you numbers, but that doesn't tell the story when we are talking about kids. The numbers are the President is requesting $600,000,000,000 for childcare. That is a lot of money. It is still not enough because we know that only 1 in every 7 children in America is receiving the childcare that they need, and that is keeping a lot of parents from having the ability to really do their utmost, be the most that they can be, because they have to worry about care for their children if they try to go to work.

I will tell you that if we weren't to get the dollars to do the expansion of the Certified Community Behavioral Health Centers, there would be a whole bunch of folks after the hour of 5:00 p.m. who won't know where to go to get help, and in many cases—we had conversation earlier about what happens to these folks that don't get care? And if they are on a drug, if they are on opioids, chances are they will end up overdosing, and we will find them, but now we will find them no longer alive. And so it is desperately needed that we make these investments.

When—as I said earlier, when a worker in America—mostly women, mostly women of color—are taking care of our next generation of leaders, and they could probably go across the street at that burger joint and apply for a job and make more money flipping burgers, something is wrong with our priority about how we treat the workers who take care of our kids.

And some of the money that the President is proposing would go not just to increase and expand the number of slots for kids to get care but would increase the ability to pay more.

Ms. DELAURO. Mr. Secretary, is that money that you are speaking about the proposal for the—the mandatory proposal for the——

Secretary BECERRA. Yes.

Ms. DELAURO. Okay. But within the one, so dealing with the shortages, does that $1,000,000,000 increase for the Child Care and Development Block Grant include the opportunity to deal with expanding of the opportunity for childcare, but also being able to deal with the underpayment and the shortage of staff?

Secretary BECERRA. Yes, it does.

Ms. DELAURO. So that $1,000,000,000 will provide that. In the meantime, we do need to get the authorization for the mandatory program to increase 16 million kids being able to get access to childcare.

Secretary BECERRA. Yes. And it does it with flexibility because it is different for some States than in other States, but we do pro-

vide dollars so they can deal with their workforce, increase the pay, increase the numbers.

Ms. DELAURO. Okay. So that is within that $1,000,000,000 that you have requested——

Secretary BECERRA. Yes.

Ms. DELAURO [continuing]. To deal with the Child Care and Development Block Grant? Thank you, and I yield back.

Ms. LETLOW. Dr. Harris, you are recognized.

AUTHORIZATION

Mr. HARRIS. Thank you very much.

Let me follow up a little bit on what Mr. Clyde asked about, the appropriation versus authorization.

Secretary BECERRA. Yes.

Mr. HARRIS. Because you were sitting on this side of the divide at one point. So you know that the Rules Committee makes a rule every time we bring an appropriation bill to the Floor that it can't be challenged because it is not authorized. That is right? It disallows that point of order, right? Or maybe you didn't read the rules that closely?

Secretary BECERRA. I know that there are various ways to make sure that at the end of the day, if you all tell us there is dollars available, we get to spend it.

Mr. HARRIS. Right. Because there could be an assumption that when we appropriate, it is a de facto authorization. But then again, why would the Rules Committee put a point of order rule in the appropriation when we bring appropriating bills to the Floor, not allowing that point of order?

But your answer was intriguing because what you said is, well, let us see if you could get the authorization through. So what you are implying is that this committee should act contrary to what we could actually pass out of an authorizing committee. That is what your answer implies, right? We should actually——

Secretary BECERRA. No, that is not true.

Mr. HARRIS. We should appropriate money when we kind of feel that the authorization committee could never pass an authorization. It would be unsuccessful.

Secretary BECERRA. No, that is not my——

Mr. HARRIS. Well, can you explain your answer? Can you explain why you answered—and I forget the exact quote, although I will pull it out of the transcript.

Secretary BECERRA. And I am responding based on my time as Secretary, where I am obligated to make sure that any dollar I spend is legally spent. And I am also responding based on my 24 years having sat where, Congressman, you are. And that is that I understand the process. At the end of the day, we may execute, but we cannot execute unless you dispose of that particular program.

Mr. HARRIS. Sure. And yes, just reclaiming my time, I mean the bottom line is that it certainly seems we can do it because we have done it. But my opinion is, like Mr. Clyde's opinion, is that we actually take some authority from authorizing committees by doing it year after year after year. And in the case of Title X, I don't know what he said, it was a decade since that has gone through an authorization committee.

MEDICAID EXPANSION

But let me ask you because you were here longer than I am. I was not here when the ACA Medicaid expansion was passed. It always intrigues me that our FMAP toward the expansion is at 90 percent, but the average FMAP for traditional Medicare, which is what we think of Medicare—the poor and elderly, the pregnant women——

Secretary BECERRA. That is——

Mr. HARRIS [continuing]. Is at 56 percent.

Secretary BECERRA [continuing]. For Medicaid.

Mr. HARRIS. For Medicaid. I am sorry. For Medicaid, yes. For Medicaid. So the FMAP is higher for the expansion.

Now if we brought that FMAP for the expansion just into the same FMAP that we have for traditional Medicaid, how much do you think we would recover from the States? Because my calculation is about $50,000,000,000, on that order. Maybe even more. In other words, you understand my question?

Secretary BECERRA. I do, but it relies on a premise that I think is faulty because in order for these States to receive those Medicaid dollars under expansion, we are by law required to offer them an FMAP——

Mr. HARRIS. Right. So that was my question. Why did we choose a much higher FMAP than the traditional FMAP? And maybe you don't know. Maybe you weren't involved in that negotiation.

Secretary BECERRA. I was certainly involved in the drafting of the ACA and in passing the ACA. And what we were trying to do is get as many people as possible in this country coverage because some folks were falling into the gaps.

Mr. HARRIS. Let me reclaim my time again. Covered under Federal dollars, using Federal dollars. But what was the—you might not remember. What was the deficit in the year that the ACA was passed? Was it over $1,000,000,000,000? I don't think so. My best recollection it was not over $1,000,000,000,000, but it is now.

So the situation has kind of changed. I mean, when we passed that bill that was overly generous with the States, we didn't have a $1,000,000,000,000 deficit. I would suggest that we should consider having the States pay their "fair share" of the expansion, and that would help us get out of the fix we are in.

DIETARY GUIDELINES

Finally, the Dietary Guidelines. Because you know, the HHS and Department of Agriculture share the Dietary Guidelines, or constructing those Dietary Guidelines. And I chair the Agriculture Appropriations Subcommittee. You pointed out sodium. Great example. The Dietary Guidelines realized that we probably have too much sodium.

You are aware there is no restriction on the use of SNAP benefits to restrict the sodium content of what you can obtain under SNAP benefits. Is that right?

Secretary BECERRA. So you are asking—I could give you an answer. I can volunteer an answer, but I would probably let Secretary Vilsack——

Mr. HARRIS. Let me just tell you, Mr. Secretary, there is no restriction. So in a strange way, we actually are funding over $100,000,000,000 a year into a program that actually does nothing to adhere to the sodium guidelines that the Department of Agriculture and the Department of HHS promulgate.

I yield back.

Ms. LETLOW. Mr. Hoyer, you are recognized.

AUTHORIZATIONS

Mr. HOYER. Thank you very much.

First, let me say that when the Congress passes a bill and appropriates money, it does, in fact, authorize that expenditure by the Federal Government. We do have a rule, of course, that requires authorization. The Rules Committee regularly waives the point of order against that rule so that expenditures perceived as necessary, but unauthorized because for whatever reasons it has not passed an authorization can, in fact, be effected.

And when the entire Congress passes that bill and the President signs it, it is law. And therefore, any implication that somehow the Secretary or any other Department would be spending money that was not authorized by the House, but nevertheless the appropriation was passed is doing something that is not authorized is incorrect.

MEDICAID EXPANSION

Secondly, the ACA, the reason we did 90 percent is because we want to encourage people to get under—get insured. And one of the incentives we gave was to say that we would pay 90 percent of the cost to the States. Because the States are being pressed very hard by the increase in their medical expenses. And so we did not believe they had the resources. So we made the resources themselves.

And I would remind everybody, the Affordable Care Act was paid for, period. And we made a very great effort to make sure that it was paid for.

HEAD START

Lastly, Mr. Secretary, those of us who advocate for spending ought to also advocate for accountability. Head Start, which I am a strong supporter of, existed from 1965 to 1995 without any Head Start effort having been canceled. Donna Shalala, who was then the Secretary, canceled one for nonperformance.

Let me ask you something. In terms of accountability for the expenditure of Federal dollars on programs that are highly supported—President Bush highly supported this, as did I and many, many others. You did as well. Do we have an accountability? Because we owe it to the American taxpayer to say we want your money spent effectively.

Can you tell me about that? I used that one program, but there are other programs as well.

Secretary BECERRA. And again here, Congressman, I appreciate the question. But I will also tell you not just as Secretary, but as a former Attorney General, it is important that we have accountability. And if you look at some of the past actions of HHS, recent

actions, we are going to enforce accountability because it is important that if you are going to get a Head Start dollar, you are using it for those kids.

And so if you are not—if you can't prove that that is how you are using that money, then that center is going to be subject to action, enforcement action to make sure that we don't provide more dollars in ways that aren't helping kids.

Mr. HOYER. Thank you very much for that.

And I would like a follow-up from your folks on how that has been affected in terms of because I think there are programs that are not functioning as we want them to do so, to the detriment of our children. So that we need to make sure those children are getting what we think we want them to have.

Thank you, Mr. Secretary.

Secretary BECERRA. Thank you.

Mr. HOYER. I yield back.

Ms. LETLOW. Thank you. Mr. Ellzey, you are recognized.

Mr. ELLZEY. Thank you, Madam Chair.

Thanks again, Mr. Secretary.

I just have a couple of quick questions.

Secretary BECERRA. Okay.

HHS WORKFORCE PRACTICES

Mr. ELLZEY. One is, as I look across at the building across the street, it looks kind of empty. So my question is simple. How many folks were working in your Department in office before the pandemic to now, and how many were working remotely before the pandemic and now? And the reason I ask this is I just got out of another hearing. I am asking everybody this question. Nobody is exempt from it. I am just curious.

Because everybody else kind of has to go back work. My constituents from time to time will complain that they are not able to get a hold of anybody at various departments. Not pointing any fingers here. So just a flat-out number, if you got it.

Secretary BECERRA. Yes. I will tell you that our folks are working full time. And because of the new flexibilities that we have learned that COVID made possible, we are continuing to have not just full-time work, but our performance, I mean there are more people today who have access to healthcare than ever before. There are close to 16.5 million people who got their healthcare directly from our marketplaces under Obamacare. There are close to 40 million people that we helped gain access through the Affordable Care Act altogether.

There are, as I mentioned before, close to 300 million Americans who have gotten vaccinated. That is all because the folks at HHS have been working. A lot of our folks, as you know, don't just work at a desk. A lot of our folks are actual practitioners who are out there in the field.

Some are the investigators that we need, and some of them do have an opportunity to have a more flexible work arrangement, and we are going to do everything we can to keep them because we have to stay competitive. Because the other guys who pay way more than we do are doing everything they can to attract the great folks that we have. And we are going to keep them with us.

By the way, we are ranked as the number-two agency to work for in the Federal Government, and we are big. And the only reason we are not number one is because we don't send people into space who work for us because that is what NASA gets to do. But otherwise, if we got to send people into space, we would be number one.

Mr. ELLZEY. Well, that was an artful dodge. I appreciate your answer. [Laughter.]

I am not going to keep continuing to poke that bear and see if I can get an answer. I don't think I will, but that is all right.

BORDER IN TEXAS

When I was a State legislator just 2 years ago, I went down with a bunch of fellow State legislators and a congressman down to the border in Texas at night. And I watched as a coyote brought a family—two sets of families across. As we watched them, and I watched this coyote set foot on American soil, which as a warrior, a formal naval aviator, I really wanted to act on that because I knew what was going on here.

And this family that came across, they got off the raft right in front of me. I am wearing night vision goggles, watching them walk right in front of me. They left an 8-year-old on the boat. And in Spanish, they said, "You forgot her." And the father in me at that point really wanted to act.

And so, oh, they went back and got her because I know full well that they will bring children across that aren't a member of the family so that they can get across and then get processed, and we are finding kids in the ditches in Texas.

I am not pointing fingers here, but what I will point out is Border Patrol agents have claimed how traffickers are recirculating those kids from family to family. Are you aware of any of that happening?

Secretary BECERRA. We have heard a number of stories. But could I just say from me you are going to hear nothing but good stuff about the Border Patrol agents that have been out there working really hard. They are doing a lot of stuff that they didn't think they would have to do in trying to help some of these unaccompanied migrant kids, and we have heard stories otherwise.

But I will tell you that there are men and women serving in Border Patrol who are having to be the first contact for some of these children who are unaccompanied. And it can be very traumatic. I want to say here thank you to those men and women who are doing the work. They got a pistol on their side, but they are also picking up those kids.

And so I think it is important that we recognize the work that is being done. It is tough work. It is a challenge. And I would say to you that we should do everything we can, whether in U.S. or working with Mexico to go after those coyotes because they are the real culprits in this.

They charge these folks to come across. They make a killing, and they know it is safe with these unaccompanied kids to do it. They probably make more money than trying to carry drugs across the border. It is easier, safer. And so I think what we have to do is

double down in our efforts to try to make sure that we stop this stuff, especially when it deals with trafficking kids.

Mr. ELLZEY. But would you say that the traffickers are recirculating those kids for this purpose? Are you aware of any of those? You are HHS. You may or may not.

Secretary BECERRA. I am not aware of it because a child that we hear about, we care for.

Mr. ELLZEY. Okay.

Secretary BECERRA. And so that kid will not recirculate. But it wouldn't surprise me, but I can't tell you that for a fact. And DHS, the Department of Homeland Security, probably could answer that question.

Mr. ELLZEY. Okay. Well, thank you very much for the answer. You know, I think we can all agree that the cartels are the epicenter of evil in the Southern Hemisphere. And they are a clear and present danger to national security, but they are also an evil force that must be reckoned with.

Secretary BECERRA. By the way, thank you for your service.

Mr. ELLZEY. Thank you, sir.

Madam Chair, I yield back. Thank you.

Ms. LETLOW. Ms. Frankel, you are recognized.

MENTAL HEALTH OF GIRLS

Ms. FRANKEL. Thank you very much.

Mr. Secretary, it is very sad that Republicans are obsessed with bullying and bashing transgender people. You know what I not have heard one peep about, not even a little peep, that is about the over 45,000 Americans who in 1 year were killed by gun-related injuries. The biggest killer of our children are guns.

And you know that, Mr. Secretary? You don't have to answer. I know that. But I want to go to another topic.

One thing, I will say this. You learn a lot here. I learned today that some of my colleagues—and I don't know whether they are right or wrong about this—but they do not want us, the Federal Government, to tell farmers what vegetables to grow. However, they do want to tell the women of this country when and if they should bring a family into this world.

And at the same time, Mr. Secretary, they want to cut Title X for family planning. They want to cut childcare, Head Start, nutrition programs, maternal health. Should I go on and on? Other than to say I think it is crazy.

All right. Let me get to my question because I do think what we are leading to and what we now know is that there are horrifying rises in the mental health issues of adolescent girls, and what we are doing in this country is going to make it worse. I would like to know what your agency is doing on this subject.

Secretary BECERRA. Congresswoman, we make a more than 20 percent increase in investments on these issues of mental health because we know that America tells us 90 percent of Americans feel that we are in—experiencing a mental health crisis in this country, and we know the numbers are exploding of our young, including those who are even younger than teens. And so we are making a major investment in that.

I could mention one particular program that is focused on children. It is called Project AWARE. We go into the schools. We try to provide kids with an opportunity to have access to mental health services, including just finding out about what is available to them. We are trying to provide some $244,000,000 for that project because we have seen how successful it has been in places throughout the country where it has been employed.

Ms. FRANKEL. Thank you, Mr. Secretary.

I yield back.

CONCLUDING REMARKS

Ms. LETLOW. Thank you. I would like to recognize Ranking Member Ms. DeLauro for closing comments.

Ms. DELAURO. Thank you very, very much, Madam Chair.

I just wanted to make a couple of points first, if I can, just for the record.

A number of my colleagues have talked about child labor, unaccompanied kids, and we all read the horrific stories in the papers about underage kids in meat plants and working late hours or working during the middle of the night. But the issue is that child labor in the United States, it is not just unaccompanied kids. It is an exploitation of vulnerable children regardless of where a child is from.

Let me mention this to you. It is something that this committee—and not everyone is here, but this committee is uniquely positioned to address. We can fund investigators at the Department of Labor Wage and Hour Division, which comes under the purview of this committee. So we need to crack down on the companies that exploit kids, that place them in dangerous workplaces.

A number of my colleagues this morning have also talked about the Southern border. They have talked about drugs and fentanyl, et cetera. And I just say to folks look at what is being said about going back, and looking at 2024, looking back at what 2022 numbers are. And if you deal with the scale of the cutbacks or what I call the lack of investment, you are going to see it is there. Read about it.

We are looking at cuts to the Border Patrol. We are looking at gutting border protections. That means that there is even more of an opportunity for fentanyl, for trafficking to continue to happen. I just ask people to please look at what it means. It is just not a phrase to say we are going to cut, go back to 2022 for 2024. It has real-life consequences, and I think we need to educate one another about what those consequences are.

I couldn't be more pleased with the 2024 budget request for HHS. Strong funding increases for public health, for maternal health, which I know the chair cares deeply about, behavioral health, mental health, childcare, early learning, so many other areas. And what our job at this committee particularly is to build on the investments that we have made in the past here.

I won't—but I worry about what is being said about the cuts, and I was pleased, Mr. Secretary, I have your letter, and we have the letters from every one of the agencies. But you outlined 200,000 slots. It is not a slot. It is a kid. It is a little kid that is not going to be able to be put into childcare or into Head Start.

Childcare, I will tell you parents are not going back to work, what that does to the economy. You are not going back to work if your kid is not in a safe place during the day.

Suicide has been mentioned, and you talked about that. I just would say opioids, we care about that. We talk about that. But look at what it has done to our ability to respond to the opioid crisis.

Health centers, 20—almost 25 million people in the United States get their primary healthcare from community health centers. What happens to their folks in those?

And you talked about Indian health services. Writ large, we continue to put them at a disadvantage, and they already are for so many issues.

So I would just say let us educate ourselves on what these cuts mean. Let us think about where the opportunities are for us to continue to make investments in the issues and the services that we provide to the American people every single day.

Should we take a look? Should we have accountability? There is no question about that. That is what the job of the Appropriations Committee is about as well.

So I thank you for your testimony today, Mr. Secretary. Thank you for the work that you are doing. It is just not your testimony today. Thank you for a career that has focused on the issues that really are front and center for the American people.

Thanks very much.

Ms. LETLOW. I would like to recognize Mr. Hoyer.

Mr. HOYER. Thank you very much, Madam Chair.

I just want to congratulate our former colleague and the former Attorney General of California. He has got a big agency. He has got a lot of programs.

Mr. Secretary, I thought your answers were honest, knowledgeable, and respectful of those who asked the questions, and I think you are serving the American people well. But more importantly, you are serving the people that this Congress wants HHS to serve well.

So thank you very much.

Ms. LETLOW. Thank you, Mr. Secretary, for joining us today.

Our staff will be following up with some questions for the record.

The subcommittee stands adjourned.

[Questions and answers submitted for the record follow:]

Committee on Appropriations

Labor, Health & Human Services, and Education Subcommittee

FY 2024 Budget Request for the Department of Health and Human Services, March 28, 2023

Questions for the Record for Secretary Xavier Becerra

Submitted by Chairman Aderholt

Administration for Children and Families (ACF)

1. The Administration for Children and Families (ACF) 2024 CJ states that "approximately 34 percent of children referred to the Office of Refugee Resettlement (ORR) in FY 2022 were 17 years old." How many of these teenagers were released to sponsors before they turned 18?

Response:
Of the unaccompanied children who were 17 years old at the time they were placed in ORR care and who were discharged from ORR care and custody during FY 2022, 43,788 were released to sponsors before turning 18.

2. How many times does ACF attempt to contact a sponsor after the release of an unaccompanied alien child to him/her?

Response:
ORR care providers make a minimum of three attempts to speak with both the unaccompanied child and the sponsor within seven days following the 30th day of the child's release from ORR custody.

3. On February 27, 2023, the Department announced a new inter-agency child labor task force with the Department of Labor. What is the cost of the task force to ACF, and how is the agency funding it? What steps has the task force taken to date to meet its objective? What outcomes has the Agency identified to determine the task force is meeting those objectives? When will the taskforce complete its audit of the sponsor vetting process?

Response:
On February 27, 2023, the Department of Labor (DOL) announced the interagency taskforce to combat child labor exploitation, of which HHS Administration for Children and Families (ACF) will be a member. We defer to the DOL on the origination and organizing details of the taskforce and look forward to participating in this important initiative with DOL and other members of the interagency taskforce. ACF does not expect to incur significant costs from participation.

Further information on the interagency task force can be found here: Departments of Labor, Health and Human Services announce new efforts to combat exploitative child labor | U.S. Department of Labor (dol.gov)

4. How many sponsors have been vetted and subsequent UACs released under the parameters of the Trusted Adult Relative Program? What category do the sponsors fall in? Of those sponsors, how many has ORR been unable to contact for the well-being check? Does the Administration have plans to expand the pilot program?

Response:
ORR, U.S. Customs and Border Protection (CBP), U.S. Immigration and Customs Enforcement (ICE), and the National Security Council developed the Category 2 Sponsor Initiative (referred to by some as the Trusted Adult Relative Program) for eligible children without lawful immigration status traveling with non-parent, non-legal guardian, non-citizen close adult relatives who may be potential sponsors. The Category 2 Sponsor Initiative, which launched in May 2022, improves ORR processing for certain children with potential Category 2 sponsors by allowing for sponsor vetting to begin prior to a child entering ORR custody. The initiative is currently underway at one CBP site in the Rio Grande Valley of Texas.

Category 2 sponsors are defined as the following:

- Category 2A: A brother; sister; grandparent or other immediate relatives (e.g., aunt, uncle, first cousin) who previously served as the unaccompanied child's primary caregiver. This includes biological relatives, relatives through legal marriage, and half-siblings.
- Category 2B: An immediate relative (e.g., aunt, uncle, first cousin) who was not previously the unaccompanied child's primary caregiver. This includes biological relatives and relatives through legal marriage.

Often, an adult relative has served as a caretaker for the child or children in their country of origin, and there are significant bonds between the family members. ORR thoroughly assesses these adult relatives on-location at the CBP facility according with all required sponsor vetting for Category 2 sponsors per Section 2 of ORR's Unaccompanied Program (UC) Program Policy Guide. Children unified with Category 2 sponsors under this initiative are being referred for ORR-funded post-release services.

As of February 28, 2023, 243 children have been enrolled in the Category 2 Initiative and have been unified with 241 vetted sponsors.

Interagency partners continue to assess the progress and outcomes of the Category 2 Sponsor Initiative and discussions on any potential expansion will be included as a part of those ongoing conversations.

5. ORR may place a child in a shelter facility, foster care, or group home (which may be therapeutic), staff secure or secure care facility, residential treatment center, or other special needs care facility if unable to find a sponsor for the child. Please provide a list of all the contracts for these services, including the cost and physical location.

Response:

Enclosed is a list of ORR-funded care providers as well as their annual budgets. For safety and security reasons ORR does not share information regarding the physical locations of care provider facilities.

Care Provider	Proj. Period	Facility Type	Approved Annual Budget	Approved and Funded Capacity in Award
A Greater Love FFA Inc Ontario	**07/01/2022 - 06/30/2025**	**TFC**	**$ 5,880,380.00**	30
A Greater Love FFA Inc Whittier	07/01/2022 - 06/30/2025	TFC	included in grant above	15
A New Leaf - Dorothy Mitchell Residence	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 9,772,832.00**	23
A New Leaf - Larry Simmons Residence	11/01/2022 - 10/31/2025	Shelter	included in grant above	25
A New Leaf - Peterson Residence	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	21
A Tender Love And Care INC	07/01/2022 - 06/30/2025	TFC	$ 6,006,466.00	48
Abbott House	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 13,003,971.00**	63
Abbott House - Shelter	02/01/2020 - 03/31/2023	Shelter	$ 9,704,818.00	51
Abbott House - TFC	**11/01/2022 - 10/31/2025**	**TFC**	**$ 9,080,768.00**	60
Ark Homes Foster Family Agency	02/01/2020 - 03/31/2023	TFC	$ 6,254,191.00	48
BCFS Baytown	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 69,467,338.00**	168
BCFS Chavaneaux	02/01/2020 - 03/31/2023	Shelter	included in grant above	80
BCFS Driscoll (335)	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 61,470,432.00**	206
BCFS El Paso (335)	02/01/2020 - 03/31/2023	Shelter	included in grant above	115
BCFS Harlingen (333)	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 98,609,031.00**	506
BCFS San Antonio Shelter	02/01/2020 - 03/31/2023	Shelter	included in grant above	110
BCFS TFC	**02/01/2020 - 03/31/2023**	**TFC**	**$ 14,585,119.00**	150
Berkshire Farm and Youth Center - Shelter Hearts	11/01/2022 - 10/31/2025	Shelter	$ 11,825,791.00	60
Bethany Christian Services - Valley Teen Ranch (CA LTFC Group Home)	**10/01/2022 - 04/30/2023**	**LTFC**	**$ 3,311,306.00**	12
Bethany Christian Services - Wedgwood Christian Services (MI LTFC Group Home)	10/01/2022 - 04/30/2023	LTFC	included in grant above	8
Bethany Christian Services of IN (BCS Indianapolis Direct)	**07/01/2022 - 06/30/2025**	**TFC**	**$ 7,343,529.00**	30
Bethany Christian Services of Michigan (SILP)	01/01/2021 - 12/31/2023	LTFC	$ 949,444.00	6
Bethany Christian Services of Middle Tennessee	**11/01/2022 - 10/31/2025**	**TFC**	**$ 3,510,188.00**	24
Bethany Christian Services of North Carolina (Charlotte)	07/01/2022 - 06/30/2025	TFC	included in grant above	20
Bethany Christian Services of Northern California	**10/01/2022 - 04/30/2023**	**LTFC**	**included in grant above**	6
Bethany Christian Services of Northern California (Modesto TAC)	04/01/2023 - 03/31/2026	Shelter	$ 2,548,995.00	12
Bethany Home Inc	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 6,959,314.00**	48
Board of Child Care - Caminos Nacional Program Cunningham Children's Home (CCH)	02/01/2020 - 03/31/2023	Shelter	$ 10,691,423.00	25
Board of Child Care - Caminos Nacional Program Florida United Methodist Children's H	**02/01/2020 - 03/31/2023**	**Shelter**	**included in grant above**	25
Board of Child Care - Caminos Program	04/01/2023 - 03/31/2026	Shelter	$ 7,578,164.00	34
Board of Child Care - Caminos Program LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 796,441.00**	10
Board of Child Care - Caminos Program Shelter	02/01/2020 - 03/31/2023	Shelter	$ 11,169,912.00	54
Board Of Child Care - Caminos West Program Campolina Way	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 6,722,726.00**	10
Board of Child Care - Caminos West Program Falling Waters	07/01/2022 - 06/30/2025	Shelter	included in grant above	30
Board of Child Care - Cunningham	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 10,578,609.00**	24
Board of Child Care - FUMCH	04/01/2023 - 03/31/2026	Shelter	included in grant above	24
Board of Child Care Kentucky United Methodist Children's Home	**07/01/2022 - 06/30/2025**	**Shelter**	**included in grant above**	24
Board of Child Care- LTFC MCHS	10/01/2022 - 04/30/2023	LTFC	$ 1,065,987.00	16
Board of Child Care-UMHC	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 4,149,429.00**	20
Building Bridges Foster Family Agency	02/01/2020 - 03/31/2023	TFC	$ 6,765,479.00	48
Building Bridges Foster Family Agency	**04/01/2023 - 03/31/2026**	**TFC**	**$ 6,273,973.00**	36
Building Bridges Foster Family Agency LTFC	10/01/2022 - 04/30/2023	LTFC	$ 974,839.00	12
Catholic Charities CYO of the Archdiocese of San Francisco	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 12,012,546.00**	40
Catholic Charities of Houston	02/01/2020 - 03/31/2023	Shelter	$ 10,766,411.00	56
Catholic Charities of the Archdiocese of Miami (Boystown)	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 6,711,248.00**	50
Catholic Charities of the Archdiocese of Miami, Inc	04/01/2023 - 03/31/2026	Shelter	$ 9,538,776.00	81
Catholic Guardian Services - Incarnation	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 4,552,215.00**	21
Catholic Guardian Services Shelter - Crotona	02/01/2020 - 03/31/2023	Shelter	$ 20,995,860.00	12
Catholic Guardian Services Shelter - Crotona	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 19,603,333.00**	12
Catholic Guardian Services Shelter Seton	02/01/2020 - 03/31/2023	Shelter	included in grant above	24
Catholic Guardian Services Shelter Seton	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	24
Catholic Guardian Services TFC	04/01/2023 - 03/31/2026	TFC	included in grant above	96
Catholic Guardian Services TFC	**02/01/2020 - 03/31/2023**	**TFC**	**included in grant above**	96
Catholic Guardian Services University Residence	11/01/2022 - 10/31/2025	Shelter	$ 4,578,902.00	24
Cayuga Home for Children DBA Cayuga Centers	**04/01/2023 - 03/31/2026**	**TFC**	**$ 65,430,743.00**	500
Cayuga Home for Children DBA Cayuga Centers	02/01/2020 - 03/31/2023	TFC	$ 112,478,555.00	400
Cayuga Home for Children DBA Cayuga Centers (NEW CAP.)	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 3,474,091.00**	35

Center for Family Services - Bridgewater	07/01/2022 - 06/30/2025	Shelter	$ 4,821,960.00	22
Center for Family Services - NJ (Camden)	**07/01/2022 - 06/30/2025**	**Shelter**	**included in grant above**	**10**
Center for Family Services- Northfield	11/01/2022 - 10/31/2025	Shelter	$ 5,039,681.00	18
Center for Family Services Shelter - Burlington	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 7,168,333.00**	**20**
Center for Family Services TFC - Voorhees	02/01/2020 - 03/31/2023	TFC	included in grant above	22
Center For Family Services TFC - Voorhees	**04/01/2023 - 03/31/2026**	**TFC**	**$ 7,521,473.00**	**16**
Center for Family Services TFC- Burlington/EGT	11/01/2022 - 10/31/2025	TFC	included in grant above	20
Center for Family Services- Woodbury (Mother/Baby)	**02/01/2020 - 03/31/2023**	**Shelter**	**included in grant above**	**20**
Center For Family Services, Inc. - Burlington	04/01/2023 - 03/31/2026	Shelter	included in grant above	16
Center For Family Services, Inc. - Mother/Baby (Woodbury)	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**12**
CENTER FOR JUVENILE MANAGEMENT INC	07/01/2022 - 06/30/2025	Shelter	$ 2,907,915.00	14
Child Crisis Arizona	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 7,493,250.00**	**51**
Child Crisis Arizona - Mesa	11/01/2022 - 10/31/2025	Shelter	$ 6,162,444.00	42
ChildrenFirst Residential Care - Gasmer/Dynamic Service Solutions	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 17,243,892.00**	**80**
ChildrenFirst Residential Care Services Gasmer	04/01/2023 - 03/31/2026	Shelter	$ 19,094,330.00	104
ChildrenFirst Residential Care Sunnyside/Dynamic Service Solutions	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 18,627,004.00**	**100**
Children's Home of Kingston	04/01/2023 - 03/31/2026	Shelter	$ 4,008,942.00	24
Children's Home of Kingston	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 3,876,961.00**	**24**
Children's Home of Poughkeepsie NY	01/01/2021 - 12/31/2023	LTFC	$ 3,092,926.00	12
Children's Home Of Poughkeepsie NY Inc	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 13,701,973.00**	**62**
Children's Village	11/01/2022 - 10/31/2025	Shelter	$ 20,546,640.00	157
Children's Village - Staff Secure	**10/01/2022 - 04/30/2023**	**Staff Secure**	**$ 12,679,857.00**	**28**
Children's Village - Therapeutic	10/01/2022 - 04/30/2023	Therapeutic	$ 5,584,823.00	12
Compass Connections	**01/01/2021 - 12/31/2023**	**Staff Secure**	**$ 18,220,464.00**	**18**
Compass Connections	01/01/2021 - 12/31/2023	Staff Secure	included in grant above	36
Compass Connections	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 7,965,258.00**	**24**
Compass Connections	01/01/2021 - 12/31/2023	LTFC	included in grant above	66
Compass Connections	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 4,467,759.00**	**24**
Compass Connections	11/01/2022 - 10/31/2025	Shelter	$ 82,197,349.00	416
Compass Connections	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**144**
Compass Connections - Baytown	04/01/2023 - 03/31/2026	Shelter	$ 73,185,281.00	168
Compass Connections - Chuvaneaux	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**80**
Compass Connections - San Antonio Shelter	04/01/2023 - 03/31/2026	Shelter	included in grant above	110
Compass Connections Casa Mariposa	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 81,510,922.00**	**104**
Compass Connections Driscoll	04/01/2023 - 03/31/2026	Shelter	included in grant above	206
Compass Connections El Paso	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**115**
Compass Connections Harlingen	04/01/2023 - 03/31/2026	Shelter	$ 89,379,352.00	475
Compass Connections Raymondville	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**50**
Compass Connections TFC	04/01/2023 - 03/31/2026	TFC	$ 17,992,147.00	150
CPLC Hummingbird House	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 7,674,200.00**	**48**
CPLC Magnolia House	11/01/2022 - 10/31/2025	Shelter	$ 5,558,661.00	24
Crittenton - LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 3,901,144.00**	**60**
Crittenton - Shelter	02/01/2020 - 03/31/2023	Shelter	$ 27,308,949.00	148
David & Margaret - LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 1,137,203.00**	**20**
David and Margaret - Shelter	04/01/2023 - 03/31/2026	Shelter	$ 14,054,612.00	89
Devereux Foundation - Colorado	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 21,186,952.00**	**30**
Devereux Foundation - Connecticut	07/01/2022 - 06/30/2025	Shelter	included in grant above	24
Devereux Foundation - Texas	**07/01/2022 - 06/30/2025**	**Shelter**	**included in grant above**	**36**
Devereux Foundation Colorado Therapeutic	01/01/2021 - 12/31/2023	Therapeutic	$ 5,695,491.00	20
Devereux Massachusetts	**07/01/2022 - 06/30/2025**	**Shelter**	**included in grant above**	**12**
Endeavors Eagle Lake Children's Center	11/01/2022 - 10/31/2025	Shelter	$ 8,557,555.00	60
Ettie Lee Youth and Family Services- John Eccles	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 2,903,475.00**	**8**
Ettie Lee Youth and Family Services- Oak Knolls and John Eccles	07/01/2022 - 06/30/2025	Shelter	included in grant above	11
Florence Crittenton Services of Orange County, Inc.	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 26,751,651.00**	**143**
Friends of Youth - Collin Ferguson	10/01/2022 - 04/30/2023	LTFC	$ 3,582,559.00	5
Friends of Youth - LTFC	**10/01/2022 - 04/30/2023**	**LTFC**	**included in grant above**	**16**
Friends of Youth Matsen House	10/01/2022 - 04/30/2023	Staff Secure	$ 5,300,067.00	6
Friends of Youth McEachern House	**10/01/2022 - 04/30/2023**	**Staff Secure**	**included in grant above**	**10**
Gulf Coast Jewish Family & Community Services, Inc.	04/01/2023 - 03/31/2026	Shelter	$ 6,758,990.00	50
Gulf Coast Jewish Family and Community Services	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 5,912,250.00**	**50**
Hands of Healing Residential Treatment Center, Inc.	04/01/2023 - 03/31/2026	Shelter	$ 5,540,904.00	24
Hannas House	**07/01/2022 - 06/30/2025**	**TFC**	**$ 8,297,604.00**	**60**
Heartland - Casa Heartland at Princeton - CHAP	02/01/2020 - 03/31/2023	Shelter	$ 49,968,548.00	12
Heartland - International Children's Center - Beverly	**02/01/2020 - 03/31/2023**	**Shelter**	**included in grant above**	**32**
Heartland - International Children's Center (ICC)	02/01/2020 - 03/31/2023	Shelter	included in grant above	40
Heartland - International Children's Reception Center (ICRC)	**02/01/2020 - 03/31/2023**	**Shelter**	**included in grant above**	**166**
Heartland Human Care Services, Inc. - Casa Heartland at Princeton (CHAP)	04/01/2023 - 03/31/2026	Shelter	$ 38,189,476.00	12
Heartland Human Care Services, Inc. - International Children's Center (ICC)	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**40**
Heartland Human Care Services, Inc. - International Children's Center Beverly (ICCB)	04/01/2023 - 03/31/2026	Shelter	included in grant above	32
Heartland Human Care Services, Inc. - International Children's Reception Center (ICRC)	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**116**
HeartShare St. Vincent's Services	04/01/2023 - 03/31/2026	TFC	$ 7,602,880.00	38
Hillsides	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 4,525,617.00**	**20**
His House- Shelter	04/01/2023 - 03/31/2026	Shelter	$ 19,662,459.00	144
His House, Inc. - Shelter	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 20,864,738.00**	**144**
His House, Inc. - TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	10
HOH Casa Sunshine (Hands of Healing)	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 6,805,204.00**	**48**
HOH Sunshine Foster (Hands of Healing)	07/01/2022 - 06/30/2025	TFC	$ 5,182,071.00	40
Holy Family Institute - Emsworth Campus	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 36,162,518.00**	**80**

Holy Family Institute – Emsworth Campus	04/01/2023 - 03/31/2026	Shelter	$ 20,239,677.00	48
Holy Family Institute - LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 2,788,088.00**	**12**
Holy Family Institute – Moon Campus	02/01/2020 - 03/31/2023	Shelter	included in grant above	80
Holy Family Institute – Moon Campus	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**48**
Inspiritus, Inc.	04/01/2023 - 03/31/2026	Shelter	$ 4,706,086.00	24
JCCA	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 3,417,912.00**	**30**
Jewish Child Care Association of New York	04/01/2023 - 03/31/2026	Shelter	$ 6,997,676.00	24
Kids in Crisis	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 3,051,632.00**	**10**
KidsPeace	02/01/2020 - 03/31/2023	Shelter	$ 25,680,189.00	112
KidsPeace	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 17,430,480.00**	**65**
LaSalle School	07/01/2022 - 06/30/2025	Shelter	$ 2,377,295.00	16
Latin American Youth Center, Inc.	**11/01/2022 - 10/31/2025**	**TFC**	**$ 1,576,601.00**	**16**
Liberty Wilderness	01/01/2021 - 12/31/2023	Staff Secure	$4,762,220	24
Lincoln Hall	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 18,410,968.00**	**100**
Lincoln Hall	02/01/2020 - 03/31/2023	Shelter	$ 16,231,647.00	100
LIRS - Ascentria Community Services (formerly LSSNE) MA Worcester LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 10,173,015.00**	**24**
LIRS – BCS MI Kalamazoo LTFC – Casa de Esperanza	01/01/2021 - 12/31/2023	LTFC	included in grant above	12
LIRS - Bethany Christian Services - MD Crofton TFC	**02/01/2020 - 03/31/2023**	**TFC**	**$ 48,687,031.00**	**36**
LIRS - Bethany Christian Services - MD Crofton TFC	04/01/2023 - 03/31/2026	TFC	$ 49,634,177.00	30
LIRS - Bethany Christian Services GA Atlanta TFC	**07/01/2022 - 06/30/2025**	**TFC**	**$ 34,149,960.00**	**36**
LIRS - Bethany Christian Services MI Alma Shelter	07/01/2022 - 06/30/2025	Shelter	included in grant above	36
LIRS - Bethany Christian Services MI Grand Rapids LTFC - Casa Agape	**01/01/2021 - 12/31/2023**	**LTFC**	**included in grant above**	**32**
LIRS - Bethany Christian Services MI Grand Rapids Shelter - TAC	02/01/2020 - 03/31/2023	Shelter	included in grant above	36
LIRS - Bethany Christian Services MI Grand Rapids Shelter - TAC	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**36**
LIRS - Bethany Christian Services MI Grand Rapids TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	30
LIRS - Bethany Christian Services MI Grand Rapids TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**18**
LIRS - Bethany Christian Services MI Kalamazoo LTFC TGH - Hacienda De Luz	01/01/2021 - 12/31/2023	LTFC	included in grant above	12
LIRS - Bethany Christian Services PA Havertown TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**30**
LIRS - Bethany Christian Services PA Havertown TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	18
LIRS - Bethany Christian Services PA Pittsburgh TFC	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	**24**
LIRS - Bethany Christian Services PA Reading TFC	07/01/2022 - 06/30/2025	TFC	included in grant above	24
LIRS - Bethany Christian Services TN Smyrna TFC	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	**12**
LIRS - Chris 180 GA Atlanta Group Home	07/01/2022 - 06/30/2025	TFC	included in grant above	36
LIRS - Chris 180 GA Atlanta TGH	**01/01/2021 - 12/31/2023**	**Therapeutic**	**$ 3,875,403.00**	**19**
LIRS - CSKF CA Moreno Valley LTFC	10/01/2022 - 04/30/2023	LTFC	$ 1,653,049.00	4
LIRS - CSKF CA Riverside TFC	**07/01/2022 - 06/30/2025**	**TFC**	**$ 9,953,225.00**	**16**
LIRS - enCircle VA Newport News LTFC	10/01/2022 - 04/30/2023	LTFC	included in grant above	6
LIRS - enCircle VA Richmond TFC	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	**16**
LIRS - Kennedy Krieger Institute & LIRS MD Baltimore TFC (NEW PROGRAM)	07/01/2022 - 06/30/2025	TFC	included in grant above	16
LIRS - Lutheran Services Carolina SC Columbia TFC	**02/01/2020 - 03/31/2023**	**TFC**	**included in grant above**	**24**
LIRS - Lutheran Services Carolina SC Columbia TFC	04/01/2023 - 03/31/2026	TFC	included in grant above	24
LIRS - Lutheran Social Services National Capital Area VA Fairfax TFC	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	**24**
LIRS BCS MI East Lansing TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	12
LIRS BCS MI East Lansing TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**18**
LIRS BCS MI Holland TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	24
LIRS BCS MI Holland TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**24**
LIRS BCS MI Muskegon TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	24
LIRS BCS MI Muskegon TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**24**
LIRS BCS MI Paw Paw TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	24
LIRS BCS MI Paw Paw TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**18**
LIRS- Diakon Child PA York LTFC	10/01/2022 - 04/30/2023	LTFC	included in grant above	6
LSS of New York - Shelter	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 9,284,822.00**	**22**
LSS of New York - Shelter	02/01/2020 - 03/31/2023	Shelter	$ 8,415,721.00	22
LSS of New York - TFC	**02/01/2020 - 03/31/2023**	**TFC**	**included in grant above**	**36**
LSS of New York - TFC (Safe Haven)	11/01/2022 - 10/31/2025	TFC	$ 8,760,584.00	56
LSS of New York - TFC 1	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**36**
LSSS Upbring - Bokenkamp Shelter	04/01/2023 - 03/31/2026	Shelter	$ 16,703,445.00	110
LSSS Upbring - Bokenkamp Shelter	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 16,097,951.00**	**110**
LSSS Upbring - Bokenkamp TFC	04/01/2023 - 03/31/2026	TFC	$ 6,611,279.00	50
LSSS Upbring - Bokenkamp TFC	**02/01/2020 - 03/31/2023**	**TFC**	**$ 6,917,263.00**	**50**
LSSS Upbring - Grace House Shelter	11/01/2022 - 10/31/2025	Shelter	$ 10,546,521.00	60
LSSS Upbring - New Hope Shelter	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 10,910,103.00**	**60**
LSSS Upbring - New Hope Shelter	02/01/2020 - 03/31/2023	Shelter	$ 9,719,833.00	60
LSSS Upbring Loma Alta	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 17,977,558.00**	**76**
LSSS Upbring LTFC	01/01/2021 - 12/31/2023	LTFC	$ 1,793,259.00	20
LSSS Upbring TFC	**04/01/2023 - 03/31/2026**	**TFC**	**$ 7,512,760.00**	**50**
LSSS Upbring TFC	02/01/2020 - 03/31/2023	TFC	$ 5,911,669.00	50
Lutheran Services Florida	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 9,626,131.00**	**64**
Lutheran Services Florida - Dream Center	02/01/2020 - 03/31/2023	Shelter	$ 8,814,469.00	64
Lutheran Social Services Of The South, Inc.	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 12,464,498.00**	**72**
MarSell Consulting & MHS-Riverside	02/01/2020 - 03/31/2023	TFC	$ 4,517,401.00	32
Marsell Consulting And MHS	**11/01/2022 - 10/31/2025**	**TFC**	**$ 9,226,014.00**	**64**
MarSell Consulting and MHS- The Believe Center-Chula Vista	07/01/2022 - 06/30/2025	TFC	$ 4,676,350.00	32
Marsell Consulting and MHS-Riverside	**04/01/2023 - 03/31/2026**	**TFC**	**$ 5,578,973.00**	**50**
Maryville Academy	07/01/2022 - 06/30/2025	Shelter	$ 4,330,811.00	25
Maryville Academy - Casa Esperanza	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 17,754,899.00**	**22**
Maryville Academy - Casa Esperanza	02/01/2020 - 03/31/2023	Shelter	$ 16,487,068.00	22
Maryville Academy - San Francisco	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**33**

Maryville Academy - San Francisco	02/01/2020 - 03/31/2023	Shelter	included in grant above	33
Maryville Academy - San Juan Diego	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	33
Maryville Academy - San Juan Diego	02/01/2020 - 03/31/2023	Shelter	included in grant above	33
Maryville Academy - St. Gabriel	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 7,000,000.00**	20
Maryville Academy St Anne for Girls	01/01/2021 - 12/31/2023	LTFC	included in grant above	20
McKinley Children's Center	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 9,463,795.00**	60
Mercy First - Therapeutic	01/01/2021 - 12/31/2023	Therapeutic	$ 3,966,398.00	18
MercyFirst - Shelter	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 13,694,749.00**	66
MercyFirst Shelter	04/01/2023 - 03/31/2026	Shelter	$ 13,393,014.00	74
Morrison / LTFC / LTGH	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 4,040,124.00**	20
Morrison Child & Family Services	04/01/2023 - 03/31/2026	Shelter	$ 5,725,867.00	25
NAFI Connecticut, Inc	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 2,753,623.00**	9
National Youth Advocate Program - GA	04/01/2023 - 03/31/2026	TFC	$ 40,812,489.00	48
National Youth Advocate Program - IL	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	48
National Youth Advocate Program - IL (Chicago)	11/01/2022 - 10/31/2025	TFC	$ 30,118,972.00	60
National Youth Advocate Program - IL (Gurnee)	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 11,164,493.00**	64
National Youth Advocate Program - IL (Naperville)	01/01/2021 - 12/31/2023	LTFC	included in grant above	64
National Youth Advocate Program - IL (second location)	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	48
National Youth Advocate Program - OH	04/01/2023 - 03/31/2026	TFC	included in grant above	48
National Youth Advocate Program - SC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	60
NATIONAL YOUTH ADVOCATE PROGRAM, INC	11/01/2022 - 10/31/2025	TFC	$ 28,975,658.00	144
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - AZ	**07/01/2022 - 06/30/2025**	**TFC**	**$ 81,386,915.00**	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - Cicero, IL	07/01/2022 - 06/30/2025	TFC	included in grant above	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - East Dundee, IL	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - IN	07/01/2022 - 06/30/2025	TFC	included in grant above	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - IN	**11/01/2022 - 10/31/2025**	**TFC**	**included in grant above**	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - LA	07/01/2022 - 06/30/2025	TFC	included in grant above	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - NV	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - OH	07/01/2022 - 06/30/2025	TFC	included in grant above	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC. - SC	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC.- GA	07/01/2022 - 06/30/2025	TFC	included in grant above	48
NATIONAL YOUTH ADVOCATE PROGRAM, INC.- GA	**11/01/2022 - 10/31/2025**	**TFC**	**included in grant above**	60
NATIONAL YOUTH ADVOCATE PROGRAM, INC.- IN	07/01/2022 - 06/30/2025	TFC	included in grant above	48
Neighborhood Ministries, Inc.	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 8,564,315.00**	46
Neighborhood Ministries, Inc.	07/01/2022 - 06/30/2025	TFC	$ 11,218,536.00	40
New Life Foster Family Agency	**10/01/2022 - 04/30/2023**	**LTFC**	**$ 1,465,532.00**	24
New Life Foster Family Agency (Colton)	02/01/2020 - 03/31/2023	TFC	$ 7,434,528.00	48
New Life Foster Family Agency (Colton)	**04/01/2023 - 03/31/2026**	**TFC**	**6,797,076**	24
New Life Foster Family Agency (Riverside)	04/01/2023 - 03/31/2026	TFC	included in grant above	24
Noank	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 1,760,179.00**	12
Noank Community Support Services, Inc.	04/01/2023 - 03/31/2026	Shelter	2,134,403	12
Noank Community Support Services, Inc. TFC	**07/01/2022 - 06/30/2025**	**TFC**	**$ 1,162,912.00**	10
Nuevo Amanecer Latino Children Services	07/01/2022 - 06/30/2025	TFC	$ 4,431,519.00	48
Pioneer Human Service - Selma Carson Home	**10/01/2022 - 04/30/2023**	**Staff Secure**	**$ 7,210,491.00**	20
Rancho San Antonio Boys Home	07/01/2022 - 06/30/2025	Shelter	$ 5,401,972.00	32
Rising Ground - Therapeutic	**01/01/2021 - 12/31/2023**	**Therapeutic**	**$ 2,593,113.00**	12
Rising Ground Inc	07/01/2022 - 06/30/2025	Shelter	$ 34,674,368.00	169
Rising Ground Inc	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	31
Rising Ground Shelter (Leake and Watts)	02/01/2020 - 03/31/2023	Shelter	$ 17,978,877.00	65
Rising Ground TFC (Leake and Watts TFC)	**02/01/2020 - 03/31/2023**	**TFC**	**included in grant above**	90
Rising Ground TFC (Leake and Watts) TFC - one of two	04/01/2023 - 03/31/2026	TFC	$ 22,925,135.00	90
Rising Ground, Inc.	**11/01/2022 - 10/31/2025**	**TFC**	**$ 12,332,682.00**	22
Rising Ground, Inc.	11/01/2022 - 10/31/2025	Shelter	included in grant above	50
Rising Ground, Inc.	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	65
Rite of Passage, Inc - Oracle	02/01/2020 - 03/31/2023	Shelter	$ 16,178,680.00	54
Rite of Passage, Inc - Queen Creek	**02/01/2020 - 03/31/2023**	**Shelter**	**included in grant above**	80
Rite of Passage-Oracle (Sycamore)	04/01/2023 - 03/31/2026	Shelter	$ 17,893,212.00	54
Rite of Passage-Queen Creek (Canyon)	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	80
Ruby's Place	04/01/2023 - 03/31/2026	Shelter	$ 1,642,022.00	7
Samaritas	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 4,972,565.00**	24
Seton Home for Pregnant Women	04/01/2023 - 03/31/2026	Shelter	$ 7,801,829.00	51
Shenandoah	**01/01/2021 - 12/31/2023**	**Secure**	**$ 5,055,099**	24
Shiloh - Boys	01/01/2021 - 12/31/2023	Therapeutic	$ 2,887,169.00	16
Shiloh - Girls	**01/01/2021 - 12/31/2023**	**Therapeutic**	**$ 2,887,169.00**	16
Southwest Key Casa Norma Linda	11/01/2022 - 10/31/2025	Shelter	$ 141,396,444.00	600
Southwest Key- Casa Nueva Amistad	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 4,472,630.00**	10
Southwest Key- LaPromesa	01/01/2021 - 12/31/2023	LTFC	included in grant above	10
Southwest Key Trail House Residential Program	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 145,560,152.00**	512
St. Peter - St. Joseph Children's Home	04/01/2023 - 03/31/2026	Shelter	$ 8,507,942.00	82
St. Peter & Joseph Children's Home	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 9,690,643.00**	82
Sunny Glen Children's Home - New Day Resiliency Center (NDRC)	11/01/2022 - 10/31/2025	Shelter	$ 39,841,026.00	250
Sunny Glen Children's Home - New Life Resiliency Center (NLRC)	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 26,065,386.00**	24
Sunny Glen Children's Home - New Tomorrow Resiliency Center (NTRC)	07/01/2022 - 06/30/2025	Shelter	included in grant above	115
SWK Amanacer f.k.a SWK Hacienda De Sol	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 72,620,711.00**	133
SWK Campbell	11/01/2022 - 10/31/2025	Shelter	included in grant above	128
SWK Canutillo	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	90
SWK Casa Antigua	11/01/2022 - 10/31/2025	Shelter	$ 61,822,084.00	304
SWK Casa Blanca	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 31,911,417.00**	44

SWK Casa Fortaleza f.k.a SWK Casa Phoenix	11/01/2022 - 10/31/2025	Shelter	$ 77,770,666.00	420
SWK Casa Franklin	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**45**
SWK Casa Houston Reliant	11/01/2022 - 10/31/2025	Shelter	included in grant above	90
SWK Casa Kokopelli	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**120**
SWK Casa Lighthouse	11/01/2022 - 10/31/2025	Shelter	included in grant above	74
SWK Casa Montezuma	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 98,702,152.00**	**191**
SWK Casa Oasis	11/01/2022 - 10/31/2025	Shelter	$ 107,984,291.00	290
SWK Casa Padre	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 145,779,554.00**	**1200**
SWK Casa Quetzal	11/01/2022 - 10/31/2025	Shelter	included in grant above	236
SWK Casa Sunzal	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**222**
SWK Casita Del Valle	11/01/2022 - 10/31/2025	Shelter	included in grant above	75
SWK El Presidente	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**413**
SWK El Sueno (formerly SWK Combes)	11/01/2022 - 10/31/2025	Shelter	included in grant above	58
SWK Estrella	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**300**
SWK Glendale	11/01/2022 - 10/31/2025	Shelter	included in grant above	68
SWK La Esperanza (formerly Processing Center)	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**75**
SWK Mesa	11/01/2022 - 10/31/2025	Shelter	included in grant above	54
SWK Nueva Esperanza	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**200**
SWK Pleasant Hill	11/01/2022 - 10/31/2025	Shelter	included in grant above	26
SWK Rio Grande	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**160**
SWK San Diego	11/01/2022 - 10/31/2025	Shelter	included in grant above	74
The Children's Community Programs of Connecticut, Inc	**07/01/2022 - 06/30/2025**	**TFC**	**$ 6,115,275.00**	**24**
The Villages Inc	04/01/2023 - 03/31/2026	Shelter	$ 8,295,753.00	62
The Villages, Inc.	**02/01/2020 - 03/31/2023**	**Shelter**	**$ 8,054,082.00**	**62**
There is Hope, Inc. - Rancho Cucamonga	07/01/2022 - 06/30/2025	TFC	$ 7,483,100.00	20
There is Hope, Inc. - Riverside	**07/01/2022 - 06/30/2025**	**TFC**	**included in grant above**	**20**
Timber Ridge School	07/01/2022 - 06/30/2025	Shelter	$ 3,642,832.00	20
Trinity Youth Services	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 4,204,800.00**	**24**
Urban Strategies - Refugio Alamo	11/01/2022 - 10/31/2025	Shelter	$ 15,307,751.00	24
Urban Strategies - Refugio Iglesia De Dios Shelter	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**36**
Urban Strategies - Refugio Ignite Shelter	11/01/2022 - 10/31/2025	Shelter	included in grant above	20
Urban Strategies - Refugio Maranata	**11/01/2022 - 10/31/2025**	**TFC**	**$ 1,750,347.00**	**12**
Urban Strategies San Benito	11/01/2022 - 10/31/2025	Shelter	$ 16,043,420.00	84
USCCB - Archidocese Philadelphia	**11/01/2022 - 10/31/2025**	**TFC**	**$ 3,312,751.00**	**12**
USCCB - Bethany Christian Services Modesto	02/01/2020 - 03/31/2023	Shelter	$ 8,532,773.00	12
USCCB - Bethany Christian Services of Michigan - Bellaview (Girls)	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 6,152,307.00**	**6**
USCCB - Bethany Christian Services of Michigan - Casa Del Sol (Boys)	01/01/2021 - 12/31/2023	LTFC	included in grant above	12
USCCB - Bethany Christian Services of Michigan - Kalamazoo (f.k.a USCCB- Bethany Chri 01/01/2021 - 12/31/2023		**LTFC**	**included in grant above**	**8**
USCCB - Catholic Charities of Fort Worth Shelter	02/01/2020 - 03/31/2023	Shelter	included in grant above	24
USCCB - Catholic Charities of Fort Worth Shelter	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 5,699,292.00**	**24**
USCCB - Catholic Charities of Fort Worth TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	5
USCCB - Catholic Charities of Fort Worth TFC	**04/01/2023 - 03/31/2026**	**TFC**	**included in grant above**	**5**
USCCB - Catholic Community Services Tacoma	01/01/2021 - 12/31/2023	LTFC	included in grant above	6
USCCB - Catholic Family Center	**01/01/2021 - 12/31/2023**	**LTFC**	**included in grant above**	**6**
USCCB - CCC Richmond TFC	02/01/2020 - 03/31/2023	TFC	included in grant above	10
USCCB - Commonwealth catholic charities Richmond LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**included in grant above**	**10**
USCCB - Commonwealth Catholic Charities Richmond Shelter	02/01/2020 - 03/31/2023	Shelter	included in grant above	10
USCCB - Commonwealth catholic charities Richmond Shelter	**04/01/2023 - 03/31/2026**	**Shelter**	**included in grant above**	**16**
USCCB Catholic Charities West Michigan TFC (CC West MI TFC)	07/01/2022 - 06/30/2025	TFC	$ 3,047,690.00	12
USCCB- Commonwealth Catholic Charities Norfolk	**11/01/2022 - 10/31/2025**	**Shelter**	**included in grant above**	**12**
USCCB Commonwealth Catholic Charities Virginia Beach Shelter	07/01/2022 - 06/30/2025	Shelter	included in grant above	10
USCRI- Rayo De Luz	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 9,744,431.00**	**48**
USCRI- Rinconcito del Sol	11/01/2022 - 10/31/2025	Shelter	$ 18,607,717.00	100
VILLAGE FAMILY SERVICES, THE	**07/01/2022 - 06/30/2025**	**TFC**	**$ 3,429,569.00**	**22**
VisionQuest - Gwen Mikeal Village	11/01/2022 - 10/31/2025	Shelter	$ 11,125,657.00	50
VisionQuest - Sam Mahan Center	**11/01/2022 - 10/31/2025**	**Shelter**	**$ 9,649,244.00**	**48**
VisionQuest- Steven Rogers	01/01/2021 - 12/31/2023	LTFC	$ 9,329,250.00	50
VisionQuest -Wallis (Juan Pirtle)	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 11,139,382.00**	**64**
Vista Del Mar Child and Family Services	07/01/2022 - 06/30/2025	Shelter	$ 7,338,051.00	24
Welcoming Arms - Dobbs Ferry	**07/01/2022 - 06/30/2025**	**Shelter**	**$ 10,080,187.00**	**24**
Welcoming Arms - New Windsor	07/01/2022 - 06/30/2025	Shelter	included in grant above	36
Youth For Tomorrow - LTFC	**01/01/2021 - 12/31/2023**	**LTFC**	**$ 1,439,105.00**	**11**
Youth For Tomorrow Shelter	02/01/2020 - 03/31/2023	Shelter	$ 28,811,017.00	145
Youth For Tomorrow Shelter	**04/01/2023 - 03/31/2026**	**Shelter**	**$ 28,250,637.00**	**145**
Youth For Tomorrow TFC	04/01/2023 - 03/31/2026	TFC	included in grant above	25
Youth For Tomorrow TFC	**02/01/2020 - 03/31/2023**	**TFC**	**included in grant above**	**50**
YouthCare	02/01/2020 - 03/31/2023	Shelter	$ 3,455,315.00	15
				22833

6. The Agency has received specific set asides of $1.1 million and $1.7 million in FY 2022 and FY 2023 for technical assistance funding for the improvement of ACF's ability to prepare timely LIHEAP formula estimates when requested by committee staff. Please describe in detail how the Agency has used those funds to date to improve their processes and what needs may remain unmet for the purpose of the funding.

Response:
ACF has used the technical assistance funding provided in FY 2022 and FY 2023 to prepare timely formula estimates to committee staff and make progress towards automating the LIHEAP funding formula. Additional funding in both years has been leveraged to support needed federal and contract staffing to ensure timely responses are provided to Congress; ACF has been able to meet and exceed the requirement from Congress to respond to formula requests within 10 days of receipt. ACF is also in the process of onboarding a statistician who will improve our ability to collect, manage, and analyze the large data sets required to run the LIHEAP formula. In addition to building staff capacity to respond to these inquiries, ACF has been working to automate the LIHEAP funding formula calculation. This has involved significant staff time and oversight of the development of an automated tool for running the LIHEAP funding calculation formula. In future years, LIHEAP will be responsible for paying any additional fees associated with maintaining use of the tool and making routine updates, as well as training staff on how to use the tool. Prior to FY 2022, only one federal staff member was able to run the manual LIHEAP formula. With the investments in FY 2022 and FY 2023, ACF will soon have multiple staff members who are able to run funding formula calculations using the automated tool which will allow us to respond to inquiries even more quickly.

7. Please provide a list of all grantees and total number of applications for the Rural Community Development programs for the past five fiscal years.

Response:
The Rural Community Development (RCD) grant awards are issued for a 60-month project period (from 09/30/2020 to 09/29/2025) with five 12-month budget periods. The last Notice of Funding Opportunity (NOFO) was issued in FY 2020. For the FY 2020 competition, the Office of Community Services (OCS) received sixteen applications, eight received awards for funding, four were disapproved for funding and four were screened as ineligible. Each budget year, the FY 2020 recipients each submit updated applications that provide status updates on prior year's activities and provide plans for the use of the new funding.

The current grant recipients are:

Recipient Names	City	State	States Served
Communities Unlimited, Inc.	Fayetteville	AR	Alabama, Arkansas, Louisiana, Mississippi, Oklahoma, Tennessee, Texas
Great Lakes Community Action Partnership	Fremont	OH	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, Wisconsin
Inter-Tribal Council of Arizona, Inc.	Phoenix	AZ	EPA Regions: 5, 6, 7, 8, 9, and 10
Midwest Assistance Program, Inc.	Maryville	MO	Iowa, Kansas, Minnesota, Missouri, Montana, North Dakota, Nebraska, South Dakota, Wyoming
RCAP Solutions, Inc.	Worcester	MA	Connecticut, Massachusetts, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, the U.S. Virgin Islands, Vermont
Rural Community Assistance Corporation	West Sacramento	CA	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Nevada, New Mexico, Oregon, Utah, Washington

Southeast Rural Community Assistance Project, Inc.	Roanoke	VA	Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia
United South and Eastern Tribes, Inc.	Nashville	TN	Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico

8. Please provide a list of all the grantees for the Preschool Development Grants for the past five fiscal years.

Response:

PDG Grantee – Initial Grant	**Funded Period**
Illinois State Board of Education	12/31/2018-12/30/2019
Michigan Department of Education	12/31/2018-12/30/2019
Texas Education Agency	12/31/2018-12/30/2019
Florida Department OF Education	12/31/2018-12/30/2019
Indiana Family and Social Services Administration	12/31/2018-12/30/2019
New Hampshire University System	12/31/2018-12/30/2019
South Carolina Department of Social Services	12/31/2018-12/30/2019
Alabama Department of Early Childhood Education	12/31/2018-12/30/2019
Colorado Department of Human Services	12/31/2018-12/30/2019
Louisiana Division of Administration	12/31/2018-12/30/2019
Alaska Department of Education and Early Development	12/31/2018-12/30/2019
Kentucky Education and Workforce Development Cabinet	12/31/2018-12/30/2019
California Department of Education	12/31/2018-12/30/2019
Kansas Department of Education	12/31/2018-12/30/2019
New Jersey Executive Office	12/31/2018-12/30/2019
Washington Department of Children, Youth, and Families	12/31/2018-12/30/2019
New York Children & Family Services	12/31/2018-12/30/2019
Oregon Department of Education	12/31/2018-12/30/2019
Minnesota Department of Education	12/31/2018-12/30/2019
Mississippi Community College Board	12/31/2018-12/30/2019
Virgin Island Department of Human Services	12/31/2018-12/30/2019

Arkansas Department of Human Services	12/31/2018-12/30/2019
Nevada Department of Education	12/31/2018-12/30/2019
Montana Department of Public Health and Human Services	12/31/2018-12/30/2019
Rhode Island Department of Human Services	12/31/2018-12/30/2019
Maine Department of Education	12/31/2018-12/30/2019
Massachusetts Executive Office of Education	12/31/2018-12/30/2019
Iowa Department of Management	12/31/2018-12/30/2019
Ohio Department of Job and Family Services	12/31/2018-12/30/2019
Maryland Department of Education	12/31/2018-12/30/2019
Delaware Department of Education	12/31/2018-12/30/2019
North Dakota Department of Public Instruction	12/31/2018-12/30/2019
Arizona Department of Education	12/31/2018-12/30/2019
Utah Department of Workforce Services	12/31/2018-12/30/2019
Oklahoma Partnership for School Readiness Foundation, Inc.	12/31/2018-12/30/2019
Pennsylvania Department of Education	12/31/2018-12/30/2019
Virginia Department of Education	12/31/2018-12/30/2019
Nebraska Department of Health and Human Services	12/31/2018-12/30/2019
Vermont Agency of Human Services	12/31/2018-12/30/2019
New Mexico Department of Children, Youth, and Families	12/31/2018-12/30/2019
Hawaii Department of Human Services	12/31/2018-12/30/2019
Connecticut Office of Early Childhood	12/31/2018-12/30/2019
Government of the District of Columbia	12/31/2018-12/30/2019
North Carolina Department of Health & Human Services	12/31/2018-12/30/2019
Georgia Department of Early Care and Learning	12/31/2018-12/30/2019
Missouri Department of Elementary and Secondary Education	12/31/2018-12/30/2019
PDG Grantee – Renewal Grant	**Funded Period**
Oregon Department of Education	12/31/2019-12/30/2022
Minnesota Department of Education	12/31/2019-12/30/2022
Colorado Department of Human Services	12/31/2019-12/30/2022
Michigan Department of Education	12/31/2019-12/30/2022
North Carolina Department of Health & Human Services	12/31/2019-12/30/2022
Illinois State Board of Education	12/31/2019-12/30/2022
Rhode Island Executive Office of Health & Human Services	12/31/2019-12/30/2022
New York Office of Children & Family Services	12/31/2019-12/30/2022

New Hampshire University System	12/31/2019-12/30/2022
New Jersey Executive Office	12/31/2019-12/30/2022
Louisiana Division of Administration	12/31/2019-12/30/2022
California Health & Human Services Agency	12/31/2019-12/30/2022
Maryland State Department of Education	12/31/2019-12/30/2022
Alabama Department of Early Childhood Education	12/31/2019-12/30/2022
Missouri Department of Elementary and Secondary Education	12/31/2019-12/30/2022
Virginia Department of Education	12/31/2019-12/30/2022
Florida Department of Education	12/31/2019-12/30/2022
Washington Department of Children, Youth, and Families	12/31/2019-12/30/2022
Georgia Department of Early Care and Learning	12/31/2019-12/30/2022
Connecticut Office of Early Childhood	12/31/2019-12/30/2022
PDG Grantee – Initial Grant	**Funded Period**
Wyoming Western States Learning Corporation	12/31/2019-12/30/2020
Guam Department of Public Health & Social Services	12/31/2019-12/30/2020
Puerto Rico Department of Family	12/31/2019-12/30/2020
CNMI Department of Community and Cultural Affairs (DCCA)	12/31/2019-12/30/2020
Wisconsin Department of Children and Families	12/31/2019-12/30/2020
Idaho Association for the Education of Young Children	12/31/2019-12/30/2020
PDG Grantee – Renewal Grant	**Funded Period**
Kansas Department of Education	04/30/2020-04/29/2023
Nebraska Department of Health and Human Services	04/30/2020-04/29/2023
South Carolina Department of Social Services	04/30/2020-04/29/2023
PDG Grantee – Renewal Grant	**Funded Period**
Wyoming Department of Family Services	12/31/2020-12/30/2023
Wisconsin Department of Children & Families	12/31/2020-12/30/2023
Idaho State Board of Education	12/31/2020-12/30/2023
Puerto Rico Department of Family	12/31/2020-12/30/2023
Guam Department of Public Health & Social Services	12/31/2020-12/30/2023
PDG Grantee – Renewal Grant	**Funded Period**

Arizona Department of Education	12/31/2022-12/30/2025
Texas Workforce Commission	12/31/2022-12/30/2025
Indiana Family and Social Services Administration	12/31/2022-12/30/2025
Kentucky Education and Workforce Development Cabinet	12/31/2022-12/30/2025
Idaho State University	12/31/2022-12/30/2025
Delaware Department of Education	12/31/2022-12/30/2025
North Dakota Department of Human Services	12/31/2022-12/30/2025
Oklahoma Department of Human Services	12/31/2022-12/30/2025
Massachusetts Department of Early Education And Care	12/31/2022-12/30/2025
Pennsylvania Department of Education	12/31/2022-12/30/2025
Maine Department of Health and Human Services	12/31/2022-12/30/2025
Vermont Agency of Human Services	12/31/2022-12/30/2025
Nevada Department of Education	12/31/2022-12/30/2025
University Of Hawaii Systems	12/31/2022-12/30/2025
Montana Department of Public Health and Human Services	12/31/2022-12/30/2025
Utah Department of Health and Human Services	12/31/2022-12/30/2025
Alaska Department of Health and Social Services	12/31/2022-12/30/2025
Ohio Department of Job And Family Services	12/31/2022-12/30/2025
State of New Mexico	12/31/2022-12/30/2025
Arkansas Department of Human Services	12/31/2022-12/30/2025
Mississippi Department of Human Services	12/31/2022-12/30/2025
PDG Grantee – Planning Grant	**Funded Period**
Nebraska Department of Health and Human Services	12/31/2022-12/30/2023
Rhode Island Executive Office of Health and Human Services	12/31/2022-12/30/2023
New Hampshire University System	12/31/2022-12/30/2023
Virginia Department of Education	12/31/2022-12/30/2023
Kansas Department of Education	12/31/2022-12/30/2023
South Carolina Department of Social Services	12/31/2022-12/30/2023
Colorado Department of Early Childhood	12/31/2022-12/30/2023
Minnesota Department of Education	12/31/2022-12/30/2023
New York Office of Children and Family Services	12/31/2022-12/30/2023
Michigan Department of Education	12/31/2022-12/30/2023

Missouri Department of Elementary and Secondary Education	12/31/2022-12/30/2023
Tennessee Department of Education	12/31/2022-12/30/2023
West Virginia Department of Health and Human Resources	12/31/2022-12/30/2023
Alabama Department of Early Childhood Education	12/31/2022-12/30/2023
Illinois State Board of Education	12/31/2022-12/30/2023
New Jersey Department of Labor and Workforce Development	12/31/2022-12/30/2023
Washington Department of Children, Youth, and Families	12/31/2022-12/30/2023
North Carolina Department of Health and Human Services	12/31/2022-12/30/2023
Connecticut Office of Early Childhood	12/31/2022-12/30/2023
Louisiana Division of Administration	12/31/2022-12/30/2023
California Health & Human Services Agency	12/31/2022-12/30/2023

9. Please provide a list of all the grantees for the Refugee School Impact Program for the past five fiscal years.

Response:
The table below includes all grantees for the Refugee School Impact Program from FY 2019- 2023.

State	Grantee
Alabama (ASA, and AUSAA)*	Inspiritus, Inc – FY22 (ASA) FY23 (AUSAA)
Alaska	Catholic Social Services of Alaska FY22 – FY23
Arizona	Arizona Department of Economic Security FY19 - FY23
Arkansas	Canopy NWA FY20 – FY23
California	California Department of Social Services FY19 – FY23
Colorado	Colorado Department of Human Services FY19 – FY23
Connecticut	Connecticut Department of Social Services FY19 – FY 23
Delaware (ASA)*	Executive Office of the Governor of Delaware FY22 (ASA) FY23 (REA)

District of Columbia	District of Columbia Department of Health FY22 – FY23
Florida	Florida Department of Children & Families FY19-FY23
Georgia	Georgia Department of Human Services FY19-FY23
Idaho	Jannus, Inc FY19-FY23
Illinois	Illinois Department of Human Services FY19-FY23
Indiana	Indiana Family and Social Services Administration FY19-FY23
Iowa	Iowa Department of Human Services FY19-FY23
Kansas	Kansas Department of Children and Families FY19-FY23
Kentucky	Catholic Charities of Louisville FY19-FY23
Louisiana	Catholic Charities of the Diocese of Baton Rouge, Inc. FY19-FY23
Maine	Catholic Charities Maine FY19-FY23
Maryland	Maryland Department of Human Services FY19-FY23
Massachusetts	Commonwealth of Massachusetts Department of Health and Human Services FY19-FY23
Michigan	Michigan Department of Labor and Economic Opportunity FY19-FY23
Minnesota	Minnesota Department of Human Services FY19-FY23
Missouri	International Institute of Metropolitan St. Louis FY19-FY23
Montana	Montana Department of Public Health and Human Services FY19-FY23
Nebraska	Nebraska Department of Health and Human Services FY19-FY23
Nevada	Catholic Charities of Southern Nevada FY19-FY23
New Hampshire	New Hampshire Department of Health and Human Services FY19-FY23
New Jersey	International Rescue Committee, Inc FY19-FY23
New Mexico	New Mexico Department of Human Services FY19-FY23
New York	New York Office of Temporary & Disability Assistance FY19-FY23
North Carolina	North Carolina Department of Health & Human Services FY19-FY23
North Dakota	North Dakota Department of Human Services FY19-FY23
Ohio	Ohio Department of Job and Family Services FY19-FY23

Oklahoma	Oklahoma Department of Human Services FY19-FY23
Oregon	Oregon Department of Human Services FY19-FY23
Pennsylvania	Pennsylvania Department of Human Services FY19-FY23
Rhode Island	Rhode Island Department of Human Services FY19-FY23
South Carolina	South Carolina Department of Social Services FY19-FY23
South Dakota	Lutheran Social Services of South Dakota FY19-FY23
Tennessee	Catholic Charities of Tennessee, Incorporated FY19-FY23
Texas	United States Conference of Catholic Bishops FY19-FY23
Utah	Utah Department of Workforce Services FY19-FY23
Vermont	Vermont Agency of Human Services FY19-FY23
Virginia	Virginia Department of Social Services FY19-FY23
Washington	Washington State Department of Social and Health Services FY19-FY23
Wisconsin	Wisconsin Department of Children and Families FY19-FY23

*ASA stands for the ASA Afghanistan Supplemental Appropriations Act, 2022 and the Additional Afghanistan Supplemental Appropriations Act, 2022. AUSA stands for the Additional Ukraine Supplemental Appropriations Act, 2022.

Administration for Community Living (ACL)

10. The Administration for Community Living (ACL) FY 2024 CJ states that the Agency will focus on "the expansion of information and referral services, independent living skills training, peer counseling, individual and systems advocacy, and support for transitions" in the Centers for Independent Living (CIL) Program. Please describe in detail how the Agency settled on these expansion areas. What stakeholder outreach was conducted to CILs?

Response:
The services targeted for expansion are the five required by statute, and CILs have consistently asked for additional funding to provide them. Need for these services has exceeded capacity for many years, and the gap has grown as the populations of people with disabilities has grown. (This includes a rapidly increasing number of older adults who develop disabilities as they age. In fact, last year, people ages 60 and older became the largest age group served by the CILs.) The pandemic accelerated the increasing demand; today, more people need services, and many people need more services, than ever before.

Within these five categories, CILs provide a wide range of support that makes independent living possible, such as assistance with accessing transportation, personal care assistants and other critical community living services; help connecting to assistive technology; assistance with navigating state systems of services and supports, including determining eligibility and applying for programs; training and peer support for developing independent living skills; and support with moving from nursing homes and other long-term care facilities to homes in the community.

The CARES Act provided $85 million to CILs that was available until expended, which allowed CILs to greatly increase the number of people served; preliminary data show a 25% increase in services provided. With supplemental funding exhausted, additional funding is needed to maintain services for these people, and to further increase capacity to address remaining gaps.

Stakeholder input is central to ACL's operations. ACL hosts quarterly calls with all independent living grantees, communicates regularly with individual CILs by email and phone, and reviews annual performance reports that share information related to the CIL budgets, outcomes, and their concerns. ACL also meets monthly with the National Council for Independent Living, (NCIL), the ACL-funded independent living training and technical assistance center, and the National Association of Statewide Independent Living Councils, and engages frequently with the Association of Programs for Rural Independent Living (APRIL), to hear their issues and concerns. Finally, ACL seeks input from a wide range of people with disabilities and disability advocates. This outreach has allowed ACL to stay closely connected and to have ears to the ground regarding what its CILs need.

Health Resources and Services Administration (HRSA)

11. In 2018, the United Network for Organ Sharing (UNOS) made significant changes to heart transplant selection criteria to reduce waitlist times, among other reasons. However, it is my understanding that some in the heart transplant community are raising questions about the impact these changes have had on physician practice patterns. How is HRSA monitoring long-term changes in both clinical outcomes and quality of life post-transplant?

Response:

The Organ Procurement Transplantation Network (OTPN) develops and implements policies approved by the OPTN Board of Directors. They are required to collect data, monitor, and report on new policies and policy changes at various intervals post-implementation. The OPTN issued 4-month, 1-year, 2-year, and 3-year post-implementation reports following the 2018 changes to adult heart allocation policy. They will also continue to monitor and report issue reports at the end of years 4 and 5.

The 3-year report is the most recent report and is titled Three-Year Monitoring of Heart Allocation Proposal to Modify the Heart Allocation System. These reports contain data on clinical outcomes comparing pre- and post-implementation results. HRSA reviews OPTN post-implementation monitoring reports. If these reports reflect that trends are not progressing towards stated goals, then the OPTN Committee will evaluate for additional policy changes.

12. What data has HRSA collected or received via UNOS regarding the impact of the heart transplant selection criteria, and what does the data indicate with respect to the change in heart transplant selection criteria?

Response:
The OPTN has collected and reported on adult heart transplant data post-policy implementation of the 2018 heart allocation policy changes. The OPTN issued 4-month, 1-year, 2-year, and 3-year post-implementation reports following the 2018 changes to adult heart allocation policy. They will also continue to monitor and report issue reports at the end of years 4 and 5.

Overall, the report shows that transplant rates have increased, particularly for the most medically urgent candidates, while post-transplant outcomes have remained constant. There has been no substantial impact on the number of waiting list registrations, transplants performed, or heart utilization. In addition, the changes to the adult heart allocation system have not had a noticeable impact on pediatric heart transplant candidates.

The report also looks at the median distance traveled and the median time spent waiting before a transplant, especially for the most medically urgent candidates.

13. What role is HRSA playing in oversight of these changes?

Response:
In 1984, Congress enacted the National Organ Transplant Act (NOTA), establishing the Organ Procurement and Transplantation Network (OPTN) to create a national system in accordance with established medical criteria to match organs and individuals included in a national list of individuals who need organs. Congress authorized the Department of Health and Human Services to have oversight of the OPTN and directed that it be operated under contract.

Through our recently announced Modernization Initiative, HRSA intends to take action to increase transparency and accountability in the organ procurement and transplantation system.

14. How will HRSA work with UNOS to make appropriate adjustments to the system to help improve patient outcomes and quality of life while maintaining shorter wait times?

Response:
On March 22, 2023, HRSA announced a multi-year OPTN Modernization Initiative designed to improve effectiveness across the organ donation, procurement, and transplantation system. The Initiative is intended to strengthen accountability, equity, and performance in the organ donation and transplantation system through a focus on five key areas with the following goals:

- Technology – ensure that the system is reliable, secure, patient-centered, user-friendly, and reflective of modern technology functionality. There is a continuous focus on improved IT system functionality and security, while ensuring continuity of services, protecting patient safety, and accelerating innovation in line with industry-leading standards.
- Data Transparency and Analytics – ensure data is accessible, user-friendly, and patient-oriented. The modernization process provides easily accessible, high-quality, and timely data to make informed patient, donor, and clinical decisions; measure and evaluate program performance; inform oversight and compliance activities; and support the advancement of scientific research
- Governance – The OPTN Board of Directors is high-functioning and has greater independence; represents the diversity of communities; and delivers effective policy development.
- Operations – The OPTN is effective and accountable in its implementation of organ policy, patient safety and compliance monitoring, organ transport, OPTN member support, and education of patients, families, and the public.
- Quality Improvement and Innovation – The OPTN promotes a culture of quality improvement and innovation across the network by leveraging timely data and performance feedback, collaborative learning, and strategic partnerships

HRSA will continue to focus on meeting the needs of patients and families by strengthening and providing equitable access to transplantation, improving safety and health outcomes, and empowering patients and providers with the data needed to make informed, shared decisions.

15. GAO and the HHS Office of the Inspector General have made numerous recommendations to HHS to improve oversight of the 340B Program and ensure that participating entities are truly eligible and comply with program requirements. Many of these recommendations remain unimplemented. HHS has requested regulatory authority for the 340B Program and has indicated that such authority is necessary to implement many of these recommendations. Can you please explain why HHS needs

regulatory authority to ensure compliance with 340B Program requirements and implement outstanding recommendations from GAO and others?

Response:
Congress enacted the 340B Program to help safety net health care providers stretch the resources they receive as far as possible by saving on their purchases of outpatient drugs.

Despite the broad reach and impact of the Program, HRSA's regulatory authority in this area is limited, and this often leads to disputes over covered entity and manufacturer compliance and HRSA's oversight in the Program.

Over the years, we have received recommendations from the GAO and significant feedback from Congress about the Program. We agree that more needs to be done to ensure compliance, which is in direct alignment with our FY24 Budget Proposal.

- The Budget includes a proposal to enhance program integrity by requiring covered entities to annually report to HRSA on how the savings benefit the communities they serve and provide HRSA regulatory authority to implement this requirement.
- The Budget also proposes explicit regulatory authority to strengthen compliance and transparency related to the use of contract pharmacies.

We also believe that the proposals in the President Budget, if enacted, would provide HRSA the ability to adequately address some of the recommendations that the GAO has raised in its studies on the 340B Program, including the 2018 Contract Pharmacy Study.

16. Since FY 2019, Congress has reserved funding within the National Health Service Corps Loan Repayment for loan repayment for primary care providers at Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs. In FY2023, this set-aside was $15,600,000.

    How many individuals received an award under this set-aside in Fiscal Years 2021 and 2022? How many individuals applied for, but did not receive, an award under this set-aside? Additionally, what is the breakdown of recipients by discipline (e.g. physicians, dentists, NPs, PAs, etc.)?

Response:
In FY 2021, 266 primary care providers at Indian Health Service facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs received an award through the set-aside, an additional 95 were eligible and were awarded through the NHSC's other awards, while 50 applicants either declined the award or were found ineligible. In FY 2022, 197 individuals were awarded through the set-aside, an additional 88 were eligible and were awarded through the NHSC's other awards, while 91 applicants either declined the award or were found ineligible.

FY 2022	
Discipline	**Awarded**
Certified Nurse Midwife	2
Certified Registered Nurse Anesthetist	1
Dentist	17
Health Service Psychologist	1
Licensed Clinical Social Worker	15
Licensed Professional Counselor	16
Marriage and Family Therapist	3
MD/DO	26
Nurse Practitioner	39
Pharmacist	44
Physician Assistant	19
Psychiatrist (MD/DO)	8
Registered Dental Hygienist	5
Registered Nurse	5
SUD Counselor	15
Grand Total	**197**

FY 2021	
Discipline	**Awarded**
Certified Nurse Midwife	8
Dentist	35
Health Service Psychologist	6
Licensed Clinical Social Worker	14
Licensed Professional Counselor	35
Marriage and Family Therapist	11
MD/DO	22
Nurse Practitioner	44
Pharmacist	46
Physician Assistant	19

Psychiatrist (MD/DO)	1
Registered Dental Hygienist	12
Registered Nurse	3
SUD Counselor	10
Grand Total	**266**

National Institutes of Health (NIH)

17. The administration's budget proposal again requests a substantial increase for the Office of Nutrition Research at NIH, from $1.3 million enacted in fiscal year 2023 to $121.3 million in fiscal year 2024. Please explain the specific new initiatives that would be funded and how they would avoid duplicating the nutrition-related work done by other agencies.

Response:
The Office of Nutrition Research (ONR) at the National Institutes of Health (NIH) will utilize the funds to support critical and innovative clinical research in five major areas to address nutrition disparities and diet-related chronic diseases, such as obesity, diabetes, heart disease, and cancer, which are among the most deadly and costly drivers of health care costs. All of these ambitious initiatives support the NIH mission and will advance the goals of the *National Strategy on Hunger, Nutrition, and Health*[1] and the objectives of the *2020-2030 Strategic Plan for NIH Nutrition Research*.[2]

NIH provides the evidence base, through basic and clinical research in the field of nutrition science, that informs the development and evaluation of strategies and interventions to prevent and treat nutrition insecurity, diet-related chronic diseases, and health disparities among diverse populations across the lifespan. NIH-supported studies provide the critical evidence-base for strategies that can be implemented in real-world settings. These strategies are used in programs and policies developed and implemented by other federal agencies, including CDC, USDA, and FDA.

CDC works with national groups, states, and communities to advance nutrition and public health priorities through prevention programs.

USDA's mission is to serve all Americans by providing effective, innovative, science-based public policy leadership in agriculture, food and nutrition, natural resource protection and management, rural development, and related issues with a commitment to deliverable equitable and climate-smart opportunities that inspire and help America thrive.

[1] www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf
[2] dpcpsi.nih.gov/sites/default/files/2020NutritionStrategicPlan_508.pdf

FDA's nutrition initiatives help ensure people in the United States have greater access to healthier foods and nutrition information that can be used to identify healthier choices more easily. Increasing the availability of healthier foods could improve eating patterns and, as a result, improve everyone's health and wellness.

The NIH initiatives that will be supported by these additional funds in FY 2024 include:

- **Food is Medicine Networks or Centers of Excellence**[3] aims to focus on nutrition science research that will collaborate with the community to reduce diet-related chronic diseases and health disparities. Food is Medicine is an umbrella term for programs that respond to the critical link between diet and health involving (1) the provision of Food is Medicine Services and (2) a nexus to the health care system. NIH is best positioned to conduct clinical health outcomes, implementation science and efficacy research embedded in health care systems. This innovative program will support research on the effectiveness of increasing attention on food and nutrition insecurity within the medical system. It will develop the evidence base to optimally deliver culturally sensitive Food is Medicine services, including medically tailored meals and groceries, produce prescriptions, culinary medicine, and teaching kitchens to communities across the country. It will also expand clinical nutrition training for health professionals and medical school curricula.
- **Nutrition and the Developmental Origins of Health and Diseases (DOHaD):**[4] Rates of obesity and other diet-related diseases are increasing at a disproportionately higher rate in children and adolescents. There is increasing concern that food, health, nutritional status, the microbiome, and related environmental exposures during pregnancy and early life may be responsible for future disease risk and underly the increasing rates of obesity and other diet-related diseases. There is limited data currently available on the role of these unique factors on infants from birth to 24 months of age. This discovery science program will study human milk composition, dietary intake, and nutritional status to answer critical questions about the developmental origins of disease and could ultimately lead to tailored diets for improving the health of the pregnant mother and child.
- **Stimulating Research to Understand and Address Hunger, Food and Nutrition Insecurity:** [5] Over 34 million Americans are experiencing food insecurity, which is defined as the lack of consistent access to enough food for an active, healthy life, and is a major public health concern. Food insecurity is an independent risk factor for morbidity and mortality in some chronic health conditions. To address this issue, an NIH-wide funding opportunity will support novel and innovative research on approaches that address nutrition security and its effects on a variety of health outcomes.
- **Expansion and Diversification of the Nutrition Science Workforce**

[3] grants.nih.gov/grants/guide/notice-files/NOT-OD-23-107.html
[4] grants.nih.gov/grants/guide/notice-files/NOT-OD-22-157.html
[5] grants.nih.gov/grants/guide/notice-files/NOT-OD-22-135.html

- Advanced Training in Artificial Intelligence for Precision Nutrition Science Research [6] programs will build a well-trained future nutrition science workforce capable of using Big Data, artificial intelligence, and other advanced techniques to address complex challenges in nutrition science. The program emphasizes the diversity of trainees and research topics focusing on nutrition disparities and chronic diseases disproportionately affecting underrepresented groups.
- Diversity, Equity, Inclusion, and Accessibility (DEIA) in the Nutrition Science Workforce:[7] ONR will develop NIH-wide funding initiatives to increase the diversity of the nutrition science workforce using strategies that focus on all levels of training.

These ONR initiatives are a coordinated whole-of-government approach. ONR is working closely with other federal agencies to ensure that these initiatives work synergistically and do not duplicate other federal research programs. This ongoing process is accomplished through ONR's leadership on nutrition research coordinating committees including the Interagency Committee on Human Nutrition Research, NIH Interagency Nutrition Research Coordinating Committee, FDA-NIH Joint Leadership Council Working Group on Nutrition, and Federal Data Consortium on Pregnancy and Birth to 24 Months. ONR led the collaboration of 12 federal agencies and offices, (i.e., ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, ODPHP, USDA, and VA) on the development and release of a Request for Information on Food is Medicine Research Opportunities.[8] While federal agencies have distinct roles in advancing nutrition, their efforts are complimentary and not duplicative. For example, NIH's role in supporting basic and clinical research in nutrition science provides the evidence base for other agencies, including CDC and USDA. The implementation science research proposed focuses on health outcomes that NIH is best positioned to support.

18. Excluding the budget's request for ARPA-H, the requested increase for base NIH funding from fiscal year 2023 to fiscal year 2024 is $919M, and the requested increase for the Office of Nutrition Research is more than 10 percent of this total. Given the many areas of basic scientific research the agency is involved in, please explain the prioritization for nutrition research activities over other research areas or operational activities at NIH.

Response:
ONR at the NIH is advancing nutrition science to promote health and to reduce the burden of diet-related diseases and nutrition health disparities. Diet-related chronic diseases including obesity and diabetes are increasing at an alarming rate and are some of the most deadly and costly drivers of health care costs. Nutrition research is of critical importance across NIH because these diseases impact people at all stages of life, affect multiple organ systems, and are within the mission of several NIH institutes, centers, and

[6] grants.nih.gov/grants/guide/rfa-files/RFA-OD-22-027.html
[7] dpcpsi.nih.gov/onr/iwg/diversity-equity-inclusion-and-accessibility-deia-in-the-nutrition-workforce
[8] grants.nih.gov/grants/guide/notice-files/NOT-OD-23-107.html

offices (ICOs). NIH provides the crucial evidence base, through basic and clinical research that informs the development and evaluation of interagency strategies and interventions to prevent and treat diet-related chronic diseases, such as diabetes, heart disease, obesity, and cancer, and address health disparities among diverse populations. ONR will utilize these additional funds to support critical and innovative clinical research in four major areas to address diet-related chronic diseases. All of these initiatives support the NIH mission and will advance the goals of the *National Strategy on Hunger, Nutrition, and Health*[9] and the objectives of the *2020-2030 Strategic Plan for NIH Nutrition Research.*[10] ONR has developed the following initiatives in close collaboration with other federal agencies and NIH ICOs through its Strategic Plan Implementation Working Groups.

Cross-cutting and multidisciplinary ONR initiatives include (as detailed in NIH QFR 17):

- Food is Medicine Networks or Centers of Excellence
- Nutrition and the Developmental Origins of Health and Diseases (DOHaD)
- Stimulating Research to Understand and Address Hunger, Food and Nutrition Insecurity
- Expansion and Diversification of the Nutrition Science Workforce
  - Advanced Training in Artificial Intelligence for Precision Nutrition Science
  - DEIA in the Nutrition Science Workforce

19. Please provide information on how the administration's fiscal year 2024 budget request for NIH will facilitate more grants for researchers who are in the early stages of their career? Does the NIH expect the number of early-stage investigators to increase or decrease in fiscal year 2024 under this budget proposal, and by how much?

Response:

NIH has been long committed to expanding opportunities that support and prioritize researchers early in their career. In 2017, NIH established the Next Generation Researchers Initiative (NGRI) in an effort to further cultivate and support talent entering the biomedical and behavioral research workforce.[11] This initiative aims to bolster opportunities for early-stage investigators (ESIs).[12] ESIs are defined as those within 10 years of completing their terminal degree or postgraduate clinical training and who have not previously competed successfully for a substantial NIH independent research award. In addition, applications from ESIs are given special consideration during peer review as well as at the time of funding consideration.

NIH Institutes and Centers have prioritized — and will continue to prioritize — funding for ESIs as part of NGRI. The initiative also tracks the impact of ESI funding

[9] www.whitehouse.gov/wp-content/uploads/2022/09/White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf
[10] dpcpsi.nih.gov/sites/default/files/2020NutritionStrategicPlan_508.pdf
[11] grants.nih.gov/ngri.htm
[12] grants.nih.gov/grants/guide/notice-files/NOT-OD-17-101.html

prioritization, including subsequent grant submission and success. As a result of this initiative, NIH has substantially increased funding support provided to ESIs, increasing from 978 in FY 2016 (before NGRI was started) to 1,513 in FY 2021[13] and 1,609 in FY 2022 (a record high number).[14] Though NIH anticipates continued progress, FY 2023 data and FY 2024 projections are not yet available at this time. NIH remains strongly committed to the goals of NGRI to fund more early-career investigators, protect and retain meritorious at-risk scientists, and enhance the diversity of the biomedical research workforce.

In addition to NGRI, NIH has several other programs and initiatives developed with the intention to enhance career progression and funding opportunities for early career investigators.[15] Selected examples are below:

- Stephen Katz ESI Research Grant Program (no preliminary data allowed in the grant application)[16]
- Director's Early Independence award
- NIH Director's New Innovator Award Program
- Maximizing Investigators' Research Award
- NIH Pathway to Independence Award
- Research Opportunities for New and "At-Risk" Investigators to Promote Workforce Diversity
- New Investigators to Promote Workforce Diversity in Genomics, Bioinformatics or Bioengineering and Biomedical Imaging Research
- High Priority, Short-Term Project/Bridge Award
- Maximizing Opportunities for Scientific and Academic Independent Careers program
- NIH Loan Repayment Program (LRP) award amounts support up to $50,000 per year in student loan debt for qualified investigators (LRPs can be competitively renewed)
- Funding provided for Childcare Costs for Ruth L. Kirschstein National Research Service Award Individual Fellows and Trainees
- Supplements to promote research continuity for early career investigators experiencing critical life events

NIH will continue working with the research community to enhance support for the next generation of biomedical scientists. For instance, a new ad hoc Advisory Committee to the NIH Director (ACD) Working Group (WG) was recently formed in December 2022 and charged with re-envisioning NIH-Supported Postdoctoral Training.[17] NIH recognizes the concerns faced and raised by these early career researchers, including the decreasing numbers of NIH-supported postdocs in recent years.[18] The WG will assist the ACD in formulating recommendations. To facilitate their deliberations, the WG conducted four

[13] nexus.od.nih.gov/all/2021/07/12/data-on-implementing-nihs-next-generation-researchers-initiative/
[14] report.nih.gov/nihdatabook/category/15
[15] researchtraining.nih.gov/career/early-career
[16] nexus.od.nih.gov/all/2020/11/09/introducing-the-stephen-i-katz-early-stage-investigator-research-grant-program/
[17] nexus.od.nih.gov/all/2023/02/14/share-your-thoughts-on-how-to-re-envision-nih-supported-postdoctoral-training/
[18] nexus.od.nih.gov/all/2023/03/02/number-of-postdoctoral-researchers-supported-by-nih-grant-awards-fy-2017-fy-2022/

public listening sessions on the role, duration, structure, and value of the academic postdoc (including impacts on underrepresented populations); international postdoc concerns; compensation and benefits (including child and dependent care); and job security, career prospects, and quality of life.[19] The WG is also currently reviewing responses received on a Request for Information[20] from postdoctoral fellows and other members of the research community who provided input on:

- Perspectives on the roles and responsibilities of the academic postdoc
- Fundamental issues and challenges inhibiting recruitment, retention, and overall quality of life of postdoctoral trainees in academic research
- Existing NIH policies, programs, or resources that could be modified, expanded, or improved
- Proven or promising external resources or approaches that could inform NIH's efforts to improve the postdoctoral training ecosystem.

Separately, NIH also issued another request for information seeking feedback on revising and simplifying the peer review framework for research project grant applications.[21] Among other things, the proposed changes will allow peer reviewers to focus on scientific merit by evaluating whether or not appropriate expertise and resources are available to conduct the research, thus mitigating the undue influence of the reputation of the institution or investigator. Such a change could directly benefit researchers earlier in their career as the focus will be on their research ideas, not their pedigree or affiliation.

NIH has long understood that supporting the future biomedical workforce is essential to cutting-edge scientific advances and lasting impact on human health needs. It is a high priority for NIH to identify, grow, and retain investigators across these critical career stages, because they convey new insights, develop innovative ideas, and advance the translation of scientific research into improved health for all.

Centers for Medicare & Medicaid Services (CMS)

20. Medicaid enrollment has swelled during the last three years, what is HHS doing to support states in reassessing eligibility for more than 90 million beneficiaries in Medicaid?

Response:
HHS, through CMS, has been working with all states for well over a year to prepare for the "unwinding" of the continuous enrollment condition that expires March 31, 2023. In addition, in October 2022, CMS issued final rulemaking to establish a Medicare special enrollment period (SEP) to Coordinate with Termination of Medicaid Coverage, which allows individuals who have missed a Medicare enrollment period to enroll in Medicare after termination of Medicaid eligibility. CMS has also established a Marketplace Special

[19] acd.od.nih.gov/working-groups/postdocs.html
[20] grants.nih.gov/grants/guide/notice-files/NOT-OD-23-084.html
[21] nexus.od.nih.gov/all/2022/12/08/update-on-simplifying-review-criteria-a-request-for-information/

Enrollment Period from March 31, 2023 through July 31, 2024 for consumers who are no longer eligible for Medicaid or CHIP due to the end of the continuous enrollment condition.

CMS is working closely with states on their unwinding plans, including assessing state compliance with federal Medicaid redetermination requirements and, where necessary, developing mitigation strategies to address gaps/deficiencies.

21. HHS is granted considerable discretion in approving demonstrations in the Medicaid program, with an estimated third of federal Medicaid funds flowing through those demonstrations. Demonstrations are supposed to be budget neutral to the federal government. Recent demonstration approvals indicate that HHS is rolling back some of its budget neutrality policies. How will those changes affect federal liabilities and what is the rationale for liberalizing cost limits?

Response:
In requiring demonstrations to be budget neutral, CMS strives to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. Based on CMS's and states' experience implementing the approach to budget neutrality described in a 2018 State Medicaid Director Letter (SMDL), it has become apparent to CMS that this approach may limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. In recent section 1115 approvals, CMS has reevaluated certain aspects of the budget neutrality approach described in the 2018 SMDL, in an attempt to better support state innovation. The agency has made several changes that are intended to give states greater access to funding, including "savings" from prior approval periods, while still maintaining fiscal integrity. These changes include an updated approach to calculating the "without waiver" (WOW) baseline, which refers to the projected expenditures that could have occurred absent the demonstration and is the basis for the budget neutrality expenditure limit for each approval period. CMS has also made changes to its approach to budget neutrality in recent approvals that are expected to improve states' flexibility to test worthy innovations—specifically, coverage of certain services that are intended to address beneficiaries' health-related social needs (HRSN), and that CMS anticipates might result in overall reductions in future Medicaid program costs. Under the recent approvals, states' HRSN expenditures will be subject to expenditure caps, to help ensure that the state maintains its investment in the state plan benefits to which enrollees are entitled while testing the benefit of the HRSN services. These adjustments to the 2018 approach improve the balance between the availability of expenditure authority to support program innovation and the need for fiscal restraint.

22. Rural health remains a concern given the makeup of my state and Alzheimer's impacts many of my constituents. I am encouraged that there is a new class of Alzheimer's treatments that gives families hope that they will have more quality time with their loved ones before the disease takes hold. But that time will most likely not

be extended to those rural beneficiaries if the CMS policy for coverage with evidence development moves forward. It will require additional clinical trials and/or registries that could create logistical challenges for patients in rural areas as well as providers who are already stretched thin to meet the needs of those in rural settings. How does CMS plan to ensure those with Alzheimer's in rural settings gain access to therapies?

23. CMS formally responded to a request for reconsideration of the Alzheimer's coverage policy established in the National Coverage Analysis stating that coverage with evidence development 'could potentially provide greater access nationwide at more treatment sites, more rapidly.' However, this is not the real-word experience for anyone who has participated in a Coverage with Evidence Development (CED) study. It can take several months/years to create a CED protocol and for CED studies to be ready for patient enrollment before the first patient visit – it took almost two years to launch a study focused on use of Alzheimer's diagnostics in diverse populations. How does CMS intend to bring access to patients on an expedited basis with the current track record on CED, when approximately 2,000 patients per day become ineligible for this class of therapies as they transition from early Alzheimer's disease to moderate Alzheimer's?

Response for Questions 22 and 23:
Alzheimer's disease is a devastating illness that affects millions of Americans and their families. CMS is committed to helping people get timely access to treatments and improving care for people with Alzheimer's disease and their families. CMS has a responsibility to ensure that people with Medicare have appropriate access to therapies that are reasonable and necessary for use in the Medicare population. Our protocol requirements ensure appropriate clinical care, and reassure patients and their caregivers that further research with anti-amyloid monoclonal antibodies will be conducted in settings to minimize potential harms from the treatment. As is outlined in the Medicare National Coverage Determination (NCD) with CED for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease, we do not restrict the setting of approved clinical trials in order to ensure that anti-amyloid monoclonal antibodies that receive FDA approval based upon evidence of efficacy from a direct measure of clinical benefit may be given to a broader patient population.

24. Hospitals in Alabama are facing acute financial pressure because of a health care disparity created by a specific Medicare regulation called the Medicare Area Wage Index. The Wage Index system is broken, and it is punishing cost effective hospitals in majority rural states. Despite increases in labor costs, the Wage Index level in my state consistently decreases over the years and the decline is projected to continue.

    Action is vitally important to ensure that patients have access to care in states like Alabama. Is CMS pursuing any rule-making actions to fix this problem? Will the Administration commit to finding a way to help hospitals in majority rural, cost-effective states?

25. The current Medicare Wage Index system creates a disparity that effectively punishes efficient hospitals in mostly rural states. In many of these states, the bureaucratic burden created by this reimbursement formula is creating a serious problem for hospitals. These hospitals are experiencing financial pressures as Wage Index rates rapidly decrease over the years, reducing Medicare reimbursements in order to subsidize increases to hospitals in a handful of states.

    Would you consider repealing this wage index and replacing it with a more accurate and fair system that would help to relieve some of those financial pressures placed on so many hospitals, including the ones in my state?

26. Alabama's hospitals are in a uniquely burdensome situation. The existing programs designed to protect access to care in areas of the country with barriers to care are not working in Alabama. 14 hospitals have closed since 2011 and those still operating are facing workforce shortages, a dominate private insurer, the lowest Medicare reimbursement in the country, and high rates of uninsured. Without relief, the state will continue to see a drain of resources and talent in the areas that need them the most and the widespread hospital closures will continue.

    Will you work with the entire Alabama Congressional delegation and our hospitals to develop an innovative approach to protect the health care infrastructure in my state, preventing future hospital closures and ensuring access to care?

Response for Questions 24-26:

HHS, through CMS, is committed to promoting Medicare payment accuracy and hospital stability. The Social Security Act requires that, as part of the methodology for determining prospective payments to hospitals, the standardized amounts for area differences in hospital wage levels are adjusted by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. This adjustment factor is the wage index, which must be updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from Medicare Cost Reports, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation.

In computing the wage index, we derive an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. In applying the law, CMS strives to ensure access for all beneficiaries while maintaining incentives for the agency's hospital partners to operate efficiently.

HHS looks forward to working with the Alabama Congressional delegation and other stakeholders as it looks at innovative ways to prevent future hospital closures and expand access to care across the country.

27. In 2019 CMS introduced the Low Wage Index Policy for at least four years. This policy gave a proportional adjustment to the wage indices of every hospital in the bottom quartile of wage index rates, many of which are in my state. In creating this policy CMS stated that it wanted to "rethink rural health care" and see if the adjustment helped close the gap between high and low wage index hospitals. Unfortunately, the last four years have been abnormal because of the COVID-19 pandemic, making it impossible to honestly understand the impact the Low Wage Index Policy had on hospital wages. Since this policy is set to expire at the end of September, is the Administration open to considering a four-year extension of the policy?

Response:

In an effort to focus on inequities within the health care system in rural areas, in August 2022, CMS finalized a policy in its Fiscal Year 2023 Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Final Rule to permanently cap wage index decreases. To increase the predictability of Medicare payments for hospitals and mitigate instability and significant negative impacts to hospitals resulting from changes to the wage index, CMS applied a 5 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline. That is, under the FY 2023 policy, a hospital's wage index will not be less than 95 percent of its final wage index for the prior FY. CMS is also applied this wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount. This means that other hospital payments did not decrease because CMS capped changes for other facilities at a certain percentage.

The FY 2023 rule also continued policies to address wage index disparities impacting low wage index hospitals, particularly those in rural areas. Commenters asserted that the plain language of the statute does not provide for a free-floating rural floor that is not linked to the rural wage index. Based on comments received in response to the CY 2023 proposal, CMS did not finalize the rural floor wage index policy as it was proposed, which would have excluded hospitals that have reclassified from urban to rural from the calculation of the rural floor, and the wage index for rural areas in the state in which the county is located as referred to in section 1886(d)(8)(C)(iii) of the Social Security Act. Rather, CMS finalized a policy that calculated the rural floor as it was calculated before FY 2020. For FY 2023 and subsequent years, CMS finalized a policy to include the wage data of hospitals that have reclassified from urban to rural in the calculation of the rural floor, and the wage index for rural areas in the state in which the county is located as referred to in section 1886(d)(8)(C)(iii) of the Act.

Centers for Disease Control and Prevention

28. Out of the total funding that the fiscal year 2024 budget puts toward the Cancer Moonshot through the Department of Health and Human Services, $839 million is allocated to the Centers for Disease Control and Prevention. Could you provide the rationale for prioritizing the CDC for an allocation of this size? The Cancer Moonshot's goals are to cut the death rate from cancer by half within the next 25 years and improve the lives of people with cancer and cancer survivors. How would the Administration envision the CDC making progress in achieving these goals with this Cancer Moonshot allocation?

Response:
In FY 2024, CDC requests an increase of $182.5 million above the FY 2023 enacted level to support the Cancer Moonshot initiative. This includes a $15.0 million increase for HPV prevention within the Domestic Immunization program, $11.0 million increase for tobacco-related cancer control programs, $35.0 million increase for Environmental Health to support cancer cluster investigations, and $121.5 million increase for Cancer Prevention and Control, distributed across programs. Increased funding will build upon ongoing efforts and support a range of programs, including breast and cervical, colorectal, ovarian, and comprehensive cancer programs to promote primary cancer prevention, early detection and treatment, and support to survivors and caregivers. This also enables CDC and health departments to conduct cancer studies in communities with unusual patterns of cancer and environmental concerns and to expand laboratory studies and method development around human health and exposure to hazardous substances in order to understand how exposures may contribute to the development of cancer. CDC will also provide state and local cancer programs with funds and guidance to implement proven practices that improve policy, system, and environmental variables to increase equity in cancer prevention, detection, and treatment. Funds will also support evaluation activities to ensure continuous improvement in practices and outcomes. These funds would also enable CDC to increase vaccine uptake through its work with professional and other organizations, including health systems, health plans, and payors, to increase awareness, education, and training on HPV vaccination.

29. Since FY2020, Congress has provided $1.415 billion for CDC's data modernization initiative, and, in its FY2024 budget request, CDC requested an additional $340 million.

    What is the estimated cost to complete CDC's data modernization initiative, and what is the timeline for completion?

Response:
CDC has made tremendous strides modernizing public health data using the $1.175 billion specifically appropriated for this effort since FY 2020, which includes $375 million provided through annual appropriations and $800 million provided through COVID-19 Supplementals. Data modernization is an all-of-public health effort, requiring

the close collaboration of CDC, state and local health departments, health care providers and vendors, and other public health partners. Most, if not all, state and local health departments are depending on CDC's modernization support, and many continue to rely on manual, duplicative processes like paper- and fax-based reporting and internal data systems that cannot talk to one another. By the end of FY 2026, CDC expects to develop key data and technology solutions and modernize some of the core data systems replacing outdated platforms to benefit all health departments and CDC programs and improve the connectivity of systems across public health. These large initial investments are critical for making the transition to flexible, scalable cloud-based tools that can meet the needs of public health practitioners in supporting communities. As with all technology, public health infrastructure and data systems of the United States need sustained resourcing for long-term continuous modernization to stay up-to-date and response ready.

Information on CDC's 2021-2022 DMI Implementation Plan and CDC's Public Health Data Strategy, including key partnerships and notable milestones are available on the CDC DMI website. CDC's 2021 and 2022 Snapshots are also available online, reflecting recent impacts and progress.

Provider Relief Fund

Mr. Secretary, I am concerned by reports of significant misuse of federal funds under the COVID-19 Uninsured Program. The Department spent over $24 billion in taxpayer funding on the COVID-19 Uninsured Program, and we continue to receive reports of egregious waste, fraud, and abuse in the program.

For example, according to recent news reports, an owner of a Chicago laboratory was recently charged with making over $83 million in fraudulent claims to the COVID-19 Uninsured Program.

On March 31, 2021, the Government Accountability Office (GAO) recommended that the Secretary of Health and Human Services, "finalize and implement a post-payment review process to validate COVID-19 Uninsured Program claims and to help ensure timely identification of improper payments, including those resulting from potential fraudulent activity, and recovery of overpayments." HHS agreed to GAO's recommendation and reported that it had adopted a "post-payment audit strategy for the Uninsured Program, which includes detailed protocol and procedures for the assessments of the Uninsured Program to be executed by audit contractors."

Following up on GAO's March 2021 recommendation, please provide the following updates:

30. How many post-payment audits of providers' compliance with the requirements of the COVID-19 Uninsured Program have been completed by HHS?

Response:
HRSA regularly conducts post payment analysis of claims activities and when anomalous or suspicious activity is identified takes administrative action and/or makes a referral to the Office of the Inspector General (OIG) Office of Investigations as appropriate. As part of our strong collaboration with the OIG, we also regularly provide data files of claims activity to the OIG Office of Investigations for on-going review and identification of potential fraud. HHS is actively engaged in the post-payment assessment and audit process. This work is ongoing.

31. What is the total amount of funding HHS has identified as improperly spent on the COVID-19 Uninsured Program based on such post-payment audits?

Response:
HHS is actively working with the Office of the Inspector General and has referred providers that we have identified with suspicious claim activity to the OIG – who in turn works with the Department of Justice – on investigations and enforcement.

32. How much money has HHS recovered as a result of such post-payment audits?

Response:
HHS has referred providers, worked closely with OIG on data analysis and complying evidence, testified at trials, and is an ongoing partner with law enforcement on program accountability work. HHS also is actively working on audits, assessment, and compliance reviews of claims.

33. What trends has HHS identified with respect to the types and causes of any improper payments identified in such post-payment audits?

Response:
HHS is actively working with the OIG to track and support their efforts to take law enforcement action against providers who violated the intended use of the Uninsured Program. HHS also uses a risk assessment strategy to identify potentially problematic providers and pursue further oversight action.

34. What policy errors has HHS identified in the administration of the COVID-19 Uninsured Program that left the program vulnerable to waste, fraud, and abuse?

Response:
The COVID-19 Uninsured Program was designed to be responsive to the pandemic's unprecedented impact and scale and the urgency of reducing community infection rates. HHS worked to ensure this access quickly during a major public health emergency while supporting the critically important need to ensure program integrity. HHS worked to screen providers and payments on the front end and has focused on post-payment actions directly and in partnership with the HHS' Office of Inspector General.

35. What policy recommendations has HHS developed that could apply to future Public Health Emergencies as a result of the post-payment audits it has conducted for the COVID-19 Uninsured Program?

Response:
HHS is continuing to implement the post-payment strategies necessary to support program integrity objectives and will continue to fully assess and identify policy recommendations as this work advances.

Office of the Secretary

36. Please provide information regarding the number of complains the Department's Office of Civil Rights has received regarding religious based exemptions to any COVID-19 vaccine requirement.

Response:
The Office for Civil Rights' Enforcement Division database indicates that as of March 28, 2023, OCR has received 537 total complaints filed involving religious objections related to COVID-19 vaccines and/or COVID-19 vaccine exemption policies. Please note that number reflects the most recent count of cases received of that type and that case classifications can change over time upon further review of the contents or upon receipt of additional information from a complainant or a covered entity.

37. A congressional directive related to Breastfeeding Services and Supplies, found on page 220 of House Report 117-403, calls upon HHS to deliver a report on how health insurers have implemented comprehensive lactation services, the standards insurers use to set reimbursement rates for breastfeeding supplies and services, and the current best practices used to provide coverage to help women breastfeed. Furthermore, HHS was also directed to respond to a request for examination of the impact of clinically recommended breastfeeding rates on associated Medicaid expenditures, urgent care costs, and direct and indirect medical costs including workplace productivity and employee retention. What is the status of your agency's response, and expected timeline and schedule of steps being taken, to provide this report?

Response:
HHS has encountered several challenges in addressing this report request, included, but not limited to a lack of access to the requisite data. HHS is committed to working with subcommittee staff to resolve these issues.

38. According to a GAO report published in February 2023 on COVID-19 relief, Congress has appropriated nearly $350 billion to the Public Health and Social Services Emergency Fund (otherwise known as the PHSSEF). This money was intended to develop and procure vaccines, drugs, devices, tests, PPE and other

emergency supplies to address the COVID-19 pandemic; but Congress included flexibilities to allow for it to be repurposed to address other threats. As of January 31st – there remains nearly $20 billion in unexpired, unobligated funds within the PHSSEF.

a) Can you please provide the committee a detailed accounting and summary of the unspent COVID-19 emergency supplemental balances that remain available to HHS?

Response:
The PHSSEF has approximately $$22.3 billion left unobligated in COVID-19 supplemental funding – only 6 percent of the of total we have received – with the remainder planned to support critical projects and in the process of execution. HHS shares with the Committee on Appropriations periodic spend plan reports and supplemental balances reports. We are including as part of this response the most recent supplemental balances report, which provides greater detail on the unobligated funding.

b) How do you plan to allocate these funds in 2023 across ASPR's key programs, including BARDA, SNS and Project BioShield?

Response:
All of the funds are committed against important priorities. For example, the SNS requires funds to physically warehouse products purchased during COVID. Money is set aside for those leasing contracts but the bills will still need to be paid over the course of the coming years. Other examples include funds for domestic manufacturing contracts. In order to provide funding certainty to manufacturers, ASPR pays these contracts over a number of years rather than a lump sum up front.

c) Why has the ASPR suggested both publicly and to Congress that there were not enough funds to address public health threats – including last summer's Mpox outbreak?

Response:
Today, the Administration for Strategic Preparedness and Response (ASPR) is working on more high-consequence, no-fail missions than ever before. We are living in an increasingly interconnected world where diseases and other threats can travel quickly, unnoticed for days. In addition, infectious disease outbreaks are becoming more frequent and natural disasters more deadly as a result of the increasing changes to our climate. To keep up with the evolving threat landscape, ASPR must remain nimble and ever vigilant while learning from each response it leads.

In 2022, the Administration requested additional appropriations to conduct a simultaneous, full-scale response to both COVID-19 and Mpox. In the absence of

additional resources, we were forced into making challenging tradeoffs. For example, ASPR identified early in the response the desire to send Mpox countermeasures to more than five locations per state; however, due to limited funds, additional distribution contracts were not able to be put into place until months after the start of the response. COVID-19 funds were not able to be used for this effort.

d) How will you ensure that the ASPR is preparing for a myriad of threats and ensuring the American tax dollar is put to good use?

Response:
Today, ASPR is working on more high-consequence, no-fail missions than ever before. ASPR's mission is to assist the country in preparing for, responding to, and recovering from public health emergencies and disasters. ASPR accomplishes this mission in several ways, including developing, stockpiling, and distributing response tools against multiple threats; sending clinical response teams to places in times of crisis; and ensuring our health care and public health partners have the knowledge and tools they need to navigate today's challenges and confront whatever challenges lay ahead. This work is needed to keep the nation safe, and the funds discussed above are required to accomplish this mission.

Submitted by Rep. Juan Ciscomani

39. On March 28th, I asked Secretary Becerra questions regarding when the Office of Refugee Resettlement (ORR) conducting wellness-check calls with a sponsor family after a child is placed into a home, how many calls go unanswered to the sponsor family and the child, along with how many additional outreach attempts does ORR make if the original call goes unanswered. Please provide clarification on:
    a. How long after a UAC is placed with a sponsor does the original wellness check call take place?

        Response:
        ORR care providers make a minimum of three attempts to speak with both the unaccompanied child and the sponsor within the seven days following the 30th day of the child's release from ORR custody.

    b. What percentage of those wellness-check calls go unanswered?

        Response:
        In FY 2022, ORR care providers were able to contact the child, the sponsor, or both in 81 percent of the households.

    c. How many attempts does ORR make with conducting wellness-check calls if the original call goes unanswered?

        Response:
        ORR care providers conducting the Safety and Well-Being calls must make three attempts to speak to both the child and sponsor separately through any contact numbers provided. Each attempt is documented. Following numerous attempts to contact each individual at any available contact numbers, it is possible that within a household, an ORR care provider may only contact and speak with either the child or the sponsor but may not successfully contact both. In these circumstances, if care providers identify or suspect any safety concerns with the child, they are required to report to the appropriate investigative agencies. Those who may benefit from additional resources are referred to ORR's National Call Center.

40. The Fiscal Year (FY) 2022 Consolidated Appropriations Act, which Congress passed and President Biden signed into law, included report language in the Labor, Health and Human Services, Education section acknowledging that Tardive Dyskinesia (TD) is a persistent, irreversible, and potentially disabling neurological condition characterized by involuntary movements, which affects at least 600,000 people in the United States. The report language encourages the Department of Health and Human

Services (HHS) to prioritize the importance of screening for, diagnosing, and treating TD. Congress also requested a report by mid-September 2022 outlining the Department's existing resources for patients, providers, and caregivers related to TD. Could you please provide an update on this effort, which agency or office is leading this effort, and when the report to Congress should be expected?

Response:
Tardive dyskinesia (TD) is a serious, persistent, and disruptive involuntary movement disorder characterized by uncontrollable, abnormal, and repetitive movements of the face, torso, and/or other body parts. TD may be disruptive to people's lives due to the symptoms themselves and the impact they have on emotional and social well-being.

TD is caused by prolonged use of treatments that block dopamine receptors in the brain. These treatments include antipsychotic medications commonly prescribed to treat mental illnesses such as schizophrenia, bipolar disorder, and depression, and certain anti-nausea medications. In individuals with TD, these treatments are thought to result in irregular dopamine signaling in a region of the brain that controls movement. Though most cases of TD occur after an individual has taken a prescribed medication for years, some may occur with shorter use.[22] Often physicians will try to stop, reduce, or modify antipsychotic treatment; however, there is little evidence to support the efficacy of this practice. In 2017, the U.S. Food and Drug Administration approved valbenazine (Ingrezza) and deutetrabenazine (Austedo) as treatments for TD.

NIH supports basic scientific research and clinical trials research that, through different approaches, may enable a more complete understanding of the causes of TD. These projects have included investigations of the neural structures implicated in TD, novel treatments for various mental illnesses that could be used in place of current dopamine blocking treatments that can lead to TD, and approaches for monitoring and treating drug side effects, including TD. Taken together, this work may yield important insights to improve the lives of those living with the disorder.

[22] rarediseases.org/rare-diseases/tardive-dyskinesia/?filter=complete-report

Submitted by Rep. Andrew S. Clyde

41. Secretary Becerra: Since we now know that pandemic mitigation measures like lockdowns were a giant failure, why should we entrust the agencies who failed the taxpayers so profoundly with a huge budget?

Response:
Thanks to the Biden-Harris Administration's whole-of-government approach to combatting COVID-19, we are now in a better place in our response than at any point of the pandemic. One of the critical components of our response has been ensuring all Americans have easy access to COVID-19 vaccines, free of charge. Over the last two years, the Administration has effectively implemented the largest adult vaccination program in U.S. history, with nearly 700 million doses of COVID-19 vaccines given to 270 million Americans.

HHS and its operating divisions continue to work tirelessly to protect the American people from health threats like COVID-19 and strive to apply best public health practices to all our work. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, caused by human error or deliberate attack, we fight disease and support communities and citizens in their efforts to do the same.

HHS is working to reach people where they are. and we use trusted messengers to help. HHS works with our Pharmacy Partners and our We Can Do This campaign to use trusted community messengers to answer questions and provide accessible information about COVID-19 vaccines. We also launched the COVID-19 Community Corps, a network of nearly 20,000 community leaders and volunteers who serve as trusted local voices.

42. Secretary Becerra: Americans by large have lost confidence in the Public Health, how do you propose to change that knowing that we left our most vulnerable populations unprotected during lockdowns?

Response:
A variety of stakeholders and partners rely on the Department and its operating divisions for the latest scientific information and data to inform their actions and decision-making. We are committed to releasing clear and timely information and are always looking for ways to improve. For example, as part of the CDC Moving Forward initiative, CDC is reviewing, and if necessary, modifying its process for developing public health guidance both during and outside public health emergencies. This review includes listening sessions and outreach with a range of partners, including both public and private sector partners at the state, tribal, local, and territorial levels and other organizations involved in public health.

Through the CDC Moving Forward initiative, CDC is prioritizing public health communications. CDC's goal is to put tools in the hands of state and local health departments to enable them to effectively communicate vital health information. As

always, CDC will provide resources for state and local health departments to communicate to their communities, such as Communication Resources for Health Departments | CDC, and during outbreaks of significance, we will continue to hold regular meetings to provide public health authorities with real-time information and materials to help inform their communications on the ground. CDC also hosts a State, Tribal, Local, and Territorial (STLT) Collaboration Space where communicators for state and local health agencies can access the Communication Resource Center, which has free, customizable CDC tools and resources that can enhance local communication efforts. It will be important to plan in advance, support, and activate these trusted sources faster and more often to better serve the public.

CDC is also focused on its communication with the American public. Through project "clean slate," CDC is rebuilding the "front door" to CDC so that its public website structure, operability, and utility is markedly enhanced using contemporary and future oriented communications technology used by certain private sector entities.

Other agencies across the enterprise contributed to protecting vulnerable populations. For example, ACL addresses the coronavirus's impact and health inequalities through community-based programs targeted towards the aging and disabled population. ACL awarded two grants totaling $125 million to rapidly increase the number of older adults and people with disabilities who have received the updated COVID-19 vaccine and annual flu vaccine. These programs will distribute funding and leverage partnerships across the aging and disability networks to host community vaccine clinics, provide in-home vaccinations, provide transportation to vaccination sites, conduct outreach and education to older adults and disabled people, and more.

43. Secretary Becerra: Do you agree that the World Health Organization's conduct during the COVID-19 pandemic resulted in needless loss of life and personal freedoms in this country and elsewhere around our planet?

Response:
COVID-19 reminded us that infectious diseases do not stop at our borders and that global engagement and coordination is required to protect Americans against current and future health threats. We must all internalize, better understand, and ensure that the lessons of COVID-19 and prior infectious disease threats are reflected in a clear strategy for addressing future pandemics, including effective surveillance and detection, rapid response, and sustained efforts to support recovery. HHS believes that the World Health Organization (WHO) is an essential organization that can play a key role in this effort by working to strengthen its and its Member States' capacities. At the same time, HHS supports ongoing efforts to strengthen the WHO and make it more agile, transparent, and efficient.

It is important that the United States continues to be an effective leader at the WHO, in order to help build consensus and collegiality among Member States to prevent, prepare for, and respond to health emergencies.

Submitted by Rep. Jake Ellzey

In 2021, the Department of Health and Human Services (HHS) and the Department of Homeland Security (DHS) signed a Memorandum of Agreement (MOA).

The 2021 MOA replaced a previous 2018 MOA between HHS and DHS and removed some requirements for background checks for potential sponsors of Unaccompanied Alien Children.[23]

Specifically, the 2021 MOA removed the requirement that your office of Refugee Resettlement must provide biographic and biometric data for all adult members of a sponsor's household in order to check the Federal Bureau of Investigation's national and statewide criminal history, child abuse and neglect, and sex offender databases prior to placement of a Unaccompanied Alien Children.[24]

44. What was the rationale for removing the biographic and biometric data for all adult members of a potential sponsor's household that was made available to check the Federal Bureau of Investigation's national and statewide criminal history?

Response:
In late 2018, ORR reviewed the effects of the June 2018 Memorandum of Agreement (MOA) among ORR, Immigration and Customs Enforcement, and Customs and Border Protection that expanded biometric background checks. The expanded checks were done in addition to those previously required by ORR policy,[25] specifically, that FBI fingerprint checks are required for sponsors in Categories 2B and 3, as well as some Category 1 and 2A sponsors, adult household members, and adult caregivers. The purpose of this review was to assess whether the new procedures yielded any new information that enabled ORR to identify child welfare risks that it would not have found under its prior policies. ORR also examined whether a correlation existed between the expanded biometric background checks and a child's length of stay in ORR care. It was determined that none of the information gleaned from ICE biometric background checks yielded automatic sponsor disqualification or additional child safety and welfare concerns, and in fact, was a negative influence on sponsors coming forward to take care of custody of a child for fear of biometric information being shared for the purpose of immigration enforcement.

Following the assessment, between December 2018 and June 2019, ORR issued four operational directives that that updated its background checks processes to be consistent with pre-MOA policies. FBI fingerprint background checks would only be required for all sponsor categories and adult household members in cases where there were risks to the child, the child was especially vulnerable, and the case was being referred for a home study. Without such instances, Category 1 sponsors and Category 2A sponsors no longer

[23] S. Comm. on Homeland and Gov't Affairs, Report on Federal Care of Unaccompanied Children: Minors Remain Vulnerable to Trafficking and Abuse 30-31 (Dec. 2022).
[24] Id.
[25] https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-2#2.5

required biometric-based background checks. Lastly, close adult relative sponsors in Category 2 were broken into sub-classes of Category 2A and 2B which affected background check requirements for each. FBI fingerprint background checks were and still are required for all Category 2B sponsors.

45. How has removing these requirements made the children in the care of HHS safer under the current Memorandum of Agreement compared to the 2018 MOA?

Response:
In March 2021, ORR rescinded the 2018 MOA, and DHS and ORR signed a memorandum of understanding on consultation and information-sharing policies between the two agencies regarding unaccompanied children—formalizing the December 2018–June 2019 operational directives that previously been adopted. ORR was able to identify what information it needs at the time of referral and after placement to make proper placement decisions. ORR and DHS ensured that the information was relevant to the timely placement and transfer of children in ORR care. Additionally, none of the information gleaned from ICE biometric background checks yielded automatic sponsor disqualification or additional child safety and welfare concerns, and in fact, was a negative influence on sponsors coming forward to take care of custody of a child for fear of biometric information being shared for the purpose of immigration enforcement.

46. What did HHS replace these biographic and biometric data with so as to best check a potential sponsors criminal history?

Response:
ORR determined that individualized suitability assessments of sponsors would continue without obtaining fingerprints from all household members, all parents or legal guardians, or certain close relatives in appropriate cases. Under ORR's operational directives it was determined that none of the information gleaned from ICE biometric background checks yielded automatic sponsor disqualification or additional child safety and welfare concerns, and in fact, was a negative influence on sponsors coming forward to take care of custody of a child for fear of biometric information being shared for the purpose of immigration enforcement.

Sponsor suitability assessments gave the field the individual decision-making and operational flexibility necessary to make case-by-case determinations of what is in the child's best interest and whether adult household members needed to be fingerprinted. ORR policy[26] requires FBI fingerprint checks for sponsors in Categories 2B and 3, as well as some Category 1 and 2A sponsors, adult household members, and adult caregivers.

[26] https://www.acf.hhs.gov/orr/policy-guidance/unaccompanied-children-program-policy-guide-section-2#2.5

47. What current HHS legal authority does HHS believe needs to be paired down or eliminated, and why?

Response:
We believe we are appropriately using, and our mission is advanced by, our existing authorities.

48. Is HHS or any subagency currently funding gain-of-function research in any lab in China? If so, where?

Response:
HHS awarding agencies are not currently funding enhanced potential pandemic pathogen research in China.

49. Is HHS or any subagency currently funding gain-of-function research in any lab in any country *other than* China or the U.S.? If so, where?

Response:
HHS awarding agencies are not currently funding enhanced potential pandemic pathogen research in any countries, including China or the United States.

50. In light of the Government Accountability Office's January 2023 report, entitled "HHS Could Improve Oversight of Research Involving Enhanced Potential Pandemic Pathogens," what steps HHS has taken, since the report was issued, to improve the oversight of gain-of-function research?

Response:
HHS awarding agencies are not currently funding enhanced potential pandemic pathogen research in any countries, including China or the United States.

51. What percentage of the HHS workforce was working at a workplace 5 days-a-week prior to the pandemic and what percentage of the HHS workforce is currently working at a workplace 5 days-a-week?

Response:
HHS employees are working full-time. HHS, like other agencies, utilizes telework and other workplace policies to stay competitive with the private sector and build a diverse workforce across the country.

52. Prior to the pandemic, what percentage of the HHS workforce was working remotely and what percentage of the HHS workforce is currently working remotely?

Response:
The Department believes that organizational health and organizational performance should be the foundation for future operational decisions as we continue to increase meaningful in-office work. As always, our north star will continue to be delivering on our mission, which means building on the innovations and technology that we have put to work over the last three years to ensure we are enhancing the health and well-being of all Americans.

Submitted by Rep. Andy Harris

HHS Employee Telework Policies

53. How many HHS employees are working a full-time approved telework schedule?

54. Can the Department provide VPN data, PIV card use in laptops, or some measure of accountability that shows that staff are working from home?

55. Please provide a list of the cities/states from which these employees are approved to telework full-time along with their current, official duty station.

56. Please describe the process by which HHS ensures that its employees are receiving the proper locality pay adjustment for their remote work address as stated in their full-time telework agreement?

57. Can HHS confirm that all employees who telework full-time have changed their work location of record as an HR action such that they are receiving the locality pay adjustment that corresponds to their remote work location?

Response for Questions 53-57:
HHS employees are working full time. HHS, like other agencies, utilizes telework policies to stay competitive with the private sector and build a diverse workforce across the country. The Department believes that organizational health and organizational performance should be the foundation for future operational decisions as we continue to increase meaningful in-person work.

As always, our north star will continue to be delivering on our mission which means building on the innovations and technology that we have put to work over the last three years to ensure we are enhancing the health and well-being of all Americans.

Unallocated HHS COVID funds

In your testimony you told Representative Moolenaar that $70 to $90 billion in unobligated dollars in various federal agencies for COVID emergency relief have not been "signed on the dotted line" or committed but are in "the pipeline to be signed on the dotted line."

58. Please clarify what you meant in your response. Have grant agreements or contracts been signed to obligate the government to payment for these grants or contracts?

Response:
As of March 27, 2023, HHS has approximately $29.4 billion left unobligated in COVID-19 supplemental funding. All balances are intended for critical, ongoing activities.

Increasing longer-term capacity requires activities over multiple years. Congress funded various HHS activities, which are by design implemented over multiple years. Examples include NIH research, FDA product oversight responsibilities, initiatives to reduce provider burnout and supporting graduate medical residency training, the enhancement of the federal and local public health workforce, modernization of CDC and state level public health data and threat forecasting systems, enhancement of domestic and internal technical and laboratory capacity, enhancement of domestic manufacturing capacity to mass produce vaccine and therapeutics, and development of medical countermeasures.

HHS can commit resources for specific purposes even without fully obligating them. For example, HHS often announces grant programs (with competitive, formula or supplemental awards) that cite multiyear periods of performance.

59. Are these $70 to $90 billion obligated but not yet expended? Or, are these amounts unobligated and yet to be obligated?

Response:
All balances are intended for critical, ongoing activities, such as monitoring the safety and efficacy of vaccines, conducting multi-year research and development on new medical countermeasures, and sustaining stockpiled countermeasures and protective equipment for the next emergency. These investments also support our public health preparedness infrastructure. CDC continues to invest supplemental funding at the federal, state, and local levels to build our nation's capacity to respond to COVID-19, but also, for other future threats.

NARCAN OTC

Earlier this morning, I was pleased to see the FDA approved NARCAN® Naloxone nasal spray as an over-the-counter (OTC) emergency treatment of opioid overdose. According to CDC data, overdose deaths have risen fivefold over the past two decades. And in 2021 alone, 106,000 Americans lost their lives to an overdose. We applaud this next step given the crippling grip the opioid crisis continues to have on this country.

60. Given this shift in status from prescription to over-the-counter, how does FDA plan to work across the Administration to help ensure access to this life-saving drug isn't confusing to patients?

Response:
Now that FDA has approved Emergent Biosolutions' 4 mg intranasal naloxone product (Narcan) as safe and effective for nonprescription use, it will take some time for nonprescription Narcan to be available on retail shelves. In the interim, remaining stocks

of Narcan labeled for prescription should continue to be available, including availability in pharmacies through state standing orders that enable individuals access to Narcan without a patient-specific prescription. Importantly, the agency will continue working with government partners, manufacturers, and other stakeholders to help ensure that naloxone remains available during and after the time needed for the manufacturer to implement the switch of Narcan nasal spray from prescription to nonprescription status.

61. What steps will you take to increase the awareness of this change and educate Americans on naloxone?

Response:

HHS recognizes that this is an important opportunity to provide information on naloxone and to distribute the live-saving opioid overdose reversal drug as needed. As such, we are working together with our colleagues across the Department along with practitioners, harm reduction agencies and other treatment professionals to provide information and advice on naloxone distribution.

In addition to these collaborative efforts, SAMHSA introduced the element of State Naloxone Saturation Plans as part of the FY 2022 State Opioid Response (SOR) grant application. For the FY 2022 SOR grant application, SAMHSA required states to submit their own naloxone saturation plans that include the following elements:

- The amount of naloxone needed to achieve saturation in their communities,
- Estimated gaps in naloxone availability,
- Potential acquisition and distribution mechanisms to reach priority communities and populations,
- Funding and budgetary needs to achieve saturation,
- A timeline for implementation.

SOR grant recipients and sub-awardees are required to use SAMHSA's grant funds primarily to support direct services, which includes the purchase and distribution of naloxone. The inclusion of these plans in state grantee applications are essential in helping states effectively address the opioid crisis by ensuring that states are strategically thinking about and incorporating naloxone distribution strategies into their SOR grant plans so that it is readily available in communities that need it most.

Similar to the SOR program, other SAMHSA grant programs such as the First Responders-Comprehensive Addiction and Recovery Act Grants, Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths, and the Harm Reduction Grant Program, also allow grantees to use funding for the purchase and distribution of naloxone as part of their efforts to address the opioid overdose epidemic. Related, the Centers for Substance Abuse Treatment and Substance Abuse Prevention are coordinating on planning a Naloxone Saturation Policy Academy. The intent of this convening, which is tentatively scheduled for summer 2023, is to teach SAMHSA grantees to identify policy, practice, and program options for advancing naloxone saturation.

The change to non-prescription status for certain forms of naloxone should have minimal impact on SAMHSA grants, as grantees will be able to continue to purchase and distribute naloxone products as they have done in the past. While naloxone is a critical tool in preventing opioid overdose deaths, it is just one component of a larger effort to address opioid misuse and overdose. SAMHSA continues to support a comprehensive approach to combatting the opioid overdose epidemic, including prevention, treatment, and recovery efforts, while also prioritizing access to naloxone and other life-saving resources. SAMHSA will continue to work with its partners to ensure access to and coverage of naloxone.

62. Do you expect additional treatments will be approved in the months to come?

Response:
Pursuant to several federal statutes and regulations, including the Freedom of Information Act (FOIA) [5 U.S.C. 552], the Trade Secrets Act [18 U.S.C. 1905], and FDA regulations [21 CFR 20.61(c); 21 CFR 312.130(b); 21 CFR 314.430(c) and (d)(1)], FDA generally cannot acknowledge or disclose the existence of an application (including an Investigational New Drug Application) for human drug (including biological) products, unless the existence of such application previously has been publicly acknowledged or disclosed. FDA cannot at this time provide insight into the possibility of or timing for approval of other nonprescription naloxone products, including a switch of other prescription naloxone products to nonprescription status. The Agency will work with any sponsor seeking nonprescription status or switch of its naloxone product and encourages sponsors to contact the Agency as early as possible to initiate discussions.

Background: Sevenfold Administrative Fee Increase

The *No Surprises Act* permits the implementing Departments to assess an administrative fee, which should be reasonably calculated to address the Departments' costs to operate the independent dispute resolution (IDR) system. Until this year, that non-refundable administrative fee was $50 for each party. However, in December 2022, with a notice of 4 business days, CMS announced a 600% increase, from $50 to $350 for each party, reversing its own decision of just two months prior to keep the fee steady at $50 for 2023. This has created a barrier to the use of IDR for the significant number of claims for which the total requested payment is less than $350 and the amount-in-dispute even smaller, which is often the case in emergency medicine, radiology, and other specialties. In addition, current batching criteria do not allow providers to combine claims into meaningful or sizable batches that overcome this fee increase or promote efficiency in the system.

63. Did CMS analyze how many claims would be effectively ruled out by its fee increase to $350? If so, what was the projection?

64. With restrictive batching requirements, how can providers with claims under $350 access the IDR process when the fees exceed any possible recovery?

65. If IDR is effectively eliminated as an option for those providers, what is the recourse that CMS suggests for inappropriate underpayment by health plans?

Response to Questions 63-65:
The No Surprises Act requires the Departments to establish the IDR administrative fee at a rate where the total amount of fees paid is estimated to be equal to the amount of expenditures estimated to be incurred by the Departments in administering the Federal IDR process. There is a very high volume of disputes being submitted for resolution, which led to increased Federal administrative costs. Through December 5, 2022, there were over 160,000 disputes submitted for resolution through the IDR portal, nearly 10 times greater than the Departments initially estimated. During that time, non-initiating parties challenged the eligibility of over 68,000 disputes for the Federal IDR process. IDR entities have had to perform a substantial amount of outreach and analysis to determine whether a submitted dispute is eligible for the Federal IDR process. Assessing the information received and making an eligibility determination can be a time-consuming process for IDR entities, but an eligibility determination must be made before a dispute can proceed to IDR. Cases can be ineligible for a number of reasons. Some common reasons include: incomplete documentation, lack of compliance with applicable timelines, non-completion of open negotiation, incorrect batching and incorrect jurisdiction (federal vs State). These issues are detailed in our first report on the IDR process and the amended 2023 fee guidance. In order to address these issues, the Departments have engaged a contractor and government staff to conduct pre-eligibility reviews, which have also led to increased Federal costs. The Departments are also considering additional policy and operational improvements, including through rulemaking, to improve the process for determining the eligibility of disputes and ultimately increase the speed with which certified IDR entities render payment determinations. We plan to adjust the Administrative fee as operational requirements change over time.

Public Health Service Act section 2799A–1(c)(3) directs the Departments to specify criteria under which multiple qualified IDR items and services may be considered jointly as part of one payment determination (batching). Multiple claims for qualified IDR items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity (batched items and services) only if certain conditions are met. The Departments established regulations governing the batching of qualified IDR items and services in the October 7, 2021 Federal Register. Specifically, regulations permit items or services to be submitted and considered jointly as part of one payment determination only if the items or services are billed by the same provider or facility, the payment would be made to the same plan or issuer, the disputed items or services are the same or similar items and services, and the disputed items or services were furnished during a 30-day period. The term "same or similar items or services" is

used throughout the regulations, and items or services are the "same or similar" if billed under the same service code or a comparable code under a different procedural code system. The regulations also permit the resolution of "bundled" services (*i.e.*, multiple services an individual received during a single episode of care which are billed or paid as part of a bundled payment arrangement) into a single IDR proceeding.

Background: Nonpayment by Health Plans

The *No Surprises Act* established an independent dispute resolution (IDR) process to resolve disputed payment amounts between insurance companies and providers. Providers have informed Congress that, even after the provider prevails in the IDR, health plans consistently fail to actually pay the amounts owed in the timeframes specified in law and regulation. In some instances, the insurers pay incorrect amounts; in others, they fail to pay at all. This tracks feedback received by CMS in its listening session on January 5, 2023, during which multiple stakeholders stated that plans are not meeting their payment obligations following an adverse IDR decision. The agency has created an online portal where providers may submit complaints about nonpayment. However, providers consistently report never receiving response or follow-up communication from the agency. Providers' failure to receive payment, especially after paying fees up front, then awaiting a substantial backlog of payment determinations poses a significant issue for cash flow for provider practices and does nothing to bring health plans to the table to negotiate in-network agreements.

66. What concrete enforcement plan does CMS have to provide recourse for providers with regard to nonpayment by health plans following an IDR decision?

Response:
Through the independent dispute resolution (IDR) process, regulations issued by HHS, along with the Departments of Labor and the Treasury (the Departments), require that the losing party remit payment within 30 days of a payment determination. If the prevailing party believes that the non-prevailing party isn't complying with the Federal dispute resolution process payment requirements, they should contact the No Surprises Help Desk to submit a complaint. While states are generally responsible for enforcing provisions of the NSA that apply to state-regulated insurers and providers, CMS will directly enforce any NSA provision (or provisions) that a state fails to substantially enforce.

The Departments are actively investigating complaints that we have received about timely payment and are working to determine what is causing payment delays. We believe that at least one of the factors relates to how plans ingest information after a payment determination and then work through their business processes to make the ultimate payment. Until very recently, IDR entities would email payment determinations to disputing parties. On March 17, 2023, we released an update to the Federal IDR system so that the payment determination notices will now come from the IDR portal –

this should remove a number of the manual steps for plans to correlate the information that is part of a payment determination with the appropriate provider. We are continuing to investigate all of the complaints that we have received about timely payment to determine if there are other issues or actions that we need to take.

Price Transparency Requirements

The Biden Administration has completely failed on its implementation of the 'Advance Explanation of Benefits' requirement, a major new transparency tool passed in the No Surprises Act that would give patients visibility into prices and network status on the front end of non-emergency services. This should have been implemented by Jan. 1, 2022, but the Biden administration only issued an RFI last fall. Hospitals will need to provide Good Faith Estimates to health insurers to operationalize this policy.

67. When does the Secretary intend to implement and enforce this policy?

Response:
The Departments of Labor, Health and Human Services, and the Treasury received feedback from the public about the challenges of developing the technical infrastructure necessary for providers and facilities to transmit the data to plans and issuers that the good faith estimates require. In September 2022, the departments released a Request for Information (RFI) that seeks information and recommendations on transferring data from providers and facilities to plans, issuers, and carriers. That RFI also sought comment on ways in which plans could leverage work already undertaken for compliance with the Transparency in Coverage self-service price comparison tool to comply with the Advanced Explanation of Benefits (AEOB) provision. The Departments intend to undertake notice and comment rulemaking in the future to implement AEOB requirements including establishing an appropriate data transfer standard. Until that time, the Departments will defer enforcement of the requirement that plans and issuers must provide an Advanced Explanation of Benefits.

As a result of the Transparency in Coverage rules, as of January 1, 2023, plans and issuers must make price comparison information available with respect to an initial list of 500 identified items and services. By January 1, 2024, plans and issuers must make price comparison information available with respect to all covered items and services. This information must be made available through an internet-based self-service tool and in paper form, upon request. Typically, consumers receive an Explanation of Benefits after receiving care, which details the prices charged by the provider, the plan's contracted or negotiated rates, consumer cost-sharing obligations, and other information. Consumers will have access to this type of information before receiving care and can use it to compare prices and better estimate potential out-of-pocket costs.

Coverage of Alzheimer's Disease Treatments

Secretary Becerra, in an HHS interview conducted shortly after your confirmation highlighting your goals for your first 100 days as Secretary, you specifically discussed the FDA-approved Alzheimer's treatment Aduhelm, stating that "Americans are looking for opportunities and options, and we want to make sure we can provide them when they're safe and effective." The millions of Americans living with Alzheimer's and other dementia are, in fact, looking for opportunities and options to access life-changing treatments. Every day without access to FDA-approved drugs, more than 2,000 people transition to a more advanced stage of Alzheimer's where they will no longer be eligible for treatment.

68. Considering FDA has approved two treatments in this class - most recently Leqembi - for the treatment of Alzheimer's disease which means FDA has said they are safe and effective, what have you been doing to "make sure" you "can provide them" when CMS has effectively restricted access for Medicare beneficiaries?

Response:
The FDA performs a vital and an important role. CMS recognizes the important and related – but different – roles of the respective agencies. The FDA determines whether to approve a new medical product based on a careful evaluation of the available data and a determination that the medical product is safe and effective for its intended use but does not consider the specific needs of the Medicare patient populations. CMS conducts its own independent review to determine whether an item or service is reasonable and necessary for use in the Medicare population and should be covered nationally by Medicare.

The final national coverage decision on FDA approved monoclonal antibodies (mAbs) directed against amyloid for the treatment of Alzheimer's Disease allows for flexibility in a less rigorous study design for mAbs that receive FDA approval for the treatment of AD based on a direct measure of clinical benefit. In addition, based on public comment, we did not finalize the patient exclusion criteria in order to allow appropriate access to patient subpopulations that may need treatment based on ongoing research. The final decision also does not restrict the setting of approved clinical trials to ensure that anti-amyloid mAbs that receive FDA approval based upon evidence of efficacy from a direct measure of clinical benefit may be given to a broader patient population.

69. Since the FDA has declared them safe and effective and the VA has made the right decision to cover this treatment for veterans, why not leave it up to the Medicare patient and their medical provider to decide if the treatment is right for them?

Response:
It is my understanding that the U.S. Department of Veterans Affairs has issued exclusion and inclusion criteria for its coverage of lecanemab using statutory authorities that are different from Medicare's. By statute, CMS is required to make coverage decisions based

on whether something is reasonable and necessary for the treatment of an illness or injury for the Medicare population

CMS Coverage of Other Future Treatments

CMS has come under fire for its restrictive coverage policy for recently approved therapies by the FDA to treat Alzheimer's Disease. We are aware of additional CMS policies through Star Ratings that would also restrict patient access to products that could be approved by FDA and would restrict access to those products based on the setting of care that a patient resides in.

70. Can you describe how you will address the disconnect between FDA approval and CMS restricting access to Medicare beneficiaries moving forward to ensure today's seniors have access to innovative medications?

Response:
The FDA performs a vital and an important role. CMS recognizes the important and related – but different – roles of the respective agencies. The FDA determines whether to approve a new medical product 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 conducts its own independent review to determine whether an item or service is reasonable and necessary for use in the Medicare population and should be covered nationally by Medicare. CMS and FDA will continue to work together as appropriate on new innovative medical therapies.

71. Is it your view that CMS policies and a patients' setting of care should take precedent over the decision between a physician and patient?

Response:
We recognize the importance of physician-patient shared decision making. Based on published evidence including medical professional society recommendations and guidelines, Medicare coverage policies may assist informed decision making by providing additional context and support, e.g., when facility criteria are needed to help patient outcomes and experience.

Submitted by Rep. Barbara Lee

Public Health Emergency

Thank you for your response to my October 2022 letter urging HHS to declare gun violence a public health emergency (PHE). Over the years, various declarations were made – from natural disasters to substance abuse and biological threats. Amid the devastating coronavirus pandemic, many Americans face another ongoing public health crisis: the increasing threat of community gun violence – particularly in communities of color. Under the Public Health Service Act, the HHS Secretary may declare a PHE and "take such action as may be appropriate to respond," authorizing the Secretary to make grants, conduct research, and take any other action to respond to the crisis.

72. What needs to be done so that the gun violence epidemic is appropriately framed so that HHS can declare a public health emergency?

Response:
Firearm injury is a significant and growing public health problem in the United States and a leading cause of death in young people. The President and this Administration have been clear that gun violence is a public health epidemic.

CDC reports described an unprecedented 35 percent increase in the firearm homicide rate between 2019 and 2020 and then another 8 percent increase in 2021. The firearm suicide rate among persons aged 10 and older also increased 8 percent from 2020 to 2021. These increases have widened disparities in rates by race and poverty levels. More than 80 percent of homicides are the result of firearm injuries, and firearms were used in 55 percent of suicides in 2021. Collecting data such as this is foundational to CDC's public health approach to firearm violence prevention that includes collecting data to understand trends and differences across groups, supporting research to develop prevention strategies and to understand what works, and sharing that information to help states and communities make informed decisions about prevention activities.

CDC's more than 40-year history working to prevent violence informs our comprehensive violence prevention approach—employing both fast-acting and longer-term approaches to achieve sustainable solutions. CDC is dedicated to collaborating with other agencies within HHS and the rest of the federal government that have different and complementary roles to play to prevent firearm death and injury.

HHS agencies, including the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), are supporting comprehensive research programs to develop and implement interventions and strategies to prevent gun violence death and injuries in our country.

Violence is a serious public health problem that impacts the health and safety of Americans. In 2022, CDC released two Vital Signs *Morbidity and Mortality Weekly*

Reports (MMWR) that raised awareness about the historic rise in firearm deaths and widening disparities in homicide rates disproportionately impacting boys and young men of color. One publication highlighted how implementation of comprehensive public health strategies that employ proven approaches to address underlying economic, physical, and social conditions contributing to the risks for firearm violence and suicide could reduce rates and disparities. A second *MMWR* this year highlighted that the firearm homicide rate in 2021 was 8.3 percent higher than it was in 2020, with the highest rates among persons aged 25–44 years. Non-Hispanic Black or African American persons continued to experience the highest firearm homicide rates in every age group.
CDC has a long history of leading violence prevention efforts. CDC uses a public health approach to violence prevention that includes collecting data to understand trends and differences across groups, supporting research to develop and rigorously evaluate prevention.

73. Given that there is ample precedent for a report of this nature, can Congress count on HHS to provide a nation-wide Surgeon General report on gun violence to help better inform violence prevention strategies? I have requested this within my FY24 appropriations requests.

Response:
Gun violence prevention is a critical public health issue. In 2021, there were 48,830 gun-related deaths. This is a particularly prevalent public health issue for children. In the U.S., in 2020, gun-related injuries became the leading cause of death among children and teens; 65 percent of these deaths were due to violent assault, 30 percent were ruled as suicides, and 5 percent were accidental. The U.S. is the only country among peer nations that has seen an increase in the rate of child and teen firearm deaths in the last two decades (42 percent since 2000). In addition to loss of life and injury, children's exposure to gun violence has far-reaching mental health effects and those effects are not felt equitably: neighborhoods where poverty is most concentrated bear the brunt of gun violence exposure and the associated trauma.

The Office of the Surgeon General has been focused on raising awareness on the harms caused by gun violence, talking directly to communities about the impacts of gun violence, with a particular focus on children and their mental health and well-being and highlighting the possible solutions to address this critical public health issue.

With respect to Surgeon General Reports, the Office of the Surgeon General prioritizes reports that are statutorily required. Nevertheless, the Office will continue to focus on using all possible tools to effectively advance public understanding of ongoing public health crises and the solution set to address them, including and importantly gun violence prevention.

Gun Violence Research Equity

The recent allocations of federal funding for gun violence research have allowed both the CDC and NIH to create grants for research. Given the racial disparities associated with gun violence, it is imperative that these grants be issued to a diverse group of researchers.

74. What is HHS doing to ensure these research dollars are spent equitably and are responsive to all facets of our nation's gun violence crisis? How are you ensuring that new research dollars are spent to better understand the nature and impact of gun violence on communities that have historically been under-researched but face elevated risk of gun violence?

Response:
CDC is supporting a diverse portfolio of research projects to advance our understanding of firearm violence and how to prevent it. CDC has funded 22 two- and three-year research and evaluation projects since FY 2020 to better understand and prevent firearm-related injuries, deaths, and crimes in the United States. Many types of firearm injuries are represented in our awards, including firearm homicides/assaults, suicide/self-harm, and unintentional firearm-related injuries. Several funded research projects focus on strategies to address disparities in firearm violence and the needs of disproportionately impacted communities and populations, including urban communities of color.
Some specific examples of funded projects include the following:

- Analysis of longitudinal studies on youth exposure to violence and subsequent gun use in urban areas at high risk for gun violence.
- An investigation of how individual, social network, and neighborhood characteristics are associated with firearm risks for youth experiencing homelessness.
- Evaluating a hospital-based violence prevention program paired with firearm counseling and community case management to reduce the risk of firearm-related violence and injury in adult victims of violence.

CDC anticipates announcing additional firearms research projects in the fall of 2023, funded under RFA-CE-23-005: Research Grants to Inform Firearm-Related Violence and Injury Prevention Strategies (R01) and RFA-CE-23-006: Research Grants to Rigorously Evaluate Innovative and Promising Strategies to Prevent Firearm-Related Violence and Injuries (R01). Both funding announcements encourage applicants to focus on populations disproportionately impacted by violence and to consider the underlying social and structural conditions that contribute to inequities in risk. Also, the application reviewers are asked to consider the significance of the research, including to "what extent will the proposed research address the needs of communities experiencing disproportionate burden of firearm-related injuries, deaths, and crime?" when scoring the applications.

In FY 2023, NIH plans to expand the current Community Led Interventions for Firearm and Related Violence, Injury and Mortality Prevention (CLIF-VP) research network with additional research sites. The NIH Office of Behavioral and Social Science Research (OBSSR) coordinated with other Institutes, Centers, and Offices to publish a Notice of Funding Opportunity (NOFO), PAR-23-066,[27] and supports additional research projects to develop and test interventions at the community or community organization level that aim to understand and prevent firearm and related violence, injury and mortality. The NOFO also supports the addition of new research sites into the CLIF-VP network. Research on violence, including community violence intervention research, provides the basis for evidence-based strategies that communities can implement to improve their ability to reduce violence. Expanding the CLIF-VP network will allow for a more robust evaluation of the impact of several community level interventions across multiple locales. In addition, NIH is building the opportunities for research on firearm mortality and injury prevention across different domains of health. Community level interventions function by modifying characteristics of organizations, environments and settings such as schools, workplaces, and neighborhoods.[28] NIH published a Notice of Special Interest (NOSI), NOT-OD-23-039,[29] which solicits research to improve understanding of the identification of those at risk of firearm injury (including self- and other-directed, victims and perpetrators, accidental injury), the development, piloting, and testing of innovative interventions to prevent firearm injury and mortality, as well as the evaluation of approaches to improve the implementation of existing, evidence-based interventions to decrease firearm injury and mortality. NIH anticipates projects from this NOSI will include a variety of settings (e.g., health care, community, legal system, schools), populations and multi-level, cross-sector partnerships when appropriate. Both the CLIF-VP NOFO and the NOSI are comprehensive in their consideration of risk for victimization and/or perpetration across the lifespan and across sexual and gender identities, people with developmental disabilities or cognitive impairments (e.g., Alzheimer's disease and its related dementias), comorbid conditions (e.g., psychiatric or substance use disorders), or other at-risk populations such as pregnant and post-partum individuals, justice/legal system involved individuals, veterans, and members of the military. In addition, consideration of NIH designated health disparity populations (who are often disproportionately impacted by firearm injury and mortality), is encouraged: specifically, Blacks/African Americans, Hispanics/Latinos, American Indians/Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, socioeconomically disadvantaged populations, underserved rural populations, and sexual and gender minorities.

To improve the diversity of the research workforce by recruiting and supporting post-baccalaureate, predoctoral students, post-doctorates, and eligible investigators from groups that have been shown to be underrepresented in health-related research, NIH supports a program of Diversity Supplements to many grant mechanisms. Researchers are welcome to apply for these as applicable to their research. It is a standing opportunity to

[27] grants.nih.gov/grants/guide/pa-files/PAR-23-066.html
[28] www.nimhd.nih.gov/about/overview/research-framework/nimhd-framework.html
[29] grants.nih.gov/grants/guide/notice-files/NOT-OD-23-039.html

add diversity to research and research sites that has been successful.[30] In addition, more opportunities for researchers hoping to develop expertise in firearms injury and prevention research are available through NIH solicited K18[31] NOFOs for Career Enhancement Award to Advance Research on Firearm Injury and Mortality Prevention, which encourages both participation of investigators and mentors from diverse and underrepresented or underserved backgrounds.

Kidney Disease

In 2020, Members of Congress, rare kidney disease experts and patients participated in a rare kidney disease policy roundtable with explored how advances in treatment and care will extend kidney health, address health inequities, and ultimately reduce health care costs related to end-stage kidney disease. In August 2022, a STAT article called this time a "golden era" of research and treatment for rare kidney diseases. Additionally, in a current clinical trial, a new treatment for the 150,000 Americans with rare kidney disease IgAN – which disproportionately affects Asian Americans – holds the promise of delaying the time from diagnosis to dialysis, transplant, or death by nearly 11 years.

75. Given the potential of novel therapies and care to reduce the impact of chronic kidney disease driven by rare kidney diseases, what is HHS doing to take advantage of these developments and how can Congress support these efforts?

Response:
NIH, particularly the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), has a robust research portfolio addressing IgA nephropathy and other rare kidney diseases. A key element of this effort is the NIDDK-supported Cure Glomerulonephropathy (CureGN) Consortium, a multi-center, international consortium of children and adults with rare kidney diseases such as focal segmental glomerulosclerosis, membranous nephropathy, IgA nephropathy/vasculitis, and minimal change disease. CureGN is yielding valuable information to better understand the causes of these diseases, their progression, and their responses to therapy. CureGN is also helping to identify biomarkers with potential for use in diagnostic tests. In addition to its research efforts, the Consortium has strived for a patient-centered approach by connecting those with glomerular diseases and building a network of support for participants through patient information sessions with CureGN study staff as well as peer support groups. Investigator-initiated studies are also central to NIDDK's rare kidney disease research efforts. For example, NIDDK-supported grantees at the University of Alabama, Birmingham are investigating the molecular causes of IgA nephropathy and identifying genetic variations that may help explain why some populations are more likely than others to develop the disease. Discoveries from some of these projects are spurring development of a potential diagnostic test for IgA nephropathy.

[30] grants.nih.gov/grants/guide/pa-files/PA-21-071.html
[31] grants.nih.gov/grants/guide/pa-files/PAR-23-108.html and https://grants.nih.gov/grants/guide/pa-files/PAR-23-107.html

At the intersection of kidney-care innovation, data, and partnerships, the HHS KidneyX Innovation Accelerator is transforming this landscape though its public-private partnership to incentivize the development of artificial kidneys. When artificial organs and novel therapies are ready for human use, then the Advanced Research Projects Agency for Health (ARPA-H), National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and other NIH programs, including the NCATS (National Center for Advancing Translational Sciences) rare disease program, will transition these technologies and scale solutions in collaboration with the HHS Office of the Assistant Secretary for Health (OASH) working across the government. CDC's Chronic Kidney Disease and FDA's Kidney Health Initiative are also driving biomedical and health breakthroughs to reduce disease burden with priority on health equity and bridging disparities of health. [

Medicaid Unwinding

HHS's Assistant Secretary for Planning and Evaluation has warned that, during the Medicaid unwinding, 15 million people, disproportionately people of color and children, will lose Medicaid if the program provides the same level of protection as it did in the past. On his very first day in office, President Biden signed an executive order asking federal agencies to overcome "potential barriers that underserved communities and individuals may face to enrollment in and access to benefits … in Federal programs." Implementing the order, the Office of Management and Budget emphasized the need to cut families' administrative burdens. OMB reported that such "administrative burdens … do not fall equally on all…, leading to disproportionate underutilization of critical services … often by the people and communities who need them the most. Burdens that seem minor when designing and implementing a program can have substantial negative effects for individuals already facing scarcity."

76. During the unwinding, how can the Administration prevent Governors from burdening families with needless administrative requirements that trigger major health care losses in historically disadvantaged communities? How can we ensure that, to prevent such a result, Medicaid provides much better protection than in the past? What is the Administration doing to make sure that every state uses reliable data to renew eligible families whenever possible?

State Medicaid Oversight

In last year's bipartisan Omnibus appropriations bill, we granted you considerable enforcement authority to hold state Medicaid agencies accountable for following federal law. But formal enforcement takes time. CMS has recognized that, starting in April, hundreds of thousands of eligible people could lose Medicaid improperly before formal enforcement can begin. To its credit, CMS is using immediate mitigation plans to prevent families from losing health care while states are rectifying potential legal violations.

77. What can you tell us about these mitigation plans? Will they prohibit states from terminating beneficiaries for procedural reasons while states are coming up to snuff?

Response to Questions 76 and 77:
HHS, through CMS, has been working with all states for well over a year to prepare for the "unwinding" of the continuous enrollment condition that expired March 31, 2023.

CMS is working closely with states on their unwinding plans, including assessing state compliance with federal Medicaid redetermination requirements and, where necessary, developing mitigation strategies to address gaps/deficiencies.

Federal Child Care and Early Learning Programs

Recognizing child care is an integral pillar to supporting our children's long-term success and a robust economy, Congress has come together to provide long-standing bipartisan support at the federal level of high-quality early learning and child care programs. Yet, for millions of working families with young children, child care is still unavailable or unaffordable. This has only gotten worse in recent years, as the child care sector is still down approximately 60,000 jobs from pre-pandemic levels, leaving families with an even smaller supply of care even as nearly all other sectors have completely recovered. In my home state of California, the infant-toddler child care crisis causes $17 billion per year in lost wages and productivity. California receives an estimated $1 billion in Child Care and Development Block Grant (CCDBG) funding.

78. How can Congress help ensure that children have access to high-quality learning and developmental opportunities, while enabling their parents to go to work and support their families? How does HHS plan to carry out important programs like CCDBG, Head Start, and Preschool Development Grant Birth to Five (PDG B-5) to ensure my communities receive the support they need to address the $122 billion child care crisis?

Response:
High quality early care and education from birth to kindergarten entry is one of the most significant and impactful investments we can make as a nation. When children have access to high-quality early learning programs, the benefits extend across their lifespan: they are more likely to succeed in school, graduate from high school, and go on to college. Early learning programs also make it easier for parents— especially mothers—to become employed, boosting family earnings and promoting economic stability and well-being. Unfortunately, early care and education programs, including both child care and preschool, are financially out of reach for many children and families, and current federal investments in child care and early learning fall far short of meeting the true need.

Congress can address this critical gap for families and boost our economy by enacting a new initiative to expand access to early care and education, as proposed in the President's Budget. The President's plan enables States to increase child care options for more than 16 million young children and lower costs so that parents can afford to send their children to the high-quality child care program of their choice, allowing them to go to work or pursue training with the peace of mind that their children are being set up for a lifetime of success. The Budget also funds a Federal-State partnership that provides high-quality, universal, free preschool, offered in the setting of a parent's choice—from public schools to child care providers to Head Start—to support healthy child development and ensure children enter kindergarten ready to succeed. The proposal enables States to increase preschool access and quality. The Budget provides access to high-quality preschool to all of the approximately four million four-year-old children in the Nation, and gives States the flexibility to expand preschool to three-year-olds after preschool is available to all four-year-olds. The estimated cost of these child care and preschool investments is $600 billion over 10 years.

HHS continues to support states and local communities to implement critical early care and education programs, and proposes increased investments in these supports. The President's Budget proposes an annual increase of $1.1 billion for Head Start to increase compensation to recruit and retain Head Start staff, an annual increase of $1 billion for the Child Care and Development Block Grant to help low-income working families access affordable, high-quality early care and education programs, and a $45 million increase for Preschool Development Grants Birth to Five program to build state and local early childhood capacity to reach families with the greatest needs, including children in rural communities, children with disabilities, and families with young children experiencing homelessness.

Federal PREP Act Authorities

Vaccines are vital to protecting and preserving the health and economic wellbeing of older adults, the chronically ill, and entire communities. The Biden Administration navigated the complicated and costly coverage landscape to increase access to vaccines under Medicare and Medicaid. Yet, longstanding inequities in vaccine coverage have hindered our nation's disease prevention efforts and put millions of Americans needlessly at risk of becoming sick or dying from vaccine-preventable diseases. Health equity depends on vaccine access—and thankfully, the Inflation Reduction Act (IRA) provisions eliminating cost-sharing for vaccines will soon bring us another step closer. Patients have come to expect that they can access these vital healthcare services at their local pharmacy, particularly in minority and underserved communities, where the neighborhood pharmacy may be the only healthcare provider for miles.

79. Vaccine access has increased due to the temporary authorities you issued under the federal PREP Act—the PREP Act declarations are vital to our nation's public health response and include authority for pharmacists and pharmacy technicians to perform all ACIP-recommended vaccinations for children ages 3-18. The PREP Act

declarations make it clear these important health care authorities will continue until October 1, 2024. Can you please confirm that you plan to keep these vital public health authorizations for pharmacists and pharmacy technicians, including for childhood vaccinations for ages 3-18, in place until October 1, 2024?

Response:
The end of the COVID-19 Public Health Emergency (PHE) does not automatically terminate Public Readiness and Emergency Preparedness (PREP) Act coverage for activities related to COVID-19 countermeasures. For all activities not related to a federal agreement, public and private entities conducting countermeasure programs and providers authorized under state law, or by the Secretary's PREP Act declaration for COVID-19 countermeasures, are covered (subject to the terms of the Act and the declaration) through October 1, 2024, or the end of any federal, regional, state, or local declared emergency, whichever is first. More information will become available in the coming months.

Oversight of Maximus

According to a recent report, 48% of the frontline workers at Maximus, the largest federal call center contractor who provides services for CMS, are Black and Latina women; however, they represent only 5% of the company's executives. Meanwhile white men make up only 9% of frontline workers, but they account for nearly 50% of executives, according to recent data released by the company itself.

80. Given the Biden Administration's clear commitments to centering racial equity in the operations of the federal government, does HHS plan to investigate Maximus for its apparent failure to address systemic racial disparities within its workforce? What steps is HHS willing to take to ensure that this contractor and others' selection, development, and retention practices are in line with the priorities of the administration?

Response:
CMS will continue to monitor the established clauses in its contract and be diligent in ensuring that the contact center vendor is in compliance with all Federal Rules and Regulations set forth in the FAR, any Executive Orders, and the Service Contract Act (SCA), which governs this contract.

Submitted by Rep. John R. Moolenaar

CMS – Alzheimer's Treatment/Therapeutics Coverage

I continue to hear from seniors in my district related to Alzheimer's treatments. During last week's hearings in the Senate, you mentioned that there is a different legal standard when CMS reviews a drug for Medicare coverage.

81. Can you elaborate on the standard as well as other treatments or class of treatments that have been denied coverage by Medicare when they have FDA approval?

Response:
The FDA performs a vital and an important role. CMS recognizes the important and related – but different – roles of the respective agencies. The FDA determines whether to approve a new medical product 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 conducts 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. In this case, Medicare's National Coverage Determination (NCD) provides coverage with evidence development to support rigorous studies to help answer whether this drug improves health outcomes for the Medicare population, and includes a coverage pathway for broader access to these drugs if they receive FDA traditional approval.

During the hearing last week with Senate appropriations LHHS subcommittee, you said CMS was waiting to get evidence from clinical trials showing success. The CLARITY AD trial – which was the Phase 3 confirmatory trial – has been completed and the results have been published in the New England Journal of Medicine that show the treatment works.

82. What other standards is CMS looking at?

83. If they are waiting for traditional approval from the FDA - which is anticipated in July - in what ways will CMS be ready to remove the restrictions on access?

Response to Questions 82 and 83:
The final national coverage determination (NCD) provides a coverage pathway that could provide broader, appropriate access for anti-amyloid monoclonal antibodies that receive FDA approval based on evidence of efficacy from a direct measure of clinical benefit. CMS intends to be nimble and respond to all new evidence – especially related to the clinical benefit of future therapeutics. If new evidence emerges for anti-amyloid monoclonal antibodies that addresses the questions specified in the NCD, CMS will move swiftly to review and consider whether a reconsideration is warranted.

Medicare Part D Reimbursement – Compounded medications
As you may be aware, Medicare has an inconsistent policy on how it reimburses for compounded medications. Medicare Part D plans are not allowed to reimburse for prescriptions that are compounded from bulk drug ingredients. Beneficiaries pay out-of-pocket for these prescriptions and it's a financial barrier that many seniors continue to face. I have directed CMS to provide a report on Medicare Part D's reimbursement policy related to compounded medications to this Committee since FY22 Labor-HHS bill became law, and then again in the FY23 Labor-HHS bill report that passed as part of the omnibus.

84. Why is the agency denying access to these plans despite their meeting all statutory requirements, particularly for plan year 2022?

Response:
The statutory definition of a covered Part D drug at section 1860D-2(e) of the Social Security Act generally includes the requirement that such drug is approved by the FDA and is used for a medically accepted indication. Multi-ingredient compounds are products extemporaneously prepared by pharmacies to provide drug therapies that are not commercially available as FDA-approved finished products in the same dose, formulation, and/or combination of ingredients. Multi-ingredient compounds may be covered under Part D only if they contain at least one ingredient that independently meets the definition of a Part D drug (Part D drug ingredient) and do not contain any ingredients covered under Part B as prescribed and dispensed or administered as part of the compound. Multi-ingredient compounds meeting both criteria are referred to as Part D compounds.

Compounded drug products can contain: (1) all Part D drug product components; (2) some Part D drug product components; or (3) no Part D drug product components. As defined in CMS regulations (42 CFR §423.120(d)), only compounds that contain at least one ingredient that independently meets the definition of a Part D drug, and that do not contain any ingredients covered under Medicare Part B as prescribed and dispensed or administered, may be covered under Part D. Only costs associated with those components that satisfy the definition of a Part D drug are allowable costs under Part D. Like other Part D drugs, Part D compounds may or may not be included on a Part D plan's formulary. Part D sponsors are responsible for choosing which, if any, Part D compounds are included on their formularies. Similar to other Part D drugs, if a beneficiary receives a prescription for a Part D compound that is not on their plan's formulary, they may request a formulary exception from the plan sponsor (as outlined in 42 CFR § 423.578). CMS has provided extensive guidance to Part D plans sponsors in the August 10, 2018 HPMS memorandum, "Medicare Part D Coverage of Multi-Ingredient Compounds."

Fentanyl Overdose Crisis

Fentanyl is a crisis in this country. It is killing adults and teens at record levels. In the first nine months of last year there were more than 79,000 drug overdose deaths. Nearly all of the fentanyl is coming across the southern border with Mexico.

85. As the health secretary, do you think the Biden Administration's border policies have failed to keep the American people safe from the fentanyl that is killing them?

Response:
The Department of Health and Human Services is focused on supporting and improving the health of our nation and defers to our colleagues at the Department of Homeland Security regarding the Administration's border policies.

China – COVID

Mr. Secretary, China has covered up the origins of COVID for more than three years.

86. In your estimation, do you believe the theory that it was a lab leak?

Response:
The Department of Health and Human Services is focused on supporting and improving the health of our nation and defers to intelligence communities regarding the theory on origins of COVID.

87. Is HHS doing any work in China right now?

Response:
We take into consideration many factors when we decide to collaborate. In areas where we have continued to engage with China, it is in the United States' best interest.

88. How much cooperation is HHS currently receiving from authorities in China?

Response:
It varies considerably, dependent on the topic. We take this and other factors into consideration when we decide how we may participate in an activity or with an institution.

89. Do you believe any of the statistics the CCP gives you?

Response:
The public health statistics that are being shared seem to be consistent with other sources. However, we are aware that some data may not be shared.

CDC – Public Health Infrastructure
I've been advised that CDC has been experiencing data collection problems for vaccine tracking. For example, the CDC has been overcounting the number of vaccinated Americans related to COVID vaccinations. During the pandemic under the emergency, CDC provided a sole source award to a company to link and track this vaccine data. As part of this partnership, CDC has also been purchasing data from this company. It's my understanding this approach has received mixed results. Despite that, CDC has continued this sole source.

Since this company's technology is proprietary, it is not interoperable with the technology from other vendors with linkage technology that have taken an open approach to support public health infrastructure.

90. Could you explain how CDC decision to continue this partnership is helping bring greater insights into disease surveillance and enhancing the ability of America's health systems to respond?

Response:
Initially, HHS/Operation Warp Speed (OWS) executed a limited competition contract with HealthVerity to gather and integrate COVID-19 immunization data. The contract was transitioned from HHS to CDC in 2021. Since 2021, CDC has expanded the use of Privacy Preserving Record Linkage (PPRL) technology provided by HealthVerity for its routine immunization reporting of e-identified data by jurisdictions on a quarterly basis. PPRL is a strategy that allows records to be linked together without revealing identifying information. With PPRL, records from two different sources are linked by encrypting each person's identifying information within each record. A third party can then compare the hashed values to see if a pair of records are from the same person, without revealing that person's identity. As of April 12, 2023, an additional seven jurisdictions have implemented this technology to report routine immunization data to CDC while preserving privacy.

By utilizing PPRL technology, COVID-19 vaccine administration data received from pharmacies, dialysis centers, the Indian Health Service, and some jurisdictions could be linked even though they were reported by different systems. To date, seven states have implemented PPRL as part of routine immunization which includes COVID-19 data, an additional four states are using PPRL to only share COVID-19 data. A total of 12 jurisdictions, including 6 territories, are in the process of adopting PPRL systems to share immunization data.

The technology also allowed CDC to link vaccines administered in pharmacies in a privacy preserved manner with de-identified COVID-19 case, claims, and triage data to assess and share scientific evidence on vaccine effectiveness among population groups.[1]

The pilot phase of this project for COVID-19 vaccination resulted in improved completeness of vaccine administration data, providing reports on 86 million new vaccine doses that otherwise would have been missed and increasing reporting on the number of individuals with at least 1 dose by 62 percent, the number of individuals completing the primary series by 74 percent, and the number of individuals completing the primary series and 1 booster dose by 136 percent.

This technology directly supports efficient data analysis of large volumes of vaccination data in an expedited timeframe. The analyzed data is used to provide feedback to the jurisdictions on their current immunization program and establish a national view of immunization coverage for various vaccines. Adoption of this technology will reduce routine immunization reporting burden for the jurisdictions every quarter by allowing jurisdictions to report only new vaccination events instead of cumulative reporting. Furthermore, these data could be further analyzed by linking de-identified data across various other data streams, such as laboratory test results and epidemiologic case reporting utilizing the same technology, providing a more comprehensive data picture for an individual.

[1] Relative Effectiveness of Coronavirus Disease 2019 (COVID-19) Vaccination and Booster Dose Combinations Among 18.9 Million Vaccinated Adults During the Early Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Omicron Period—United States, 1 January 2022 to 31 March 2022 | Clinical Infectious Diseases | Oxford Academic (oup.com)

91. What is the rationale for CDC sole sourcing a technical capability that is available for competition in the general health data industry?

Response:
The original contract of this technology was awarded through limited competition by HHS and OWS for COVID-19 immunization data. As stated above, CDC expanded the scope to include de-identified routine immunization data.

This technical solution of PPRL is vendor proprietary and sharing of this technical capability between different vendors is not possible. There are 11 jurisdictions who have already implemented this technology, 12 jurisdictions have signed up for implementation, and more are in the pipeline for adoption. Transitioning to a different vendor would result in the need to re-implement new technology and re-do the work, resulting in significant additional cost and time burden for jurisdictional partners and the U.S. government.

The PPRL IDs are unique to each vendor and cannot be compared or linked between two vendor solutions for the same individual. Adoption of an open-source solution will add significant burden to the government to manage an end-to-end solution/service that requires specific expertise, requires initial technical and ongoing support, and is resource intensive to stand up and maintain. Open-source solutions will continue to require a third

party honest brokering service to ensure linkage services are done in a privacy preserved manner.

The U.S. government will continue to assess the market for necessary advances in industry technology and promote open competition in the future as appropriate.

92. Does CDC have plans to reevaluate this partnership and possibly consider working with multiple technology providers to increase the ability to get data which is prohibitive under the current structure?

Response:
CDC continues to conduct market research to be familiar with the latest trends in this technology. Utilizing the original market research effort and competition effort from the award issued in November 2020 along with independent research, several industry partners were identified. These industry partners were again contacted in February 2023 to provide an assessment of the perceived challenges of transitioning from one vendor to another. Based on the feedback, it was concluded that each vendor offers proprietary solutions that are not easily integrated and transferable.

Submitted by Rep. Mark Pocan

Heart Transplant Selection Criteria Oversight

93. In 2018, the United Network for Organ Sharing (UNOS) made significant changes to heart transplant selection criteria to reduce waitlist times, among other reasons. How is HRSA monitoring and evaluating long-term changes in both clinical outcomes and quality of life post-transplant? And if HRSA determines that adjustments are necessary to improve patient outcomes while maintaining shorter wait times, how will HRSA work with UNOS to make those adjustments?

Response:
The Organ Procurement Transplantation Network (OTPN) develops and implements policies approved by the OPTN Board of Directors. They are required to collect data, monitor, and report on new policies and policy changes at various intervals post-implementation. The OPTN issued 4-month, 1-year, 2-year, and 3-year post-implementation reports following the 2018 changes to adult heart allocation policy. They will also continue to monitor and report issue reports at the end of years 4 and 5.

The 3-year report is the most recent report and is titled Three-Year Monitoring of Heart Allocation Proposal to Modify the Heart Allocation System. These reports contain data on clinical outcomes comparing pre- and post-implementation results. HRSA reviews OPTN post-implementation monitoring reports. If these reports reflect that trends are not progressing towards stated goals, then the OPTN Committee will evaluate for additional policy changes.

Maximus

94. The National Labor Relations Board is currently investigating a charge filed by the Communications Workers of America against a CMS call service contractor, Maximus, alleging that Maximus illegally offered workers a bonus for reporting to work while a strike was ongoing in four states last November. Did CMS compensate Maximus for those bonuses? And if so, what will happen if the NLRB finds merit to the charges, which would mean that CMS had spent taxpayer money on illegal union-busting?

Response:
CMS will continue to monitor the established clauses in its contract and be diligent in ensuring that the contact center vendor is in compliance with all contractual terms, Federal Rules and Regulations set forth in the FAR, any Executive Orders, and the Service Contract Act (SCA), which governs this contract.

Submitted by Rep. Bonnie Watson Coleman

Contraceptive Desert Study
The Consolidated Appropriations Act, 2023 (H.R. 2617) included report language requesting the Department of Health and Human Services study contraceptive deserts and the extent to which Federal policy changes can improve access. The critical information gathered by HHS as part of this study will help identify where and how policy changes can improve access to all forms of contraception for the estimated 19 million women in need of publicly funded contraception who live in contraceptive deserts defined as counties in which there is no reasonable access to the full range of contraceptive options. This is an issue of particular importance following the Supreme Court ruling in Dobbs and one which disproportionately impacts low-income people and people of color since they are more likely to live in contraceptive deserts.

95. Secretary Becerra, the report, along with its recommendations is due to be completed within 180 days of enactment. Can you report on the progress your agency has made towards completing this report?

Response:
OASH and ASPE are prioritizing completion of the report on contraceptive deserts.

Cardiovascular Disease (CVD)
The Committee report language that accompanied the Consolidated Appropriations Act of 2023 included an acknowledgement of the growing prevalence and severe economic burden of cardiovascular disease (CVD) in the US as well as health plans' prohibitive utilization management practices imposed on patients attempting to access modern biological CVD treatments. The Committee requested HHS develop a report, which focus on both the challenges facing providers and patients to accessing modern biological CVD treatments and the healthcare costs incurred related to postponed, delayed, or suboptimal treatments associated with CVD, within 180 days of the bill's enactment (no later than June 27, 2023).

96. Given the importance of reducing the burden of CVD among the millions of Americans with CVD, could you please confirm the Department is prioritizing the requested analysis and is on track to deliver the report prior to the deadline?

Response:
ASPE agrees that reducing the burden of CVD is important and we are working expeditiously to analyze the requested information. We are developing a plan for the report, including analyses of data that address the topics of interest expressed in the Committee's request. We have reviewed background materials and are at work on the report.

Maternal Mental Health
Suicide and overdose are the leading cause of maternal mortality in the United States. African American women are *three times* more likely to die from a pregnancy related complication than white mothers. In New Jersey, 101,000 moms give birth every year and it is estimated that

20,000 of them will suffer from a maternal mental health condition. Congress has continued to increase funding for the HRSA Screening and Treatment for Maternal Mental Health and Substance Use Disorders program, but HRSA has been slow to expand the increases to new states. New Jersey was one of the states that applied for a grant but never received one due to limited funding.

97. What is HRSA doing to expand the number of states who receive a grant through this program? How will the FY24 budget prioritize maternal mortality, and early interventions especially in the cases of maternal mental health conditions?

Response:

HRSA is expanding targeted investments such as the Screening and Treatment for Maternal Mental Health and Substance Use Disorder (MMHSUD) program. With the increase in funding provided in FY 2023, HRSA recently released a Notice of Funding Opportunity to expand the program to up to 14 total states, tribes, and tribal organizations. The reauthorization of the MMHSUD program included in the Consolidated Appropriations Act, 2023 will support an increase of seven additional states or tribes, doubling the number of programs HRSA currently supports. The FY 2024 Budget proposes to continue funding to support this expanded program.
HRSA is also expanding support for the National Maternal Mental Health Hotline with increased funding provided in FY 2023 to promote widespread national awareness and use of the hotline. The hotline is available 24/7, 365 days a year, and provides free, confidential emotional support, information, and referrals to any pregnant and postpartum mothers facing mental health challenges and their loved ones. The FY 2024 Budget continues this important work.

The FY 2024 Budget also continues to prioritize maternal health by including funding to launch new maternal health programs, including projects such as:

- $55 million for Addressing Emerging Issues and Social Determinants of Maternal Health. Community-based organizations will use funds to support projects aimed at reducing maternal mortality and adverse maternal health outcomes.
- $25 million for Growing and Diversifying the Doula Workforce to develop and/or expand programs to recruit doula candidates and then employ them as doulas in the communities, ultimately supporting improved birth outcomes.

The FY 2024 Budget would also expand current initiatives that support maternal health including the Healthy Start program ($185 million, $40 million above FY 2023 enacted) which supports community-based strategies to reduce racial and ethnic disparities in infant and maternal mortality and improve perinatal outcomes for pregnant and postpartum individuals and their children. The budget also expands the Integrated Services for Pregnant and Postpartum Women program in FY 2024 to $25 million ($15 million above FY 2023 enacted) to support innovative maternal health programs that coordinate services and supports across care providers to deliver care for pregnant and postpartum people.

The FY 2024 Budget request also continues support for critical maternal health programs including the Title V Maternal and Child health Block Grant program, the Innovation for Maternal Health or AIM program ($15.3 million, level with FY 2023 enacted) and the State Maternal Health Innovation Grants ($55 million, level with FY 2023 enacted).

OASH/OWH efforts to prioritize maternal mortality in FY 2024 include advancing the Maternal Mental Health Task Force co-led by OASH/OWH and SAMHSA. OASH/OWH will launch the Postpartum Depression Campaign in May 2023 and will continue to monitor outcomes in FY 2024. Additionally, the Maternal Morbidity and Mortality Data & Analysis Initiative includes a focus on maternal mental health. The FY 2024 Budget also includes $10 million in the HHS Office of Minority Health for Achieving Equitable Maternal Health Outcomes Initiative.

Expanding Access to Midwives and Birth Centers

America continues to rank far behind almost all other developed countries in birth outcomes for both mothers and babies. We have unacceptably high rates of maternal and infant mortality, preterm births, and severe complications of pregnancy, and these tragedies all disproportionately impact communities of color and rural areas. Compounding these dire statistics is a mounting shortage of both trained maternity care providers and hospital birthing units, creating "maternity care deserts" that impact almost a third of all US counties, and leave a growing number of rural and underserved communities with no access to maternity care.

Midwives and birth centers are widely cited as a critical part of the solution to addressing these problems in our maternity care system. However, despite decades of compelling research supporting midwives and birth centers as viable and cost-effective solutions to this nation's maternity care crises, midwives and birth centers are underutilized in this country. Midwives currently attend less than 10 percent of all births in the US, compared to countries like Great Britain, Sweden, Norway and France where midwives oversee more than half of all maternity care. And even though birth center births have increased by 17.5% since 2019, only 255 of 3143 US counties currently have birth centers (March of Dimes, 2022).

98. What is HHS doing to support midwifery education and what funding do you need to expand the numbers of midwives being trained in this country?

Response:

The FY 2024 President's Budget proposes $25 million, an increase of $17 million over FY 2023 for the Maternity Care Nursing Workforce Expansion Program, to increase the number of qualified nurses in the primary care workforce by funding training enhancements and practice of advanced nurses and traineeships for nursing students.

HRSA supports midwifery education through the following programs:

- The National Health Service Corps (NHSC) Scholarship Program supports students pursuing a postgraduate degree or postgraduate certificate from a school or program in nurse midwifery education in return for a commitment to provide services in a Health Professional Shortage Area (HPSA).

- The NHSC's Loan Repayment Programs (LRPs) also work to match certified nurse-midwives with communities across the country with the greatest need for their services. In FY 2022, the NHSC SP and LRPs supported 271 certified nurse-midwives fulfilling service commitments in high-need communities.
- The Scholarships for Disadvantaged Students Program promotes diversity among the health professions by providing awards to eligible health professions and nursing schools to provide scholarships to students from disadvantaged backgrounds who have a demonstrated financial need and are enrolled full-time in a health profession program or nursing program. In FY 2023, the SDS program received $5 million to educate both nursing and non-nursing midwives to address the national shortage of maternity care providers, and specifically to address the lack of diversity in the maternity care workforce.
- The Nurse Corps Loan Repayment Program and Nurse Corps Scholarship Program also support Nurse Midwives.

99. What has HHS done to increase access to birth centers in rural and underserved communities?

Response:

HRSA has partnered with agencies across the government to develop and implement the White House Maternal Health Blueprint. HRSA is working with our agency partners on the need to expand access to care particularly in rural and underserved communities. Examples of HRSA specific initiatives to support improving access to maternal care include the HRSA-funded Rural Maternity and Obstetrics Management Strategies (RMOMS) program to build networks to coordinate the continuum of care with the goal of increasing access to care for women in rural communities. HRSA also recently announced a funding opportunity to support health centers to improve maternal health and reduce racial and ethnic maternal health disparities by partnering with patients and the community to develop and pilot innovative, patient-centered, scalable models of care delivery that address both the clinical and health-related social needs of health center patients at highest risk of maternal morbidity and mortality.

Submitted by Rep. Julia Letlow

CMS Medicare Advantage Plan
Secretary Becerra, the calendar year (CY) 2023 Advance Notice for Medicare Advantage contained significant payment changes that have been reported will have an adverse impact on premiums and benefits for beneficiaries who choose to enroll in an MA plan.

I am very concerned about the impact of these changes on the more than 452,000 Medicare beneficiaries in Louisiana who are in MA. According to reports, because of these changes, plans will have less resources from your CMS and therefore will have to make a terrible choice between increasing beneficiary premiums, reducing supplemental benefits, such as dental coverage, or doing both. Some estimates that I have seen indicate that MA premiums could rise by as much as $45 per month for some individuals.

Specifically, I am concerned that the outlook for my home state of Louisiana is worse: Louisiana is estimated to be the 3rd highest in the nation in terms of the related reductions of $62.35 per member per month or a total of $748.26 per year.

100. How do you propose that beneficiaries on fixed incomes find another $62 a month to pay for an increase in premiums at a time when they are facing unprecedented inflation and high costs of everything?

101. How do you answer the beneficiaries who are calling me worried that the Biden Administration is cutting their Medicare and taking away much-needed services, like transportation, meals, and dental care?

102. Medicare beneficiaries, physicians, nurses, hospitals, health systems, health plans, and others in the health care field all have expressed grave concern to me about the negative impact of CMS's proposed rate and methodology changes for CY 2024 Medicare Advantage plans. The changes are vast and could increase premiums and reduce benefits and there was only a 30 day comment period. Given the significant concern and short time frame in which stakeholders had to assess impact, why wouldn't CMS step back and delay any such changes for a year, allowing a more full and fair assessment and collaboration between all the affected parties? What harm will come in waiting, while significant harm will come if you proceed.

Response to Questions 100-102
Core Medicare benefits, such as hospital care and physician visits, are guaranteed in Medicare Advantage like they are in Medicare fee-for-service. Regardless of the payment update, Medicare Advantage plans must cover those core Medicare benefits. We expect Medicare beneficiaries to continue to have a broad array of choices of MA plans with supplemental benefits. CMS anticipates stable premiums and benefits for beneficiaries in 2024, as seen previously in years with comparable updates. Historical experience shows plans compete in this highly competitive market to keep premiums down and maintain supplemental benefit levels, with beneficiary choice remaining strong.

As required by law, CMS adjusts payments to health plans offering MA to reflect the expected health care costs of enrollees based on health status and demographic characteristics through a process known as "risk adjustment." This ensures CMS pays more for enrollees with greater health care needs and reduces incentives for plans to favor healthier beneficiaries. CMS routinely makes updates to the MA risk adjustment model to reflect more recent utilization and cost patterns and to ensure MA payments accurately reflect the costs of care for MA enrollees. In February, CMS proposed routine technical updates to improve the accuracy of MA payments in the 2024 Advance Notice. CMS received public feedback on these proposals, and will take this feedback into account when finalizing the 2024 Rate Announcement.

(Lead in for Q's 103-105) Medicare Advantage Advanced Notice
Secretary Becerra, on February 1, 2023, your agency released a proposed rule called the 2024 Medicare Advantage Advance Notice. In it, your administration claims you will be giving the program a 1% pay bump yet every other expert analysis is saying it's a payment cut including doctors, patient groups and insurers.

103. Secretary Becerra, what was the average premium for MA beneficiaries this year?

104. Do you know what some experts are saying the average cost of a MA plan in my state could increase to if this rule you released is finalized?

Response to Questions 103 and 104:
CMS projects the average premium for 2023 Medicare Advantage plans is $18 per month. CMS anticipates stable premiums and benefits for beneficiaries in 2024, as seen previously in years with comparable updates. For example, in 2015, MA plans experienced a payment increase of 0.4 percent compared to 2014. Following those payment updates, the MA market remained strong and continued to grow. Historical experience shows plans compete in this highly competitive market to keep premiums down and maintain supplemental benefit levels, with beneficiary choice remaining strong.

105. Secretary Becerra, I have a letter from the AMA where they are saying there was no transparency provided with the massive changes you are proposing in this rule. In fact, they are concerned about patient care. Who did your agency consult when deciding on a rule that everyone else says is cutting the Medicare Advantage program?

Response:
In February, CMS proposed routine technical updates to improve the accuracy of MA payments in the 2024 Advance Notice. As required by law, CMS sought public comment on the CY 2024 Advance Notice and will take this feedback into account when finalizing the Rate Announcement. CMS received a large number of comments in response to the CY 2024 Advance Notice and appreciates the commenters thoughts and input regarding payments under the MA program.

106. What has HHS done to increase access to birth centers in rural and underserved communities?

Response:
HRSA has partnered with agencies across the government to develop and implement the White House Maternal Health Blueprint. While HRSA does not generally have access to capital funding for maternal health initiatives, HRSA is working with our agency partners on the need to expand access to care particularly in rural and underserved communities. Examples of HRSA specific initiatives to support improving access to maternal care include the HRSA-funded Rural Maternity and Obstetrics Management Strategies (RMOMS) program to build networks to coordinate the continuum of care with the goal of increasing access to care for women in rural communities. HRSA also recently announced a funding opportunity to support health centers to improve maternal health and reduce racial and ethnic maternal health disparities by partnering with patients and the community to develop and pilot innovative, patient-centered, scalable models of care delivery that address both the clinical and health-related social needs of health center patients at highest risk of maternal morbidity and mortality.

107. In the RMOMs program, how many competitive applications were considered highly qualified and scored exceedingly well, but did not get funded, and how much funding would it take to reach those that missed out on the grant opportunities?

Response:
HRSA is grateful for Congress' support for the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program. The number of competitive applications varies from year to year As the need continues to increase in rural communities, it is anticipated that additional resources may be needed to meet the demand. In 2023, HRSA will support 7 continuing awards and 2 new awards. The 2024 Budget includes $10.4 million for RMOMS, an increase of $2.4 million above the FY 2023 Enacted level.

108. Data shows that people with economic insecurity are at increased risk for developing post-traumatic stress disorder (PTSD), a mental disorder that can result in serious functional impairment that substantially interferes with - or limits - one or more major life activities. Individuals in high-poverty areas experience worse

mental health outcomes than those in low-poverty areas, and studies indicate that socio-demographic variables - including race, gender, income level, amongst other factors - can impact medical care delivery, further exacerbating disparities. To prioritize health equity for Medicaid and dually-eligible beneficiaries who experience PTSD, we must first understand what current disparities and impacts of existing policies these individuals face. What is HHS doing to increase rates of equitable screening of and treatment for individuals experiencing PTSD?

Response:

Many of SAMHSA's programs identify and serve individuals with PTSD. For example, Community Mental Health Services Block Grant (MHBG) program funds are available to states to provide comprehensive, community-based mental health services to adults with serious mental illnesses (SMI) and to children with serious emotional disturbances (SED). States may use MHBG funds for mental health services to assist individuals with SMI or SED with PTSD. Additionally, the Certified Community Behavioral Health Clinic (CCBHC) program, which is administered in partnership with the CMS and ASPE, is designed to ensure equitable access to comprehensive, coordinated behavioral health care. All CCBHCs are required to train staff who come into contact with the people they serve in trauma-informed care and CCBHCs are required to conduct an inclusive assessment of patients which includes trauma-history as a part of the evaluation and diagnosis process.

Another example of HHS efforts to address children's traumatic stress includes SAMHSA's National Child Traumatic Stress Network (NCTSN). NCTSN creates access to services that address child trauma and plays and important role in improving practice related to child trauma, including addressing PTSD. Since its creation, NCTSN has grown from a collaborative network of 17 funded sites to 184 funded sites, and over 200 previously funded affiliate centers located nationwide in universities, hospitals, and a range of diverse community-based organizations with thousands of national and local partners and has provided training on best practices and other aspects of child trauma to over 2 million participants throughout the country.

SAMHSA also funds several Centers of Excellence (COEs) in Behavioral Health for the following populations: African Americans; Asian American, Native Hawaiian and Pacific Islanders (AANHPI); Lesbian, Gay, Bisexual, Transgender, Queer, Intersex +; and a new Hispanic/Latino COE (funding announcement was recently posted, closes on May 23, 2023). These COEs provide training and technical assistance for behavioral health providers serving these populations, which can include screening and treatment for PTSD.

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
FY 2024 Budget Request for Health and Human Services
March 28, 2023

Questions for the Record
Secretary Xavier Becerra

Submitted by Rep. Steny Hoyer

1. How have the updated Head Start Program Performance Standards increased the quality of the Head Start program?

Response:
The Head Start Program Performance Standards (HSPPS) define standards and minimum requirements for the entire range of Head Start services and serve as the foundation for Head Start's mission to deliver comprehensive, high-quality, individualized services. The last reauthorization of Head Start in 2007 contained many requirements intended to drive quality improvement in Head Start programs, such as higher qualification requirements for staff and enhanced requirements for staff training and professional development, among many others.

In 2016, ACF published the revised HSPPS to strengthen the outcomes of the children and families Head Start serves, reflect best practices and the latest research on early childhood development and brain science, and to provide a clear road map for current and prospective grant recipients to support high-quality Head Start services. The revisions also promoted better use of data to track progress and reach goals across program areas, facilitated continuous quality improvement efforts, reduced burden on programs and improved regulatory clarity and transparency. OHS further revised, through regulation, the section of the HSPPS on the Designation Renewal System (DRS). The changes made were intended to maintain strong accountability for Head Start programs, while also promoting better use of data from monitoring for quality improvement purposes. OHS believes the intentions of the HSPPS revisions are being accomplished by Head Start programs.

A significant change to the HSPPS was requiring programs, over time, to offer longer service duration of Head Start's high-quality services, which research links to stronger child outcomes. Prior to the 2016 overhaul of the HSPPS, programs provided as little as 448 hours of service per year, less than half of the required annual hours put into place in the 2016 final rule (1,020 hours). Furthermore, prior to the 2016 final rule, most programs were operating below 1,020 hours of annual service for all of their center-based

slots. Programs increased their program hours in the years that followed, including through congressional investments. In FY 2022, about 500,000 children, or 81 percent of all children in center-based Head Start preschool programs, were funded to receive at least 1,020 hours (similar to the number of hours a typical school year provides) of services each program year)

The HSPPS also put into regulation the requirement in the Head Start Act that programs use the Head Start Early Learning and Outcomes Framework, which provides strategies to deliver high-quality learning. Additionally, the HSPPS codified strategies for multi-language learners, including recognizing bilingualism and biliteracy as strengths, implementing research-based teaching practices that support their development, conducting developmental assessments in the child's dominant language, and supporting the development of the home language for dual language learners if staff do not speak the language spoken at the child's home (such as having culturally and linguistically appropriate materials available or identifying volunteers who speak the same language as the child.) The HSPPS has also increased programs' focus on improving mental health for children, families, and staff. Finally, the HSPPS revisions have promoted a stronger focus on child health and safety, including environmental safety for programs.

2. Please share more information on the accountability and potential recall process for Head Start programs. What are the barometers of success in this program? Which metrics have been most helpful in evaluating the success/failure of individual programs? What constitutes a "failing" facility? If the desired results are not being achieved, what is the oversight process to begin a performance improvement plan?

Response:
OHS uses the Head Start Monitoring System to measure the performance and accountability of Head Start programs across the country. OHS assesses grant recipient compliance with the HSPPS and the Head Start Act. In particular, the HSPPS sets the standards of quality and compliance for programs. The Head Start Monitoring System gives OHS a multi-year perspective on grant recipient operations with a focus on health and safety, performance, progress, and compliance. It also provides grant recipients with opportunities for continuous improvement.

DRS is the system that determines which programs receive 5-year grants non-competitively and which programs must compete for an additional 5-year cycle of grant funding. The DRS assesses programs on a set of seven conditions to determine if the program is successfully providing high-quality and comprehensive services and in turn will receive another 5-year grant non-competitively, or whether the program must compete for another 5-year grant. If a program meets one of the seven DRS conditions, it is required to compete for on-going funding. Some of the conditions the DRS evaluates programs on include classroom quality, fiscal soundness, licensing status, good standing with other federal programs, and whether the program has deficiencies (as defined in the Head Start Act.) The DRS competitive process, which was included in the Head Start reauthorization in 2007, was initially over four years from 2012 to 2016. As a part of that process 453 grants (32 percent) were designated for competition, leading to one-fifth of

those grants being awarded to another agency Over the course of the implementation of DRS, OHS has issued more than 900 Notice of Funding Opportunity Announcements.

Finally, the national and regional training and technical assistance (TTA) systems provide support for all Head Start programs on all aspects of service delivery. These robust systems incorporate the latest research on child development across a variety of TTA supports for programs, to promote best practices in early care and education service delivery.

a. What are the barometers of success in this program?

Response:
Key measures for success of Head Start programs include positive child and family outcomes at the end of one or more programs years in Head Start (i.e., child health, development and education, economic stability, and self-sufficiency), staff development and strong fiscal management and oversight.

In its more than 50 years of service, OHS has continued to be a national laboratory for the early care and education field. Other programs, including many states, have adopted OHS standards and strategies to ensure high-quality teaching and other services, serving as a testament to the high quality and success of the standards. A large body of research indicates that Head Start children and families have experienced long and short-term benefits as a result of Head Start programs.[1]

b. Which metrics have been most helpful in evaluating the success/failure of individual programs?

Response:
OHS notes two metrics to evaluate the success and progress of individual programs, including an observational tool in monitoring to assess the quality of teacher-child interaction and requirements in the HSPPS standards related to health and safety.

First, to assess the quality of classroom environments and teacher-child interactions in center-based preschool classrooms, as required by the Head Start Act, OHS uses the Classroom Assessment Scoring System (CLASS®) as part of OHS monitoring. CLASS® is a research-based observational tool that measures three domains of teacher-child interactions that support children's learning and development: Emotional Support, Classroom Organization, and Instructional Support. During the years in which OHS has used CLASS for monitoring purposes, programs have greatly increased their focus on and made improvements in the quality of interactions in classrooms. During other monitoring reviews, OHS

[1] Carr, Robert C.; Burchinal, Margaret R.; and Vernon-Feagans, Lynne. EdWorkingPaper No. 23-740. Annanburg Brown University. March 2023.; Garces, Eliana, et al. "Longer Term Effects of Head Start." National Bureau of Economic Research Working Paper Series, No. 8054, 2000, https://doi.org/10.3386/w8054.; Partika, Anne; Johnson, Anna D.; Phillips, Deborah A.; and the Tulsa SEED Study Team. Children and Youth Services Review. 2023; 148: 106857.; Schanzenbach, Diane Whitmore, and Lauren Bauer. "The Long-Term Impact of the Head Start Program." Brookings, Brookings, 9 Mar. 2022, https://www.brookings.edu/research/the-long-term-impact-of-the-head-start-program/.

assesses programmatic efforts across a wide range of the HSPPS, including program leadership, staff qualifications and professional development, and services for children and families. This review process identifies areas where programs are most in need of improvement. Finally, OHS collects data annually from programs through the Program Information Report (PIR), which provides additional insights into how programs are performing and helps OHS to identify areas for additional support or TTA to programs.

Second, the HSPPS outline various health and safety standards with which programs must comply, including requirements related to oral health, nutrition, mental health, child mental health and social emotional well-being, and safety practices. For example, the HSPPS specify the standards for facilities where children are served, the training and background checks staff must have, hygiene practices, and requirements for supervision of children. Programs that do not comply with these standards are issued correction actions or deficiencies, with specified timelines for addressing.

c. What constitutes a "failing" facility?

Response:
OHS identifies programs in need of support and improvement through the accountability systems mentioned throughout the responses here. Programs use data collection, self-assessments, and annual audits to provide information about performance. Ongoing oversight by governing bodies and federal staff provide insight to program quality and which programs need support to improve quality. The monitoring system gathers information through on-site reviews. Finally, the DRS determines which programs are not providing high-quality and comprehensive services and therefore will be required to enter open competition for another 5-year grant.

d. If the desired results are not being achieved, what is the oversight process to begin a performance improvement plan?

Response:
All Head Start programs must collect and analyze data to inform ongoing quality improvement of their programs. They also must conduct annual self-assessment and ongoing monitoring. These requirements help ensure that governing boards have program performance and compliance information to use for oversight.

When programs receive a finding through OHS monitoring and oversight, they are required to correct the issue according to the timeframe set in the Head Start Act. The training and technical assistance system assists grant recipients in getting to compliance and with continuous quality improvement. As required by the Head Start Act, OHS conducts follow up reviews to confirm correction of any monitoring or oversight findings.

3. Overall, how is HHS ensuring that Head Start kids are being taught/served well and that federal dollars spent on this program are being put to good use? What is HHS doing to hold Head Start to a standard of success?

Response:

As mentioned in the previous responses, OHS employs a robust system to ensure federal Head Start dollars are being well spent and programs comply with the HSPPS, statutory requirements of the Head Start Act, and other federal laws and regulations. All Head Start grant recipients receive an on-site monitoring review every 3 years to determine if recipients meet all fiscal, classroom instruction, and comprehensive services standards. Local Head Start programs must conduct annual audits and follow the Uniform Guidance as issued by OMB, which applies to all recipients of federal grant funding. In addition, Head Start grant recipients are subject to improper payment reviews. OHS provides TTA based on current research to continuously improve services and ensure that programs deliver high quality, comprehensive services to children and families with the greatest needs.

WEDNESDAY, MARCH 29, 2023.

ADDRESSING THE CHALLENGES OF RURAL AMERICA

WITNESSES

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LENITA JACOBS-SIMMONS, DEPUTY ASSISTANT SECRETARY, EMPLOYMENT AND TRAINING ADMINISTRATION, DEPARTMENT OF LABOR

CARRIE COCHRAN-McCLAIN, CHIEF POLICY OFFICER, NATIONAL RURAL HEALTH ASSOCIATION

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TEARSANEE C. DAVIS, D.N.P., DIRECTOR OF CLINICAL PROGRAMS AND STRATEGY, UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Mr. ADERHOLT. Good morning. Good to have everybody here today.

And this is a hearing that so many of us have been looking forward to, and I am glad to welcome everybody to the Labor, Health and Human Services Subcommittee of Appropriations. And glad to be here with my colleagues and thank all the witnesses for being here. Thanks for taking time out of your schedule to carve time to be here and testify and talk about some rural issues that are facing America.

I am proud to represent the Fourth Congressional District of Alabama. It is composed of about 14 counties in the northcentral part of the State of Alabama. It is actually the only congressional district in Alabama that actually borders three States. I border Mississippi, Tennessee, and also Georgia.

And my district has only 3 cities with a population over 20,000. I do encompass some areas that are a little bit more populated than that, but wholly contained within the district, there is only 3 over 20,000. I will also give you some perspective. I represent also part of Tuscaloosa, where the University of Alabama is, and that stadium holds well over 100,000 people.

So the Fourth District is a beautiful district, a diverse area, so much to offer. Great people, as I always say. But like many rural parts of our country, we face unique challenges, and I have found that many of our policy debates here in Washington sometimes overlook and sometimes disregard many of the challenges that rural Americans face.

Many of our colleagues also represent rural areas. Our districts have been changed by the limited access to healthcare, workforce

opportunities that are insufficient, and an education system that often is not able to meet the needs of students and especially those with disability. It is my intention this morning for the hearing that we will shed some light on some of these challenges that are faced by rural constituents and also present solutions to address them.

I would also like to start with some basic information. Just under 50 million Americans live in rural areas, making it just under 14 percent of the U.S. population. A typical rural district contains less than 10 percent of the typical urban county, with just over an average population of 20,000.

Access to healthcare, lack of specialty care and nursing shortages, high rates of opioid addiction, lack of facilities, and a disproportionate burden of chronic disease relative to the rest of the country are challenges that we face in rural communities. Due to the geographic isolation, we also face lack of access to many educational services, such as specialized services for children with disabilities and opportunities for higher education near home.

Unemployment in rural areas reached levels not seen since the Great Depression back in the 1930s, and even now, rural unemployment continues to be higher than the national average. We face challenges in developing and maintaining a high-skill workforce, with some areas' local economies reliant on a single industry or a single sector.

And while it is not the jurisdiction of this particular subcommittee, I would be remiss if I didn't take just a minute to mention the impact of limited access to broadband in rural America. And I know this is something that I share with my colleague from Wisconsin, Mr. Pocan, because we sat on the Agricultural Subcommittee of Appropriations, which that was an issue that we dealt with. And, oh, I remember even years ago that that was an issue there, and I am sure you still deal with it in rural Wisconsin as well.

But these areas represent a smaller customer base and more difficult terrain, and in addition, it is a lower adaption rate. And this results in higher prices and sometimes fewer options. As more services move online, especially in the education and healthcare sector, the gap between the urban and the rural areas for Internet service will only magnify the gap in access between urban and rural populations.

The departments covered by this subcommittee have several programs targeting rural populations. We have asked witnesses from each agency to come before us today to speak about the work that these programs are doing to address the challenges of our communities.

We also plan to hear from a second panel this morning of experts in the area of health, education, and workforce development, who can tell us more about the day-to-day challenges they face in delivering these important services to rural America.

Rural Americans are the backbone of this country. The small businesses, healthcare workers, and the educators of my great State of Alabama and many rural States continue to strive to better their communities despite the disparities that they do face. It is past time that we draw attention to these issues and certainly to take action.

I look forward to hearing from our speakers this morning about the programs that they are working on for rural America and see what they can do to help the committee serve all Americans.

I would like to now turn to the committee's ranking member, Ms. DeLauro, for any remarks that she would like to make. Ms. DeLauro.

Ms. DELAURO. Thank you very, very much, Mr. Chairman.

And I will keep the larger seat. Thank you very much. It is very comfortable.

Mr. ADERHOLT. Oh, good. Good. Yes.

Ms. DELAURO. So, thanks. Let us just get the important business out of the way.

But thank you so much for holding this hearing, and it is a critical and important hearing. I want to say a thank you to the agency officials and the outside experts that will join us today. Deputy Assistant Secretary Jacobs-Simmons, Associate Administrator Mr. Morris, Deputy Assistant Secretary Ruth Ryder, thank you so much for being with us.

And our second panel is Dr. Carrie Cochran-McClain, Dr. Tearsanee Davis, Ms. Laura Scheibe, and Dr. Brittany Hott. Thank you all very, very much for really helping us to lay out the issues that are critical and important in terms of rural America.

I look forward to taking a closer look at the programs in the Department of Labor, Health and Human Services, and Education that serve rural America. Our rural communities are integral to our national economy, to our history, to our identity. And about one-fifth of all Americans live in rural parts of our country. And unfortunately, the challenges these communities face are too often overlooked and poorly understood.

Addressing these enduring issues and advancing equity and opportunity for people in rural areas is something that I care deeply about. Connecticut has larger cities, but we do have very rural communities in our State as well.

Rural Americans are more likely to die of chronic illnesses than their urban counterparts. Rural communities have higher childhood and adult poverty rates, less access to healthcare, less likely to have health insurance.

In reviewing your testimony, I noted from two of our witnesses—Dr. Cochran-McClain and Associate Administrator Morris—that since 2010, 147 rural hospitals have closed. In the United States, the wealthiest nation in the world, millions of people cannot get the healthcare that they need. This is unacceptable.

Beyond healthcare, accessing childcare is more difficult in rural areas, as is accessing higher education and finding a job.

And to Dr. Hott, as you mention in your testimony, almost 17 percent of your rural students live below the poverty line, and nearly 15 percent qualify for special education services. Teachers lack the resources and the support that they need to do their job. On top of that, nearly 40 percent of rural students have inadequate Internet access at home.

And on top of all of this, rural families also struggle with the same challenges that all working class and underserved families face. They are living paycheck to paycheck, with jobs that do not pay them enough and costs that are too high. And they have not

seen their wages increase in years. They personally feel the impacts of our most urgent health crises, including the epidemics of opioid and substance use disorders, unconscionable rates of maternal mortality, chronic diseases, and mental health crises.

Because these obstacles impact the health and the financial well-being of our rural communities so intensely, this committee has made great strides to increase funding for the targeted programs that support the health, safety, and prosperity of rural areas. As you know, we increased funding for rural health programs that specifically address rural communities most pressing health crises. This includes the Rural Communities Opioid Response Program that fights substance use and provides often lifesaving support to people who are in desperate need.

We also created the Rural Emergency Hospitals Technical Assistance Program to better support rural hospitals and the people they serve. And to safeguard the health of women and mothers at a time when more than half of our rural counties lack hospital obstetric services and maternity mortality rates are simultaneously rising, we strengthened the Rural Maternity Obstetrics Management Program, RMOMS, to meet this critical, but unmet need in rural areas.

To increase the quality of and access to good educational opportunities for rural schools, we strengthened the Rural Education Achievement Program to increase the capacity of school districts to serve students. At the same time, we funded large formula grants that serve students everywhere, including rural students.

These include increases for the Title I grants that provide Department of Education funding to support low-income students in our Nation's public schools and the IDEA grants that support students with disabilities across the country, recognizing the great needs that rural communities in our country face with these areas.

To help workers and working families, we improved job training program grants that help workers in rural areas gain the skills they need to succeed in their jobs. The programs we fund in this bill have the capacity to drastically improve people's lives at every stage of their life, and we must do more.

We must find high-quality schools and childcare to grow opportunity for children and their families. We must support high-quality job training programs, apprenticeships to help workers reenter the workforce or find a better-paying job.

We must find the health programs that improve access to lifesaving healthcare and prevent or treat chronic illnesses. And as Dr. Tearsanee Davis makes clear, to make sure that healthcare is more accessible for families, we must increase our support for telehealth programs and other critical tools that keep people connected to and accessing the healthcare that they need.

As you mention in your testimony, Mr. Morris, Medicare fee-for-service telehealth visits went from less than 1 million in 2019 to more than 50 million in 2020. Investing in telehealth has never been more important. This is a key way we can continue to fight unacceptable and dangerous health disparities.

I am concerned that—I am concerned, take a moment, that rural communities will suffer the brunt of the impact if some of my—some, and I say some of my Republican colleagues move forward

with their plan to roll back spending to the 2022 level. As you might know, I received letters from agency heads, including the Department of Labor, Health and Human Services, and the Department of Education, outlining the impact that these cuts would have. Just let me run through some of the ones that would most impact rural children and families.

Cuts to the Department of Education would remove more than 100,000 teachers and service providers from classrooms serving low-income students and students with disabilities funded through Title I and IDEA grants.

Cuts to the Department of Labor would cut workforce training and development for 750,000 job seekers.

Cuts to HHS, Health and Human Services, would result in fewer opioid use disorder and medication-assisted treatment programs that millions of people in rural areas depend on.

These deeply impact rural families. Some people have questioned the approach to analyzing these cuts on the premise that the Republican majority will cut spending, but that these cuts might not be shared equally. The members of this subcommittee know well that if certain other programs are exempt from cuts, health and education programs that working families rely on would be cut by even more than the Office of Management and Budget's current estimates.

This subcommittee can and must do more to lift up our Nation's most vulnerable so that every person, no matter their background or zip code, has the opportunity to contribute, to succeed, and yes, to prosper. This means strengthening the programs we just spoke about, not gutting them.

Again, welcome, and I thank all of our witnesses this morning for testifying and obviously letting us know what more can be done.

Mr. Chairman, with that, I yield back.

Mr. ADERHOLT. Thank you.

At this time, I would like to introduce the panel that we will have.

We have Mr. Tom Morris. Tom Morris serves as the Associate Administrator for Rural Health Policy in the Health Resources and Services Administration of the U.S. Department of Health and Human Services. So, welcome.

We also have Ruth Ryder who is Deputy Assistant Secretary for the Office of Policy and Programs, Formula Grants, in the Office of Elementary and Secondary Education at the U.S. Department of Education.

And also we have Lenita Jacobs-Simmons, who has over 20 years experience in working at the Employment and Training Administration, serving in numerous positions. Currently, she is ETA's Deputy Assistant Secretary responsible for the Office of Unemployment Insurance, Trade Adjustment Assistance, Policy, Development, and Research, as well as oversight of regional operations.

So, at this time, you each have 5 minutes to deliver your remarks. But of course, your entire testimony will be included in full.

So, Mr. Morris, we will begin with you. Welcome. And I look forward to your testimony.

Mr. MORRIS. Chairman Aderholt, Ranking Member DeLauro, members of the subcommittee, thank you for the opportunity to testify before you today on behalf of the Health Resources and Services Administration and the Federal Office of Rural Health Policy.

I am pleased to be able to discuss with you our investments in rural health, our initiatives to support rural hospitals, expand access to healthcare services in rural communities, our response to the opioid epidemic, and our efforts to grow the rural health workforce.

I also want to thank you for the recently passed Consolidated Appropriations Act of 2023 and its support of rural health efforts.

HRSA is dedicated to providing equitable care to the Nation's highest-need communities. My office acts as the focal point for rural health activities within the U.S. Department of Health and Human Services, and we are charged in Section 711 of the Social Security Act with advising the Secretary on rural health issues. In addition, we also administer a range of grant programs that support rural communities.

I am pleased to be joined today by my colleagues from the Department of Labor and the Department of Education, and we are all working together as part of the administration's Rural Partners Network initiative to link rural communities to our respective grant funding and technical assistance resources.

You brought up the issue of rural hospitals. They play a critical role in the rural healthcare infrastructure, providing essential care to small, isolated rural communities. They are an essential part of the healthcare delivery system in rural communities, along with community health centers and rural health clinics.

Our research shows that rural hospitals face considerable challenges, including low patient volume, high fixed cost, a payer mix that is heavily dependent on Medicare and Medicaid. And unfortunately, as the ranking member noted, 147 rural hospitals have closed since 2010, and many more of these face a high degree of financial risk.

In light of these challenges, the administration's 2024 budget proposal includes $30,000,000 in additional support for these facilities. This includes $10,000,000 to help those rural hospitals that are at imminent risk of closure. Also features a broader $20,000,000 effort to expand services by providing start-up funding to help rural hospitals expand into new service areas such as pulmonary rehab, cardiac rehab, cancer services, and primary care.

The 2023 enacted budget continues the funding that allows us to provide TA to rural hospitals that are seeking conversion to a rural emergency hospital, the new provider type that Congress created in 2022 to address gaps in care. We are going to continue to support rural communities through the Rural Health Outreach Program, and we are also ramping up our efforts about the need to enhance obstetric and maternal care through the RMOMS program, as mentioned earlier.

Rural communities, as you know, continue to face challenges related to the opioid epidemic. Data from the Centers for Disease Control and Prevention show that rural residents age 25 to 44 are

at a higher overdose death rate than their urban counterparts. The impact of the crisis is obviously felt nationwide, but I think in rural communities it is felt particularly acutely because of geographic isolation and the lack of treatment facilities.

The fiscal year 2023 appropriation includes $145,000,000 for the Rural Communities Opioid Response Program, RCORP. This HRSA initiative targets funds directly to rural communities to help them implement their best ideas for how to focus on prevention, treatment, and recovery. The fiscal year 2024 President's budget would request $165,000,000 for this program to expand it even more.

The administration and Congress have both made expanding behavioral healthcare services a priority, and rural areas will benefit greatly from this push. The fiscal year 2024 President's budget includes a new proposal for $10,000,000 to expand behavioral health services in the Nation's rural health clinics with start-up funding to get those services started.

Maintaining and growing the workforce is also essential for ensuring access to care. Rural areas face a lot of challenges in terms of recruitment and retention. HRSA is the lead HHS agency to train the next generation of healthcare clinicians to work in rural and underserved areas, and we appreciate your support for those HRSA programs in the budget.

Research shows that if we can expose students to rural training during their practice, they are more likely to practice there. That is certainly true for family medicine. We have put that into practice with the Rural Residency Planning and Development Grants Program. This helps rural hospitals and communities create rural residencies, and so far we have been able to create new rural residencies in 32 States.

I want to thank you again for the opportunity to discuss all of these issues with you today, for your support of HRSA, HHS, and the Federal Office of Rural Health Policy. And I look forward to answering any questions you might have.

[The information follows:]

Statement by

Thomas Morris

Associate Administrator, Federal Office of Rural Health Policy

Health Resources and Services Administration
U.S. Department of Health and Human Services

Before the
Subcommittee on Labor, Health and Human Services,
Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives

Washington, D.C.
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Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to testify today on behalf of the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP). I am pleased to discuss with you our investments in rural health, our initiatives to support rural hospitals and expand access to health care services in rural communities, our response on the opioid epidemic, and our efforts to grow the rural workforce.

To begin, I want to thank members of this Subcommittee and your colleagues in the House of Representatives and the Senate for the bipartisan, bicameral efforts to support the health and well-being of rural communities. The funding provided by this Committee helps provide rural communities with valuable resources and support in their efforts to improve access to health care for rural individuals.

HRSA is dedicated to providing equitable health care to the nation's highest-need communities—we serve people who are geographically isolated and economically or medically vulnerable. HRSA programs support people with low incomes, people with HIV, pregnant people, children, parents, rural communities, transplant patients, and other communities in need, as well as the health workforce, health systems, and facilities that care for them.

FORHP serves as a focal point for rural health activities within the Department of Health and Human Services (HHS). Section 711 of the Social Security Act charges the Director of the Office of Rural Health Policy with advising the Secretary of HHS on the effects of current and proposed policies and regulations on rural communities. FORHP ensures that there is a

continual focus on improving access to care, ranging from the recruitment and retention of health care professionals to maintaining the economic viability of hospitals and Rural Health Clinics to supporting telehealth and other innovative practices in rural communities.

As I'll describe further in my testimony, rural areas face unique challenges such as hospital closures and workforce shortage that can lead to worse health outcomes. Across the Department of Health and Human Services, we are focused on a number of activities to strengthen rural health. This includes increasing health insurance coverage for rural Americans including a budget that proposes Medicaid-like coverage to individuals in States that have not adopted Medicaid expansion. Second, we are providing support to rural hospitals to ensure their long-term sustainability and ability to deliver essential services to their communities.

We are also working to expand the pipeline of the rural healthcare workforce and facilitating access to healthcare through approaches that use telehealth or outpatient clinics. Through the White House Strategy on Hunger, Nutrition, and Health, HHS is also taking measures to improve access to healthy and affordable food options, and expanding access to nutrition programs in rural communities. HHS is also working to integrate nutrition and health by, for example, testing coverage of services such as evidenced-based nutritional assistance and medically tailored meals through ground-breaking Medicaid section 1115 demonstration initiatives in Massachusetts, Oregon, Arizona, and Arkansas. HHS is also committed to supporting physical activity for all in order to combat diet-related diseases and to funding research to inform nutrition and food security policy. The Federal Office of Rural Health Policy office supports rural communities in many ways to improve healthcare access and ultimately to improve health.

Support for Rural Hospitals and Rural Health Infrastructure

Rural hospitals play a critical role in the rural health infrastructure, providing essential care to small, isolated, or remote communities. They help attract and retain health care providers and ensure access to emergency and inpatient medical services. The rural health care delivery system also includes community health centers and Rural Health Clinics, which ensure access to primary care. HRSA's National Health Service Corps, which provides loan repayment to clinicians in return for practicing in high-need areas, including many rural communities, is a vital workforce support in rural areas.

HRSA's work includes the Rural Health Research Center grant program, which focuses a significant part of its efforts on assessing hospital finance, quality, and access to care. This research shows a number of financial driving factors affecting rural hospital viability and the potential for additional closures, on top of the more than 147 rural hospitals that have closed since 2010. Rural hospitals tend to have low patient volume and high fixed costs, which creates ongoing financial challenges. The rural population represents 19 percent of the U.S. population and is spread across 86 percent of the landmass.[1] The payer mix for rural hospitals is also heavily dependent on Medicare and Medicaid with a higher proportion of uninsured patients and a smaller share of privately insured patients relative to urban hospitals. All of these factors create a challenging environment for rural hospitals and the communities they serve.

[1] https://www.hrsa.gov/rural-health/about-us/what-is-rural

Many rural communities also have higher rates of chronic disease, higher rates of poverty, higher rates of patients who are dually eligible for Medicare and Medicaid, lower life expectancy, and higher mortality rates.[2,3,4]

While the challenges facing health care services in rural communities are complicated, there are a number of efforts aimed at supporting rural health care, including hospitals, rural clinics, and community health centers. The establishment and recognition of Critical Access Hospitals (CAH) (1,358 hospitals), Sole Community Hospitals (472 hospitals, 408 of which are located in rural areas) and the Medicare Dependent Hospitals (171 hospitals, 145 of which are located in rural areas), all can play a key role in ensuring financial viability.[5,6,7] In addition, there are over 5,000 rural health clinics and 579 community health centers serving rural communities. A significant number of CAHs, other rural hospitals, and community health centers also benefit from participating in the 340B discount drug program.

While these safety net protections are critically important to ensure access to care for essential services in rural communities, challenges remain. HRSA is working to support hospitals and respond to these challenges in a variety of ways, including:

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[2] Rural Health Research Recap. Rural Health Research Gateway. "Rural Communities: Age, Income, and Health Status." November 2018, https://www.ruralhealthresearch.org/assets/2200-8536/rural-communities-age-income-health-status-recap.pdf

[3] McBride, T., Barker, A., Hernandez, E., Jost, E., Kemper, L., Mueller, K. RUPRI Center for Rural Health Policy Analysis. "An Insurance Profile of Rural America: Chartbook." October, 2022. https://rupri.public-health.uiowa.edu/publications/other/Rural%20Insurance%20Chartbook.pdf

[4] Holmes, M., Thompson, K. North Carolina Rural Health Research Program. "Risk Factors and Potentially Preventable Deaths in Rural Communities." October, 2019. https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/08/Risk-Factors-and-Potentially-Preventable-Deaths-in-Rural-Communities2.pdf

[5] Flex Monitoring Team. "Critical Access Hospital Locations List." Current as of January 23, 2023. https://www.flexmonitoring.org/critical-access-hospital-locations-list

[6] University of North Carolina Sheps Center for Health Services Research. "List of hospitals in the U.S. (2022)." Current as of January 1, 2022. https://www.shepscenter.unc.edu/list-of-hospitals-in-the-u-s-2022/

[7] The total numbers for each hospital type includes those that have dual designations (e.g., SCH/RRC). Seven Essential Access Community hospitals are included in the SCH count.

HRSA's Medicare Rural Hospital Flexibility Grant (Flex) Program

HRSA's targeted grant dollars provide technical support to rural hospitals and CAH through a number of grant programs, many of which focus on supporting rural communities and the hospitals that serve them. In FY 2023, under the Medicare Rural Hospital Flexibility Grant (Flex) Program, HRSA invested $27 million in state Flex programs to work with CAHs to improve quality, financial performance, and integration of emergency medical services. This includes HRSA's Medicare Beneficiary Quality Improvement Program, which encourages voluntary reporting and support for CAH quality improvement activities. In 2021, State Flex Programs reported that 71 percent of CAHs demonstrated improvement in at least one core quality measure because of a Flex Program intervention. By working with CAHs to voluntarily report quality data, we are ensuring that these facilities are aligned strategically with where the rest of rural hospitals are moving in terms of a national focus on quality of care. We are also seeing enhanced financial performance for CAHs that take part in Flex program activities.[8]

HRSA's Small Rural Hospital Improvement Program

The HRSA Small Rural Hospital Improvement Program provides $20.9 million a year to assist rural hospitals that have fewer than 50 beds and that face billing and operational challenges. The funds may be used to offset ongoing operational costs given the financial challenges facing rural facilities. This includes activities such as preparing for value-based purchasing programs, participation in Accountable Care Organizations or other shared savings programs, as well as

[8] Knocke, et al. "Impact of CAH Participation in Flex Financial and Operations Improvement Activities on Hospital Financial Indicators." April 2020. https://www.flexmonitoring.org/sites/flexmonitoring.umn.edu/files/media/fmt-pb-52-2020.pdf

aligning with the coding standards of the International Classification of Diseases (ICD)-10 coding standards. The ICD is a recognized system for coding diseases and health-related conditions, which is used for diagnostic and statistical purposes by healthcare providers and researchers.

FORHP also provides additional direct support to hospitals through targeted technical assistance programs. These programs offer assistance to rural hospitals especially those at medium to high financial risk, to improve financial and clinical operations. Technical assistance also focuses on assisting health care organizations in strengthening their foundation in key elements of value-based care, including quality, efficiency, patient experience, and patient safety.

HRSA's Delta Region Programs

We also know that rural communities and their hospitals in some areas such as the Mississippi Delta region face unique challenges that call for a more targeted approach. We are investing $27 million provided by Congress in FY 2023 to provide hospitals and communities in the Delta region with more targeted support to improve health care delivery. In coordination with the Delta Regional Authority, the Delta Region Community Health Systems Development Programs provide multi-year technical assistance to strengthen financial and clinical operations to keep hospitals financially viable and protect access to care. The Delta funding also provides resources to train local residents in critical areas such as coding and billing to support rural hospitals in meeting key performance indicators for financial improvement. The Delta States Rural Development Network Program provides grants that assist communities in the Delta region to address health care disparities.

HRSA Technical Assistance to Rural Hospitals

Congress created the Rural Emergency Hospital (REH) as a new designation for hospitals to be able to offer outpatient and emergency services but not inpatient services. REHs receive enhanced Medicare reimbursement for outpatient services and an additional, fixed, monthly payment to meet local community health needs. The creation of the REH designation provides rural communities with another option to maintain access to emergency care and other essential outpatient services if their hospital is at risk of closure. With appropriations support, HRSA is funding technical assistance to rural hospitals to assess whether the REH designation is a viable option for their community.

Rural Health Care Infrastructure

The President's FY 2024 Budget for HRSA builds on these efforts and requests $30 million for helping rural communities sustain their healthcare infrastructure.[9] This includes a new program to assist hospitals at that are at immediate risk of closure by linking these facilities to technical expertise to address financial and operational gaps. This can help to maintain access to care while also developing both immediate and long-term sustainability plans. The request would also provide support to help rural hospitals expand service lines in areas of need such as primary care or ancillary services such as cardiac and pulmonary rehabilitation, behavioral health, and cancer care. The intent would be to increase availability of services that are needed in the community while also reducing the incidence of local patients seeking that care in other areas.[10]

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[9] U.S. Department of Health and Human Services. (2022). FY 2024 Budget in Brief. Retrieved from https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf

[10] Centers for Medicare & Medicaid Services. (2020). Examining Rural Hospital Bypass for Inpatient Services. Retrieved from https://www.cms.gov/files/document/ruralhospitalbypassfinalreport.pdf

HHS' Participation in the Rural Partners Network

HHS is one of 20 Federal agencies and regional commissions that make up the Rural Partners Network (RPN). Led by the U.S. Department of Agriculture (USDA), RPN is a whole-of-government program that works to expand rural prosperity through job creation, infrastructure development, and community improvement. RPN currently supports 36 community networks in 10 states and Puerto Rico. All RPN community networks receive place-based, community economic development guidance in navigating federal programs, building relationships, and identifying community-driven solutions from local full-time, federal staff. RPN is also building out Rural.gov, a one-stop shop for all rural communities to access Federal resources. HHS is actively contributing to RPN by collaborating with USDA to schedule a series of webinars on HHS programs and resources that promotes the economic and social well-being of families, children, and communities. Additionally, HHS is providing detailed information on rural health-specific funding announcements hosted on Rural.Gov. and linking each RPN to their respective State Office of Rural Health.

Rural Community Health

Through the HRSA Rural Health Outreach grant programs, rural health organizations are able to access funding to support a range of health services, including preventive care, mental health services, and access to specialists. These programs are unique in that they provide funding that is tailored to specific community needs, recognizing that rural communities have different health challenges and priorities than their urban counterparts. This funding is critical for many rural health organizations, which often have limited financial resources and struggle to attract and

retain healthcare professionals. The impact of these programs is significant, in FY 2021 they ensured that more than 434,000 rural residents had access to the healthcare services they need to live healthy and productive lives.

Maternal Care and Rural Communities

Findings from the FORHP-funded University of Minnesota Rural Health Research Center have identified the continuing loss of rural hospital obstetric services and the impact of those service closures on rural communities. These studies have documented the loss of rural hospital obstetric (OB) services, particularly in communities of color across rural America, and noted that these loses contributed to more pre-term births and emergency deliveries.[11,12]

FORHP funds 10 awardees across nine states as part of the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program with a focus on sustaining or enhancing rural hospital OB services while also using a networked approach to link rural providers together coordinate OB services. The White House Blueprint for Addressing the Maternal Health Crisis aims to improve maternal health outcomes and reduce disparities in maternal health care. The Blueprint includes a focus on rural maternal health, recognizing the unique challenges faced by rural communities, such as limited access to care and provider shortages. Strategies to address these challenges include expanding telehealth services and increasing funding for rural health

[11] Rural Health Research Recap. Rural Health Research Gateway. "Rural Obstetric Services: Access, Workforce, and Impact." April 2019, https://www.ruralhealthresearch.org/recaps/8
[12] Rural Health Research Recap. Rural Health Research Gateway. "Maternal Health Disparities: An Intersection of Race and Rurality." October 2022, https://www.ruralhealthresearch.org/recaps/17

care providers. The FY 2024 President's Budget includes $10.4 million for RMOMS, $2.4 million above the 2023 Enacted level.

HRSA's Rural Opioids Communities Initiative

Rural communities continue to face significant challenges in responding to the opioid epidemic. According to the Centers for Disease Control and Prevention (CDC), rural areas experienced overdose death rates that surpassed urban rates for residents aged between 25-44 years old in 2020.[13] Further, the rate of deaths involving psychostimulants with misuse or abuse potential was 31 percent higher in rural counties (9.4 per 100,000 standard population) than in urban counties (7.2 per 100,000 standard population), and the rate of deaths involving natural and semisynthetic opioids was nearly 13 percent higher in rural counties than in urban counties.[14]

Addressing the opioid epidemic is a national effort, but it presents unique challenges in rural communities where there is less treatment infrastructure and ongoing concerns about stigma and how to link those affected by opioid use disorder and other substance use disorders to services that may not be available locally. Small remote rural communities continue to experience access challenges. 63.1 percent of all rural counties had at least one clinician with a Drug Enforcement Administration waiver, but more than half of small remote rural counties did not.[15]

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[13] Centers for Disease Control and Prevention. Rural-Urban Disparities in Drug Overdose Death Rates — United States, 1999–2019. MMWR Morb Mortal Wkly Rep 2022;71:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm7147a3

[14] Spencer MR, Garnett MF, Miniño AM. Urban–rural differences in drug overdose death rates, 2020. NCHS Data Brief, no 440. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:118601

[15] https://onlinelibrary.wiley.com/doi/10.1111/jrh.12569

Rural communities also face challenges in recruiting and retaining providers with the necessary training and education to treat individuals with opioid use disorder. More than 60 percent of Mental Health Professional Shortage Areas in the U.S. are located in rural areas.[16]

The FY 2023 appropriation includes $145 million for the Rural Communities Opioid Response Program (RCORP), which is an initiative created by HRSA to support treatment for and prevention of substance use disorder, with an emphasis on opioid use disorder, in rural communities. This program is a unique initiative as it is the only large-scale, targeted program focused specifically on addressing substance use disorder in rural communities affected by the opioid epidemic. Since the inception of the initiative, RCORP has received more than $500 million in appropriations, with additional grant awards anticipated in summer 2023. RCORP grant recipients have provided direct opioid use disorder/substance use disorder services and technical assistance across more than 1,800 rural counties spanning 47 states and two territories.

The RCORP initiative focuses on funding sustainable community-based grant programs and technical assistance specifically addressing prevention, treatment, and recovery services to address opioid use disorder/substance use disorder and the broader behavioral health care needs of individuals with, or at risk of, opioid use disorder/substance use disorder and other co-occurring mental health disorders. Through RCORP, grant recipients have the opportunity to address emergent behavioral health care needs within their rural communities. This can be achieved by enhancing their ability to establish and expand sustainable services through building their opioid use disorder/substance use disorder health care workforce through recruitment,

[16] HRSA. Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2023. Accessed March 16, 2023. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

retention, and training activities, increasing use of telehealth, purchasing and distributing life-saving naloxone, and building strong community partnerships. These efforts can help better provide a whole-of-community response to the continuing opioid use disorder/substance use disorder epidemic and also to leverage and coordinate with other local, state and federal resources. In FY 2021, the most recent full year of grantee reported outcomes, RCORP awardees provided direct services to more than 2 million rural individuals and ensured that more than 112,000 patients received medication-assisted treatment. The FY 2024 President's Budget includes $165 million to expand the RCORP initiative, an increase of $20 million over the FY 2023 enacted budget. This funding will allow HRSA to expand important substance use disorder services in rural communities by building the capacity of rural health organizations to establish, implement, and sustain new substance use disorder service lines in rural areas. Funding will allow for new awards to address psychostimulant misuse and to allow rural communities to address their immediate opioid use disorder/substance needs.

The FY 2024 President's Budget also includes $10 million to fund a new Behavioral Health Care Initiative which will provide support to Rural Health Clinics to expand access to behavioral health care services. Rural Health Clinics are key safety net providers for rural communities and this initiative will result in an increase in the number of rural residents who receive behavioral health care services, the number of behavioral health care professionals providing services in rural communities, and the number of Rural Health Clinics that are able to bill for and sustain behavioral health care services.

Rural Residency Planning and Development Program

Maintaining and growing the health care workforce is fundamental to providing access to high quality health care in rural areas. Rural areas have historically faced challenges attracting and retaining physicians and other providers. Data from HRSA's National Center for Health Workforce Analysis shows that while urban areas have 8.0 primary care physicians per 10,000 residents, that ratio drops to 5.2 in rural areas.[17] HRSA data also shows that 66 percent of the Primary Care Health Professional Shortage Areas are in rural areas.[18] Health Professional Shortage Areas can be geographic areas, populations, or facilities and have a shortage of primary, dental, or mental health care providers. Traditionally, physician residency training programs have been concentrated in urban areas. Research shows that spending more than half of training time in rural areas during family medicine residency is associated with an over five-fold increase in a physician's subsequent decision to practice in a rural area.[19]

HRSA is responding to this research and investing in new rural residency training through the Rural Residency Planning and Development (RRPD) Program. This program supports rural hospitals and communities through the creation and accreditation of a new residency program, at which point applicants then secure funding through Medicare, Medicaid, and other sources to support the training of the residents in perpetuity. This program leverages Medicare policy that allows rural hospitals to start new residency programs and is especially important with the

[17] Rural Health Information Hub. Rural Healthcare Workforce Topic Guide. "Per Capita Rates of Health Professionals – Selected Occupations" https://www.ruralhealthinfo.org/topics/health-care-workforce#characteristics
[18] HRSA. Designated Health Professional Shortage Areas Statistics, First Quarter of Fiscal Year 2023. Accessed March 16, 2023. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[19] Russell, DJ, et al. "Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice," Journal of Graduate Medical Education, August 2022

availability of new Medicare-funded physicians residency slots that hospitals can apply for in th coming years.

Since beginning in 2019, the RRPD Program has awarded over $44 million in grants to 58 organizations across 32 states. As of September 2022, award recipients have created 31 new accredited rural residency programs in family medicine, internal medicine, psychiatry, and general surgery. These programs are currently training 188 resident physicians and they will be training approximately 418 residents when fully enrolled.[20] That number will continue to grow as other award recipients continue their residency planning and development to prepare for their accreditation application.

The Consolidated Appropriations Act, 2023, (Act) continues and expands on our past efforts to support new rural residency training. The Act provided $12.5 million which will fund 15 new RRPD awards in FY 2023 and these projects are expected to create at least 165 new rural residency slots by 2029. The FY 2024 President's Budget includes $12.7 million to fund an additional 15 new awards and increased technical assistance.

HRSA's Teaching Health Center program also supports expanded community-based residency training in rural and underserved areas. The FY 2024 President's Budget extends and increases mandatory funding for Teaching Health Center Graduate Medical Education for three years, through FY 2026, to enhance support to community-based residency training. Building on the model of the RRPD program, HRSA is also funding Teaching Health Center Planning and

[20] Health Resources and Services Administration. (2023). FY 2024 Congressional Budget Justification. Retrieved from https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf

Development grants to help communities develop new accredited physician residency programs that provides a potential pathway toward developing a Teaching Health Center residency.

Health Centers, Teaching Health Centers, and the National Health Service Corps

HRSA's longstanding commitment to underserved and rural areas includes support for high-quality healthcare services like those provided by Health Centers and for health workforce programs that serve rural communities like the National Health Service Corps and Teaching Health Centers. Almost 600 Health Centers serve more than 9.5 million rural patients where they may be the only source of care for behavioral health, substance use treatment and oral health. The FY 2024 President's Budget proposes a pathway to double the Health Center Program funding with a critical three-year down payment on this goal. With these funds, HRSA will increase support for behavioral health services, expand health center operating hours, and support new health center locations.

Rural communities also benefit from HRSA's funding to train and support clinicians to practice in rural and underserved areas. The National Health Service Corps and Nurse Corps programs provide a lifeline to rural communities by providing loans and scholarships to clinicians in rural communities. Nearly 7,500 National Health Service Corps primary care and behavioral health providers, nurses, and dentists serve more than 7.8 million rural patients.

Telehealth

The pandemic has highlighted the important role telehealth plays in ensuring access to care for more specialized services that may not be available locally. The number of Medicare fee-for-

service (FFS) beneficiary telehealth visits increased in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020.[21] The extension of the Medicare telehealth flexibilities in the Consolidated Appropriations Act, 2023 will help to ensure continued access to telehealth services.[22]

HRSA plays a lead role in supporting telehealth through the Office for the Advancement of Telehealth and a number of its grant programs that focus on services and technical assistance in rural communities, hosting the Telehealth.HHS.gov hub, and funding a licensure portability program under which physician and psychology boards cooperate to reduce the burden for telehealth clinicians who have to apply for licensure in multiple states.

Conclusion

While rural communities continue to face persistent health care challenges, there is a growing availability of resources and support to expand access to quality care, address workforce shortages, and support rural infrastructure. Investment in initiatives that prioritize improving rural healthcare, such as behavioral health and workforce shortages, can address the unique challenges rural communities face. Such efforts can make significant strides in reducing health disparities and ensuring equitable access to quality care for all individuals, regardless of their location.

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[21] https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf

[22] https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency#:~:text=The%20Consolidated%20Appropriations%20Act%20of,emergency%20through%20December%2031%2C%202024.

Thank you again for the opportunity to discuss these rural health issues with you today and for your support of HRSA's work to improve access to care in rural communities across the country. I would be pleased to answer any questions you may have.

Mr. ADERHOLT. Thank you. Ms. Ryder.

Ms. RYDER. Chairman Aderholt, Ranking Member DeLauro, and distinguished members of the committee, thank you for the opportunity to share the Department of Education's critical work to meet the needs of the 9.7 million students enrolled in rural schools.

I am Ruth Ryder, and I serve as the Deputy Assistant Secretary for Policy and Programs in the Office of Elementary and Secondary Education, OESE, at the U.S. Department of Education.

OESE implements programs to support disadvantaged students under the Elementary and Secondary Education Act, ESEA. In this role, I oversee a broad range of management, policy, and program functions related to formula and discretionary grant programs under the ESEA.

I have served at the Department for over 35 years in a number of roles and have been a classroom teacher, special education teacher, and district administrator. I am honored to be here with my esteemed colleagues from the Department of Labor and the Department of Health and Human Services and appreciate our cross-agency collaboration through the Rural Partners Network.

It is important to note that the largest source of funding to rural schools comes through our formula grants under the ESEA Title I and Part B of the Individuals with Disabilities Education Act, known as IDEA. These funds serve millions of students in rural communities by providing critical academic support, preschool services, school improvement, educator professional development, and before and afterschool programming. We also compete discretionary grants that may include a rural priority.

For the purposes of this statement, I will focus on programs that are directed to specifically serve rural students.

First, I am pleased to share some programmatic updates from OESE's Division of Rural, Insular, and Native Achievement Programs, RINAP, and they administer the Rural Education Achievement Program, REAP. REAP is designed to help rural school districts that may lack the personnel and resources to effectively compete for Federal grants and that often receive grant allocations that are too small to be effective to meet their intended purposes.

The two grants within REAP are the Small, Rural School Achievement Program, SRSA, which awards formula grants directly to eligible school districts to carry out activities authorized under other specified Federal programs, and the Rural and Low-Income Schools Program, RLIS, which is designed to address the needs of students that attend rural and low-income schools.

In 2022, the Department awarded $195,000,000 in REAP funds to support approximately 6,200 rural school districts across the United States. These rural school districts, which met small and/or low-income eligibility criteria, are using their REAP funds this school year for a variety of activities, including supporting supplemental teaching and learning activities, digital resources, high-quality professional development, school-based mental health services, and partnerships with outside healthcare entities.

This summer, we estimate that we will award another 4,200 SRSA grants and provide RLIS program funding to another 2,000 rural school districts through our State subgrants.

OESE administers a number of grants that support specific needs across the country, including in rural communities. Recently, OESE released grant awards for two new grant programs under the Bipartisan Safer Communities Act to increase the number of mental health providers in schools, including the Mental Health Service Professional Demonstration Grant Program, which provides grants to support and demonstrate innovative partnerships between schools and institutions of higher education to train school-based mental health providers for employment in schools and school districts, which we know is a particular need for students in rural communities.

The partnerships with institutions of higher education must include one or more high-need school district or State educational agency on behalf of one or more high-need school districts. Eligibility for SRSA or RLIS are two ways that school districts can show that they are high-needs LEAs.

In closing, the Department has a multifaceted approach to address the needs of students in rural communities. Recently, the Department hired a Director of Rural Engagement, who will lead our rural work, including the rural strategy and action team, which brings together nine different offices in the Department. Our goal is to ensure that support and funding is reaching communities in need and that technical assistance is available to meet the unique needs of rural students.

I welcome the opportunity to answer your questions.

[The information follows:]

U.S. Department of Education

Written Testimony of Ruth Ryder
Deputy Assistant Secretary for Policy and Programs, Office of Elementary and Secondary Education
Before the Subcommittee on
Labor, Health and Human Services, Education, and Related Agencies
U.S. House of Representatives

March 29, 2023

Chairman Aderholt, Ranking Member DeLauro, and distinguished Members of the Committee, thank you for the opportunity to share the Department of Education's (Department's) critical work to meet the needs of the 9.7 million students enrolled in rural schools.

We know some challenges can be especially acute in rural areas due to underinvestment, and limited connectivity.[1] The challenges of rural communities are unique. The Department is laser- focused on supporting these communities with funding opportunities, technical assistance, and other support tailored to these settings. I am pleased to share the work underway to support these communities.

I. Agency Commitment to Supporting Rural Communities

The Department is one of 20 Federal agencies and regional commissions that make up the Rural Partners Network (RPN). The RPN, led by the U.S. Department of Agriculture's Rural Development team, works to expand rural prosperity through job creation, infrastructure development, and community improvement. It aims to transform how the Federal government supports rural communities, collaborates with local residents, and amplifies rural priorities with the goal of inclusive, sustainable economic growth at the forefront of its mission.

In 2022, the RPN selected its pilot cohort of community networks located in 10 States and Puerto Rico. 37 community networks in Alaska, Georgia, Kentucky, Mississippi, Nevada, New Mexico, North Carolina, Puerto Rico, West Virginia, and Wisconsin, as well as the San Carlos Apache Tribe, the Tohono O'odham Nation, and the Cocopah Indian Tribe in Arizona are receiving support from the RPN. To support long-term economic success, all community networks will receive place-based community economic development guidance in navigating federal programs, building relationships, and identifying community-driven solutions from local full-time, federal staff.

The RPN is also curating a set of resources to help people living in rural communities navigate programs, elevate rural needs, and access information on what is working in rural communities throughout the nation. Interested stakeholders and community members may visit Rural.gov for a comprehensive look at the RPN, including program goals, affiliated partners, and activities in pilot communities—with additional resources to come.

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[1] Some digital divides between rural, urban, suburban America persist | Pew Research Center

Another example of the Department's commitment to rural engagement and prosperity is the Rural Strategy and Action Team (RSAT), a Department group dedicated to advancing support of rural children and youth. Comprised of Department employees from nine program offices, RSAT meets monthly to discuss rural needs, opportunities, resources, and best practices. It identifies policy and programmatic shortcomings that affect rural communities and, through detailed analysis, presents workable solutions that inform Department leadership and the RPN. Members of RSAT respond to education-related inquiries arising from the RPN and develop new resources to support rural education in geographically isolated areas.

I'm also pleased to share that we recently appointed a new Director of Rural Engagement to continue to build on these efforts. The Director will coordinate the Department's efforts around these very important issues. The new Director will represent the Department in meetings with stakeholders and other federal agencies. They will also be responsible for leading regular, proactive engagement with rural stakeholders around the country. This includes ensuring their concerns are heard and communicating policy decisions and updates back to them on a consistent basis via roundtables, conferences, webinars, and other events. The Director will develop a cohesive engagement strategy that elevates rural educational needs and opportunities, determine resources and partnerships needed to advance rural education, and identifies and shares rural best practices that exist around the country. Additionally, they will co-chair the Department's internal RSAT and provide direct support to RPN community networks.

II. Unique Challenges for Rural Students

Addressing the Digital Divide

We know that learners living in rural areas are among those most impacted by the digital divide. As of 2020, approximately 37 percent of students in rural areas reported having inadequate internet connectivity at home. In September of 2022, The Department's Office of Educational Technology (OET) published a resource, *Advancing Digital Equity for All: Community-Based Recommendations for Developing Effective Digital Equity Plans to Close the Digital Divide and Enable Technology-Empowered Learning* that discusses barriers faced by learners in rural areas to accessing high-speed internet and technology tools for learning, as well as strategies rural communities have utilized to increase access. This resource supports leaders in developing effective digital equity plans that leverage President Biden's Bipartisan Infrastructure Law's $65 billion for high-speed internet investments to address the needs of learners, families, and caregivers – particularly those living in rural and under-resourced communities. The resource was informed by listening sessions with organizations representing learners furthest from digital opportunities, including those in rural areas, through OET's Digital Equity Education Roundtables Initiative.

Teacher Shortages

According to a recent survey by the National Center for Education Statistics, most schools reported starting the 2022-2023 school year short-staffed for both instructional and non-instructional staff, with the most severe shortages for special education personnel.[2] Additionally,

[2] U.S. Department of Education. School Pulse Panel Survey available at School Pulse Panel (ed.gov)

the Department has heard from a number of states about the challenges they face in recruiting and retaining teachers, particularly in high need areas such as rural communities. There are acute challenges in rural communities that affect staffing such as housing, recruiting/attracting new teachers and creating the infrastructure to develop teacher pipelines with educational preparation programs. The pandemic only exacerbated the educator shortages our underrepresented rural districts had previously experienced

In January, Secretary Cardona issued a call to action focused on our priorities to "Raise the Bar in Education" and eliminate teacher shortages. First, to recruit and retain teachers, teachers should be compensated appropriately through a livable wage. Second, to ensure that we are investing in retaining our teachers, the Department supports models that recruit the next generation of teachers. Federal dollars are helping to make this a reality, for example, many districts have used their American Rescue Plan funds to invest in innovative and effective teacher recruitment and preparation strategies, like Grow Your Own programs that enable districts to develop their own paraprofessionals into teachers, and even get high school students on track to becoming teachers. Due to a collaboration with the Department of Labor, nationwide we are seeing more states and districts use teacher Registered Apprenticeship programs to expand these Grow Your Own programs and teacher residency programs and pay individuals for their training to become teachers while earning a certification.

Chronic Absenteeism

The number of students missing at least 18 days of school a year doubled to 16 million in 2021-2022 from 8 million students before the pandemic.[3] This means that one out of every three public school children was chronically absent during the second full school year of the pandemic. Re-engaging these students can be especially challenging for students who live far from their school buildings, as is common in rural areas. Across the country, districts are using American Rescue Plan dollars to support these students. In October 2021, the Georgia Department of Education's Office of Rural Education and Innovation announced a partnership with Graduation Alliance and an investment of $5 million in Elementary and Secondary School Emergency Relief funds to support the location, engagement and individual support of up to 50,000 students in rural areas who have disengaged from school or are chronically absent due to COVID-related school disruptions, who are in danger of failing one or more classes, or whose families have requested additional support. Similarly, Colorado launched a Rural Program Development grant with American Rescue Plan funds, to support the development of a wide range of programs that support re-engaging and strengthening student engagement–particularly for those students most affected by the pandemic.

The American Rescue Plan is helping to support rural students across the country. The Department also has programs that provide ongoing support and technical assistance to support rural communities.

III. U.S. Department of Education Holistic Approach to Serving Students in Rural Communities

[3] More information available at: https://www2.ed.gov/datastory/chronicabsenteeism.html

a. Office of Elementary and Secondary Education Programs –

I am also pleased to share some programmatic updates from the Division of Rural, Insular, and Native Achievement Programs (RINAP) within the Office of Elementary and Secondary Education (OESE). RINAP administers the Rural Education Achievement Program (REAP), which is designed to help rural school districts that may lack the personnel and resources to compete effectively for federal competitive grants and that often receive grant allocations in amounts that are too small to be effective in meeting their intended purposes. The two initiatives within the REAP are the Small, Rural School Achievement (SRSA) program, which authorizes the Secretary to award formula grants directly to eligible school districts to carry out activities authorized under other specified federal programs, and the Rural and Low-Income School (RLIS) program, which is designed to address the needs of rural, low-income schools. For the RLIS program, the Secretary awards formula grants to State educational agencies (SEAs), which, in turn, award subgrants to eligible local educational agencies (LEAs) either competitively or on a formula basis. The funds are to be used to carry out activities specified in the Elementary and Secondary Education Act of 1965 (ESEA).

In 2022, the Department awarded $195 million in REAP funds to support approximately 6,200 rural LEAs throughout the United States. These rural LEAs, which meet eligibility criteria for being small and/or low-income, are using their REAP grant funds for a variety of activities, including supporting supplemental teaching and learning activities during the 2022-23 school year. Youth mental health is a priority of the Biden-Harris Administration, and, among many other activities, REAP funds may be used to support school-based mental health services and partnership programs with outside health care entities. REAP funds may also support the training of specialized instructional personnel on trauma-informed practices, and bullying, harassment, and suicide prevention.

In fiscal year (FY) 2023 we estimate that we will award approximately 4,200 SRSA grant awards, which, by volume, is approximately 55 percent of the grants annually awarded by OESE. In response to feedback from rural education stakeholders the Department committed to simplifying and improving the SRSA grant application process beginning with the FY 2019 grant cycle.[4] Direct feedback from SRSA grantees indicates that the team's efforts to simplify the application process and provide topical, streamlined technical assistance navigating the application process have led to increases in participation in the program as well as general satisfaction with the application process.

Each year REAP makes iterative improvements to the application process. The FY 2023 SRSA grant application, which is open through April 14, 2023, builds on prior efforts. First, school district data is pre-populated into the application (e.g., applicant's physical address, contact information, and Unique Entity ID (UEI)) to support the applicant school district in completing the application as quickly and easily as possible. The FY 2023 application also includes the SAM.gov UEI expiration date so that applicants have it as a reference to ensure their UEI registration remains active in SAM.gov. Finally, the Department created an SRSA Post-Application information document to provide school district administrators with concise next steps, links to helpful resources, and answers to REAP's most frequently asked questions relating

[4] For more information see: https://www2.ed.gov/about/inits/ed/rural/rural-education-report.pdf

to the SRSA application process. On average, the application for funding that took over three hours to complete in FY 2019 now takes approximately ten minutes to submit.

Another office within RINAP implements the Alaska Native Education Program, which in September 2022 announced 28 new grants totaling $35 million that will fund innovative projects that recognize and address the unique educational needs of Alaska Natives. Many of these grant dollars will support Alaska Native students and families living in some of the most rural communities in Alaska.

I would also like to bring to your attention work funded by the Department's Institute of Education Sciences (IES). Through IES' National Center for Education Research (NCER), the Center for Education Policy Research at Harvard University launched the National Center for Rural Education Research Networks (NCRERN),[5] and the University of Missouri in partnership with the University of Virginia and the University of Montana created the National Center for Rural School Mental Health (NCRSMH).[6] NCRERN works to build the capacity of local educational agencies to employ evidence-based continuous improvement strategies in rural schools. NCRERN's work will also apply rigorous research to identify and evaluate "best practices" available for increasing student attendance and improving high school students' learning and preparation for careers and postsecondary education that will be disseminated to rural communities. NCRSMH partners with rural schools in Missouri, Virginia, and Montana to develop a comprehensive set of teacher and student surveys, tools, interventions, and professional development materials to help identify, prevent, and intervene in mental health concerns among students.

Additionally, IES' National Center for Education Statistics (NCES) has been taking steps to improve the availability of rural education data and resources. NCES is in the process of updating its report on rural education, which was last released in 2007, and has developed a new resource hub called "Education Across America." The website is designed for those interested in the condition of education in the country's diverse geography—its cities, suburbs, towns, and rural areas. Currently, the resource hub serves as a central repository of tabulations produced by NCES. Future releases will include indicators and summary reports that focus on specific locales. Rural areas will be highlighted first and foremost. Furthermore, NCES will continue to maintain the education geographic services. These education geographic services, such as the locale lookup tool and boundary files, provide information about school and school district demographic, economic, and geographic characteristics.

b. Additional Grants in OESE Supporting Rural Communities –

OESE also administers several competitive grant programs that support rural communities in meeting the holistic needs of students.

Full-Service Community Schools

The Full-Service Community Schools (FSCS) program provides support for the planning, implementation, and operation of full-service community schools that improve the coordination,

[5] More information available at https://www.rural.gov/blog/regional-comprehensive-centers
[6] More information available at https://www.rural.gov/blog/building-partnerships-support-mental-health-needs-diverse-rural-schools-national-center-rural

integration, accessibility, and effectiveness of services for children and families, particularly for children attending high-poverty schools, including high-poverty rural schools.

The ESEA directs the Department to use at least 15 percent of available FSCS funding to award grants to eligible entities to carry out activities in rural areas. The ESEA also directs the Department to prioritize making awards to grantees that serve REAP eligible school districts.

In FYs 2018 and 2019, the Department used a competitive preference priority to award grants to serve rural communities; in FY 2022, the Department used the authorizing language to create an absolute priority for applicants that propose to serve two or more schools eligible for the Title I, Part A schoolwide program and include a school district that satisfied the requirements under REAP. Since the 2018, this program has served 79,522 students in 130 rural schools.

Promise Neighborhoods

The purpose of the Promise Neighborhoods (PN) program is to significantly improve the academic and developmental outcomes of children living in the most distressed communities of the United States, including ensuring school readiness, high school graduation, and access to a community-based continuum of high-quality services. The program serves neighborhoods with high concentrations of low-income individuals; multiple signs of distress, which may include high rates of poverty, childhood obesity, academic failure, and juvenile delinquency, adjudication, or incarceration; and schools implementing comprehensive support and improvement activities or targeted support and improvement activities under section 1111(d) of the ESEA.

By statute, the PN program competition prioritizes funding rural communities, which ensures that a portion of the PN funds is set aside for those communities. The PN program is currently funding 7 communities that applied under the rural priority. These grants are located in Kentucky, Mississippi, and South Carolina, with Kentucky and Mississippi having multiple communities receiving grants. The total planned grant amount for these rural grantees is $143,792,400.

Additionally, the PN program provides comprehensive technical assistance to rural grantees. This includes leadership development for key project staff and results-based accountability training to ensure that grantee leaders can use data effectively to identify and meet their communities' needs.

While the pandemic created a challenging environment for our grantees, many of the rural grantees were able to use their funds to improve community and family engagement through the use of technology. Previously many events were held in person because of inadequate internet access in rural areas. This limited the number of families who could participate due to lengthy commutes. Grantees pivoted, working with partner school districts and community organizations to improve internet access that allowed them to recreate these events virtually. Many events and programs have remained virtual so that they are accessible to more families and have increased knowledge of the program.

Impact Aid

The Impact Aid Discretionary Construction Grant Program provides grants to eligible Impact Aid school districts to assist in addressing their school facility emergency and modernization needs. These school districts have a limited ability to raise local revenue for capital improvements because they have large areas of federal land within their boundaries. As a result, these districts face difficulties in responding when their school facilities are in need of emergency repairs. In the last six years, 100 percent of Impact Aid Discretionary Construction funds have gone to rural districts for construction projects that remediate urgent health and safety problems for students, staff and administrators. This program makes approximately $18 million in awards every other year. Recent grants have fixed leaking roofs, broken heating and cooling systems, and inadequate fire suppression systems, and shored up foundations cracking from the effects of climate change. Grant funds have also been used to build a new school building, to replace a building that would have cost more to renovate than to demolish, and to construct a new building. Rural districts in particular struggle to find funds to improve aging school buildings, and the Impact Aid Discretionary Construction program is the only competitive program in OESE that is dedicated to addressing this need.

Title I, Part C – Migrant Education Program (MEP)

The Migrant Education Program (MEP) funds academic and supportive services for the children of families who migrate to find work in the agricultural and fishing industries. The Office of Migrant Education does not collect any specific data to identify whether a migratory child lives in a rural area; however, many migratory families do reside in rural areas due to the nature of their work in the agricultural and fishing industries. With support from the MEP program, migratory children can receive instructional services (such as educational activities for preschool-age children and instructional support in elementary and secondary schools, including tutoring before and after school) and support services (educationally related activities, including advocacy, for migratory children; health, nutrition, and social services for migratory families; necessary educational supplies; and transportation).

High School Equivalency Program (HEP) and College Assistance Migrant Program (CAMP)

HEP helps migratory and seasonal farmworkers (or their children) who are 16 or older and not currently enrolled in school to obtain the equivalent of a high school diploma and, subsequently, to gain employment or begin postsecondary education or training. Additionally, CAMP assists students who are migratory or seasonal farmworkers (or their children) who are enrolled in their first year of undergraduate studies at an institution of higher education. While HEP and CAMP do not have a specific data indicator for rural students, a significant number of the total students served by these programs come from rural areas or have immediate family members from rural areas.

Education Innovation and Research

The Education Innovation and Research (EIR) Program provides funding to create, develop, implement, replicate, or take to scale entrepreneurial, evidence-based, field-initiated innovations to improve student achievement and attainment for high-need students and to rigorously evaluate such innovations. The EIR program is designed to generate and validate solutions to persistent

educational challenges and to support the expansion of effective solutions to serve substantially larger numbers of students.

For FY 2022, the Department held three EIR grant competitions: Early-phase, Mid-phase, and Expansion. All three competitions included two competitive preference priorities that aligned with the Administration's acknowledgment of the timely and urgent needs in Pre-K-12 education related to addressing the impact of COVID-19 and promoting equity. The Early-phase and Mid-phase competitions included absolute priorities for STEM and social and emotional learning skills. EIR also has a statutory requirement that at least 25 percent of funds be awarded to rural applicants.

Across the FY 2022 Expansion, Mid-phase, and Early-phase competitions we awarded $38,931,114 to projects serving rural areas and funded $18,296,561 in non-competing continuation awards to projects serving rural areas. In addition, multiple other applicants plan to serve some rural schools but did not meet the program's definition of "rural." The EIR program has often exceeded the 25 percent statutory set-aside for rural applicants and has successfully worked within the Department and externally to recruit and encourage novice rural applicants to apply for the grants. For example, the program has targeted outreach toward REAP grantees, programs within the Office of Indian Education, as well as external rural organizations and networks. This rural outreach strategy has also included recruitment of peer reviewers, to deepen the Department's bench of peer reviewers with experience working in and/or supporting education in rural settings.

School Climate Transformation Grant

The School Climate Transformation Grant – local educational agency (LEA) program allows school districts to develop and adopt, or expand to more schools, multi-tiered systems of support, such as Positive Behavioral Interventions and Supports, that guide the selection, integration, and implementation of evidence-based practices for improving school climate and supporting student social and emotional well-being. Research shows that students who learn in safe, inclusive, and supportive learning environments are more likely to improve academically, participate more fully in the classroom, and develop skills that will help them be successful in school and in life. In FY 2019, the Department prioritized supporting certain communities that would uniquely benefit from this program, including establishing an absolute priority for LEAs located in rural areas or serving Tribal communities. Of the 69 FY 2019 grantees funded under this program, over 40 percent (29 grantees) met this absolute priority.

Mental Health Service Professionals Demonstration Grants

The Mental Health Service Professional Demonstration Grant Program provides competitive grants to support and demonstrate innovative partnerships to train school-based mental health service providers for employment in schools and LEAs. The partnerships with institutions of higher education must include one or more high-need LEA or a State educational agency on behalf of one or more high-need LEA and REAP eligibility was one way for applicants to demonstrate high-need.

Innovative Approaches to Literacy (IAL)

The IAL program supports high-quality programs designed to develop and improve literacy skills for children and students from birth through 12th grade in high-need LEAs and schools. The Department intends to promote innovative literacy programs that support the development of literacy skills in low-income communities. The FY 2023 competition includes a competitive preference priority for applicants proposing to serve rural communities.

Out-of-School Time Career Pathway program

The Out-of-School Time Career Pathway program provides grants to SEAs that, in partnership with eligible entities in the State, will provide students expanded options to participate in a career pathway program, outside regular school hours or as part of an expanded learning program. The FY 2020 competition included a competitive preference priority for rural communities, and all grantees that received an award addressed the rural priority.

Office of Indian Education

For school year 2022-2023, the Office of Indian Education (OIE) issued 1,276 Indian Education formula grants impacting over 424,300 Native students across 38 states with a total disbursement of $109,855,141. These grants provide an annual distribution of funds to help meet the unique cultural, language, and education needs of Indian students and help ensure that all students meet the challenging academic standards in their State. Approximately 35 percent of the school districts that receive funds are small and rural, which tells us that rurality is not the exception, but rather the norm for many of our Native communities.

c. Office of Postsecondary Education Grants

Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP)

GEAR UP provides grants of up to seven years to states and partnerships to provide services at high-poverty middle and high schools. GEAR UP grantees typically serve an entire cohort of students beginning no later than the seventh grade and follow the cohort through high school. GEAR UP funds are also used to provide college scholarships to participating students. The FY 2021 competition included an invitational priority for applicants that would serve students located in rural communities. In FY 2021, three of the four successful state applicants addressed this priority along with seven of the 27 successful partnership applicants. In FY 2022, the Department awarded grants to additional applicants from the FY 2021 competition, including two additional state applicant and four additional partnership applicants.

Rural Postsecondary and Economic Development Grant Program

The Rural Postsecondary and Economic Development Program supports rural students in accessing and completing postsecondary education. This program received FY 2022 appropriations under the Fund for the Improvement of Postsecondary Education and awarded 16 grants in June 2022. Specifically, the grants are used to implement strategies and programs to increase the rates of postsecondary enrollment, persistence, and completion among rural students through the development of high-quality career pathways aligned to high-skill, high-wage, and

in-demand industry sectors and occupations in the region. For FY 2023, Congress provided $45,000,000 for competitive grants to institutions of higher education and other public and private non-profit organizations and agencies.

d. Office of Special Education and Rehabilitative Services (OSERS)

The Individuals with Disabilities Education Act of 2004 (IDEA) authorizes formula grants to states provides for discretionary grants to states, locals, institutions of higher education, and non-profit organizations to build and support SEA and LEA capacity to implement the IDEA Parts B and C. Many of these grant-supported activities generate knowledge and provide services of interest and utility to professionals, families, and children with disabilities across all regions of states, inclusive of rural communities. Among the authorized grants programs, two provide significant support to the rural special education systems and the children and families they serve.

Community Parent Resource Centers (CPRC)

Community parent resource centers are parent training and information centers, operated by local parent organizations, that help ensure underserved parents of children with disabilities, including low-income parents, parents of children who are English learners, and parents with disabilities, have the training and information they need to enable them to participate effectively in helping their children. Community parent resource centers are required to establish cooperative partnerships with the parent training and information centers in their states. The Office of Special Education Programs within OSERS has awarded 27 CPRCs, 12 of which have defined rural communities as their service area.

State Personnel Development Grants (SPDG)

The SPDG program focuses on professional development needs. Awards are provided only to State Education Agencies. Each state must spend at least 90 percent of its funds on professional development activities, including the recruitment and retention of qualified special education teachers. No more than 10 percent of the state's funds can be spent on state activities, such as reforming special education and regular education teacher certification (including recertification) or licensing requirements and carrying out programs that establish, expand, or improve alternative routes for state certification of special education teachers. The Network hosts monthly meetings for a community of practice, States with Small Populations. Currently, approximately ten states actively participate in this activity.

Appropriations under the Education of the Deaf Act (EDA), the Act to Promote the Education of the Blind, and the Helen Keller National Center Act (HKNCA)

OSERS Office of the Assistant Secretary administers appropriations under the EDA and the HKNCA. The EDA appropriations support partnerships between The Alabama Institute for Deaf and Blind (AIDB) and Gallaudet University (Gallaudet University Regional Center South and Regional Early Acquisition of Language), National Technical Institute for the Deaf (NTID

Regional STEM Center and Southeastern Interpreter Guidance Network), and American Printing House for the Blind (Center for Assistive Technology Training). These partnerships focus on supporting southeastern states and greatly impact deaf, blind, and DeafBlind students in rural areas. Some of the AIDB partnerships are currently expanding to serve rural communities in the Pacific Northwest.

Since 1969, HKNC is the only national program providing comprehensive vocational rehabilitation services to youth (16 and older), working-age adults, and seniors (55 and better) with combined hearing and vision loss (DeafBlind). HKNC serves 10 regions across the country, which include rural communities, through virtual assessments and in-person training opportunities. The Technology Employment Achievement and Mastery (TEAM) supports working-age adults who require further work-readiness skills in order to obtain employment. TEAM utilizes an online customer service training program that teaches on-the-job skills such as conflict resolution, resolving customer disputes and effective communication techniques. HKNC also is the largest participant in the DeafBlind Equipment Distribution Program. These services are most requested in rural areas.

IV. Technical Assistance for Rural Communities

Rural, Insular, and Native Achievement Programs (RINAP)

To improve technical assistance to rural communities, the Department recently created an SEA work group for its Rural Education Achievement Program (REAP) State Coordinators, which meets on a quarterly basis. The structure and focus of this work group followed the advice of REAP State Coordinators, who in June 2020 provided the Department feedback during a listening session on how to better understand local, rural concerns regarding education during the COVID-19 pandemic. As a result, during SEA work group meetings the REAP team shares program updates and policy guidance (such as the Department's 2022 notice inviting applications to fund projects that support high-need school districts seeking to improve school-based mental health services), while also providing a venue for resource sharing, questions, and nationwide collaboration. RINAP also conducts regular oversight and monitoring activities, hosts webinars for states and school districts related to the administration of the SRSA application and presents regularly at national conferences, such as the National Forum to Advance Rural Education and the National Association of ESEA State Program Administrators annual conference. In addition, RINAP hosts an annual technical assistance meeting for the Insular Areas and the Republic of Palau to provide guidance on topics such as the allowable use of funds and building staff capacity, as well as periodic project director meetings for the Alaska Native Education and Native Hawaiian Education programs. Events such as these help ensure that grantees are aware of, and have access to, Department technical assistance resources and other opportunities for support.

Regional Educational Lab Program (REL)

The Department's Institute for Education Sciences supports 10 regional labs that partner with educators and policymakers nationwide.[7] For nearly 60 years, the RELs have collaborated with

[7] For more information see: https://ies.ed.gov/ncee/rel/

school districts, state departments of education, and other education stakeholders to help generate and apply evidence, with the goal of improving learner outcomes. REL work is change-oriented, rigorous, and high-leverage, supporting consequential local, regional, or statewide decisions about education policies, programs, and practices. RELs contribute to the growing body of research on how experiences within the nation's education system differ by context and student group, thereby impacting outcomes and identifying potential solutions.

The RELs are statutorily required to "develop strategies to utilize schools as critical components in reforming education and revitalizing rural communities in the United States," and "report and disseminate information on overcoming the obstacles faced by educators and schools in high poverty, urban, and rural areas." The Education Sciences Reform Act requires that at least 25 percent of the aggregate funding for the 10 RELs be dedicated to rural issues.

The current cycle of RELs began their work in 2022 and are thus in the beginning stages of developing and providing their supports to all partners (including those representing rural communities). Several examples of these ongoing supports are described on the REL program website, which includes a topic page for rural education that includes a database of products and supports the RELs have provided to rural schools since 2017.[8]

In Alaska REL Northwest is partnering with the district to implement evidence-based strategies to continuously monitor and improve working conditions toward increased teacher retention to ensure all students are consistently served by qualified educators for the Alaska's Improving Teacher Retention and Recruitment in Rural and Remote Schools Partnership. Like many school districts in Alaska, the Lower Kuskokwim School District has a pressing need to attract and retain educators in a variety of positions throughout the rural, remote district. In Mississippi, The Mississippi Adolescent Literacy Partnership creates a collaborative environment where stakeholders and REL Southeast staff bridge contextual knowledge and expertise with use of research and evidence-based practices that support the improvement of adolescent literacy skills.

Unlocking Career Success Community of Practice

As part of the Secretary's Unlocking Career Success initiative, an initiative designed to blur the lines between high school, college, and career, the Office of Career Technical and Adult Education is setting up a community of practice (COP) for rural districts who have exemplary programming or initiatives within one of the four keys of the initiative: dual enrollment, work-based learning, workforce credentials, and career advising and navigation.[9] The objectives of the COP are to provide a small group setting for influential education leaders to discuss the four keys, to source exemplars for national distribution, to discuss problems of practice and problem solve, and finally, to provide a regular touchpoint and feedback loop between the Department and rural districts nationwide.

Conclusion –

[8] For more information see: https://ies.ed.gov/ncee/rel/topics?topics=Rural+Schools&page=1
[9] For more information see: https://cte.ed.gov/unlocking-career-success/

In closing, the Department has a multifaceted approach to address the needs of students in rural communities. Our goal is to ensure that funding is reaching the communities in need and that there is technical assistance available tailored to the unique needs of rural students. I welcome the opportunity to answer your questions.

Mr. ADERHOLT. Thank you. And Ms. Jacobs-Simmons, you have the floor.

Ms. JACOBS-SIMMONS. Good morning. Chairman Aderholt, Ranking Member DeLauro, and distinguished members of the subcommittee, I am pleased to be here today to discuss the Department of Labor's job training programs and the role they play in rural economies throughout the United States.

America's rural communities are strong, dynamic, and economically diverse. Rural businesses are creating high-skilled, good-paying jobs in new and expanding industries from real estate and education to health, finance, and manufacturing.

In 2021, employment and manufacturing of transportation equipment, including electric vehicles, increased by 5 percent in rural counties. These are exciting trends. But rural workers and businesses face barriers that continue to hold them back.

Rural communities have persistently high rates of long-term unemployment, and they often lack access to the education and training opportunities that give workers the skills needed for the growing number of good rural jobs.

Rural communities, without reliable, affordable, high-speed Internet, struggle to connect their businesses with the larger economy and to provide the services and training needed to grow a skilled workforce.

The Department recognizes that to continue the strong economic growth, rural workers need access to employment services, such as skills assessment and career counseling, and they need it in their own communities with reliable broadband. They need high-quality workforce education and training programs that have a proven track record for getting workers good jobs. And they need effective work-based learning strategies like registered apprenticeship and on-the-job training that are created in partnership with businesses who understand the local economy.

Last year, through a network of almost 2,300 American Job Centers nationwide, almost 10 million people sought information and services from the publicly funded workforce system. People find this system through a variety of front doors, including libraries, mobile service centers, and virtually from their homes.

For 2021, over 1.2 million participants had a barrier to employment. This included long-term unemployment, receipt of food stamps assistance, and/or homelessness, just to name a few.

The primary source of funding for these services is the Workforce Innovation and Opportunity Act, or WIOA. DOL's WIOA formula programs are allocated to States through a formula. The Department distributes these funds to States, who then allocate funds to local areas where business-driven workforce development boards establish policies and determine how to spend the funds based on local labor market data and employer demand.

WIOA is working to place individuals with some of the highest barriers to employment in quality jobs. WIOA creates opportunities for effective work-based learning in the critical rural sectors my co-panelists have discussed here today. This includes education, nursing, and I would like to acknowledge our teacher apprenticeship effort.

These industry-led apprenticeships and training programs offer high-quality pathways, on-the-job learning, and industry-recognized credentials. In addition, the Department makes targeted rural investments with discretionary funding. This is to respond to the shifting economy and the economic landscape of today and the known demands of tomorrow.

The Workforce Opportunity for Rural Communities, or WORC, initiative is also ensuring Americans in rural communities impacted by economic transitions, including the energy sector, have access to job training and support services to place them in good jobs in high-demand occupations. The Department has awarded over $118,000,000 to support these grants.

We also support these efforts through our H–1B Skills Training Grant for Rural Healthcare and nursing expansion grant programs that address workforce shortages, expand diversity in the pipeline of quality healthcare professionals. In the coming months, we expect to announce up to $80,000,000 to support this work.

A thriving rural workforce requires thoughtful strategies for recruiting, for training, and for retaining workers and job seekers in rural communities. Together, we can provide more rural Americans with the tools that they and their communities need to access good jobs and to contribute to America's future.

Thank you again for inviting me today, and I am pleased to answer any questions.

[The information follows:]

STATEMENT OF

LENITA JACOBS-SIMMONS

DEPUTY ASSISTANT SECRETARY

EMPLOYMENT AND TRAINING ADMINISTRATION

UNITED STATES DEPARTMENT OF LABOR

BEFORE THE

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

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

March 29, 2023

Chairman Aderholt, Ranking Member DeLauro, and Members of the Subcommittee, thank you for the invitation to join you today to talk about the efforts that the U.S. Department of Labor's (Department) Employment and Training Administration (ETA) is leading to help workers, job seekers, and businesses in rural areas throughout the United States.

In the most recent Employment Situation Report released by the Bureau of Labor Statistics,[1] the American economy added 311,000 jobs in the month of February and remained near its historic low unemployment rate at 3.6 percent. With 12.4 million jobs added since President Biden took office, and an average of 351,000 jobs added per month over the past three months, this growth continues the steady, stable progress that is bringing opportunities to more workers and security to more families across the country. Despite this job growth, it is critical that we ensure all workers and communities can participate and benefit from this progress.

ETA is considering how we can invest in underserved communities, including rural communities, to ensure that all workers in America succeed. Specifically, we are looking at how to rebuild the communities that have fed and fueled our country over centuries so that America enjoys a stronger tomorrow. The potential that rural America holds in driving our nation's growth is why the Department has been intentional in our focus on equity and access for rural America to ensure that individuals from underserved and underrepresented rural communities have equitable access to the services of the workforce system. By ensuring access to resources and directing investments to smaller communities, we recognize that a well-invested and employed rural America can continue to thrive. Rural America is central to America's strong economic recovery. However, our rural communities also face unique challenges.

According to the 2022 National Healthcare Quality and Disparities report produced by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, nearly

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[1] The Employment Situation, March 10, 2023: https://www.bls.gov/news.release/empsit.nr0.htm

63 percent of U.S. counties are considered "whole county" primary care health professional shortage areas, indicating a lack of primary care professionals that threatens access to services. Rural counties have disproportionately received this designation. Between 2010 and 2021, 136 rural hospitals closed, threatening rural residents' access to services provided by those hospitals. These problems were exacerbated by the COVID-19 pandemic. Today, because of the Affordable Care Act, the percentage of people under age 65 with health insurance coverage is at historically high levels, but people in low-income households and rural communities, among others, are significantly less likely to have health insurance coverage.[2]

Other challenges include slower population growth, higher average age, and a declining working-age population. 2021 marked the first time in U.S. census history where people aged 65 years and older made up more than 20 percent of the population in nonmetropolitan areas, a 25 percent increase from the 2010 rate. Comparatively, in metropolitan areas, just 16 percent of the population was aged 65 and older in 2021. In nonmetropolitan areas, while the 65+ population has substantially risen over the last decade, from 2010 to 2020, we saw a decline in the working-age population by 4.9 percent, and a decrease in the population under age 18 by 5.7 percent.

Workers in rural America face comparatively high rates of long-term unemployment and often lack of access to training opportunities to develop the skills aligned to growing and emerging jobs in critical industry sectors. Further, approximately 22 percent of Americans in rural areas and 28 percent of Americans in Tribal lands lack quality broadband access, according to the FCC. Rural areas are typically comprised of some of our most vulnerable workers from our underserved communities. By developing our rural workforce, we empower families and their communities to attain economic stability and prosperous communities.

Despite these challenges, through targeted investments, we can develop and unleash the exceptional skills and talents of a rural workforce. Our rural communities are dynamic and have become *more* economically diverse and *more* racially diverse over time. We are seeing growth in rural industries that are employing higher and higher shares of high-skill workers in our rural communities. From 2001to 2019, the six highest growth industries in rural America were in real estate, education, administrative, professional services, health, and finance.

To better support these changing communities, the Department is providing job training and supportive services to workers in rural communities impacted by energy transitions. We are building pathways to good jobs in a reindustrializing American heartland. We are expanding job training and workforce pathways for underserved and marginalized youth in rural communities to ensure they have the soft and hard skills necessary to succeed in today's and tomorrow's workforce. We are driving broadband access and digital literacy initiatives to ensure our rural communities are included, and not left behind, in upskilling efforts. The Department is prioritizing good jobs in the workforce system through guidance, performance management, strategic use of funding opportunities, cross agency collaboration, and provision of technical assistance to support good jobs workforce strategies. In 2022, the Department, along with the Department of Commerce, published the Good Jobs Principles, which describe common

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[2] https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html

characteristics of good and stable work and emphasize diversity, equity, inclusion, and accessibility to help ensure that individuals from underserved communities do not face systemic barriers in the workplace. Underserved communities are persons adversely affected by persistent poverty, discrimination, or inequality, including Black, Indigenous, people of color; LGBTQ+ individuals; women; immigrants; veterans; individuals with disabilities; individuals in rural communities; individuals without a college degree; individuals with or recovering from substance use disorder; and justice-involved individuals. By embedding these Principles into workforce strategies with state and local areas, we are developing the workers in some of our most underserved communities.

Targeted Investments in Rural Workforce Development

Enacted in 2014, the Workforce Innovation and Opportunity Act (WIOA) is the backbone of America's workforce development system - with approximately $3.6 billion in formula funding per year going to states and local areas to provide training and career services that help working people across the country get the skills they need and help employers secure a qualified workforce. The Department allocates these funds to states and outlying areas via a statutorily defined formula. In turn, states allocate funds by formula to the local areas, where local workforce development boards make policy decisions and services are delivered locally by a network of approximately 2,300 American Job Centers (AJC).

In the most recent program year (PY 2021) for which data is available, the formula programs served approximately 2.7 million participants, of which 1.2 million had a barrier to employment. Despite these barriers, WIOA participants earned the highest wages since WIOA was enacted. Our data shows individuals who complete WIOA training programs have higher rates of employment than those who did not complete training, so increasing training opportunities for underserved communities remains a priority. As the nation has rebounded from the COVID-19 pandemic, states and local areas have relied on support from WIOA funding and programs to prepare Americans for good-paying jobs in high-demand fields and across communities.

In addition, ETA has made targeted discretionary investments in rural regions and provides technical support to our grantees, including States, Outlying Areas, Local Workforce Development Boards, and other entities, to help them succeed and overcome unique challenges and needs such as those experienced in rural areas.

An example of these targeted efforts includes the Workforce Opportunity for Rural Communities (WORC) Initiative, a partnership with the Appalachian Regional Commission, the Delta Regional Authority, and the Northern Border Regional Commission to support workers in rural communities impacted by economic transitions, especially in the energy sector. WORC funds provide job training and supportive services to dislocated workers, incumbent workers, and new entrants to the workforce to help connect them with good jobs in high-demand occupations.

- Last year, Alabama's Department of Commerce received a $1.3 million WORC grant to implement clear and proven strategies—such as work readiness, career coaching, mentoring, supportive services, and employment-driven training—to prepare residents to enter five

highly in-demand industries, including the Advanced Manufacturing, Healthcare, and Information Technology fields. This grant will lead to jobs paying at least $15/hour with benefits.

- The First Tennessee Development District also received $1.3 million through a WORC grant to design and implement a one-of-a-kind project that not only offers resources for an employer and their current workforce but cultivates an additional pipeline of peer navigator-supported employees from the justice-involved and recovery communities.
- Through four rounds of WORC grants, ETA has awarded more than $121 million to 81 grantees to serve participants in these regions. In Fiscal Year (FY) 2022, ETA announced a fourth round of WORC grants for a total of nearly $35 million to 26 grantees and is increasing these investments in FY 2023 with an expanded reach to include the Northern Border Regional Commission.

To address access barriers to good jobs, the Department is also committed to helping individuals and communities impacted by the opioid epidemic. The Centers for Disease Control and Prevention (CDC) has shown that rural Americans may be disproportionately impacted by opioids. Rural Americans face less access to healthcare and health insurance, which can lead to poor health outcomes.[3] To address the opioid crisis, the Department has awarded approximately $121 million to entities through its National Health Emergency Dislocated Worker Grants and nearly $20 million for the SUPPORT Act grants (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act).These grants provide grantees with resources to offer workforce services for individuals in communities impacted by the health and economic effects of opioids, including skills development and retraining. The SUPPORT Act grants delivered training and employment services that encourage individuals to enter professions that could address the increased need for workers in fields that assist individuals impacted by opioids. States and other eligible grantees can apply for National Health Emergency grants at any point.[4]

- For example, Connecticut received approximately $4.8 million through an opioid disaster recovery grant which is being used to provide eligible participants with disaster-relief employment as peer navigators in American Job Centers (AJC) and community centers, in rural areas of Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham counties. These positions provide the opioid-impacted population with the appropriate referrals for counseling and supportive services, as well as guide them through preparations for reemployment. Additionally, funds will assist with the provision of career and training services to eligible individuals wanting to transition to fields addressing the opioid crisis, such as credentialed counselors and recovery coaches.
- Maryland received $4.6 million in SUPPORT Act funding to implement its Beating the Odds project, which focuses on two goals: supporting local areas hit hardest by the opioid

[3] About Rural Health | CSELS | OPHSS | CDC

[4] National Health Emergency | U.S. Department of Labor (dol.gov)

crisis through delivering holistic, integrated workforce solutions aligned with the state's strategic response; and increasing the pipeline of workers by providing training and support activities to those who have been impacted by opioid use disorders (OUD) or those who seek to transition to professions that support individuals with SUDs. These funds are planned to serve over 700 participants through the end of 2024 including participants in the rural counties of Frederick, Washington, Alleghany, and Garrett.

WIOA's Indian and Native American (INA) Program also strengthens rural economies through its investments in tribal workforce development. The program is designed to help American Indian, Alaska Native, and Native Hawaiian individuals obtain jobs and become self-sufficient through the provision of employment, education, training, and supportive services. In FY 2023, Congress appropriated $60 million for the INA program.

The INA program allows tribes to design their programs in a manner that best fits the needs of those communities, consistent with the principles of the Indian Self Determination and Education Assistance Act. Sixty-five of our tribal grantees participate in what is referred to as the 477 program (based on the original enactment in 1992 under P.L. 102-477, which was amended in 2017 under P.L. 115-93), which allows Federally recognized tribes to combine multiple federal employment and training programs into a single award, putting decisions about program design and implementation into the hands of tribes. The Department continues to work closely with the Department of the Interior to support this program. We are proud of the Memorandum of Agreement that was signed last year after tribal consultation and provides more flexibility for tribes, and we're looking forward to partnering with tribes that are looking to expand how they use the 477 program.

Finally, ETA and the Biden-Harris Administration are working to improve and fortify community colleges through our Strengthening Community Colleges Training Grant Program, which aims to build the capacity of these colleges to collaborate with employers and the public workforce development system to meet local and regional labor market demand for a skilled workforce. We recently awarded the third round of grants, providing $50 million to 15 colleges to increase educational and economic opportunities for people in underrepresented communities, including rural areas. These grants will fund a variety of different projects across the country, including projects in New Jersey, Texas, and California.

- For example, Chippewa Valley Technical College in Eau Claire, Wisconsin received almost $5 million through the most recent round of funding to recruit, train, and prepare rural secondary and postsecondary students, including students of color, for essential healthcare careers across rural western Wisconsin and focus on addressing existing equity gaps preventing widespread access to educational and economic opportunities.

Two years ago, we awarded $40 million in H-1B Skills Training grants for Rural Healthcare. Those grants 1) increase the number of individuals training in healthcare occupations that directly impact patient care; and 2) alleviate healthcare workforce shortages by creating sustainable employment and training programs in healthcare occupations (including behavioral, mental, and substance use disorder healthcare) serving rural populations. Those grants will operate through 2024. In the next few months, we will award approximately $80 million for Nursing Expansion Grant Program to address bottlenecks in training the U.S. nursing workforce and to expand and diversify the pipeline of qualified nursing professionals who can fill quality jobs in healthcare.

To help identify and address barriers workers faced regarding access to state unemployment insurance benefits, the Department has awarded to date more than $200 million in funds through Unemployment Insurance Equity Grants to states. Funded by the American Rescue Plan Act and administered by ETA, the grants allow states to implement projects that seek to remove barriers related to race, age, ethnicity, language proficiency, disability status, geographic location, or other systemic issues that make it difficult for people to access unemployment insurance benefits.

Sector Strategies to Meet Critical Workforce Needs in Rural Areas

ETA's strategies to put America back to work following the COVID-19 pandemic and help American businesses compete in the global economy include investing in high-quality workforce training programs and expanding access to underserved communities; scaling evidence-based practices including sector-based training and career pathways; and expanding and increasing access to Registered Apprenticeships and effective work-based learning.

According to the USDA, trucking accounts for 70 percent of agricultural and food product transportation and represents 30 percent of all ton-miles moved on U.S. transportation systems.[5] A strong, stable, and safe trucking workforce that offers good-paying jobs to millions of truck drivers is a critical lifeblood of our economy. That's why we worked with the Department of Transportation to launch the Trucking Action Plan to Strengthen America's Trucking Workforce, which promoted Registered Apprenticeship to get more well-trained drivers on the road. Through this initiative, 102 new apprenticeship programs were developed and approved, surpassing the goal of 90 employers in 90 days, and 574 new truck driver apprentices were hired as a direct result of the challenge. This shows how the public workforce system can respond to the workforce needs of industry and business, adapting to changes in the economy.

Education is foundational to success regardless of geography, but rural America is experiencing a teacher shortage crisis. Together with the Department of Education, we developed an alternative affordable option to develop and train educators through Registered Apprenticeship. We are seeing Registered Apprenticeships grow and giving rural school districts opportunities to

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[5]Agricultural Transportation Research and Information Center, USDA: https://www.ams.usda.gov/services/transportation-analysis/research

develop their teacher pipeline through this proven "earn and learn" model. We are prioritizing using funds to expand Registered Apprenticeship to new sectors and occupations, and increase access for underrepresented populations and communities, including rural areas. Funding for Registered Apprenticeship will provide critical support for states and other partners looking to start and expand teacher apprenticeship programs. Students need qualified teachers who are prepared to teach them, and who reflect the diversity of our students.

The Department recently published a Request for Information (RFI) on using Sector Strategies to Meet Critical Workforce Needs Across Industries. We asked for input from all stakeholders involved directly and indirectly in economic and workforce development on the use of models that address the workforce needs of specific industry sectors within a local or regional labor market through a strategic sector partnership. This stakeholder input will inform the Department's efforts in developing sustainable and scalable sector strategies that can support rural communities through economic development and workforce collaboration to meet local and regional sector needs for skilled workers in quality jobs while meeting broader Administration objectives, such as equity and the inclusion of historically marginalized populations and underserved communities within those sectors, and responsiveness to the needs of businesses and the economy in critical industries during and beyond the pandemic.

Innovating Workforce Development to Meet Rural Community Needs

The COVID-19 pandemic and other emergencies required states and local areas to adapt service delivery strategies to meet the accessibility needs of job seekers. Several states have noted that they have emphasized virtual service delivery or partnerships with schools, libraries, and other government agencies to further expand the reach to rural and underserved communities. ETA's Regional Offices work together with state and local partners to ensure individuals receive the services they need to enter and re-enter the workforce.

When Hurricane Fiona hit Puerto Rico, the State of Connecticut and a local workforce development board in southwestern Connecticut, the WorkPlace, stepped up to help. Working with ETA's Regional Office and the Federal Emergency Management Agency (FEMA), Connecticut provided Puerto Rico with a mobile unit that Puerto Rico could use to serve individuals in rural areas who could not access necessary services. This is a perfect example of federal, state, and local partners working together to meet the unique challenges faced by rural areas.

The Idaho Department of Labor has expanded its footprint by creating approximately 50 mobile AJC locations in rural Idaho for on-line unemployment insurance claims filing, job placement, and WIOA career services. These mobile AJCs are co-located at various sites, including libraries and community centers. AJC staff visit these locations on a rotational basis, anywhere from three days a week to once a month. It is not uncommon for some individuals to commute more than 50 miles to visit a brick-and-mortar AJC, so these mobile AJCs serve a critical need in rural areas.

The Oregon Employment Department uses an Equity Framework applied to new projects and programs to identify access factors that disproportionately impact rural populations, including

lack of internet, inability to travel lengthy distances for in-person services and needing services in Spanish, which is the second most common language for rural Oregonians. The Equity Framework assists Oregon in taking these factors into consideration to reduce or eliminate disproportionate impacts on rural communities. Oregon is also conducting outreach to historically underserved populations. This outreach includes tribal consultation, as Oregon's nine Federally recognized tribes are located in rural areas, as well as calling unemployment insurance claimants living in rural areas to assist them in filing claims and accessing reemployment services.

Mother Lode Job Training (MLJT) is a rural workforce development agency covering four California counties, more than 5,000 square miles, and housing two state prisons with populations over 4,000 inmates each. Currently funded through WIOA and other grants to prepare the workforce with the skills needed to meet the demands of business and provide a self-sustaining wage to workers, MLJT has successfully completed a statewide pilot to launch secure versions of California's Management Information System and workforce development tool, CalJOBS, to prisons. This successful program has achieved "first-in-nation" status, with real-time data-sharing from within the prisons to the State Workforce Development MIS System. To reduce recidivism, MLJT uses this tool to provide workforce development services inside the prisons to provide a continuum of service pre- and post-release. It has been proven that employment cuts recidivism in half. Providing pre-release workforce development services with uninterrupted transition to post-release services is the method needed to accomplish this. With incarceration costing the state $100,000 per inmate annually, the cost savings this program will bring the state is substantial, and the goal of the grantee is to cut recidivism by 24 percent.

It's not just where we invest, it's how we deliver our services and how workers get trained. While there are approximately 2,300 AJCs across the nation, this number has steadily declined over the past 20 years and broadband, transportation, and childcare barriers continue to create challenges for the rural workforce in accessing services. This is why state and local workforce boards have pursued the concept of bringing services into the rural areas. As demonstrated by the examples shared, this is done through a variety of ways, to include mobile units, connection points at libraries, community-based organizations or faith-based organizations, to virtual services that are administered through cellphones. The innovations occurring at the state and local level are providing promising practices about how to reach underserved and marginalized populations throughout the country and should inform future efforts to invest and strengthen the public workforce system.

Broadband and Digital Literacy

Access to broadband is important for economic opportunity in rural areas, which need the technological capability to connect with the global economy. Digital skills are workforce skills, which is why the Department joined Commerce, Education, and the Institute of Museum and Library Sciences in developing an RFI, published in December, requesting information on digital literacy and resilience. Specifically, the RFI sought public comments on successful approaches related to digital skills attainment and competency development in education and training efforts, the strategies our education and workforce development systems are employing to assess and

ensure individuals are digitally resilient, and any challenges the education and public workforce systems are facing. ETA also requested information on strategies to advance digital equity and inclusion in the workforce.

ETA and its federal partners will use the information collected through this RFI to inform competitive grant opportunities, further develop technical assistance, inform public policy on the expansion of digital skill-building training programs that facilitate upskilling the workforce, and address demands related to digital literacy and access.

Additionally, this month the National Telecommunications and Information Administration (NTIA) at the Department of Commerce published a request for comments on the Digital Equity Act passed under the Bipartisan Infrastructure Law, which will provide $2.75 billion to promote digital equity and inclusion activities and build capacity for state-led efforts to increase adoption of broadband by their residents. The Department will watch this effort closely and collaborate with Commerce to identify the lessons learned from comments and share our expertise from prior experiences developing a pipeline for the digital workforce.

WIOA can also serve as a powerful tool to support digital literacy efforts. Within our guidance, ETA has highlighted that states can use WIOA funding to overcome digital skills gaps by paying for devices and broadband internet services and referring participants to the Affordable Connectivity Program, which helps families and individuals access affordable broadband and discounts on devices like laptops, tablets, or mobile phones.

We are also highlighting success stories where our grantees have established promising practices in digital literacy, including on the Central Coast of California, which launched a project that offers job seekers workshops on digital literacy. The county is providing digital literacy training, equity in access, and upward mobility in government work for individuals of color, and ongoing support of partnering to address the digital divide in communities resulting from lack of access to training or internet service. The experience gained from this grant will be applied to improve digital literacy for youth, including youth with disabilities.

Job Corps

Job training is often hard to come by in rural America. Job Corps, with 121 centers nationwide, has been an important education and training resource for young people and employers in rural areas. Job Corps provides academic and career technical training, counseling, and placement services for eligible youth into either an entry level job, registered apprenticeship, military service, or additional post-secondary education. Twenty-one Job Corps centers are operated by the Department of Agriculture, many of which are located in former Civilian Conservation Corps areas. These centers include a course of study on addressing, preventing, and fighting wildfires to train students on becoming firefighters. Amid more than 66,000 wildfires that burned nearly 7.6 million acres of land across the country in 2022, students in Job Corps Centers combined to provide 204,633 total hours of support to federal firefighters – a 20 percent increase over the previous year.

Government-wide Initiatives

The Department of Labor is a part of the Rural Partners Network, which is a whole-of-government effort to transform the way federal agencies partner with rural communities to create economic opportunity. Through the Rural Partners Network, primarily led by USDA, the Administration is marshaling the combined resources of federal agencies and other providers to partner directly with rural people and places and unlock the full potential of rural America. To support this effort, 13 key federal agencies, including DOL, identified Rural Desk Officers to serve as a front door for Rural Partners Network Staff and rural communities as they navigate the resources available across the federal government.

In addition to this interagency effort, the Administration also has made historic investments in rural communities through the American Rescue Plan and the Bipartisan Infrastructure Law, including investments that provide rural Americans with high-speed broadband, support economic development, and strengthen workforce development in rural communities. The Department has worked with our federal partners to ensure that these funds work for rural American workers—whether they are to build bridges, expand access to high-speed internet, or manufacture chips. As part of that effort, the Administration released a Bipartisan Infrastructure Law Rural Playbook[6] that helps rural communities understand funding that is available under the law and other sources, as well as the Equitable Workforce Development for Infrastructure Jobs guide, which provides other sources of funding that can be leveraged to support workforce development.[7]

Again, the Department also partnered with the Department of Commerce to establish Good Jobs Principles, with the aim to improve job quality throughout the country by providing critical information to workers, employers, and government entities.

Through the administration of programs authorized by WIOA, the Department continues to provide guidance and technical assistance to the workforce system to promote equity and job quality and to leverage infrastructure and other funding to create economic opportunities for workers and jobseekers in rural areas. States and local areas can use funds from the other initiatives in coordination with the services provided by WIOA to ensure businesses have the workers they need.

- In October 2022, ETA published Training and Employment Notice 08-22,[8] Building Pathways to Infrastructure Careers: Framework for Preparing an Infrastructure Workforce. This guidance provides a framework and vision for the public workforce system as a strategic partner in creating and supporting pathways to millions of good-paying infrastructure jobs.
- In January 2023, ETA issued guidance to the workforce system, Training and Employment Guidance Letter 07-22, Increasing Employer and Workforce System Customer Access to

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[6] Bipartisan Infrastructure Law Rural Playbook: https://www.whitehouse.gov/build/resources/rural/
[7] Equitable Workforce Development for Infrastructure Jobs: https://www.whitehouse.gov/build/resources/equitable-infrastructure-workforce/
[8] Training and Employment Notice 08-22, Building Pathways to Infrastructure Careers: Framework for Preparing an Infrastructure Workforce: https://www.dol.gov/agencies/eta/advisories/ten-08-22

Good Jobs.[9] This guidance outlines how the workforce system should integrate good job strategies into its employer partnerships and workforce training.

- ETA also launched a Job Quality Academy in partnership with Jobs for the Future and other national partners, which presents a unique opportunity to help the workforce system and its partners to focus on enhancing good jobs and opportunities for workers.

A thriving rural workforce requires thoughtful strategies for recruiting and retaining workers and job seekers in rural communities. ETA is working to strengthen our federal, state, and local partnerships to address disparities that workers from underserved rural communities face to obtain good jobs with family sustaining wages and benefits, free from discrimination, and with the right to join a union. The moment is right to maximize the full potential of the unprecedented federal investments in infrastructure, clean energy, manufacturing, and technology, by strengthening the public workforce system to meet the country's workforce needs and be a powerful tool for connecting under-resourced and underrepresented workers and communities to good jobs.

Thank you again for inviting me today. I am looking forward to your questions about the work ETA is doing to address the workforce challenges in rural America.

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[9] Training and Employment Guidance Letter 07-22, Increasing Employer and Workforce System Customer Access to Good Jobs https://www.dol.gov/agencies/eta/advisories/tegl-07-22

Mr. ADERHOLT. Thank you. Thanks for each of your testimony, and we will begin our questioning.

TELEHEALTH CHALLENGES

Mr. Morris, let me start out with you. Access to specialists, particularly difficult in rural communities. Advances in technology have opened the field of telehealth that enable rural hospitals to have access to consultations, training, and other medical support from specialists who actually may be hundreds of miles away.

What are some of the challenges to expanding telehealth in this respect in rural areas?

Mr. MORRIS. Mr. Aderholt, thank you for that question.

And also thanks to the Congress for extending the public health flexibilities for telehealth reimbursement under Medicare in the recently enacted omnibus bill. That was a big step in ensuring that we build on what we saw during the pandemic, when we saw a dramatic expansion in the use of telehealth as people turned to this technology.

Of course, as you know, rural areas have been relying on telehealth for some time now, and it is urban areas that sort of leveraged it during the pandemic in sort of a new way. So, anyway, I think we have been investing at HRSA in telehealth since the early 1990s. We are home to the Office for the Advancement of Telehealth.

But to your specific question, I think there are several programs that we have that are seeing dramatic use of telehealth. Obviously, there are the grant programs within that Office for the Advancement of Telehealth. We have seen great adoption by our community health centers in telehealth. Congress has also funded the maternal and child health—the Pediatric Mental Health Access Program that does more for provider-to-provider telehealth where they connect primary care docs with pediatric specialists via telehealth.

And so there are several challenges I think that are largely structural in their nature. One is cross-State licensure and the burden for clinicians to have to be licensed in multiple States. That is a pretty arduous process, and to have to do it the same way every time for multiple States can be a bit of a burden on a busy practitioner.

Second, you have already referenced this. The broadband access issue is a real challenge. You can have the greatest equipment, but if there is no broadband, it is not going to work.

A third area would be workforce. We know the technology works, but we have to have clinicians on either end of the line to really make it work.

So we have a number of efforts underway. On the licensure side, we stood up what is called the "provider bridge," where we can have clinicians that can take the common elements of licensure and post them securely so that they can then be used to make it a little bit easier to apply for licenses in multiple States.

We also continue our work to work with physicians and with social workers on a compact so that States can join together and have a common way for providers to seek licensure.

On the broadband issue, I am encouraged by the fact that the infrastructure bill has funding that the Commerce Department is

putting out as we speak to really address the remaining broadband gaps that are there. That process is underway, and hopefully, that will alleviate some of the challenges that are out there.

A third area on workforce I think we have underway, thanks to the Congress' generous support of our health workforce programs, particularly the expansion of behavioral health. If you look at the utilization of telehealth, probably the number-one application of it is around ensuring access to mental health services. And so those are the three ways that we are trying to address it.

Mr. ADERHOLT. Thank you.

RURAL PHYSICIAN TRAINING

Let me turn just to discuss rural physician training. Practicing as the only physician in a remote area I know can be a challenge. Clinicians can feel isolated. They can feel overwhelmed and unequipped to handle the unique aspects of rural medicine.

How are we encouraging medical schools to include a rural rotation or establish a rural residency track?

Mr. MORRIS. Very good question. On the medical school track, HRSA has a number of programs that can support this. The Primary Care Training and Enhancement Program allows for medical schools to apply for funding, and they have the option to develop targeted admissions or rural training tracks within that medical school curriculum.

We also have a Medical Student Education Program that can be used for this as well. The Area Health Education Centers can also play a key role in sort of exposing people to rural practice during their clinical rotations.

On the residency side, I do have to credit this committee because in 2018, the committee created the Rural Residency Planning and Development Grants. And it builds on an idea that had been around for a while that we could have residencies in rural communities, but the challenge was that it takes a lot of resources and time to get through the accreditation and the process and setting up all the various rotations for a physician residency.

And that was a big hurdle to overcome. So when the committee provided the funding for the Rural Residency Planning and Development Grants, we were able to then provide the support that helped people get through that accreditation process, and they were able to take advantage of flexibility under Medicare right now for rural hospitals to be able to create new residency programs, meaning that the committee can invest in the creation of the residency and then hand it off to either Medicare, Medicaid, or State revenue for that to be covered in perpetuity.

And so what we are seeing now is a growth in the number of rural residency programs around the country. Our research shows from the University of Washington that exposure, like having half of your time in a rural residency under family medicine, is connected to a fivefold increase in the likelihood that those physicians will choose to practice in rural communities.

So it is a model that works, and we just appreciate the support you provided over the years.

Mr. ADERHOLT. Are we doing enough for these rural residency policy grants, or could we do more? Or what is your opinion on that?

Mr. MORRIS. We are getting more high-scoring applications than we can fund under the current appropriation.

Mr. ADERHOLT. All right. Ms. DeLauro.

Ms. DELAURO. Thank you very, very much, Mr. Chairman.

First of all, let me just say—and I hope this doesn't detract from my time. I want to just say thank you for your testimony. Oftentimes, agency officials are denigrated in a number of ways, what they do, how they do it, et cetera. What just eloquent testimony. But the work that you are doing in addressing the needs of whether it is education, whether it is health, or whether it is job training is really outstanding and meeting a need.

And the second thing I would just say is this committee—and I am just proud to be on this committee—that, in fact, it would appear that while we could do more, and we could always do more, Mr. Chairman, in terms of the funding opportunities, that what is critically important is to know that the omnibus bill in December really has played, I think, a role in allowing you to carry out your mission.

And for that, I say thank you to you and working to make it—working to make your vision and our resources work for rural America.

I do have a question—I have a question for each of you. Ms. Ryder, let me just say this, and this is on education. And we have tried to create this education pipeline in the 2023 HHS bill.

I know you are aware of the nationwide teacher shortage. Can you share what the Department is doing to support more teachers entering the teaching profession, including rural areas?

Ms. RYDER. Thank you for the question. I think it is such a critical issue for our work to address teacher shortages.

The Department is advancing a major initiative, elevating the teaching profession, encouraging more young people to come into the teaching profession. Coming out of the pandemic, we had a 130,000 teacher shortage relative to pre-pandemic. But we know there were shortages before the pandemic, and our schools still have a long way to go before they are fully staffed.

You heard Ms. Jacobs-Simmons talk about the federally registered teacher apprenticeships, which we are supporting along with DOL by getting information out and really working with communities. We have 16 States that have taken up at least 1 federally registered teacher apprenticeship program, with Tennessee being the first State.

We also, through our discretionary grant programs, are supporting residency models and grow your own, which we think are really good models for rural communities where people want to stay in their rural community. If they want to be part of the school system, they can go through their training while they are actually earning a salary working within the school system.

We are——

Ms. DELAURO. I will run out of time.

Ms. RYDER. I understand.

Ms. DELAURO. And I have got the three questions, but it goes on. And I will just say to you that that is why I am concerned as I acknowledged the proposed Republican cuts to the Department's budget. Secretary Cardona shared the 22 percent cut to Title I and IDEA grant funding would amount to an equivalent of removing 100,000 teachers and service providers from classrooms serving low-income students and students with disabilities.

Ms. Jacobs-Simmons, and you talked about WIOA, yes. What is the Department doing to get teens and young adults into the workforce?

Ms. JACOBS-SIMMONS. We are committed to serving young people. The Department is part of a shared youth vision Federal partnership, and I think we have demonstrated here today how we are partnering, and the whole-of-government approach works. This commitment is to ensure that the neediest youth in America acquire the talent, skills, and knowledge they need to transition into successful adult roles.

We are meeting youth where they are in the communities to carry out the vision. We go to midnight basketball. Our programs support youth. Our Job Corps program is serving youth.

These centers provide education and career services to help youth complete their education. We are also trying to do youth on-the-job training, giving them those work experiences and looking at sectors where they can have a future. We are training, for example, in the electric vehicle community. Some of our workforce boards are targeting high school youth so that we can create a pathway to employment.

Ms. DELAURO. Great. And I will just make note to you that according to—this is the Department's analysis. A 22 percent reduction to DOL-funded workforce training and development would prevent 750,000 job seekers from accessing services. That would have an enormous impact on rural America.

EXPAND RMOMS PROGRAM

Mr. Morris—and I beg the indulgence of the chair, to ask this one last question here. Maternal mortality rate in the U.S., unacceptable, appalling. And you talked about the RMOMS program. What would it take to expand the RMOMS program to all rural areas so all pregnant women can have access to high-quality obstetric services and maternal healthcare?

I am looking for—I would love to get dollars and cents because if it looks for places where we need to plus-up, as the chairman was talking, like can we do more with grants in some areas, we need your advice in this area.

Mr. MORRIS. Ms. DeLauro, I would like to get back to you on that because we would have to sort of do some calculations to figure out what that would be. I will say that what we are trying to do with the RMOMS program is to regionalize maternal healthcare to get everybody to work together a little bit more.

That has proven to be a bit of a challenge sometimes to get all the hospitals, the clinics, everybody sort of pulling in the same direction. So we haven't had a robust number of applications to that program, but we have seen some early successes on it. But I will be happy to come back to you with more information on that.

Ms. DELAURO. Thank you. I yield back, Mr. Chairman. Thank you very much for the time.

Mr. ADERHOLT. Ms. Letlow.

Ms. LETLOW. Thank you, Mr. Chairman.

TECHNICAL ASSISTANCE TO RURAL ORGANIZATIONS

And thank you to the witness for being here. The Census Bureau estimates that 60 million people live in rural areas, and I am one of them. I represent 24 parishes in Louisiana who are mostly rural, and so my heart is definitely with our rural communities.

I have to tell you I have only been here for 2 years, but over the past 2 years, I have visited every single parish and sat down and listened to their needs. What I hear from them overwhelmingly is that they know that the federal funds are there. They know they are not always aware of the grant opportunities, but they don't have financial resources to hire grant writers to go after the funding that they desperately, desperately need. I know that those monies are set aside for them.

So my question really is to all three of you. What are you actively doing to help rural communities, know that these grant programs exist and then help them with the grant writing process so that they can apply for these funds? How do rural set-asides in grant programs help level that playing field specifically?

Ms. JACOBS-SIMMONS. I will start.

Ms. LETLOW. Thank you.

Ms. JACOBS-SIMMONS. For the Department of Labor——

[Pause.]

Ms. JACOBS-SIMMONS. Okay. For the Department of Labor, we have, one, changed our Funding Opportunity Announcements so that they are more designed so that community-based organizations can easily apply. We are also conducting various webinars and trainings. I recently attended one in Memphis, Tennessee, where we are talking to people about how to apply for our funding opportunities, and that was recently in the Southeast region.

We are also working with National League of Cities and the other—and the Conference of Mayors to get the word out to our communities that these funds are available. Unfortunately, our funding cannot be used to support grant writers, but we are providing the technical assistance.

There is also some foundations that we have connected with that are willing to work with those. So we are doing outreach to rural communities and other community-based organizations.

Ms. LETLOW. Okay.

Ms. JACOBS-SIMMONS. Thank you.

Ms. RYDER. So we have been doing a major initiative around growing our grantee pool, and we really want to diversify the grantees who are applying. We have been greatly increasing our outreach. We have been working with the Organizations Concerned with Rural Education, OCRE, and the NREA, National Rural Education Association, to get information out to rural grantees.

You mentioned the rural set-asides for some programs. We do have several programs that include a rural set-aside. The Promise Neighborhoods, Full-Service Community Schools, and our Education Innovation Research programs have set-asides, and we have

consistently exceeded those set-asides, being able to fund high-scoring applications. So we feel like our outreach to rural communities in those programs has been successful.

Ms. LETLOW. Okay.

Mr. MORRIS. And Congresswoman, thank you for the question. It really is an important issue.

And we have a number of efforts underway. We work very closely with each of the 50 State Offices of Rural Health and the State Rural Health Associations. There is a State Rural Health Association in Louisiana, and they can be a key resource, I think, for rural communities in sort of accessing that TA.

We also are working with Dr. Cochran's organization, the National Rural Health Association, to have a targeted sort of promotion of our grants over the next couple of years. We also have an effort underway to look at underrepresented groups that either haven't applied or are applying and not scoring well and see if we can do targeted technical assistance to all of those as well.

And then I think the point about philanthropy is an important one. We have for the last 10 years worked with the Rural Health Philanthropy Partnership to educate them about our programs. But we also invite our Federal colleagues to those meetings as well because sometimes the grants can—like in Missouri for an example, they hire grant writers on behalf of community organizations that lack capacity. So that is a model I think worth replicating.

Ms. LETLOW. It is encouraging to hear that these efforts are underway, and I would just—I encourage you to keep doing it. So many of my constituents don't have access to rural broadband, when you talk about webinars, when you talk about outreach over the Internet, even that is still a struggle I want to do everything I can in my capacity to make sure that there is an awareness. I am especially interested in the RMOMS program. I think that that is wonderful for our rural communities, especially our women, as you know. I don't have to belabor statistics to you. You have seen them.

I just want to know how we can best partner with you to increase awareness and help my rural communities apply for these grants.

Thank you. I yield back.

Mr. ADERHOLT. Mr. Hoyer.

Mr. HOYER. Thank you very much, Mr. Chairman.

And thank all of you for being here and for the service you perform for our people.

Mr. Morris, you indicated—or I am sorry, Ms. Ryder, you indicated 35 years experience. Mr. Morris, how much experience do you have?

Mr. MORRIS. Twenty-five years.

Mr. HOYER. Twenty-five years. And Ms. Simmons.

Ms. JACOBS-SIMMONS. I just celebrated my 24th anniversary with the Department of Labor.

Mr. HOYER. So that is about 80-plus years experience. We have heard—the chairman mentioned in his opening remarks something that I thought was very relevant, and that is broadband. One of the problems that so many people living in rural areas have is not access to broadband.

We passed a very significant piece of legislation, the infrastructure bill, which includes $65,000,000,000 for rural broadband. All of us I think are very concerned about the rural areas because a significant number of our people live there. To the extent they do better, we all do better. Unfortunately, that did not have very broad-based support on the other side of the aisle, but it is being implemented now.

In addition to that, we passed a very substantial piece of legislation, which dealt with substantially increasing by $55,000,000,000 water projects. Many in rural areas of our country rely on septic tanks and perhaps wells.

I want to ask the three of you—and the reason I asked for your experience, this very substantial experience—over the last 2 years, 3 years, frankly, we passed very significant pieces of legislation, starting with the Rescue Plan, the infrastructure plan, the CHIPS bill, the Inflation Reduction Act, and the Safe Communities Act, which one of you mentioned.

I would like the three of you—and this is the only question I am going to ask this time because of time, and I want to give you the time—to give me your view as to how impactful those pieces of legislation were, including the omnibus to which the chair responded, have had on rural areas from your experience, relatively speaking.

Mr. Morris, we will start with you.

Mr. MORRIS. Well, I think any time we have an investment in rural communities, it is a net plus. And all of the pieces of legislation that had healthcare aspects to it I think have been tremendously beneficial.

The broadband in particular, in addition, it is not just the infrastructure bill, but the ongoing work of the FCC and the USDA to support broadband. It has sort of become fundamental to healthcare. So I think that is critically important.

The other one I would point to is just the dramatic expansion of health profession training dollars. Given the challenges that I think we all recognize with the healthcare workforce and the stress they have been under over the last couple of years, that money, while not rural specific, will definitely benefit rural communities.

Mr. HOYER. And which bill specifically are you referring to?

Mr. MORRIS. That has been mostly through the appropriations process.

Mr. HOYER. The omnibus and other legislation?

Mr. MORRIS. Yes.

Mr. HOYER. Ms. Ryder.

Ms. RYDER. I would like to speak to the Bipartisan Safer Communities Act. The Department received $2,000,000,000; $1,000,000,000 in formula grants, which we distributed to States in September of last year. These funds will be used to meet the really critical school safety and mental health needs that we are seeing in schools.

The funds will be distributed to high-needs LEAs, and States are working on getting those funds out right now. We will be providing support to them in identifying best practices for them to implement.

The other $1,000,000,000 went towards increasing the number of mental health providers in schools, school counselors, school psy-

chologists, school social workers through the School-Based Mental Health Program funding, which goes to school districts primarily to hire, respecialize, retrain mental health professionals within the school system. And then the Mental Health Services Professional Demonstration Grant, which I mentioned earlier, which is increasing the pipeline of people going into school mental health professions.

Mr. HOYER. And that bill to which you referred also made a substantial contribution to local police departments, funding local police departments so they could maintain safety, which we have seen so dramatically, unfortunately and tragically, over the last few days.

Ms. Simmons.

Ms. JACOBS-SIMMONS. Yes, sir. As you are aware, those bills—in those bills, there was no direct funding to the Department of Labor. However, in the infrastructure bill—and we are critical partners. Each of those bills requires coordination with workforce development. So we are leveraging our WIOA dollars in communities to work with entities that are receiving the grants under the infrastructure bill and the CHIPS bill.

That is how we are working. And as I said, we are leveraging the WIOA funds that we currently have to try to support those initiatives.

Mr. HOYER. Thank you. Thank you, Mr. Chairman.

Mr. ADERHOLT. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Mr. Chairman. And thank you for having this hearing today and focusing on the rural—needs of rural America.

And I appreciate all of you being here and your testimony today.

I have a very—20 counties, rural Michigan. Family farms are really the cornerstone of the rural communities in my district and really across the country. The adverse effect wage rate is having a severe impact on family farms in my district. And Ms. Jacobs-Simmons, are you familiar with that? Is that part of your area?

Ms. JACOBS-SIMMONS. It is not, sir.

Mr. MOOLENAAR. Okay. Well, this would be something where I would welcome your help on this because recently we spoke with a fifth-generation grower and recent college graduate who decided not to take responsibilities for her family farm. And the primary reason was the financial instability and unpredictability of the long-term, the labor issues.

And one of the issues she raised is that Michigan farmers using the H–2A programs were required to pay $17.34 per hour, a 12.8 percent increase from the 2022 rate of $15.37. And what strikes me is this is a Government mandate to pay certain wages that they want to be competitive, they want to pay their workers fair wages, but these kind of Federal Government requirements are making Michigan the fourth-highest wage state for agriculture, and it is actually discouraging people from continuing as family farms.

And that is a concern. I don't know if you have heard that concern before, but I would ask you to consider the implication on that.

Ms. JACOBS-SIMMONS. Yes, sir. We have our Office of Congressional Affairs here, and we will look into it.

Mr. MOOLENAAR. Okay. Thank you.

The second area I would like to talk about, we all mentioned the rural broadband and the importance of that. I recently had a discussion with the electric cooperatives in our State, very excited about different grant opportunities to build out rural broadband.

One of the things they struck me was when they said that they are applying for like a $50,000,000 grant to do a project, and it was going to cost $10,000,000 additional for them to use that grant because of Davis-Bacon prevailing wage requirements. That concerns me because we have so many areas of need for rural broadband, and when you think of $50,000,000, you think it would be going to build out this needed infrastructure. And instead, it is a Government mandated wage issue where they are not going to be able to do as much in that area.

Is that something you have heard anything about, or are you concerned about that?

Ms. JACOBS-SIMMONS. Again, that is not in my area of responsibility. That is our Wage Hour Department, and I don't—am not involved with that, sir.

Mr. MOOLENAAR. Okay. All right. Well, again, if you could just—these increasing costs are really hurting rural America because it is based on a formula that may have nothing to do with the cost of living in some of these rural areas.

HEALTH/CARE CLINICIANS

Well, and finally, I appreciate the work you are doing to help the healthcare clinicians. How do you—what is the description of the healthcare clinician? What categories would that be?

Mr. MORRIS. Thank you, Mr. Moolenaar. It is a catch-all term, but I use it to refer to everything from the physicians, nurse practitioners, physician assistants, all the allied health professions, lab techs, everybody that basically has a clinical roll.

Mr. MOOLENAAR. Very broad range?

Mr. MORRIS. Yes, sir.

Mr. MOOLENAAR. Okay.

Mr. MORRIS. It is easier than listing all of them.

Mr. MOOLENAAR. One of the things in talking with some of the health centers in my district in some of the rural areas, they are really trying to do some innovative things. For example, family healthcare in Baldwin, Michigan—Second District—it has trained four dental assistants, one registered dental assistant, two medical assistants, and they are planning to use a program through the Michigan Health Center Careers Training Program to train additional medical and dental assistants and pharmacy technicians.

And I guess my main thing is how do we support those initiatives in local areas, and then not get in the way of kind of a "one size fits all" when these programs seem to know their communities and what is most needed and what is most effective?

Mr. MORRIS. Well, Mr. Moolenaar, I think that is exactly the right approach in terms of being community specific. And I think sometimes we do tend to focus a lot on the physician and sort of the advanced practice nurse professions, but all of those are important. And that is where the partnership with the Department of Labor has been really valuable.

In HRSA, we fund universities and colleges and also some associate degree programs. But the Labor Department, their programs is very much laser-focused on a lot of the professions you mentioned. And so like last year, we worked together on a nursing initiative. And I think when we both do what we can do well within our authorities, and then do it collaboratively, I think it pays off for the community just in terms of flexibility.

Mr. MOOLENAAR. Thank you. I know I have exceeded my time. Thank you, Mr. Chairman.

Mr. ADERHOLT. Mr. Pocan.

Mr. POCAN. Thank you, Mr. Chairman. And I just want to say thank you for having this hearing. This would be great if this was across all the subcommittees because as we talk about these issues, I am thinking of things that aren't related to this subcommittee as well I would like to talk about related to rural areas. But really appreciate you having this today.

I live in a rural town of 830 people. I got broadband about half way through living out there. So I know what it is like not to have broadband. It kind of sucks. [Laughter.]

Mr. POCAN. Have propane heat, everything else. So, and my district also has some of the most rural parts of Wisconsin. There are 72 counties in Wisconsin. Two in the State don't have a stop and go light, and one is in my district, Lafayette County.

So the issues, though, that I see the most as I go to these rural communities is, unfortunately, decades ago they lost that last manufacturer that employed a lot of the people, and they just haven't really bounced back from that.

So you have an agrarian or an agricultural economy. You have a home-based business or self-employed economy. But I hear if you don't have broadband, which we have talked about many times, and you don't have a post office, they are not in business. So a lot of those issues aren't directly related to some of your budgets, but that is what I hear the most when I go around.

I guess the concern that I have and I share with the ranking member is that we are hearing there could be some substantial cuts proposed to the budget. There is some in leadership on the Republican side of the aisle that have proposed going back a couple years spending. And if you take that number and look at the discretionary nondefense spending—because I have been told that our chair of the full committee has said we are not going to be cutting defense—that is like a 22 percent cut.

IMPACT OF FUNDING CUTS

And I guess my question is specifically in your three areas, if you could just address if there was something you wanted to highlight that is important for rural America that if they are looking at a 22 percent cut across the board, what is something you really want to say please be very careful because this is a program that benefits rural constituents in all of our districts? And just love you to highlight what the concern you have is.

And Mr. Morris, we could start with you.

Mr. MORRIS. Thank you, Mr. Pocan, for that question.

It is very hard to pinpoint like one program and elevate it over the others. I think that any cuts result in fewer grants, fewer com-

munities served. So within the Federal Office of Rural Health Policy, the budget lines I think would all be affected by any sort of reductions, but we would make do the best we can with what Congress provides to us.

Mr. POCAN. So would that result in perhaps less healthcare outreach in rural communities?

Mr. MORRIS. Yes. For example, like with our Rural Communities Opioid Response Program, if this was to happen, we would not make any new grants in the coming year, and we would not be able to make all of our continuation grants for the grants that we have already funded.

Mr. POCAN. Thank you. Ms. Ryder.

Ms. RYDER. So I would mention, and I did in my opening statement, the REAP program, the Rural Education Achievement Program. I think that is critical funding for small rural school districts, and the funds are allowed to be used in a flexible way, which I think is an advantage for these school districts.

But I do also want to go back to the fact that the large formula funding, the Title I at $18,000,000,000, the IDEA at $14,000,000,000 is really critical funding that also goes out to all rural school districts. And many of you mentioned students with disabilities, and the IDEA funds to all school districts to support the diverse needs of children with disabilities.

Mr. POCAN. Thank you. Ms. Jacobs-Simmons.

Ms. JACOBS-SIMMONS. Like my colleagues, it is hard to focus on one. But we have the Workforce Innovation and Opportunity Act, which is the principal funding for our programs. And that is what enables us to leverage our funds with our colleagues here, and it is across our program and the Department of Labor and the tens of millions of folks we serve.

Mr. POCAN. Thank you. Well, I just—yes, I hope that what we have been hearing doesn't happen because for all the reasons that you said. But I really do appreciate having a hearing like this, and I do think, Mr. Chairman, if more committees did it, because all of these other questions I would have. But the number-one thing does seem to be jobs in those communities, and you go there, and unfortunately, it has been decades long.

And at least the CHIPS bill is going to help restore in some communities some ability to have jobs. We need to make more things here again. Steny has been saying that for decades. But that really is, I think, at the crux of much of this.

So thank you so much. Thank you, and I yield back.

Mr. ADERHOLT. Dr. Harris.

Mr. HARRIS. Thank you very much.

And thanks, all of you, for your help with rural communities.

BALANCED BUDGET

You know, mention was made of the omnibus bill in December, but I will tell you that that omnibus bill, the increased spending, led to increased inflation, which Americans are tired of. And they made unrealistic—they built unrealistic expectations. I mean, we cannot sustain a $1,000,000,000,000 a year deficit in this country.

And while I understand there are numerous programs, everybody wants to spend more money on good programs. The money just

isn't there. We can pretend it is. President Biden pretends it is there. He is 1 month late presenting a budget that never, ever balances.

I don't know about your families. My family budget has to balance. Your employer's budget doesn't have to balance. It is pretty amazing. I know a lot of private employers in my district. They wish they could have budgets that don't balance. It is completely unrealistic.

So let me ask you, because there are other solutions. And the lazy man's effort is to say, well, assume it is a 22 percent across-the-board cut. Nobody is talking about a 22 percent across-the-board cut, but let us set up a strawman and let us talk about it. And that is what we have been doing for the last few days here.

That is fine. If that is the way you want to play, that is fine. But let me ask you specifically, Mr. Morris, how many of your grants have a required State co-funding or copay?

Mr. MORRIS. The only one that we have is the State Offices of Rural Health. They have to match every dollar three to one.

Mr. HARRIS. So that is it? For all the other grants, you don't require a State match?

Mr. MORRIS. No, sir.

Mr. HARRIS. Well, that is pretty interesting because the traditional Medicaid program, which people hold up as a perfect example of State and Federal cooperation, has an average 44 percent State match. So, within your programs, if we just instituted a, oh, half of that match, 22 percent, we just heard that number somewhere. Maybe we should just ask—what do you think? Should we just ask States to maybe help us out? Because, remember, they have balanced budget requirements. We don't.

There sitting in my State billions of dollars that have been sent to them for COVID, billions of dollars unspent. Do you think it might be realistic for us, do you think it would be helpful if we asked them instead of cutting back the programs, ask them to cost share in some of them, some of those grants?

Mr. MORRIS. Dr. Harris, I——

Mr. HARRIS. It is semi-rhetorical question. I mean——

Mr. MORRIS. Yes, and I understand that.

Mr. HARRIS [continuing]. Of course, in order to preserve some of this, maybe we should just ask States to actually pay "their fair share." That is the bottom line, their fair share. And remember, traditional Medicaid, 44 percent fair share.

So, Ms. Jacobs-Simmons, on the WIOA grants, what is the State-required co-pay, co-share?

Ms. JACOBS-SIMMONS. There is no match.

Mr. HARRIS. None, wow. So here is another program where the State benefits—and look, I served in the State legislature for 12 years before I came here. The best thing we ever had was a Federal program with no State match because, man, you wanted to pull up—you wanted to back up to that and have the Federal truck unload the dollars into your State. No incentive for performance. All you wanted was more money coming into your State.

I would suggest that what this Congress should look at is making States pay their fair share.

Now, Ms. Jacobs-Simmons, in your testimony, I have heard that only about a third of WIOA participants, the people who actually—the workers get skills training. Is that correct? I heard it is 36 percent, somewhere around there?

Ms. JACOBS-SIMMONS. I don't have that number. I will be happy to get it.

Mr. HARRIS. Would you get that number to me? Because let me tell you, if it is about one-third getting skills training, what is going on? My understanding is that is the purpose of the program is to train people for modern jobs, to give them the skill set they need.

Shame on us if we have a program that $3,600,000,000 funding, and only one-third of the people are actually getting skills training. That doesn't work. Maybe what we should do is ask the States to pay their fair share, and maybe the States would keep an eye on whether or not those programs were actually training people with the skills they need.

So I would suggest that a return to pre-COVID spending levels, the Federal share, is a perfectly reasonable thing. People understand COVID is over. The time for $1,000,000,000,000 deficits has to draw to a close. The President's budget, remember, has $1,000,000,000,000 deficits forever, for all intents and purposes forever. Never balances. It is completely unrealistic to believe we can continue on that spending pathway without asking States to pay their fair share.

I yield back.

Mr. ADERHOLT. Mr. Harder

Mr. HARDER. Thank you so much, Mr. Chair, for holding this very important hearing. I am excited to be here, and I think I echo my colleague's point, Mr. Pocan, that we should be doing this in all of our subcommittees. I think it is tremendously important.

And thank you so much to all of our panelists for being here.

RURAL AND INDERSERVED COMMUNITY CRITERIA

I represent San Joaquin County in California, and we consider ourselves pretty rural and pretty underserved. We are the nut and fruit basket of the entire world. We have a fraction of the physicians that we need. We have 26 percent fewer primary care physicians, 34 percent fewer dentists than the State average.

We have a whole bunch of healthcare outcomes that reflect that deep disparity. The average life expectancy in my district is 6 years less than it is just an hour and a half away in Silicon Valley or San Francisco.

However, most of the really tremendous programs that HRSA supports in the rural and underserved areas we don't qualify for. That doesn't make a whole lot of sense to me. I think a lot of these criteria are based on States that have lower cost of living than California, that have smaller counties than California does. We have about 800,000 people in our county.

And so if you look at us across the county, you may see us as an urban or semi-urban area, even though there are some deep rural pockets. And so I am thinking about some of the programs that we desperately need in my district, like the work for Teaching Health Center Graduate Medical Education, the effort to support

more residency programs in rural areas. And yet we often do not benefit from that.

Mr. Morris, can you talk a little bit about the criteria that HRSA uses for allocating those grants? Specifically, what does it take to be both a rural and an underserved community?

Mr. MORRIS. Mr. Harder, happy to answer those questions.

So, with our programs, we do have to define what is rural and what is not. And I take your point about the size of California's counties. Some of them are bigger than States as you move east.

What we have done over the years in trying to do that is realizing that there is no perfect definition that fits the entirety of this country, so we use the county definition used by the Office of Management and Budget for non-metro counties. But we realized we needed to do more than that.

We then identified through the USDA's rural-urban commuting areas those rural Census tracks within metro counties, and we made a special adjustment for California because some of your Census tracks are also bigger than anywhere else in the country. So we are constantly trying to figure out ways that we are not disadvantaging any community.

The most recent change we made to our definition of rural is we identified metro counties that had no urban population. They were just sort of pulled into metro because of commuting data, and we have adjusted that and made those areas eligible. But we are happy to work with your office to identify the places that you feel are really disadvantaged on that and see what we might be able to do.

On your reference to some of the programs, so that affects the programs you apply for in the Federal Office of Rural Health Policy, but more broadly in HRSA, those programs are not real specific. So you mentioned Teaching Health Centers. Anybody can apply for that, rural or urban. What does come into play is are you medically underserved? Do you have a health professional shortage or any of those sort of things?

Mr. HARDER. Thank you. I think one of the challenges that we have, if you drive around my district, it feels pretty rural. And it is full of almond trees and wine grapes. A lot of folks live in those rural areas spread out, but we do have some urban centers. I mean, Stockton has 300,000 people. That is where most of the hospitals are that are applying for these programs, even if they serve rural populations that are spread out.

How do you take that into account? Because when I talk to our hospitals, they don't qualify for any of this, even though they serve a very rural population.

Mr. MORRIS. One of the changes Congress made around 2020–2021 was with our Rural Health Outreach Grants. They redefined the eligibility so urban entities could apply on behalf of their rural eligible areas.

So, for instance, your hospital in Stockton sees a lot of those rural patients in the outlying areas. As long as they are serving patients from the rural eligible Census track, they can apply for our funding and tap into that.

Mr. HARDER. Got it. Got it. Well, thank you. That is very helpful to know.

I would love to work with you on that because I think we are a poster child for a rural and underserved community that desperately needs more physicians that wants them to be homegrown, that wants to make sure that we are bringing along all sorts of healthcare opportunities. And yet, as I go line by line through the HRSA rural office support system, we are not eligible for a lot of that, and I feel like we should be able to.

So I would love to hear more about what those criteria are and specifically if there are programs that might apply to our district. And thank you for all the work you do. We just want to make sure that we get what we believe are eligible for.

Thank you so much. I yield back.

Mr. ADERHOLT. Thank you. Mr. Ellzey.

Mr. ELLZEY. Thank you, Mr. Chairman. Thank you for holding this hearing.

Before I begin my questions, I would like to address my friend and colleague from California and the comment that you made that many of us in Texas have long suspected that is you do represent the land of fruits and nuts. Did I hear you say that? [Laughter.]

Mr. HARDER. Absolutely. Absolutely.

Mr. ELLZEY. Okay. Very good. I just wanted to clarify that.

To our panel today, thank you for being here. It is clear from the work that you do that you serve our country and you have servant's hearts, and I appreciate the work that you do. It is not an easy task. And I am grateful for you being here.

I am a supporter of programs dealing with job training and retraining. Rural healthcare, I represent Texas 6, which is south of Dallas, which means I am in nine rural counties while the urban stuff is up north of me. So we have a lot of veterans in rural areas and veterans in general, and so I am glad we are having this hearing today.

The first question is for Ms. Jacobs-Simmons. What do you see as the biggest barriers to rural America using DOL-provided funds for successful job training programs?

Ms. JACOBS-SIMMONS. As we have discussed here today, too much of rural America doesn't have access to broadband. The lack of reliable high-speed broadband severely hinders the nature and quality of the education and training programs. It impacts their ability to get to the programs, transportation, the whole 9 yards.

I would see that as the biggest barrier.

Mr. ELLZEY. Thank you very much. That is a good answer.

And I would like to note that just a year ago—I don't know how long it is going to take—but we spent $65,000,000,000 ensuring that everybody in America has broadband, regardless of where they are.

So I don't know what the measure of effectiveness for how long that is going to take is. My guess is it takes them some time. But hopefully, we will get there fairly soon.

RURAL TARGETED FUNDING

Mr. Morris, it can be hard for my small rural communities to get Federal support that larger communities can access for help with things like treating people with substance abuse disorder, especially during COVID and after COVID, even when, as you know,

the needs are greater and greater in some rural communities. So how do HRSA's programs address this challenge, and what can this subcommittee do to make sure that HRSA meets those needs?

Mr. MORRIS. Mr. Ellzey, thank you for the question.

I think you have hit on an important point, which is rural targeted funding, and one of the things that we are particularly thankful for, for the committee, is the ongoing support of the Rural Communities Opioid Response Program. Because I think it gets at the point you are making, which is that a lot of times with sort of public health funding, we tend to distribute the funds through the States, and that is a very effective and efficient mechanism, and it gives the States a role in sort of deciding where those funds go.

But sometimes the rural communities have unique needs that don't necessarily fit in with that. And so by providing support for the RCORP program, we are specifically allowing rural communities that are facing opioid use disorder, substance use disorder, to come up with their own solutions because everybody sort of sees it differently. And so we want to provide them with the flexibility to do that, and you can do that through a rural targeted program that emphasizes community control.

And the other part we do is we don't provide a grant to just one entity. We make them come in as a network so that more people in the community and the region are invested in that project's success.

Mr. ELLZEY. Thank you very much, sir.

Finally, Ms. Ryder, in the time that I have left, how do rural school districts use Federal funding to help address educational challenges in rural America?

Ms. RYDER. So I think rural school districts are using their funds in roughly the same way as all. They are using it for teacher salaries. They are using it to support personnel, materials, supplies, and so on.

I do think one of the things we see in rural communities is more instruction that is done over virtual mechanisms, and that speaks to the broadband issues that we have been hearing here. But I know we see rural communities using funds to access advanced placement courses through virtual learning and, also other high-needs areas such as math and science.

And also we are increasingly seeing telehealth-related services being provided to students with disabilities, and I think rural communities take advantage of that with their funding as well.

Mr. ELLZEY. Thank you very much. Thank you all for you time.

And I would like to thank the attendees in the audience today. Seeing a lot of folks in the seats really does make a difference as we have these hearings so we can know how important it is to people in the United States.

Mr. Chairman, I yield back. Thank you.

Mr. ADERHOLT. Thank you. Mr. LaTurner.

Mr. LATURNER. Thank you, Mr. Chairman.

Good morning to the panel today. Thank you all for being here.

EXPANSION OF TELEHEALTH

Mr. Morris, you discussed in your testimony the role of telehealth in serving rural communities where access to care may be limited.

One of the few silver linings of the pandemic was that we were able to expand access to telehealth across the country, and Congress did provide some additional support on this front through its recent extension of the Medicare telehealth flexibilities.

Given HRSA's role on this issue through the Office for Advancement of Telehealth, what do you believe are the primary lessons learned from the expansion of these services in the past several years?

Mr. MORRIS. Mr. LaTurner, thank you for the question, and your point is well taken on the silver lining of the pandemic in the sense that while rural communities have long leveraged telehealth, I think we saw that the whole country benefited from it. And as a result of that, the need to reimburse those services is really important. So the passing of the flexibilities in the recent appropriations bill was critically important.

I think some of the key lessons learned are that there are still challenges with cross-State licensure, where a clinician has to get licensed in multiple States in order to provide telehealth services. And we have got some efforts underway at HRSA to try to reduce that burden and get States to work together on that.

We have talked about the broadband and how important that is going to be. You can't provide telehealth without the capacity to actually deliver the service.

And then the third area is just making sure that we have the workforce there to do it, and the Congress has supported these programs to expand the number of clinicians that work in rural and underserved areas. In particular, the expansion of the behavioral health workforce training because mental health is probably the highest utilization service within telehealth.

RURAL EMERGENCY HOSPITAL DESIGNATION

Mr. LATURNER. I appreciate that. As you mentioned, Congress recently created the rural emergency hospital, or REH, designation for hospitals to provide rural communities with another option to maintain access to emergency care and other essential outpatient services in their hospitals is at risk of closure. However, the law restricts REH eligibility to only those facilities who are designated as either a critical access hospital or inpatient hospital with no more than 50 beds as of December 27, 2020.

Would you support expanding eligibility for REH designation to facilities that previously had the CAH or appropriate inpatient designation and is still serving the same community, but whose provider designation changed before the enactment of the CAA?

Mr. MORRIS. The rural emergency hospital designation, I thank the Congress for creating it because I think it does give communities another option. Before, you could either be a hospital or you weren't, and now this is a viable option for them.

Anytime you write a piece of legislation, you have to set eligibility criteria, and in this case, they picked a firm date by the Congress about when you could be applying and how long you could be essentially closed. So I think what we can commit to is working with Congress to see where the pain areas are that folks are identifying where they think they might benefit from REH status but are currently precluded by the existing statute. And get a better sense

of those, and then work with you to figure out how best to proceed on that.

But it is a concern I have heard from rural stakeholders.

Mr. LATURNER. Do you support extending the eligibility?

Mr. MORRIS. I think we support working with you to figure out how to do that best. I can't speak for legislation and those things.

Mr. LATURNER. Okay. I look forward to working with you on that.

I yield back, Mr. Chairman. Thank you.

Mr. ADERHOLT. Thank you, Mr. LaTurner.

At this time, we will take about a 5-minute recess. We have got our second panel that will be coming on. So we have to make some adjustments to the mike over here that Ms. Jacobs-Simmons has been having to deal with. So we will take about a 5-minute break, and we will send along our second panel.

Thank you.

Ms. DELAURO. Mr. Chairman, just let me just apologize to the panel, if I can. There are five hearings that I am trying to get to today. So I appreciate all your work.

Thank you very, very much.

[Recess.]

Mr. ADERHOLT. Okay. Again, good morning. As we begin panel two, I will try to keep my remarks brief.

Our second panel consists of recognized experts in addressing rural issues.

First, we have Dr. Carrie Cochran-McClain. She serves as the Chief Policy Officer at the National Rural Health Association, responsible for driving the policy agenda for rural health for a 21,000 member organization. Carrie has more than 20 years of experience working in Federal healthcare policy development, including leadership roles at the Health Management Associates, U.S. Department of Health and Human Services, and the Federal Office of Rural Health Policy.

Second is Dr. Brittany Hott. Dr. Hott is an Associate Professor of Special Education and Associate Director of the Institute for Community and Society Transformation at the University of Oklahoma. Over the last 23 years, Dr. Hott has served as a special education teacher, instructional leader, teacher, educator, and researcher. Her focus—her work focus is on instructional methods for rural students with learning and behavioral disabilities, assessment and evaluation in rural education, and the translation of special education research to rural practice.

And next we have Ms. Laura Scheibe. Laura serves as South Dakota's Director for Career and Technical Education and the Director of the Division of College, Career, and Student Success at South Dakota Department of Education.

She oversees secondary CTE programs and coordinates closely with the Board of Technical Education to oversee the State's four public technical colleges. She also guides Jobs for America's Graduates South Dakota, which offers school counseling, dual credit, student wellness and supports, and other initiatives that work together to ensure students are prepared for success through and to after graduation.

And fourth witness is Dr. Tearsanee?

Dr. DAVIS. Tearsanee.

Mr. ADERHOLT. Tearsanee, okay. I will just say it quickly. Tearsanee Davis. She serves as the Director of Clinical and Advanced Practice Operations at the University of Mississippi Medical Center's Center for Telehealth. She has earned her bachelor's degree in nursing from the University of Southern Mississippi, her master's of science from Alcorn State University, and her Doctor of Nursing practice from none other than University of Alabama Birmingham. Dr. Davis has conducted extensive research into telehealth medicine and worked on five studies into the effectiveness of telehealth.

I want to thank all of our witnesses for coming today, and now I would like to turn to my ranking member to offer any remarks that she would like to make.

Ms. DELAURO. Mr. Chairman, I just want to welcome our guests. Anxious to hear their testimony. I had referenced them in my opening remarks and so forth, and really grateful for the work that you do in addressing these really serious challenges that people are facing and really making opportunity real for folks.

So thank you very much. And with that, I will yield back.

Mr. ADERHOLT. Very good. Well, welcome again. It is good to have all of you here. And you will—what we will do is each of you will have 5 minutes to provide your testimony, but your full written testimony will be included in the record.

So, Dr. Cochran-McClain, we will begin with you.

Ms. COCHRAN-MCCLAIN. All right. Well, thank you, Chairman Aderholt and Ranking Member DeLauro, for this hearing to discuss the many challenges facing rural America.

I have the honor of representing the National Rural Health Association and grateful to advocate for the nearly 60 million individuals who call rural America home.

In the coming year, we look forward to working with you to strengthen rural healthcare safety net and to ensure individuals and families across rural America have access to critical healthcare services they need.

I would like to thank the subcommittee for their vision and leadership in the creation of a number of critical programs mentioned here today, including the Rural Residency Planning and Development Program, and for making the rural healthcare workforce a continued priority.

Unfortunately, the pandemic exacerbated healthcare workforce shortages that have plagued rural communities for decades. Nearly three-fourths of rural counties are health professional shortage areas, and 1 in 10 counties don't even have a physician. With far fewer clinicians per capita, the maldistribution of healthcare providers between rural and urban areas results in increasingly unequal access to care, which negatively impacts rural health outcomes.

Research shows that rural exposure during healthcare clinical training results in higher rates of rural practice. However, less than 2 percent of physician residency training is in rural settings. We seek your support for initiatives that expand the capacity of rural areas to train future clinicians through community-based rural residency training.

Further, we urge you to maintain funding for core rural workforce development and distribution programs, such as the Area Health Education Centers and the National Health Service Corps. Now, more than ever before, it is crucial for the subcommittee to fund programs that seek to address healthcare crises in rural America.

As you mentioned, the rural hospital closure crisis continues to intensify with 147 rural hospitals shutting their doors. Of those remaining, as many as one in three are vulnerable to closure.

When a rural hospital closes, not only does the entire community lose access to care, but a major employer and community linchpin disappears, impacting the larger region. Investing in strong rural health infrastructure is critical to the future of rural areas, and NRHA calls on the subcommittee to consider proposals, including the President's budget request, for the financial and community sustainability for at-risk rural hospitals program, as well as the Rural Hospital Stabilization Pilot Program.

As you all know, COVID–19 devastated the financial viability of rural practices. It disrupted rural economies, and it has eroded availability of care. Medical deserts are appearing across rural America, leaving many without timely access to healthcare services.

In one of the more distressing examples, rural communities across the Nation are struggling to maintain obstetric services, with two-thirds of our Nation's maternity care deserts located in rural counties. Rural maternal mortality rates are nearly 60 percent higher in rural areas than large metropolitan communities. And that is why we need targeted—that is why we need your continued leadership for targeted solutions that help rural hospitals and clinicians keep delivering maternal health services to rural families.

Compared to their urban counterpart, individuals living in rural areas are more likely to die of the five leading causes of death. Further, untreated behavioral health needs, including treatment for substance use disorders, continue to plague our rural communities at alarming rates.

Opioid use disorders are the fastest-growing subtype of SUD nationwide, with overdoses related to synthetic opioids significantly higher in rural areas. That is why continued funding for programs like the Rural Communities Opioid Response Program located in the Federal Office for Rural Health Policy are so essential.

It is also why we count on your support for the newly established Centers for Disease Control and Prevention Office of Rural Health, an essential new voice for rural public health within the administration.

NRHA recognizes that strong, productive rural communities depend on access to timely and high-quality care to fulfill the significant role they play in our Nation's economy and the overall well-being of the entire country. As we often like to say, rural areas provide the fuel, food, fiber, and fun our urban and suburban neighbors rely on.

I would like to once again thank the subcommittee for their leadership and opportunity to join you today. The investments we seek for rural health programs at the U.S. Department of Health and

Human Services are a small portion of overall healthcare spending but are critical to the families and communities in rural America and our Nation as a whole.

[The information follows:]

National Rural Health Association

Dr. Carrie Cochran-McClain, Chief Policy Officer, National Rural Health Association

Testimony Submitted for the Record to the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies – FY 2024

On behalf of the National Rural Health Association (NRHA), I urge continued funding for critically important rural health programs in the Fiscal Year (FY) 2024 budget. NRHA appreciates the Subcommittee's attention to the challenges facing rural communities by holding this hearing and applaud your leadership in supporting the rural health care infrastructure. Our testimony outlines recommendations we believe will strengthen the rural health care safety net and ensure that rural Americans maintain access to critical health care services.

NRHA is a national nonprofit membership organization with more than 21,000 members, whose mission is to improve the health and health care of rural Americans. We provide leadership on rural issues through advocacy, communications, education, and research. NRHA's membership is a diverse collection of individuals and organizations that share a common interest in ensuring all rural communities have access to quality, affordable health care.

Now, more than ever before, it is crucial that the Subcommittee fund programs that seek to address the health care crises in rural America. Rural health care providers, who were struggling to keep their doors open prior to COVID-19, have been hit hard by the pandemic. The rural hospital closure crisis continues to intensify. Since 2010, 147 rural hospitals have shuttered their doors. As many as one in three rural hospitals are vulnerable to closure, with another third of these being at high risk of ceasing services. The pandemic also exacerbated health care workforce shortages that have plagued rural communities for decades. Nearly seventy percent of rural counties are Health Professional Shortage Areas, and one in ten rural counties have no physicians at all. With far fewer clinicians per capita, the maldistribution of health care providers

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between rural and urban areas results in unequal access to care and negatively impacts rural health outcomes.

Compared to their urban counterparts, rural Americans are older, more likely to have underlying health conditions, and less likely to have health insurance or financial resources to build back post-COVID-19. Individuals living in rural areas are more likely to die of the five leading causes of death. Further, untreated behavioral health needs, including treatment for substance and opioid use disorders continue to plague our rural communities at alarming rates.

Rural residents often encounter barriers to healthcare that limit their ability to obtain the services they need. COVID-19 devastated the financial viability of rural practices, disrupted rural economies, and eroded availability of care. Medical deserts are appearing across rural America, leaving many without timely access to healthcare services. In one of the more distressing examples, rural communities across the nation are struggling to maintain obstetric services, with two in three maternity care deserts located in rural counties.

NRHA recognizes the critical role that rural communities play in the overall wellbeing of America. Rural areas provide the fuel, food, fiber, and fun (recreation) that urban and suburban parts of our country rely on. Strong, productive rural communities depend on access to healthcare facilities and providers to fulfill their critical role in our nation's economy.

The investment in rural health programs at the US Department of Health and Human Services (HHS) is a small portion of federal health care spending, but it is critical to rural Americans. We encourage the Subcommittee to recognize that rural America has a healthcare crisis and desperately needs immediate solutions. Several indispensable discretionary programs help ensure the efficient and equitable delivery of health care services in rural areas. The HHS Federal Office of Rural Health Policy works to increase rural healthcare access, strengthen health

networks, and supported innovative research and programmatic efforts to address the unique needs of rural America. NRHA asks for continued funding for core rural health programs such as the **State Offices of Rural Health ($18m), Rural Health Policy Development ($14.5m),** and the portfolio of **Rural Health Care Services Outreach Grants ($90m).**

Further, NRHA urges the Subcommittee to appropriate targeted funding to support programs addressing the most pressing health care and public health needs in our rural communities.

Stemming Rural Hospital Closures: When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin ends, impacting the larger community. Investing in a strong rural health infrastructure is critical to the future of rural areas. NRHA calls on Congress for continued support for crucial programs like Health Resources and Services Administration's (HRSA) **Rural Hospital Flexibility grants ($73m),** which are used by states to implement specific rural strategies to ensure access to primary care in rural communities. Utilization of these grants is an effective way to provide relief and resources to struggling small rural hospitals. This proven grant program can be used by rural hospitals, rural health clinics, and other rural providers for community-based initiatives for health equity, behavioral health, telehealth, and new models of care.

Further NRHA urges the Subcommittee to support the President's FY24 budget proposal for HRSA's **Financial and Community Sustainability for At-Risk Rural Hospitals Program ($10m),** which is a new program that will target rural hospitals at-risk for imminent closure. The program will serve communities nationwide to provide intensive, short-term technical assistance to struggling rural hospitals, focusing on those sites that are essential access points in particularly vulnerable rural communities. The **Rural Hospital Stabilization Pilot Program ($20m)** is a

pilot program to provide support to at-risk rural hospitals to enhance and/or expand needed service lines in order to improve long-term rural hospital viability. The program would assess gaps in rural hospital services where expansion would meet local need and generate additional service volume to improve financial operations for the participating hospital working towards longer term viability for rural safety net facilities.

Building a Robust Rural Healthcare Workforce: Research shows rural exposure during health care clinical training results in higher rates of rural practice. However, less than 2 percent of physician residency training is located in rural settings. HRSA's **Rural Residency Planning and Development Program ($14.5m)** seeks to expand the capacity of rural areas to train future clinicians by increasing number of rural residency training programs to subsequently increase the number of physicians choosing to practice in rural areas. Since 2019, the program has created 32 new accredited rural residency programs in family medicine, internal medicine, psychiatry, and general surgery and received approval for approximately 415 new residency positions in rural areas. Additionally, NRHA calls on the Subcommittee to continue funding of core HRSA workforce development and distribution programs such as **Area Health Education Centers, Title VII and VIII Workforce Training grants,** and **National Health Service Corps.**

Ending the Rural Opioid Epidemic: Opioid use disorder (OUD) is the fast-growing subtype of substance use disorders (SUD) nationwide, with overdoses related to synthetic opioids significantly higher in rural communities. The **Rural Communities Opioid Response Program (RCORP) ($165m)** is a multi-year initiative that addresses barriers to treatment and prevention services for SUD, including for OUD. RCORP is one of the only federal programs with a uniquely tailored rural response to the opioid public health emergency facing our country.

National Rural Health Association

Further, solutions are needed to address the severe behavioral healthcare workforce shortages through rural America. The **Rural Health Clinic (RHC) Behavioral Health Initiative ($10m)** increases access to mental health services to allow clinics in rural areas without existing behavioral health providers to expand the availability of mental healthcare.

Addressing Rural Maternity Deserts: More than half of all now rural counties lack access to hospital-based obstetric services, with rates of closures increasing at an alarming rate. Rural maternal mortality rates are nearly 60 percent higher in rural areas when compared to large metropolitan communities. HRSA's **Rural Maternal and Obstetric Management Strategies (RMOMS) ($24.8m)** program aims to develop financially sustainable and integrated network models to increase access to maternal and obstetrics care in rural communities and ultimately improve maternal and neonatal outcomes. In FY 2024, NRHA encourages the Subcommittee to provide funding to continue established and expand new RMOMS grantee program cohorts, as well as support the Rural Maternal and Obstetric Care Training demonstration.

Protecting Rural Public Health: Rural areas throughout the country were disproportionately impact by mortality rates caused by COVID-19. The newly established **Centers for Disease Control and Prevention (CDC) Office of Rural Health ($10m)** will serve as an essential voice for rural public health within the Administration. NRHA calls on the Subcommittee to ensure the office has resources to effectively address health disparities facing the 60 million Americans living in rural communities.

NRHA is grateful for your support in recognizing the need for providing a sound future for the delivery of rural health care. We hope you will continue to support the millions of Americans in rural and underserved areas by acknowledging and considering these funding priorities.

Mr. ADERHOLT. Thank you so much.

Next we will hear from—let us go ahead with Dr. Hott.

Ms. HOTT. Good afternoon, Chairman Aderholt, Ranking Member DeLauro, and subcommittee members. Thank you for the opportunity to provide testimony and participate in the hearing today.

Thank you to the National Center for Learning Disabilities for connecting us.

I am a proud graduate of rural schools. I am a recipient of State and Federal personnel preparation support that provided the training necessary to serve our rural students and their teachers. My research is situated in rural communities, where almost 17 percent of our rural students live below the poverty line, and 14 percent qualify for special education and related services.

Often, our rural schools are portrayed negatively through a deficit-oriented lens. This is not reality. Our rural districts have so many strengths, including a strong sense of community, teacher autonomy, effective and longstanding partnerships, and the ability to implement individualized interventions. When district personnel and our communities leverage these strengths, we have the potential to enhance instruction and, ultimately, outcomes for students.

For example, preliminary results from current projects at the University of Oklahoma that serve rural students that are funded through the Office of Special Education and Rehabilitative Services and the Office of Elementary and Secondary Education have been quite positive. Our school partners report increased student academic achievement, decreased suspensions, and improved capacity to deliver special education services.

I am going to talk to you about challenges facing our rural educators, but I don't want us to forget the strengths and the opportunities that we have. Unfortunately, our rural educators continue to face significant challenges, including longstanding and pervasive personnel shortages, lack of access to professional development, and lack of resources.

Although there is a troubling lack of research reporting the educational outcomes of students receiving special education services from our rural localities, current data indicates that rural students with disabilities perform significantly below their peers with disabilities from suburban localities in mathematics and reading and are more likely to receive suspensions and expulsion.

Rural students with disabilities face many of the barriers that we have heard about today, including lack of broadband access, low expectations, geographic isolation, poverty, and teaching quality. These disparities directly impact postsecondary options, particularly in STEM fields where rural students are uniquely situated to contribute to our workforce.

IDEA funds flow through to districts and schools that provide these services. Yet we have yet to fully fund IDEA. Increases in funding are needed to support our rural students and ensure access to high-quality programming.

These concerns are not only limited to our students. Similar disparities pointing to inequitable treatment, resources, and results can be seen in our rural special education teaching force. These shortages limit access. These shortages lead to an inability to provide early intervention services for children and an overemphasis

on compliance. They are more pronounced in our rural districts, where schools are twice as likely to experience difficulties with teacher retention than our suburban counterparts.

Many rural localities face high levels of teacher turnover, which is even more pronounced in rural localities serving our high-poverty schools. Teacher attrition creates significant financial burdens for our districts and our schools, and it reduces student achievement. Although alternative routes to certification and provisional educator preparation pathways offer some reprieve from these shortages, individuals who pursue alternative certification are two to three times more likely to exit our field.

With respect to equity, students of color and students from low socioeconomic backgrounds are upwards of four times more likely to be taught by a teacher licensed through alternative programs. Addressing the achievement gaps between rural high-need schools and their suburban and urban counterparts requires thoughtful and deliberate action. Comprehensive training increases teacher retention.

To alleviate these issues, we have found success in using networked communities of practice and grow our own programs. This investment hedges poor outcomes that have resulted from emergency and alternative certification programs that do not provide training through mentored student teaching experiences and comprehensive curriculum. It also builds a community of educators that can maximize the strengths to meet student needs.

In summation, I am here asking for your support to ensure our children are workforce ready, highly productive, and strong citizens. We cannot do that without funding for IDEA, personnel preparation, and research.

[The information follows:]

Brittany L. Hott, Ph.D., BCBA-D

Associate Professor & Associate Director Institute for Community & Society Transformation

University of Oklahoma

Good afternoon, Chairman Aderholt, Ranking Member DeLauro, and subcommittee members. Thank you for the opportunity to provide testimony and participate in the Rural Issues Hearing. Thank you to the National Center for Learning Disabilities for connecting us. I am Dr. Brittany Hott, a special educator and board certified behavior analyst (BCBA) with doctoral distinction. I serve as an associate professor of special education and associate director of the Institute for Community and Society Transformation (ICAST) at the University of Oklahoma. My testimony is based on 23 years of experience as a special education teacher, instructional leader, teacher educator, and researcher.

I am a proud graduate of rural schools. I am a recipient of state and federal personnel preparation support that provided training to serve our rural students and their teachers. My research is situated within rural communities, where nearly 30% of U.S. schools serve one-fifth of all public-school students. Almost 17% of our rural students live below the poverty line and over 14% qualify for special education services.[1]

Often our rural schools are portrayed negatively through a deficit-oriented lens. This is not reality. Our rural districts have many strengths including a strong sense of community, teacher autonomy, effective and longstanding partnerships with students and families, the ability to implement individualized interventions, and opportunities to act as special education advocates.[2] When district personnel leverage these strengths, we have the potential to enhance instruction and ultimately outcomes for students. For example, preliminary results from current

projects at the University of Oklahoma funded through the Office of Special Education and Rehabilitative Services (special education doctoral leadership training) and the Office of Elementary and Secondary Education (behavior analyst, school counselor, and social worker training) are positive. School partners report increased student academic performance, decreased suspensions, and improved capacity to deliver special education services in Oklahoma because of these programs. I am going to talk about many challenges facing rural educators and the students we serve, but I want us to remember our strengths and successes.

Unfortunately, our rural educators continue to face significant challenges including longstanding and pervasive personnel shortages, lack of access to professional development and coaching, and resource disparities.[3] Urban and suburban districts face similar challenges related to teacher shortages; however, these challenges manifest quite differently in rural districts, which often impedes access to specialists and resources.

Rural Student Outcomes: Increase Funding for the Individuals with Disabilities Improvement Act (IDEA) State Grants to at least $16.26 million for FY 2024.

Although there is a troubling lack of research reporting the educational outcomes of students receiving special education services from rural localities, current data indicate that rural students with disabilities perform significantly below their peers with disabilities from suburban localities in mathematics[4] and reading[5], and are more likely to receive suspensions and expulsions.[6]

Rural students with disabilities face many barriers to accessing quality instruction and intervention including: (a) lack of broadband access, (b) low expectations, (c) geographic isolation, (d) poverty, and (e) teaching quality.[7] Further, descriptive reviews of Individualized Education Programs (IEPs) for students attending schools in rural areas note a lack of assessment data, progress monitoring, and specialized instruction to support academic growth[8] and poor

social and behavioral supports.[9] These disparities directly impact postsecondary options, particularly in STEM fields where rural students are uniquely situated to contribute to our workforce. IDEA funds flow through to districts and schools that provide special education and related services to children with disabilities. We have yet to fully fund IDEA. Increases in funding are needed to support our rural students and ensure access to high quality instructional programming.

Personnel Shortages: Increase Funding for the Individuals with Disabilities Act Part D (National Activities) Personnel Preparation Program to $300 million for FY 2024

Concerning outcomes are not only limited to students. Similar disparities pointing to inequitable treatment, resources, and results can be seen in the rural special education teaching force. This acute need is reflected in (a) data demonstrating national and state-level shortages of special educators and (b) data reflecting a dearth of special education faculty to train future special educators, particularly rural educators. The National Coalition on Personnel Shortages in Special Education and Related Services reports that 98% of school districts in the US experience special education teacher shortages. These shortages result in limited access to special education and related services, an inability to provide early intervention services, and an overemphasis on special education compliance. These shortages are even more pronounced in many rural districts where schools are twice as likely to experience difficulties with teacher retention than their suburban counterparts.[10]

These issues are exacerbated in rural contexts where it is difficult to attract educators due to remote locations and lower salaries. Many rural localities face high levels of teacher turnover, which is more pronounced in high poverty rural schools with less desirable working conditions. Teacher attrition creates significant financial burdens for schools and districts[11] and reduces

student achievement.[12] Although alternative routes to certification and provisional educator preparation pathways offer some reprieve from teacher shortages, individuals who pursue alternative certification are 2 to 3 times more likely to exit the special education profession than their comprehensively trained colleagues.[13] With respect to equity, students of color and students from low socio-economic backgrounds are upwards of 4 times more likely to be taught by a teacher licensed through alternative programs[14] resulting in the least prepared or qualified individuals supporting students with the greatest needs.

Addressing the achievement gaps between rural high need schools and their suburban/urban counterparts requires thoughtful deliberate action. Comprehensive training increases teacher retention. To alleviate these issues, we have found success using networked communities of practice and grow our own programs. This investment hedges poorer outcomes that have resulted from alternative and emergency certification programs that do not provide training through mentored student teaching experiences and a comprehensive curriculum. It also builds a community of educators that can maximize rural strengths to meet student needs. The Teacher Quality Partnerships program allows this work to happen.

In addition to the critical shortages of special education teachers, there are also faculty shortages. Higher education faculty are highly trained to develop quality, comprehensively trained special educators and conduct research. A long standing, well-documented, and pervasive shortage of special education faculty (in general) continues to impact the quality of teacher training programs[15] as well as the depth and breadth of our research base. The initial Special Education Faculty Shortage study established a clear link between the shortage of special education faculty and the shortage of qualified special education teachers. Over two decades later, growth in special education doctoral program graduates has not been sufficient to keep up

with needs. Data suggest that Institutions of Higher Education (IHEs) will need to produce at least six times the current number of faculty to generate new knowledge and in turn produce the next generation of special education teachers; yet, between 2009 and 2018 there was a 19% reduction in the number of special education doctoral programs.[16] This is the lowest level of training programs, 79 total, in several decades, which sharply decreases the special education faculty prepared to assume leadership and higher education positions. Like teacher recruitment and retention challenges, IHEs serving rural localities have trouble hiring special education faculty. For example, Oklahoma is a predominantly rural state. Findings from a survey of Oklahoma's IHEs with special education training programs indicate that 1 to 4 additional faculty members are needed to support program needs. Additionally, half of the institutions estimate one to three special education retirements over the next five years. Over half of the institutions indicate they have experienced at least one failed special education faculty search and one institution stated that they had 10 failed searches attempting to find qualified special education faculty member.[17] This pattern of difficulty securing strong faculty qualified to support and develop critically needed programming, engage in meaningful research, and to collaborate with rural partners illuminates the extreme need for additional preparation of special education faculty members.

In summation, I am here asking for your support to ensure our children are workforce ready, highly productive, and strong citizens. We do not have time to wait. Please support the aforementioned increases in IDEA, personnel preparation, and research funding.

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Mr. ADERHOLT. Thank you. Ms. Scheibe.

Ms. SCHEIBE. Good morning, Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee. Thank you for the opportunity to appear before you today to share a bit of the national landscape on career and technical education, or CTE, and the success South Dakota's technical colleges have had in meeting rural workforce needs.

My name is Laura Scheibe, and I have the honor of serving as the State CTE Director in South Dakota, and I am currently serving as the elected president of Advance CTE, a 103-year-old organization that represents me and my peers in all 50 States, the District of Columbia, and U.S. territories.

CTE marries students' interests and abilities with business and industry demand. It is no longer an either/or proposition between technical training and a 4-year university degree, but rather, a yes/and. A pathway along a continuum that can meet learners where they are, both literally and figuratively, with stackable credentials that have workplace and personal value.

So what does this look like on the ground in the States? South Dakota is where rural gets real. With fewer than a million residents and one area code that covers the entire State, our expanses are vast, but our economy and our people are thriving. With 2 percent unemployment and labor force participation at 70 percent, we do not have room to not get workforce right. The State's technical college plays a vital role in this equation.

In the years that COVID–19 hit college enrollment hard, our system barely skipped a beat. We actually gained students over a 5-year period, increasing enrollment by 9 percent. While nationally, 2-year public college enrollment declined by more than 19 percent. Across the system, 67 percent of students graduate, 98 percent are placed, and 89 percent choose to stay in State.

So what is our secret? The technical college label is deliberate. Most programs are eligible for funding from the Carl D. Perkins Career and Technical Education Act, or Perkins, the primary Federal investment in CTE.

Out of our four technical colleges, this year three were named to the top 15 percent of all 2-year colleges in the country, and the fourth won the award in 2017. It is not just me saying our technical colleges are great.

The skills learners master help our rural communities thrive and our economy grow. Whether it is independent contractors looking to meet skyrocketing demand or long-term care facilities trying to stay open, CTE is often the answer.

Our colleges are intentional in meeting the needs of adults for whom traditional schedules might not work. Campuses are building satellite locations to meet rural needs, as well as online, high-flex, and even competency-based education options to meet learners literally where they are, complete with labs on campus on the weekend or with business partners in the learner's community.

Scheduling and options accommodate working adults to keep them engaged and move them—and keep them moving forward to a credential, and industry gains the workforce needed to keep doors open. While these delivery options can get a student to enrollment, our supports keep them there. Learners move through their pro-

grams as a cohort, a built-in support and accountability network of their peers to help them persevere.

Additionally, Perkins-funded student success coordinators meet not just counseling needs, but transportation, affordable housing, and navigating postsecondary as a first-generation student. For learners facing barriers, this can make all the difference to move from poverty into a family-sustaining career.

To achieve these results takes resources. A CTE classroom looks like a well-equipped workplace. Although the investment in our future workforce pays off, doing CTE well is costly. That is where our colleges are good stewards of the taxpayer funding they do receive and leverage those dollars to attract industry investment.

Perkins plays a significant role in helping us deliver affordable, high-quality education. My State's fiscal year 2023 allocation is $6,000,000, with $2,300,000 in formula grants to postsecondary and a separate reserve fund that specifically benefits rural communities. This Federal investment means our students can experience, not just learn, their skills and come out workforce ready.

As a State, South Dakota invests its own funding into the system, including through one of our most successful programs, the Build Dakota Scholarship. It was conceived as State and donor-funded scholarships for learners in high-wage, high-demand areas. Yet last year, 81 percent of awardees benefited from $3,100,000 in industry commitments.

Industry's partnership has stretched the State's funding, grown the number of awards per year, and has guaranteed workforce for those employers. A sure thing in an economy when little is certain.

Across the system, you will find industry professionals helping shape programs, bringing their own workforce needs to colleges or providing millions of dollars of state-of-the-art equipment. In short, you will find industry at the technical college table.

In sum, I hope you take away that these keys to success are not secret and can and do work throughout the country. CTE is achieving real results for learners, and the Federal investment is vital to that success. We are proud of how we in South Dakota are working together to meet the needs of learners in industry to create an economic future that values both urban and rural alike.

Thank you very much, and I would be happy to stand by for questions.

[The information follows:]

Written Testimony of Laura K. Scheibe, State Career and Technical Education Director, South Dakota Department of Education and President, Advance CTE
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Good morning Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee. Thank you for the opportunity to appear before you today to share a bit of the national landscape on Career and Technical Education (or CTE) and the success South Dakota's technical colleges have had in meeting rural workforce needs.

CTE marries student interest and abilities with business and industry demand. It is no longer an "either/or" proposition between technical training and a four-year university degree but rather a "yes, and;" a pathway along a continuum that can meet learners where they are – both literally and figuratively – with stackable credentials that have workplace and personal value.

Nationally, employers view CTE positively in a manner that sets CTE up to shine. It is a widely held perception, with nearly 80% of respondents in a recent survey indicating our country needs more CTE to prepare our students for the jobs of today and tomorrow.

So what does this look like on the ground in a state?

South Dakota is where rural gets real. With fewer than a million residents and one area code that covers the entire state, our expanses are vast but our economy and our people are thriving. With 2.0% unemployment and 70% labor force participation, we do not have room to *not* get workforce right. The state's technical college system plays a vital role in this equation.

In the years that COVID-19 hit college enrollment hard, our technical college system barely skipped a beat. We actually gained students – over a five-year period South Dakota's unduplicated enrollment has increased nine percent, while nationally two-year public college enrollment declined by more than 19% and in our region, by 14%. Across the system we retain 78% of students and 67% of students graduate. The system's placement rate is 98% -- with 89% choosing to stay in state and 93% of those employed in their field of study.

So what's our secret?

In South Dakota, the technical college label is deliberate. Most every program is eligible for funding from the Carl D. Perkins Career and Technical Education Act (Perkins), the primary federal investment in CTE which promotes responsiveness to both industry and learner needs. Out of our four technical colleges, in 2023 three were named to the top 15% of all two-year colleges in the country. The fourth? Lake Area Technical College won the Aspen award as *the* best in 2017, and therefore is no longer eligible for that ranking. It is an endorsement that it is not just me saying our technical colleges are great.

The skills learners at the state's technical colleges master help our rural communities thrive and our economy grow. Whether it is independent contractors looking to meet skyrocketing demand or long-term care facilities trying to stay open, CTE is often the answer. Western Dakota Tech offers health sciences to meet the health care needs of Philip, a regional hub town of not even 800. But for that program, residents would have to drive more than an hour to Rapid City. In this satellite campus and others like it throughout the state, adults keep their community ties, reskill into high demand fields, and industry gains the workforce needed to keep doors open.

Our colleges are also intentional in meeting the needs of adults – juggling full-time work, dependents, and life generally – for whom traditional schedules might not work. Campuses are building online, HyFlex, and even competency-based education options to meet learners literally where they are – complete with labs and clinicals on campus on the weekend, or with business partners in the learner's community. Scheduling and options accommodate working adults to keep them engaged, keep them connected, and keep them moving forward to a credential.

While these delivery options can get a student to enrollment, our supports keep them there. Learners move through their programs as a cohort – a built-in support and accountability network of their peers to help them persevere. Additionally, Perkins-funded Student Success Coordinators meet not just educational counseling needs, but transportation, affordable housing, and navigating postsecondary as a first-generation student. For learners facing barriers, this can make all the difference to move from poverty into a family-sustaining career.

To achieve these results takes resources. A CTE classroom looks like a workplace and requires modern equipment to keep pace with industry. Although the investment in our future workforce pays off, doing CTE well is costly. That is where our colleges are good stewards of the taxpayer funding they do receive and leverage those dollars to attract industry investment.

Perkins funding plays a significant role in helping us deliver affordable high-quality education. Our Fiscal Year 2023 allocation is $6 million, with $2.3 million in formula grants to postsecondary. This federal investment means our students learn on modern, industry-grade equipment so they come out workforce ready. Additionally, our state's Reserve Fund, a flexible portion of Perkins, is a critical tool that allows us to further expand activities benefiting our rural communities. At the secondary level, this funding supports innovation and equipment not otherwise possible for small districts. Perkins formula funds, while vital, simply are not enough. The Reserve Funds help fill that gap.

As a state, South Dakota invests general dollars into the CTE system, including supporting tuition freezes and a dedicated salary fund to help pay closer to industry wages for industry professionals in the classroom – ensuring CTE programs can compete for that talent pool. In January the governor announced $10 million of state funds for equipment grants – matching two-to-one. Perkins, and industry, will help our schools leverage that match.

One of our most successful programs, the Build Dakota Scholarship, speaks directly to student and industry partners. In 2015 the state and a donor came together to fund full-ride scholarships in high-wage, high-demand areas for students who would then work in the state in their field for three years. Industry has long supported our students and stepped forward to partner on this initiative too. Last year 81% of awardees benefitted from $3.1 million in industry commitments. This has stretched the state's funding, grown the number of awards per year, and is guaranteed workforce for those employers – a sure thing in an economy when little is certain. Students graduate debt free, free to build their career and their lives rooted in a community. And in fact, one of our original Build Dakota scholars has started his own company and is now sponsoring a student himself. That's the power of partnerships.

Industry steps up to the plate to sponsor scholars. But you will also find them helping shape programs and bringing their own workforce needs to colleges. Southeast Tech boasts more than 300 companies who advise on programs. And the college has set up ten new programs in three years – including a teleconstruction diploma to meet the 5G tower needs of our country – each the result of relationships with industry. Businesses provide Mitchell Tech with millions of dollars of state-of-the-art technology and equipment at no or low cost, attracting students and companies alike. Lake Area Tech partners with national equipment companies to train students on service and repair.

Our placement rates and industry partnerships speak to our strong industry alignment. But alignment does not start at postsecondary. We are deliberate in supporting CTE in middle school, high school, through to technical colleges and even our university system.

As I have spoken to, South Dakota's technical colleges serve nontraditional adult learners, looking to reskill into a career that can better meet their needs where they are. But we

also need traditional aged-adult learners on campus who come to us confident in their career choices, fresh from their high school diplomas. Both ways are vital to meeting the state's workforce needs. And South Dakota excels at each.

All but one of our 149 public school districts offer approved CTE, which can give students a pathway into technical colleges (and in fact some of the coursework is technical college dual credit). Half of any given graduating class has taken a CTE course of study. Industry and technical colleges help write academic content standards, they collaborate on equipment and coursework, and for one-third of our districts, a technical college actually runs the Perkins consortium which makes their CTE programming possible. This innovation, which came out of Perkins V and is supported by Perkins funding, has been a game changer to revitalize smaller programs throughout the state. Why does this matter? Research from 2021 indicates that South Dakota CTE concentrators are faster to graduation, faster out of the gate into postsecondary and faster to a two-year credential. Which means faster into building their career and our workforce.

This is deliberate investment in our K-12 students. By exposing students to options and empowering them with experiences and skills, we help them confidently choose a path. CTE also lowers the risk for employers who choose to sponsor students' programs, because both sides enter those partnerships with clear expectations of outcomes.

In sum, I hope you take away that these keys to success are not secret, and can and do work throughout the country. CTE is achieving real results for learners across the country and the federal investment is vital to that success. We are proud of how we in South Dakota are working together to meet the needs of learners and industry, to create an economic future that values both urban and rural alike.

Mr. ADERHOLT. Thank you. And last, but certainly not least, Dr. Davis.

Dr. DAVIS. Chairman Aderholt, Ranking Member DeLauro, and members of the committee, it is an honor to appear before you to share from my perspective a portion of the challenges rural communities encounter while in pursuit of reasonable access to health services.

I thank the committee for the opportunity to testify before you today and anticipate a thoughtful and productive discussion.

My name is Tearsanee Davis, and I currently serve as the Director of Clinical Programs and Strategy at the University of Mississippi Medical Center's Center for Telehealth in Jackson, Mississippi. Additionally, I am a dually certified nurse practitioner trained in family practice and psychiatric mental health. I am a native of Durant, Mississippi, Holmes County, the poorest county in the poorest State as of 2019.

My testimony today is drawn from my personal and professional experiences while living and working in rural Mississippi, as well as my knowledge of efforts aimed to alleviate rural residents' lack of access to quality care.

Many factors contribute to disparities in health, such as unavailability of needed resources, socioeconomic issues, and lack of knowledge. Funding made possible by committees such as this enable us to implement programs, test models of care, and integrate innovation into practice in Mississippi that have a national impact.

The University of Mississippi Medical Center's Center for Telehealth is a Telehealth Center of Excellence, as designated by the Health Resources and Services Administration, and its partners have worked diligently to understand and address issues that continue to plague our State. There is more work to do.

It is no secret that rural areas have their own set of challenges that undoubtedly affect the health of the residents. Special populations like expectant mothers and those with substance use disorder have unique needs that are often unmet within their communities.

Mississippi's maternal mortality rate is among the highest in the Nation. Federal programs like the Rural Maternity Obstetrics Management Strategies, RMOMS, program are available to help many States connect obstetric services to create networks that better address the needs of rural mothers. However, in States like Mississippi, where there is a shortage of physicians who specialize in high-risk maternity care and more rural hospitals are discontinuing obstetrical services, more mothers and babies are at risk.

In Mississippi alone, fatal drug overdoses in people under the age of 35 nearly doubled from 2019 to 2020. This increase in death has mostly affected the African-American population and people under the age of 35. Timely access to substance use disorder treatment in rural areas is but one way to reduce the impact of this epidemic.

Recently, the Department of Psychiatry at UMMC was awarded a grant by SAMHSA to provide emergency consultation, medication-assisted treatment, Web-based linkage to resources, and education to consumers, families, and providers for substance use disorder.

These are just a couple of examples of how funding you authorize helps us build new models, but sustaining them remains a challenge. Over the past 20 years or so, Mississippi has made great strides in creating partnerships between larger healthcare systems and community providers to bring the care to the patients using telehealth. Funding from HRSA, USDA, and the FCC have made the expansion of these services faster.

Our community health centers are invaluable to the health of our people. For many, they are the hope of consistent, high-quality, equitable healthcare for all. The role of innovation and digital solutions to transform the healthcare delivery system has steadily increased in Mississippi, but it was birthed out of necessity, and now it must be sustained out of necessity.

Through those early programs, we learned that the need was much greater than acute care. It was about specialty services, convenient care, and school-based services. Very few providers are choosing to live and work in these rural areas, and those that do are at capacity or do not stay.

As the only academic medical center and Level I trauma center, it is our responsibility to address the needs of the entire State and to aid rural health providers in caring for their patients. Where you live should not determine your health.

Thank you.

[The information follows:]

Testimony before the United States Senate Committee on Appropriations

Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

March 29, 2023

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Chairman Aderholt, Ranking member DeLauro, and members of the committee, it is an honor to appear before you to share, from my perspective, a portion of the challenges rural communities encounter while in pursuit of reasonable access to health services. I thank the committee for the opportunity to testify before you today and anticipate a thoughtful and productive discussion.

My name is Tearsanee Davis, and I currently serve as the Director, Clinical Programs and Strategy at the University of Mississippi Medical Center, Center for Telehealth in Jackson, Mississippi. Additionally, I am a dually certified nurse practitioner, trained in family practice and psychiatric mental health. I am a native of Durant, Mississippi, Holmes County, the poorest county in the poorest state as of 2019. My testimony today is drawn from my personal and professional experiences while living and working in rural Mississippi, as well as my knowledge of efforts aimed to alleviate rural residents' access to quality care.

Many factors contribute to disparities in health such as unavailability of needed resources, socioeconomic issues, and lack of knowledge. Funding made possible by committees such as this enable us to implement programs, test models of care, and integrate innovation into practice in Mississippi that have a national impact. In addition to concerns that affect rural communities, I will share how the University of Mississippi Medical Center (UMMC), a Telehealth Center of Excellence as designated by the Health Resources and Services Administration (HRSA), and its

partners have worked diligently to address the issues that continue to plague our state. There is more work to do.

Provider Shortage While there is still a massive shortage of physicians, this problem has extended to include many other healthcare professionals. A poll conducted in 2022 revealed that 23% of nurses are considering leaving and less than 45% currently work in the hospital setting[1]. The Association of American Medical Colleges predicts that the U.S. could face a shortage of 37,800 to 124,000 physicians by 2034[2]. These shortages directly affect the health of the community. Rural hospitals continue to fight to remain open, despite efforts to recruit and retain highly skilled clinicians. These shortages result in fewer services being offered locally, more transfers to other facilities, and unnecessary delays in care. Since the early 2000s, UMMC has honored its commitment to increasing rural access to highly skilled medical professionals through the use of Telehealth. The Telemergency program provides remote support to more than 20 critical access emergency departments across the state. The UMMC Center for Telehealth continues to be instrumental in bridging the gaps due to shortages or maldistribution of providers and nurses. Thanks to funding from the Federal Office of Rural Health Policy Office for the Advancement of Telehealth, we have supported rural hospitals and clinics by providing Telehealth specialty consultations such as neurology, psychiatry, and critical care in rural emergency departments as well as in inpatient settings. Federal funding through the Telehealth Network Grant Program (TNGP) has made this possible. Although challenges remain, more people are receiving the care they need in their local communities.

Payor Challenges Payor challenges are not unique to rural providers, but they do contribute to fewer providers choosing to practice in rural primary care clinics. Center for Medicare & Medicaid Services (CMS) reimbursement rates are not increasing with the rate of inflation. The latest

consumer price index measure showed that healthcare experienced a 7.7% increase in overall cost[3]. In rural areas, this margin grew significantly more due to the demand for nurses and the lack of supply. CMS has not increased its rate of provider pay to match this increase, resulting in an overall reduction in provider reimbursement[4]. Additionally, providers are having difficulty keeping up with the varying tasks include entering social determinants of health codes (z-codes), meeting compliance measures in the clinic or hospital, meeting value-based outcome measures, attending cybersecurity trainings, handling downloads and denials of services, and fighting Medicare and private insurance audits. Lastly, more Medicare beneficiaries are moving to Medicare Advantage (MA) plans[5]. The challenge is that they are not subject to the value-based care promoted through CMS, as they are a private plan funded with Medicare dollars. The MA plans do not provide the same level and guarantee of benefits as original Medicare. They pay providers less, and often times will actually mislead clients / patients into a false understanding of benefits. This is ultimately hurting both providers and patients. A strict requirement of guaranteed payment, reduction of down codes and denials, and significant client / patient education is needed in order to allow for a positive outcome for patients.

Behavioral Health Mental Health America created a ranking system that weighs the prevalence of mental illness in the state with the accessibility to mental health services. States ranked 1-13 have lower mental illness and higher access to services, while states ranked 39-51 have a higher prevalence of mental illness and lower rate of access to care. Mississippi ranks 36th[6]. Understanding how access to mental health services was measured would prove valuable. An analysis of the supply of behavioral health providers per 100,000 people in rural and urban U.S. counties revealed that there is there are almost 3 times more providers per 100,000 people practicing in urban areas than there are in rural areas[7]. An additional consideration is that a number

of those counted may not be providing direct patient care services, may not accept government funded health coverage, or may not accept insurance coverage at all. In 2015, several FQHCs partnered with UMMC to provide behavioral health services to their patients using Telehealth. This allowed us to leverage behavioral health providers to the extent the rural clinics needed them. It eliminated the need for the clinics to recruit and retain these providers, but most importantly provided access to evidence based care in rural communities. This model of care reduces the stigma around seeking care for mental health concerns. Considering disparities with transportation, child care, employment options, and financial constraints rural and/or low-income residents experience; community health centers and rural health clinics have become increasingly important and have a need to expand services further.

Maternal Health Mississippi has major challenges in its maternal health care delivery and health outcomes. In a ranking completed by the United Health Foundation, Mississippi ranked worst in infant mortality, low birthweight, children in poverty, per capita income, and its economic hardship index[8]. The state also ranked 49th in teen births, food insecurity, and preventable hospitalizations; 47th in its low birthweight racial gap, and 46th in percentage of residents who are uninsured. Continue support for innovative strategies to improve these statistics is important since every county in the state is designated by HRSA as a Health Professional Shortage Area (HPSA). Thanks to the Office for the Advancement of Telehealth's (OAT), UMMC is testing a model to help expectant mothers in rural areas reduce their risk of pregnancy complications such as preterm births. Expectant mothers are monitored remotely and screened for Social Determinants of Health (SDoH), mental health needs, and domestic abuse. If needed, mothers use the direct to consumer (DTC) platform to access mental health and urgent care providers remotely. They are able to have low acuity maternal fetal medicine visits in their homes. By evaluating innovative models of care

like this, we hope to encourage policy changes that increase access to more preventive services and reduce infant and maternal mortality in at-risk populations, particularly in rural areas. This, and other programs like the Rural Maternity and Obstetrics Management Strategies (RMOMS) Program (RMOMS) aim to build networks, leveraging telehealth and specialty care so that ALL will have a chance at a healthy life.

School Telehealth In March 2022, the Mississippi Department of Education entered into a partnership with UMMC Center for Telehealth to provide urgent care and behavioral health services, along with lifestyle coaching and education to all students in K-12 and charter schools in the state. This funding was timely as the pandemic affected access for many schoolchildren. A third of the way through implementation, we have enrolled, 64 out of 100 school districts which translates to 166,600 students. School-based care means healthier students, decreased absenteeism due to minor illness, less time off work for parents due to illness of a child, and access to care for those in areas where there are few provider clinics. Prior to the pandemic, schools were not a recognized site of service for MS Medicaid. This prevented providers from billing for services if the students were at school. Although this was changed recently, there is still the issue of equity. For the program to be effective and sustainable, a model of care must be constructed that considers that all students may not be covered and those that are may still have difficulty paying copays and deductibles. Currently this program is completely funded by MDE, but we are hoping there is additional funding to allow us to continue to serve students statewide without regard for their ability to pay.

Thank you for allowing me to share my perspective. I look forward to any further opportunities to discuss the challenges rural communities face and possible solutions for alleviating the strain on the healthcare system.

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Mr. ADERHOLT. Thank you so much.

And I will kick off the question. As you mentioned, we may have a few questions here with Ms. DeLauro. As you—as already been said, we have multiple hearings that are going on this morning, and so members have been coming in and out. But I want to focus a little bit about rural hospital closures, and so, Ms. Cochran-McClain, let me address this to you.

You mentioned in your testimony the problem of rural hospital closures, and I know it far too well. And you did talk a little bit about some of the factors, but could you elaborate on some of the factors that are leading to a lot of these closures and mention any additional efforts that you think need to be done that we can do to support obviously a vital part of each community.

Ms. COCHRAN-MCCLAIN. Yes, thank you for your question, Mr. Chairman.

And I know you know about rural hospital closures because you have had a number of them in the State of Alabama. And I think I desperately wish there was one thing that I could identify and one thing that we could fix to stem the hospital closure crisis, but it varies on a community and the individual hospital about what the challenges that they are facing.

I can speak generally. Factors that lead to rural hospital closures include kind of declining financial performance. Part of that is around the payer mix and who is reimbursing them. Rural hospitals have many more public payers—Medicare, Medicaid—and are more reliant on those folks. But they also tend to pay a little bit less than some of the commercial payers.

Volume and low patient volume and the patient mix has a big impact. So you are seeing lower number of patients that you have to spread your fixed costs across. And then, as we have heard today, a lot of the patients seen in rural areas have additional healthcare challenges when compared to other populations.

And I would be remiss if I didn't mention obviously workforce staffing shortages. We saw during the pandemic was an example of when we were having shortages of nurses and others, folks having to close service lines because they couldn't continue at a high enough quality rate.

And then last, but not least, there are definitely regulatory and administrative burdens put on by payers, Medicare in particular, that make it more challenging for rural facilities to keep their doors open. And part of that is because a lot of our Federal policy is developed for larger healthcare systems and not for the situation we are facing in our rural facilities.

Mr. ADERHOLT. Thank you.

Dr. Hott, let me address some rural school challenges to you. What are, in your opinion, unique challenges faced by rural schools that you don't always see in urban school districts?

Ms. HOTT. Well, in our rural schools, we wear multiple hats. It is not uncommon to see the principal also teaching algebra and driving the school bus. And those hats, we can see that as a deficit, or we can see that as a strength.

And if we had increased funding and support to train our leaders and our teachers and ensure that we have quality teachers and quality leaders, we have better outcomes for kids. We retain those

teachers and leverage those partnerships and strengths that we have in our rural community.

Mr. ADERHOLT. Could you talk a little bit about some of the barriers that you see when rural schools go to apply for a Federal grant?

Ms. HOTT. Yes. It is tough. There is multiple hats. I didn't mention grant writing, and I didn't mention school-university partnerships as a possibility.

I think we can talk about those barriers, and we can talk about how rural schools may not have all that we need, but we can also talk about what we do have. And we have those strong university and school partnerships, particularly in Oklahoma.

The lack of trained personnel, we have solutions for that. We know that increased funding for IDEA Part D would allow us to train more leaders, would allow us to train additional teachers. So those barriers of lack of teachers, lack of retention of teachers can be addressed.

Mr. ADERHOLT. Thank you. Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

And thank you all for your powerful testimony.

Let me just ask, I have got two or three questions, but Ms. Cochran-McClain, Dr. Davis, and anyone who would care to, we talked about the closure of hospitals. And just yesterday, there was an article that said, "We Are Going Away: A State's Choice to Forgo Medicaid Funds Is Killing Hospitals." And it is focused on Mississippi, I will just tell you, Dr. Davis.

But I just want you to, if you might, just expand a little bit on. I know you said that there are multiple reasons why hospitals are closing, and but it is also care for people as well. The hospital is closing, but it is about neonatal intensive care unit closes in July.

The issue, what happened in what is the name of the town? Rolling——

Dr. DAVIS. Rolling Fork.

Ms. DELAURO. Rolling Fork, that victims of the tornado that struck the Delta last week had to be ferried 50 miles away for medical treatment because the local hospital had no power. I mean, this is more Medicaid dollars would have equipped it with an emergency generator.

In any case, talk to me a little bit about the lack of Medicaid and that on the closure of hospitals are a detriment to healthcare in rural communities. And I would like to have both of you comment on that.

You want to speak on that, Dr. Davis?

Dr. DAVIS. So I will just—I will just start. I will just start.

Without the appropriate funding, the hospitals don't have what they need. The cost of providing care is increasing. And as Ms. McClain said, there are more—the payer mix. So if you think about Mississippi, we are mostly rural, you know, and underserved, if you think about it. There are only three areas in Mississippi that are even remotely considered urban. The rest of the State is rural.

And you know I mentioned that it is the poorest State or one of the poorest States and always has been. So that equates to more of our people are on Medicaid. And so that is more people on Med-

icaid, and they are the people that need the most care. Yet there are limitations.

So what are the hospitals to do? And they try to stay open. They seek out opportunities. I have one good example is many years ago—well, not many years ago, but several years ago, the hospital that was 10 miles from my home was threatening closure, but the TelEmergency Program was able to help them stay open.

So I think that it is a cycle. It is a circle, you know, less the few people that have coverage. But they are the people that need the care, and the hospitals have to have funds to operate. And that is what we have seen is just it is the burden.

Ms. DELAURO. Yes. This article is very enlightening and I just—I read it, and it says in Mississippi, one of the Nation's poorest States, the missing Federal healthcare dollars have helped drive what is now a full-blown hospital crisis. So, and there are——

Ms. COCHRAN-MCCLAIN. Yes, and I would just add we know—and I mentioned payer mix as being one of the issues that hospitals face. And we have seen in States that have not expanded Medicaid——

Ms. DELAURO. There is about 10.

Ms. COCHRAN-MCCLAIN [continuing]. The higher rates of hospital vulnerability, rural hospital vulnerability and closure. So there is a correlation there between Medicaid expansion and rural hospitals being able to keep their doors open. I mean, it is a new payer for a lot of uninsured folks.

And I would just note before hospitals close their doors, they frequently are shutting down service lines. So because if they can't afford to keep kind of the full range of services open, they are going to look to see where they can trim. And obstetric services is one of those prime areas. Chemotherapy is another area where people tend to get their infusion local is another area. And that is why we were so excited about the President's proposal.

Ms. DELAURO. So people can—so people die.

Ms. COCHRAN-MCCLAIN. Mm-hmm.

Ms. DELAURO. People die. I mean, let us take it to where it goes. So without——

Ms. COCHRAN-MCCLAIN. Without access to care, especially emergency care or ongoing treatment for some of the chronic conditions that they face, there are definitely poorer health outcomes, and we see higher morbidity and mortality rates in rural areas compared to their urban and suburban counterparts.

Ms. DELAURO. Staggering to me that if there is one thing that Federal resources can do is to alleviate that issue, and the refusal of those dollars is—it is hard to fathom in many respects. But there isn't any more noble cause that we are engaged in than saving people's lives, and the Federal Government has the ability to do that, and it is up to the States to take advantage of that as well.

But thank you. Let me just go on, if we can.

Dr. Davis, because of countless conversations with parents in my own State of Connecticut, educators, I created the School-Based Mental Health Services Grant Program. That occurred in the 2020 Labor-HHS bill. It is about helping school districts increase the number of quality mental health trained professionals working in schools.

When they passed the bipartisan bill, Safer Communities Act, there was an additional $500,000,000 to this program on top of the resources included in our bill. The grants expand the program's reach. They move us closer to ensuring that every child goes to a school that has a qualified mental health professional on staff. And I see, Dr. Hott, you say that because I think my own view is that we ought to have a qualified medical professional, mental health professional in every school in the United States.

But my question to you, Dr. Davis, in your testimony, you highlight the partnership between the Center for Telehealth and the Mississippi Department of Education, and you say to improve urgent care and behavioral health service, along with lifestyle coaching and education to all students in K–12 and charter schools in the State.

Can you expand on the partnership, what services you provide? How do you connect students to mental health or behavioral health counseling?

Dr. DAVIS. Absolutely. So we are go grateful that in 2022 we were awarded the opportunity, given the opportunity to provide services to these K through 12 and charter schools in the State. It was made possible by ESSER funds. So we are grateful for that. It runs through September 2024, September 2024.

We are providing urgent care services, behavioral health services. The behavioral health team consists of licensed professional counselors, and we have psychiatric nurse practitioners if that child needs medication management.

And then there is also lifestyle coaching, just in regard to healthy lifestyle, a more preventive approach. And we also provide education to staff, faculty staff around the education of healthcare needs of their students and also support their school nurses.

We do have lots of challenges, though. One of the biggest challenges is all of the schools do not have the same resources. So we may have—I don't know the exact number, but we do have many schools in our State that do not have school nurses, and we feel like the school nurses are the glue. They are the glue between the healthcare team and the community. They know the parents. They know the students. They know what is needed.

And then in some districts, they have a school nurse in every building, and in some districts, they have one school nurse for nine schools that are scattered across a very large geographic area. So there is a challenge there.

The other thing is you mentioned the funding that you all have provided for mental health professionals in the schools. If they don't exist, they can't be there. And that is a problem, too. You know, the maldistribution of the mental health professionals is there just aren't enough, and especially in our most remote rural areas.

So this is where we feel like we come in is it is offered, it has been offered to every public school and charter school in the State. However, they do not have to opt in to the program. We have had—I think we have had 70 that have signed contracts to enter into this program with us, and 64 are actually live right now.

We are servicing currently 166,600 students that have access to this. The school nurse at each of these schools is the conduit. So

they are the connector. We set up a system to where they can self-schedule for the visit. The parents, guardians can join the visits remotely. So that is also an advantage of having a telehealth program.

We see ourselves as bridging the gap. We are not replacing anything. So if it is a district that has mental health professionals, we ask that they continue to do what they do so that we are better able to serve those districts that have absolutely nothing.

Ms. DELAURO. Well, thank you. Just it really is—and I will ask you if you could get back to us on that.

Dr. DAVIS. The number of school nurses?

Ms. DELAURO. No, on what you need on what kind of additional investments as a committee should we be making to deal with the issue of telehealth to ensure that every individual sees a doctor, a nurse, or a counselor? If you could just get back to us on that, that would be helpful in terms of the committee's deliberations as we go forward.

Mr. Chairman, can I ask one more question?

Mr. ADERHOLT. Go ahead.

Ms. DELAURO. Thank you.

And this has to do with the education side of the coin here. Dr. Hott, you highlight students with disabilities in rural areas and the barriers and quality instruction, intervention, increases—and calling for increased Federal funding for the instructional programming. What is your personal experience with the challenges in how IDEA and Title I funding can support positive outcomes for kids with disabilities in rural areas?

And I would just say to you, Ms. Scheibe, we increased Perkins by $75,000,000 in 2023, strong promoter of CTE, which I think we need to increase. I think it really has taken off in a very—in a very important way, and so anyway, let me just ask Dr. Hott if you have anything to contribute to this.

Dr. Hott, go ahead on IDEA and Title I funding and kids with disabilities.

Ms. HOTT. Thank you for the question. That is such an important issue, and right now, we have IDEA funds and Title I funds, and some people believe that students can only be served through Title I or only be served through IDEA, particularly students with disabilities. And that is not the case.

In our rural schools where we may have a Title I reading specialist, that person is specially trained to teach reading. We may have a child who also has a disability and is in a co-taught classroom where there is a general educator and a special educator serving a student.

That student could see the reading specialist in the morning. They could also be in the co-taught classroom where all students are benefiting, and we are capitalizing on the strength of the personnel we do have. We don't have enough personnel. That is the bottom line.

We don't have enough mental health providers. We don't have enough teachers. We don't have enough special educators. I have districts that do not have a special education teacher, no counselor, no school psychologist, and no social worker.

There are waiting lists of children to be evaluated for special education of over 100 students. A special ed director told me yesterday that she had a student in crisis, and there is one special ed teacher that is serving both the middle and high school, and she couldn't handle both situations at the same time.

Ms. DELAURO. I would just make one point about this, and that is what we were talking about before, is Medicaid. When people make reference to Medicaid, they think of—which it is true, but seniors, nursing homes, et cetera. All of which is very positive, all of which we need to look at.

What they don't realize, there are two other areas, is that children with disabilities, that is the—Medicaid is the primary way that families get healthcare for their disabled kids. I had one mother say to me, "My child would not have survived without Medicaid." And so these things are really connected in profound ways in trying to deal with the issues of healthcare and what it does.

And the other piece of Medicaid is substance use disorders. That is where so much of the care comes, and it gets paid for through Medicaid. And if we want to address that problem, that we need to look at where we need to expand Medicaid and make sure that it has the resources that it needs.

I have gone so far beyond any time that I have had here on the indulgence of the chair, but I just wanted to say again we have focused on the CTE in a very substantial way. Also with apprenticeships and registered apprenticeships, et cetera, and the school-to-work connection is really critical, and the engagement with community schools, et cetera, in creating the opportunity for youngsters to be able to get the career or technical education that they need, but also to be able to have a job at the end of the pipeline.

I can't thank you enough for the work that you are doing because you are on the ground. And please understand that you heard me speak before—and Mr. Chairman, bear with me on this. I look at this as not as a—we need to take a very, very hard look at the investments that we have made and the benefits of those investments. And if we don't build on those investments, but if we move backwards on that, we then will have not been able to—we will slip back in very profound ways to communities.

And particularly I think in rural communities where they are already suffering with a lack of investment in some areas. And you know the needs better, you know, than most. And so we have to take a look at it.

Thank you. Thank you very, very much for being here. Thank you for your testimony and for your great work. Much appreciated.

Mr. ADERHOLT. Well, thanks again for being here. But I would, before we conclude—and I know we are going over about 2½ hours here for this entire hearing. But we will conclude, but before we do, I would like to just pose one question to each of you, and you—I don't know whether you will have one or two or three or whatever, but just in your opinion, what are the biggest challenges facing—that you see facing our rural communities today, and if there is anything that this subcommittee could do to address them?

And Dr. Davis, we will start with you.

Dr. DAVIS. So I think we have—thank you—have spoken extensively about the problems, and I have brought up some of the solu-

tions or some of the things that we have done to address those things.

One of our biggest problems now, and I will speak about telehealth in particular, is sustainability of these programs, is we do rely on funding to begin these programs and to test out models of care and to get the outcomes data, and we have that outcomes data. But there is still an issue of how do I continue this program after the fact?

So when we are talking about the school-based program, that is one of our biggest concerns right now is if we are not getting the funding elsewhere, how do we generate the funding? We know it is not a program where we are going to get rich. That is not our desire. Our desire is to serve the children of the State.

If we are left to rely solely on reimbursement, then we still have an equity issue. Because having an insurance policy does not mean that you have coverage, and it does not mean you have access to that coverage if you don't have the funding to meet the co-pays and pay the deductibles, which is why we structured our school-base program as it is right now the way that it is to where we don't have to think about does that child have insurance? Can that parent pay a co-pay?

And that is something we would love to continue. Just being realistic about it, most of our kids are still not going to have access if we rely on reimbursement. So I think that is one of our biggest problems.

And then also the other programs that we—through the substance use disorder programs, the maternity programs, and all that, it all relies on reimbursement. And that is a big problem for us with telehealth with the geographic restrictions, the administrative specifications that you have to meet. They have to be in a certain place. The provider has to be in a certain place. They have to have an in-person visit after so many months. What if there is nowhere to have an in-person visit?

I feel like also a challenge coming behind the pandemic that we have is that prior to the pandemic, we had a large population of people who sadly had just accepted that they would not have access to certain services. The pandemic has allowed us to provide those services to them without regard for where they are and all of that.

And now there is concern that if we back up, these are people who have seen the mental health professionals. They are on track. They are back in the workforce. They are doing well, but there is going to be a slip back. So we are concerned about those.

Those are our biggest challenges, I would say, in telehealth.

Thank you.

Mr. ADERHOLT. Thank you. Dr. Hott.

Ms. HOTT. That is a great question. I think the biggest shortage in the rural communities that I am serving are teachers. Without comprehensively trained teachers, our children aren't able to go on to postsecondary education. They don't have access to workforce development, and ultimately, it becomes very costly.

When we train a teacher, they enter a school, and we are not able to retain them with ongoing professional development, then we lose them, and it is expensive, really expensive. Some of our school districts are reporting 18 to 24 months with unfilled job

postings for special education, and that means children go without services. And when the children go without services, they can't make that time up. It is gone.

We also have individuals who lack comprehensive training teaching our children. We need the individuals who are teaching our children because it is reality—it is not right, it is not fair, it is reality—they need resources. We need professional development.

And quite frankly, if we don't do something, the outcomes are going to be very, very poor. We are going to have more students needing Medicare and needing State support, than if we had allowed them to have the mathematics and reading and social supports that they needed while they were in K–12.

On the flip side, we know that there are many STEM job opportunities right now, and our rural kids are uniquely situated for those positions, but we have to educate them. They have to have quality mathematics instruction. They have to have quality reading instruction.

And for kids with disabilities, we need intervention. And without continued funding through IDEA Part B for kids and Part D for teachers, this isn't going to happen. And it is going to disproportionately continue to impact our rural schools.

Mr. ADERHOLT. Thank you. Ms. Scheibe.

Ms. SCHEIBE. Thank you, Mr. Chairman, for that question.

I would echo what my colleague indicated, that certainly the teacher and faculty workforce shortage is something that we definitely face in rural communities. But I would take my answer perhaps a bit higher level and say that I think one of our biggest challenges for our rural communities is how do we continue to grow our economies, and how do we find the workforce in order to meet those needs?

And I would indicate not just for today, but looking at 10 years from now. Where are our economies going to be? What is our workforce of the future? How do we begin meeting those needs today? I think that is really a challenge that all of us in a policymaking role can look at.

We have an incredible opportunity to innovate and to imagine what that future does look like down the road. We appreciate the Federal resources that help us get there.

Mr. ADERHOLT. Dr. Cochran-McClain.

Ms. COCHRAN-MCCLAIN. And I think I have two that I will mention quickly. I think one really is stemming the tide of closures of rural hospitals because they are such a hub of care in our communities and play such an important role in terms of an employer and the economic impact.

Support for programs like the Rural Hospital Flex Program, the Small Hospital Improvement Program, continued support for those, as well as consideration of the President's proposals to really help rural hospitals stabilize the financial crisis they are in, are two areas I would really love for the committee to look at.

And then the other area, like the other panel members have said here, is really just workforce. We really need to continue to build the capacity to grow and train individuals in workforce. We talked a lot about physicians today. They are an important part of it through the Rural Residency Planning and Development Program

and the Teaching Health Center GME Program. But thinking creatively about how we can use those same kind of models for nursing and other allied health professionals to really be able to—or, again, recruit, train, and retain those individuals in their rural home.

Mr. ADERHOLT. Thank you so much.

Ms. COCHRAN-MCCLAIN. Thank you.

Mr. ADERHOLT. Well, thanks so much again for your testimony here this morning and answering our questions, and we look forward to working with you to work on rural America.

And this is dismissed—is adjourned.

TUESDAY, APRIL 18, 2023.

UNITED STATES DEPARTMENT OF EDUCATION

WITNESSES

HON. MIGUEL CARDONA, SECRETARY, UNITED STATES DEPARTMENT OF EDUCATION

LARRY KEAN, BUDGET DIRECTOR, UNITED STATES DEPARTMENT OF EDUCATION

Mr. ADERHOLT. Well, the subcommittee will come to order, and I wanted to say good morning to everyone and thanks to everybody for being here.

Mr. Secretary, good to have you here and good to have the Budget Director from the Department here as well. Thank you both for taking time out of your schedule to join us, and we appreciate your presence here. I look forward to your testimony.

I do want to start by expressing some real concern with the new rule that has recently come out of the Department of Education and, of course, which would violate the Title IX when they categorically ban biological male students from participating in women's sports teams. Forcing schools to allow biological teen males into girls' locker rooms is one of the greatest overreaches of the Federal Government that so many of us have seen and feel like we have seen out of the Federal Government in quite some time.

Not only does it undermine the decades of work in giving girls the same opportunities to compete in women's sports, which was the original intent of Title IX, it creates potential unsafe situations. The proposal robs girls of the chance at fair competition.

Gender identity cannot be changed, even though there are some that would argue to the contrary. But let us be clear. Basic biology cannot be changed. Chromosomes can't be changed. The simple fact is that biological males and females are different. Biological males will have the natural advantage in size, in speed, in strength, even when they take suppressive hormones.

As biological men continue to dominate women's competitions, someone must stand up and say enough is enough. And the fact that the Department of Education is proposing a rule that says those who do so are in violation of the very rule that gave women's sports an equal footing in the first place leaves me and millions of Americans extremely concerned.

Let me turn now to the budget proposal. I also have concerns that the proposed 13 percent increase for the Department of Education will leave the next generation unprepared academically for competing in the 21st century and saddled with the highest national debt our Nation has ever seen. I believe a more responsible approach for your budget is called for, especially as painfully high inflation continues to strain American families' budgets.

The latest test scores put out by your department show significant declines in math and reading scores. And minority students, by the way, have fallen behind more than anyone else.

Closing most public schools for nearly 2 years during the pandemic period was perhaps one of the greatest public policy blunders of our lifetime, and the effects of this mistake will be suffered by our Nation I would say for actually generations to come. Closing public schools at the behest of some unions have contributed to widespread learning loss, unprecedented youth mental health crisis, and increased marginalization of students with disabilities.

There is also concern about a broader trend that we are seeing in the K through 12 education space, and that is a shifting focus away from teaching our kids to read, to write, to add and subtract, but toward indoctrinating children with the ideology that divides and that achieving equality in areas outside of academic achievement. Kids should learn how to think, not what to think, in our public schools. It is not the Federal Government's role to take over the role of parents and insert an administration's political agenda.

Sadly, the data shows that increased topline funding for the Department of Education continues to yield worse results for our kids in public schools. Something is not right, and we cannot continue as the status quo.

I would also like to touch on another area of extreme executive overreach, and that is the President's decision to conduct blanket Federal student loan forgiveness, as well as repeatedly extend the pause on student loan repayment and interest accrual. Not only is this inflationary, but it also makes hundreds of—or also people making hundreds of thousands of dollars a year are not asked to be paying their student loan debts back. I think this is blatantly unfair to the millions of Americans who never went to college and also those that don't have a student loan debt.

It is unfair to those who choose a less expensive school or work during their school in order to achieve their goal and avoid student loans, or who sacrificed during their time in school in order to pay off their debts.

Mr. Secretary, you and I share an interest in seeing students who go to college complete their studies and earn a degree. There may be agreement that the loan repayment system needs to be fixed. However, adding another repayment program in the way the Department has proposed is troubling. Even the liberal Brookings Institute has stated that this proposal would largely turn Federal loans into grants.

We do have the grant programs that are included in this committee's funding. But the purpose of loans is not to provide grants just by another name, especially in ways that are untargeted. For instance, it is higher-income borrowers who will reap the windfall of loan forgiveness benefits as part of this income-driven repayment plan.

I am a longtime supporter of Pell Grants and the TRIO program. Pell Grants and participation in TRIO help first-generation college students chart a course to a better future in the middle class. We need to continue to help these students not only enroll, but also graduate and find good-paying jobs.

Unfortunately, high inflation is eating away at the salaries of these recent graduates and making it more difficult for them to establish themselves in their careers. I know we will be addressing these topics today and many others as we move forward. But again, I want to thank you for being here.

Like I said, I did want to mention those concerns that I think are the concerns of millions of Americans across the country, but I do look forward to hearing from you this morning and from your insight and your perspective.

And at this time, I would like to turn to my colleague Ms. DeLauro for her opening statement.

Ms. DELAURO. Thank you very much, Mr. Chairman, for holding the hearing.

And I want to welcome Secretary Cardona and our Budget Director here for the Department. Mr. Kean, thank you so much for being here and for your work, both, over the past 2 years and throughout your entire career. Mr. Secretary, we in Connecticut had already witnesses your career of passion, of dedication for America's students and teachers, a commitment that has now been on full display nationally.

When you first joined the Department over 2 years ago, students and families were facing unprecedented change and disruption to their education. But as you and I both know, schools and learning provide consistency to kids who need it most. As educator Horace Mann said, and I quote, "Education, beyond all other devices of human origin, is a great equalizer." And I would add provides great consistency when it is greatly needed.

With your leadership and investments this committee made over the past 2 years—the American Rescue Plan, the Bipartisan Safer Communities Act—schools now have the resources to strengthen this great equalizer. They can better support student academic recovery, address mental health needs, and tackle nationwide teacher shortages.

Most recently, in the 2023 Government funding bill we passed and enacted in December, the committee secured a historic $3,200,000,000 increase for programs administered by the Department. We expanded programs that meet the needs of students who most need our help. We made record investments in Title I, the cornerstone of our Federal support for public education, to support students from low-income background. And we invested in IDEA grants that support kids and students with disabilities at every stage of their learning.

To build on our work to prioritize, and I quote, "whole child approaches to education," we doubled funding for full-service community schools, a program we have grown by nearly 10 times since I first became the chair of the subcommittee. My focus on these models would take a holistic approach to education, dates back to my time as a teacher at the Conte Community School in New Haven, Connecticut.

To make education accessible to even more students, we proudly fought to increase the maximum Pell Grant by $500, the most in more than a decade, for the second year in a row. We have made college more affordable so that students from diverse and under-

served backgrounds have a fair shot at a high-quality postsecondary education.

And to narrow our Nation's racial disparities in educational attainment and economic opportunity, a top priority for me, we increased our support for HBCUs and MSIs to over $1,000,000,000, an increase of 30 percent since you took office.

As we begin the 2024 Government process and to ensure that we continue to build on these critical investments, I am pleased to note that the Biden administration proposed a $90,000,000,000 budget, a 13 percent increase, for the Department that would strengthen and expand these programs to serve even more students and families.

The budget proposes important investments to ensure students from low-income backgrounds can succeed. It includes increases for programs that serve students with disabilities throughout the Nation and equips special educators with the tools they need, including IDEA personnel preparation funding.

The budget also addresses pressing issues with funding to combat teacher shortages, expands school-based mental health professionals, increase civics education, and grow community schools. And to help underserved students access higher education, the budget makes strong increases for the maximum Pell Grant and college access programs like TRIO and GEAR UP.

Students, teachers, and those who support them depend on the Department's programs, which is why I must mention how deeply concerned that I am over some of my House Republican colleagues' calls for massive spending cuts to so many of these programs. Yesterday, on Wall Street, Speaker McCarthy verified Republicans' intent to cut funding back to the 2022 level and impose dangerous caps going forward.

I am not sure that my Republican colleagues realize the impact that the proposed cuts would have. Let me read some of the scariest numbers that you shared in a letter to me.

Cuts to Title I and IDEA grant funding would take 100,000 teachers and service providers out of classrooms serving low-income students and students with disabilities.

They would strip away the opportunity for 80,000 people to attend college and impact all 6.6 million students who rely on Pell Grants by decreasing the maximum award by $1,000. They would cut work study benefits, eliminate financial support for 85,000 students working while earning a degree. Administering student financial aid would become more difficult, and 40 million borrowers would experience decreased service.

I would like to note that I know some of my Republican colleagues claim these cuts would not be implemented evenly across the board, but that is even more dangerous. Because if other programs are exempt from cuts, we both know that education programs that students and families rely on will be impacted even more than your agency estimates.

And that kind of extreme thinking is not just some hypothetical scenario, as some claim or that I have imagined. It appears to be a real goal that a majority of my House colleagues have.

Last month, Representative Massie introduced an amendment to H.R. 5 that read, and I directly quote, "Any office or program re-

lated to elementary or secondary education should be terminated by December 2023." Fully terminated. One hundred sixty-one, nearly 75 percent of House Republicans voted in favor of this amendment.

Let me reiterate, nearly 75 percent of my Republican colleagues voted to eliminate all K through 12 education funding last month. My God. My fears of these cuts and eliminations are not hypothetical because there are those who have already voted for them. And I am so grateful for the 60, 60 of my Republican colleagues who had the courage to stand up and to say no.

The amendment did not pass, and I know that those who did not vote for it know well that we should not go in this direction, and I will work with these like-minded colleagues across the aisle to make sure that this never happens. Because investing in kids, not defunding their education, is how we make our economy stronger and our future brighter.

We should be doing everything we can to increase access to these programs, not cutting off very basic education services for children who need them. And it is my plan to dive deeper into the disastrous implications of these cuts during my round of questions.

In the meantime, to my colleagues across the aisle, I say this. We garnered bipartisan support for this bill as recently as December. Republicans and Democrats came together and approved the investments that were made. But cuts of this magnitude would take back our progress at a time when we should be fighting for more investment in our students and teachers, not less.

As I have made very clear, I will never stop fighting these drastic proposals. I thank you, Secretary Cardona, for doing the same, and I look forward to your testimony.

With that, Mr. Chairman, I yield back.

Mr. ADERHOLT. Thank you.

Mr. Secretary, you have the floor. We look forward to hearing from you.

Secretary CARDONA. Thank you, and good morning, Chairman Aderholt, Ranking Member DeLauro, and distinguished members of the committee.

I am pleased to join you today to testify on behalf of President Biden's fiscal year 2024 budget request for the Department of Education.

My time in front of you today is about choices. The choice to invest in America's children or the choice to protect the status quo of underachievement. The choice to come together on behalf of the students, parents, and educators who are looking to us to serve and raise the bar for education in this country versus the choice to break down in partisanship or divisive culture wars.

It is best to think of this budget proposal by thinking of a child's journey through education. In this scenario, a child starting her educational journey builds a strong foundation for learning right away because this budget made it possible to expand high-quality preschool for more 4-year-olds across the country.

Imagine when she gets to elementary school. If she is a student with disabilities, she benefits from the additional $2,700,000,000 in this budget to help include and support her. If she goes to a Title I school, she learns the fundamentals of reading, math, and other

rigorous subjects she will need to succeed in life because that school is able to tailor instruction and use data to provide one-on-one support thanks to the $2,200,000,000 in additional funding for Title I schools in this budget.

Wherever she goes to school, she can count on having a highly qualified teacher who has gained years of experience in helping students learn and grow because we invested early to fully prepare, develop, and empower our educators. And as she walks around her school, she feels welcome and included, gaining the benefits of a strong, intentional focus on a safe, supportive school climate that helps her learn.

She sees teachers who look like her because we invested in programs that build a talented and diverse pipeline of educators, from the Hawkins grants to the Teacher Quality Partnerships.

Now imagine that this student faces some challenges with her mental health, as we know so many students do. She can go to a mental health professional right at her school who is available to help students directly because that school benefitted from our investment of another $500,000,000 to advance our goal of doubling the number of school counselors, social workers, and mental health providers available to our kids.

She and her family can also get wrap-around supports from her community because we have more than doubled funding for full-service community schools that are designed to do exactly that.

As the student comes closer to adulthood, she has pathways to careers and skills to succeed in the world. We set her up to compete and succeed in a stronger economy than ever with well-paying jobs at the ready because this budget delivered more funding for career and technical education, more funding for career-connected high schools, and more investment in helping every student become multilingual.

She also has a jump-start on her path toward earning a college degree or credential because we worked together to make postsecondary education inclusive and affordable. We increased the Pell Grant. We invested in proven strategies to help students like her better afford college and succeed in earning her degree. We supported HBCUs, TCUs, and MSIs, and we made free community college a reality nationwide.

This vision of our future isn't reality yet, but these are just a few of the incredible ways that, together, we can raise the bar for education when Congress acts to advance these educational priorities in President Biden's 2024 budget.

We have a choice to give our students more, not less with this budget. We have a choice to go back to a broken status quo or to raise the bar together. If we can work together to do what we agree needs to get done, I know we can raise the bar, and we will.

I thank you, and I look forward to answering your questions.

Thank you.

[The information follows:]

DEPARTMENT OF EDUCATION

Statement by Miguel Cardona
Secretary of Education
on the
U.S. Department of Education Fiscal Year 2024 Budget Request

Chairman Aderholt and Ranking Member DeLauro and distinguished Members of the Committee. I am pleased to join you today, and I am proud to testify on behalf of President Biden's fiscal year 2024 Budget Request for the Department of Education. As an educator and a father, I know that nothing unites America's families more than the hopes we share for our children, and that is why the Biden-Harris Administration is pushing for bold investments to ensure all students have equitable access to schools, colleges, and educators that welcome and support them, inspire their love of learning, and prepare them to succeed in whichever career they choose.

President Biden's latest budget proposal calls on Congress to act with urgency to provide our schools with the resources needed to raise the bar in education by promoting academic excellence and rigorous instruction, boldly improving learning conditions, and answering unmet challenges like the educator shortage and addressing the mental health needs of our students. Our Administration is also pushing for dramatic new investments in high-quality preschool that provide all our youngest learners with a sturdy bridge to elementary school success. The Biden-Harris Budget supports the Department of Education's efforts to boost global competitiveness by expanding opportunities for multilingual learning, redesigning high schools to include multiple pathways to college and career, and supercharging state and local efforts to make free community college a reality nationwide. To help more students from low-income backgrounds access the benefits of postsecondary education, this Budget further proposes to increase the maximum Pell Grant award and provide critical resources to address students' basic needs.

The President's fiscal year 2024 request calls for critical, targeted investments that will promote greater prosperity and economic growth for decades to come. The discretionary request is $90.0 billion for Department of Education programs, an increase of $10.8 billion over the fiscal year 2023 enacted level. The 2024 Budget prioritizes funding for several core themes that are at the heart of this Administration's vision for education in America: 1) Achieving Academic Excellence; 2) Boldly Improving Learning Conditions; 3) Creating Pathways For Global Engagement; and 4) Making Postsecondary Education Inclusive and Affordable.

ACHIEVING ACADEMIC EXCELLENCE

This Budget seeks to ensure every student receives a high-quality education. Central to that effort is Title I of the Elementary and Secondary Education Act, which delivers critical funding to 90 percent of school districts across the Nation, helping them to provide students in low-income communities the academic opportunities and supports they need to succeed. Accordingly, our request provides $20.5 billion for Title I, a $2.2 billion increase above the fiscal year 2023 enacted level. This funding will continue the historic progress we've seen over the past two years, as Congress has enacted a total increase of $1.9 billion for Title I since fiscal year 2021.

The President and I remain 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. The Budget Request reflects that commitment through a $2.7 billion increase over FY 2023 enacted levels for special education programs, including a $2.1 billion increase for Part B grants to states, a $392 million increase for Part C grants to support proposed reforms to expand early intervention services for underserved infants and toddlers, an $83 million increase for IDEA Preschool Grants, and a $186 million increase for Part D National Activities to provide targeted increases designed to support the needs of students, schools, districts, and families. These additional funds represent an important down payment on the Federal commitment to

students with disabilities, but there remains a nearly $26 billion annual gap between current funding levels and what is widely considered to be full funding of IDEA, and that is why the Administration supports legislation that achieves full funding over the next 10 years, such as the IDEA Full Funding Act. In addition, our request for IDEA National Activities includes $20 million in targeted support to help ensure that both military-connected children and other highly-mobile populations with disabilities receive the free appropriate public education to which they are entitled under the IDEA and do not experience unnecessary delays in service delivery as a result of changing schools or moving to a new school district.

The Budget proposes a new $500 million demonstration program to incentivize school districts to leverage existing federal education dollars to expand high-quality public preschool in schools and community-based settings, including Head Start, for children eligible to attend Title I schools. Districts that apply for funds under this program must demonstrate a commitment to partnering with their local Head Start programs. Preschool is an important research-based strategy proven to reduce disparities before kindergarten entry, particularly for children from low-income families. Expanding access to high-quality preschool for Title I eligible children is critical to the Department's mission to promote student achievement and preparation for global competitiveness by fostering educational excellence and ensuring equal access to high quality educational opportunities. This new investment complements the mandatory funding proposal also included in the President's Budget (at the Department of Health and Human Services, in partnership with the Department of Education), which would provide assistance to every state to establish and expand high-quality free preschool, through a federal-state partnership.

I strongly believe that high-quality public education—from prekindergarten through postsecondary learning and beyond—lifts up communities, unites people around student success, strengthens our democracy, grows our economy, and empowers people everywhere to realize their dreams. When the bar is raised in education—when we improve the core work of teaching

and learning for all students—all of our nation's students will build the skills to succeed inside and outside of school. To this end, the Budget includes $100 million for a proposed new demonstration within State Assessments program to assist local educational agencies (LEAs) in developing high-quality formative and diagnostic assessments. Assessments funded under this proposal would expand access to quick-turn information that teachers can use to identify learning gaps and tailor the learning experience to accelerate toward outcomes for all students, including students with disabilities and English learners. The Budget also includes an increase of $121 million above 2023 enacted ($405 million in total) for the Education Innovation and Research program in order to build on the Department's success in using program funds to develop an evidence base for strategies and practices that are effective in improving educational outcomes for students, including those in foster care.

BOLDLY IMPROVING LEARNING CONDITIONS

The lingering impacts of the COVID-19 pandemic have taken a heavy toll on the mental health of many students, educators, and staff. Research shows that students who receive social, emotional, mental, and behavioral supports perform better academically. Yet, there continues to be a critical gap between the number of school-based health service providers needed to provide daily supports, and the number of such providers currently in our schools. It is time we raise the bar by boldly improving learning conditions and rethinking how we invest in and provide mental health supports. We must transform from a reactive school model to a proactive model that focuses on a student's overall well-being.

Building on the $1 billion Congress provided through the Bipartisan Safer Communities Act (BSCA) to address mental health staffing shortages, the Budget provides $428 million for new awards under the School-Based Mental Services Grants and Mental Health Services Professional Demonstration Grants programs to increase the number of school-based counselors, psychologists, social workers, and other health professionals as well as mental health

programming and supports in K-12 schools. The Budget also includes $150 million under the Fund for the Improvement of Postsecondary Education (FIPSE) in the Higher Education Account to create a complementary program to hire additional staff to implement best practices for addressing the mental health needs of college students on their campuses.

Our request provides $368 million to expand Full-Service Community Schools, more than doubling current funding for this program. This significant increase in funding recognizes growing evidence that the pillars of evidence-based community schools—integrated student supports such as student mental and physical health services, expanded learning time opportunities, family and community engagement, and collaborative leadership— in concert contribute meaningfully to improved student outcomes and school performance. The Request would help take these evidence-based practices to scale by dramatically expanding the Full-Service Community Schools program to create hundreds of new community schools serving more than one million additional students, family members, and community members.

To raise the bar in education, we must also continue to elevate and respect the teaching profession. While the education sector has faced shortages in critical staffing areas for decades, the COVID-19 pandemic and tight labor market have made shortages worse, further exacerbating the already disproportionate impact on students in underserved communities. This Budget invests nearly $3 billion in educators and school leaders, including $798 million—an additional $297 million on top of current funding levels—in competitive programs that support a diverse and well-prepared pipeline of educators and strengthen teacher retention. These programs include Teacher Quality Partnerships ($132 million to effectively prepare aspiring teachers by supporting comprehensive pathways into the profession, such as high-quality teacher residencies and Grow Your Own programs (partnerships between schools, districts, community organizations, and teacher preparation programs to recruit and train teachers), that improve educator diversity, effectiveness, and retention); Augustus Hawkins Centers of Excellence ($30

million to support teacher preparation programs at Historically Black Colleges and Universities (HBCUs), Tribally Controlled Colleges and Universities (TCCUs), and Minority-Serving Institutions (MSIs)); Teacher and School Leader Incentive Grants ($200 million to support school-based models of distributed leadership); IDEA State Personnel Development and Personnel preparation ($303 million to address shortages of special education teachers); and School Leader Recruitment and Support ($40 million to recruit and train school leaders).

CREATING PATHWAYS FOR GLOBAL ENGAGEMENT

As our labor markets become increasingly global, it is imperative to prepare our students to compete on an international stage, and that includes providing better opportunities for our students in America to be multilingual. Learning another language, or multiple languages, should be expected of our students and anchored as a skill that will enhance their global engagement and increase opportunities for success. This Budget will help us achieve that goal; we are requesting $1.2 billion for English Language Acquisition grants, a $305 million increase over the fiscal year 2023 enacted level, to strengthen State and local capacity to meet the needs of English Learners and their teachers, provide for professional development on multilingual education for existing teachers and staff, and bolster the multilingual educator pipeline via post-secondary fellowships.

Our Budget strengthens the multilingual teaching workforce, by providing $90 million to build multilingual teacher pipelines and provide professional development in multilingual education, and $10 million for post-secondary fellowships to improve the quality of multilingual educator preparation. The Budget also requests $25 million for grants to States and LEAs to improve and expand instruction in world languages, offering new pathways to global learning for more students in more schools.

Lastly, in order to better serve English Learners and their families, I recently announced my intention to move functions involving the administration of State-administered grants under

Title III of the Elementary and Secondary Education Act (ESEA) from their current placement in the Office of Elementary and Secondary Education (OESE) to the Office of English Language Acquisition (OELA), where they were originally located. This Budget further proposes to rename the Office of English Language Acquisition to the Office of Multilingual and English Learners and elevate the director of that office to the Assistant Secretary level.

To further prepare our students for global success, our high schools should evolve to meet the career and college demands of today and tomorrow. Reimagining traditional educational pathways is a critical piece of the President's vision to increase successful outcomes for all students and help them compete internationally. To improve the high school to college and career pipeline and prepare students for the jobs that are coming as a result of the Bipartisan Infrastructure Law, the Inflation Reduction Act, and the CHIPS and Science Act, the Budget requests $200 million for our Career-Connected High Schools initiative. This initiative will provide competitive grants to partnerships among school districts, institutions, and employers to increase the integration and alignment of the last two years of high school and the first two years of postsecondary education. Strategies include dual enrollment, work-based learning, college and career advising, and assistance for students obtaining industry-recognized credentials. In addition, the Budget provides $1.47 billion for the Career and Technical Education (CTE) State Grants program, an increase of $43 million over the fiscal year 2023 enacted level, to support the President's goal to expand and build new models for workforce development starting in middle and high school. These pipelines are critical to providing more good-paying jobs for all Americans – and giving students a clear pathway to compete in an ever-changing economy.

MAKING POSTSECONDARY EDUCATION INCLUSIVE AND AFFORDABLE

Postsecondary education continues to play a vital role in supporting economic success for our students and for the United States as a whole. However, college affordability remains a significant barrier for many families—and it puts the dream of a college degree out of reach for

far too many students. President Biden and I are doing all we can to ensure we can deliver on the promise of postsecondary education, and we are committed to making postsecondary education more inclusive and affordable so all Americans can access its life-changing benefits.

Pell Grants have been the foundation of low- and moderate-income students' financial aid for decades; however, the value has diminished as college costs continue to rise. To expand equitable and affordable access to an education beyond high school, the Budget proposes to increase the maximum Pell Grant by $820 to $8,215 for the 2024-2025 award year, through a combination of discretionary and mandatory funding. This 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.

The Budget also expands free community college across the Nation through a new federal-State partnership. This proposed nationwide Free Community College program, supported through mandatory funding, would further ensure eligible first-time students and workers wanting to reskill can enroll in a community college to earn a degree or credential for free. To lay the groundwork for this program and scale up existing best practices, the Budget includes $500 million for a new discretionary grant program that would allow grantees to offer up to two years of free community college to eligible students, including DREAMers, enrolled in eligible programs that lead to good-paying jobs, or that fully articulate to four-year degrees. Grant dollars could be used to quickly scale-up high-quality programs – for example, existing programs with demonstrated success that can be expanded immediately – or to support new and in-demand programs. In addition, the Budget would provide two years of subsidized tuition for students from families earning less than $125,000 enrolled in a four-year HBCU, TCCU, or MSI.

It is critical to help students obtain the resources they need to persist in and complete a postsecondary education. The Budget supports innovative strategies to improve student success and degree completion through $119 million in increased funding for Postsecondary Student Success Grants in the Fund for the Improvement of Postsecondary Education (FIPSE). The Budget also promotes academic success by providing critical resources to support students' basic needs, including a $20 million increase to institutions providing affordable child care for student parents with low incomes through the Child Care Access Means Parents in School Program, or CCAMPIS. The request includes increases for Federal TRIO programs and GEAR UP, $107 million and $20 million above fiscal year 2023 enacted levels, respectively, to expand services that promote access and completion in postsecondary education for underserved individuals. The Budget enhances institutional capacity at HBCUs, TCCUs, MSIs, and low-resourced institutions, including community colleges, by providing an increase of $429 million over the 2023 enacted level. This increase includes $350 million, a bump of $300 million, for the HBCU, TCCU, and MSI Research and Development Infrastructure Grants program, funded in FIPSE.

The Budget will improve the services we provide students and families to help them pay for college through an essential investment in Student Aid Administration. We are requesting $2.65 billion to administer the Federal student aid programs in fiscal year 2024, an increase of $620 million over fiscal year 2023 enacted, to support students and student loan borrowers as they navigate the financial aid application and student loan repayment processes. The increase will allow the Office of Federal Student Aid (FSA) to continue to operate the student aid programs, protect against cybersecurity breaches to ensure protection of borrowers' personal information, implement critical improvements to student loan servicing, continue to modernize its digital infrastructure, and ensure successful administration of the financial aid programs through a simplified application process for students and borrowers. Failing to provide the requested increase to FSA for a second year in a row would result in reduced services for

students, families, and borrowers in addition to putting the systems that hold sensitive data for over 40 million Americans at risk.

EDUCATION RESEARCH, ASSESSMENT, AND STATISTICS

Education research and data are important because high-quality information about effective practices and trends in student achievement can help improve both student outcomes and the return on the public investment in education at the Federal, State, and local levels. Our Budget requests $870 million for the Institute of Education Sciences, a $63 million increase above the fiscal year 2023 enacted level, to conduct, provide and share research and scientific evidence in education, including expanding research and development to support the use of cutting-edge technology to expand and enhance effective practices in teaching and learning, and to collect data on the real-time impacts of the COVID-19 pandemic on K-12 education.

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 27 percent increase for the Office for Civil Rights (OCR) to protect students, providing a total of $178 million to advance equity in educational opportunity and delivery at Pre-K through 12 schools and at institutions of higher education. Increased funding will be used to expand staffing capacity and address a growing complaint workload, which will in turn enhance OCR's ability to resolve cases in a timely manner.

CLOSING REMARKS

I want to thank the Committee for inviting me to discuss the President's FY 2024 Budget for the Department of Education. I have often said that a budget is a statement of values. As you review and consider our budget request, I hope you see how committed President Biden and I are to boldly raising the bar in education—to transform our education system to better serve the needs of all students. Our Budget is dedicated to achieving that goal. Our children and our country deserve it. Thank you, and I will do my best to respond to any questions you may have.

Mr. ADERHOLT. Thank you Mr. Secretary.

And we will begin our Q&A session at this time for members to pose questions. We will stick by the 5-minute rule and as close as possible. So keep that in mind as we move forward with the questioning.

As I mentioned in my opening statement, as a father, I am very concerned about the proposed Title IX regulations that I believe will do grave harm to the safety and success of young women athletes and girls across the country. Under these proposed rules, a mediocre male athlete can simply identify as a female and go on to dominate women's sports.

Simply put, I would just have to ask you, do you think this is fair to biological girls?

Secretary CARDONA. Thank you, Chairman Aderholt.

Our focus at the Department of Education is to provide equal access, free from discrimination, to students. We know Title IX has helped over the last 50 years provide opportunities for girls, and we are proud of the work that we are doing to make sure that, for example, the training facilities for girls has the same attention and funding as it does for boys.

So we are proud of the Title IX proposal, and the current proposal that you are speaking about is just that. It is a proposal, and we have a window open for comments that we are going to take very seriously. The last comment period in Title IX we received over 240,000 comments, and we want to make sure that we are listening to the American people in this process as well.

Mr. ADERHOLT. I understand that a complaint against the University of Pennsylvania regarding discrimination against a female athlete has been pending at the Department of Education's Office for Civil Rights for over a year now. Can you give us any idea of when the Department will respond to the civil rights complaint?

Secretary CARDONA. Yes, thank you.

We take each of the complaints that are submitted to us very seriously. The Office for Civil Rights has received—last year, I think it was 19,000 complaints compared to about 10,000 in 2019. They are working really hard, and I am proud of their work. However, I can't speak specifically to that one.

What I can do is ask the Office for Civil Rights to reach out to your team to see what information we can provide and make sure that whatever we can provide we make it available to you.

Mr. ADERHOLT. Yes, I think that would be helpful. If you could ask them to get back with the subcommittee about their timeline on that, I think that would be very helpful.

And how is your department gathering feedback from all the parties that are concerned when there is a rulemaking process?

Secretary CARDONA. We take very seriously that process of getting feedback. As I said before, 240,000 comments when we first released the Title IX proposed rule. We have open portals for information to be shared with us. And as you can tell by that number, many people have shared information.

We welcome different perspectives. I think that is what helps us get to where we need to go. And I want to assure you, Chairman, that we welcome feedback that differs in opinion. It is not just the opinion that we share. We welcome feedback from all.

Mr. ADERHOLT. Well, I ask that because I understand the Department has held roundtables with transgender students who make up perhaps only less than 1 percent of the population, and I just want to make sure that that is also being done with other groups as well.

Secretary CARDONA. Thank you, Chairman Aderholt.

I will make sure that message is clear. And I know in my experience traveling the country, I have had conversations with families and parents and students from all different walks who shared their perspective. We remain committed to listening to different perspectives and engaging folks from whatever perspective they have.

Mr. ADERHOLT. Also in my opening comments, I mentioned about the Department pursuing mass loan cancellation. Your proposals all but turn loans into grants by having borrowers pay so little.

In this budget, we also see a massive $120,500,000,000 for a free community college proposal. These proposals will do nothing but drive up inflation and punish students who have made difficult choices, and that may have included not going to college or making lifestyle sacrifices to pay off loans responsibly.

What would you say and what do you say when you encounter middle class Americans who just ask very straightforwardly how is that fair?

Secretary CARDONA. Thank you, Mr. Aderholt.

And I appreciate your support of Pell, recognizing the importance of college affordability and accessibility. And I also appreciate, Chairman, your mention of the disparities in achievement and the achievement gaps that have widened during the pandemic.

Part of the challenge in this country is that higher education is out of reach for too many people. I have spoken to hundreds as Secretary, but I think even more jarring to me were the conversations that I had when I was a school principal talking to fourth graders who said they are not going to college because they don't want to put their parents in debt.

We have a problem in this country, and we are committed to fixing it. Part of it is making sure that loan payments don't prevent students from considering college or from buying a home. What we are proposing is an income-driven repayment plan that allows more folks to go to college and not have $600, $700 college debt bills a month, which prevents them from family planning.

So we want to make sure that while we are looking at fixing a broken system like the Public Service Loan Forgiveness Program, we are also looking to drive down college costs to make sure that there is a good return on investment.

And with regard to community college, sir, we have an opportunity of a lifetime to prepare our students for the tsunami of careers that are coming with the Bipartisan Infrastructure Plan, with the CHIPS and Science Act, and with the climate provisions of the Inflation Reduction Act. There are going to be so many jobs that, to me, providing universal access to 2-year schools will prepare our workforce, adds to the economy, making sure folks get into these jobs, making $60,000, $70,000 to start, without $150,000 in college debt.

I think we can work together to make that a possibility for this country. And not only will these students grow, their families grow, but our economy and our country will grow.

Mr. ADERHOLT. And I understand there is a lot of merit in what you say. The problem is we do have a real debt crisis in this country, and we can't overlook it.

But anyway, my time has elapsed, and I will turn to my ranking member, Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

Thank you for your testimony, Mr. Secretary.

Mr. Secretary, when really confronted with the devastating impacts of the proposed cuts, some of my Republican colleagues are dismissive. They claim that major cuts would not be implemented evenly across the board. As I mentioned and we both know, if other programs are exempt from cuts, education programs that students and parents rely on will be cut even more by the Department's estimate in your letter to me.

In fact, already in this Congress, nearly 75 percent of my Republican colleagues voted to eliminate all K through 12 education funding by the end of the year. My question—and I again want to say thank you to the 60 who voted no.

If nearly 75 percent of House Republicans had voted for Representative Massie's amendment to H.R. 5, if they succeed in their goal that authority of the Department of Education, Secretary of Education, operator, administrator, any office or program related to elementary or secondary education should be terminated on or before December 31st of 2023, what impact would that have on the students and schools around the country?

Secretary CARDONA. Thank you, Ranking Member DeLauro.

Let me just share I think we are all in agreement that we need to raise the bar in this country academically. The percentage of students reading at proficiency in the last Nation's Report Card was 33 percent. That is appalling. That is unacceptable for the United States. Thirty-three percent of our students are reading on grade level.

We are asking for Title I support. This Massie amendment would cut that. When I was a fourth grade teacher, when I was school principal, the Title I dollars were used for reading teachers to help children who were reading below grade level.

This would further exacerbate gaps not only within our country, but gaps between our country and other countries. You know, we are 31st in math compared to other countries, 9th in reading. That is unacceptable for this country.

So, Title I. Another area that it would eliminate—Impact Aid, which supports our military-connected students. So, for me, these cuts would be devastating for our students and families.

Ms. DELAURO. Thank you. Let me move to another area, Mr. Secretary.

This is a report recently came out about 2U, a for-profit online program manager showing again how the company partners with colleges to aggressively recruit students into high-cost, low-value degree programs that fail to provide promised jobs.

This is editorializing. This is my belief is that for-profit OPMs are the new predators in higher education. They split Federal stu-

dent loan revenue with colleges in exchange for aggressive recruitment services and outsource educational programming. The arrangements are predatory and unlawful under the statutory incentive compensation ban, something that I voted for in 1992.

Mr. Secretary, as you evaluate the Department's policy dealings with the 2U efforts here, can you assure me and the public that you will be prioritizing the concerns of students and taxpayers over revenue concerns of schools and the for-profit companies? And what can we expect to see from the Department on for-profit OPM recruiters, and when do we expect to see new policy?

Secretary CARDONA. Thank you.

We are committed to a thoughtful review of these online program managers. We know that they have been increasing substantially. We do know also that students are demanding flexibility and online options. We know that innovation is needed for our students to have access.

But we want to make sure that it is done in a way that protects our students, and we are going to work toward rules that help colleges create better and—better options for students, but also protecting students. It is one of those things that we want to make sure that we are getting it right. Balancing it, but also protecting students.

The last thing I want to do is end up where we were when I came in as Secretary with tremendous borrower defense claims because students were taken advantage of.

So while I do appreciate the innovation and the need for evolution and the demand that is asking for online options, I want to make sure we are doing it carefully.

Ms. DELAURO. And just when can we look forward to new policy?

Secretary CARDONA. We are anticipating this year, 2023, by the close of 2023.

Ms. DELAURO. Thank you. And I yield.

Secretary CARDONA. Thank you.

Ms. DELAURO. Thank you.

Mr. ADERHOLT. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Good morning, Mr. Secretary. Good to see you today.

Secretary CARDONA. Good morning. Thank you. Same here.

Mr. FLEISCHMANN. Mr. Secretary, I have worked with colleagues across the aisle to increase STEM education opportunities to rural and low-income communities. The most recent data shows that 3.5 million STEM-related jobs will need to be filled by 2025 in order to maintain a stable workforce. It is imperative, in my view, that we continue to support public-private partnerships to close the skills gap and to cultivate a diverse workforce.

How can Congress, in your view, help in efforts to increase STEM and computer science education in these low-income and rural communities? And what is the administration doing to promote public-private partnerships in this area?

Secretary CARDONA. Yes. Thank you, Congressman Fleischmann. I agree with you 100 percent not only that we have to develop our STEM capacity in this country, but we need to make sure we are focusing on our rural communities as well.

In my visits to different—I have been to Nebraska and Kentucky, I heard from educators, from parents and students that they sometimes felt ignored and that their needs are not being prioritized the way they felt they should be. And I agree that we need to focus on our rural communities.

I am proud to say that this budget proposal does increase education innovation research in rural communities. There is a set-aside, $100,000,000, just for rural communities to make sure that we are giving them the opportunities to innovate around STEM education.

And with regard to the public-private partnership, sir, I couldn't agree with you more. We are working really hard at the Department of Education to really remove silos and make sure that we are engaging our private partners as well in this education process because it leads to more opportunities for our students. It leads to better pathway development in our schools.

And then just one last thing I want to say about rural communities, sir. When I was in Hazard, Kentucky, one of the goals that we had there was to make sure that we are providing those high school students with career pathways where they don't have to leave Kentucky. We want to make sure that they have job opportunities there in Hazard, Kentucky, to grow that economy.

So I agree with you on that, sir.

Mr. FLEISCHMANN. Thank you, Mr. Secretary.

Historically, Mr. Secretary, I have been a big supporter of the Federal student aid, particularly the Pell Grant Program. Over 11,000 students in my district receive a Pell Grant, the single most important tool to enable low-income students to access and afford college while preserving student choice.

Can you explain how the proposed increase in the Pell Grant, along with the implementation of FAFSA simplification, expands eligibility for low-income students, and how many more students will be eligible because of these changes?

Secretary CARDONA. Yes, thank you.

I agree with you that Pell has opened doors for many students who thought college was out of reach. We know over the years the Pell increases haven't kept up with the increase in college costs. In 1979, Pell covered 80 percent of 4-year colleges and 100 percent of community colleges. Today, that number is 31 percent of 4-year colleges and 54 percent of community colleges. So thank you for the support of Pell.

And to answer your question, that and an improved, better FAFSA will increase the number of students that have access to higher education. I don't have the number off the top of my head. I know we did calculate it, but I would be happy to share it with the entire committee. Because in my opinion, this better FAFSA will open more doors to higher education, much like Pell did.

Mr. FLEISCHMANN. Thank you, Mr. Secretary.

Mr. Chairman, I will yield back.

Secretary CARDONA. Thank you.

Mr. ADERHOLT. Mr. Hoyer.

Mr. HOYER. Mr. Secretary, thank you very much for agreeing to lead to this agency. It can sometimes be very tough.

The former chairman with whom I served first when I served on this committee said as long as you take care of the education of your children and the health of your people, we will continue to live in the strongest and best nation on Earth. I believe that.

And I believe that the notion that somehow the Federal Government doesn't play a key role in both primary and secondary and higher education is wrong and will lead to the deterioration of our country's competitiveness worldwide if that is pursued.

Did you hear me?

Secretary CARDONA. Yes, yes. I can hear.

Mr. HOYER. Let me just turn on my mike. He can't hear me.

I want to ask you in that context, if we withdrew our support for primary and secondary education, what would be the impact?

Secretary CARDONA. Thank you, Congressman Hoyer.

I continue to be thankful to serve in this capacity. It is such a blessing to me to be able to serve, as a teacher and a father, to be serving as Secretary of Education.

And I agree with you. There is a tribe in Africa that says "And how are the children?" That is their greeting. Because if the children are well, the tribe is well.

The cuts that were proposed would have significant impact on schools across the country, the 50 million students in elementary, middle, and high school. I mentioned before Title I. For students with disabilities that are protected under the Individuals with Disabilities Education Act, it would affect and cut 48,000 educators in a profession that is struggling to get highly qualified teachers into the classroom for the kids that have the greatest need.

I will tell you, Congressman Hoyer, during the pandemic, I heard most from parents of children with disabilities whose needs were not being met. So those cuts would affect 7.5 million students, cutting 48,000 educators in an area where we are struggling to get teachers. That is one example.

The Federal Work Study Program would cut support for 85,000 students connecting, and Pell recipients, 6.6 million Pell recipients would have funding cut by over $1,000. So what would it mean, it would worsen public education, and it would limit access to higher education at a time where we need to double down if we are going to compete with other countries who are growing as well.

Mr. HOYER. I am a big proponent of full-service schools. In fact, there are 69 centers in Maryland named after my wife, the Judy Hoyer Early Childhood Education Program. A former Republican Governor of our State, Ted Agnew, said that "The cost of failure far exceeds the price of progress."

Secretary CARDONA. Mm-hmm.

Mr. HOYER. By that, he meant, obviously, if you invest in your children, if you invest in people's health, mental health, and education status, that you will have lesser costs, and they will be taxpayers, not tax takers.

Secretary CARDONA. Right.

Mr. HOYER. Would you comment on the impact that a—you mentioned specific programs, but that a retreat from investing in our people——

Secretary CARDONA. Yes.

Mr. HOYER [continuing]. Which is what Mr. Natcher was referring to, if you invest in your children and the people's health, you will live in a strong country. Can you comment on that?

Secretary CARDONA. Sure. And let me do it from the perspective of a lifelong educator.

You have all heard the "pay now or pay later." Investing in children is an investment in our country and in our country's strength, in our country's defense, in our country's economic prosperity. And I have seen, as an educator, what happens if students don't have the support that they need.

I once presented to a group of educators in Connecticut, and there was a graph that I had that I think it costs roughly $13,000, $14,000 on average to educate a child in Connecticut. It costs over $50,000 to incarcerate someone for a year.

Education is an investment in skill development. And I talk about the tsunami of jobs because that is where we are right now. Let me make that very clear. If we do not invest in the skill development and in the career pathways that our students need, these millions of jobs—high-skill, high-paying jobs that are going to be available very soon—will not be filled.

My greatest fear is that we are not prepared, as a Department of Education, to get our students ready to take those jobs, to add to the economy. And it is not only our children. We have many underemployed adults that need another opportunity to re-skill and get back in there, add to their family, but also add to the economy and add to their feeling of self-worth.

I have met so many adults throughout this 2-year period who said the pandemic opened my eyes, I am ready to go back to school. I need to get skills. I want to do it.

So it really is an investment, Congressman Hoyer, in not only our people, the American people, but in our economy and our country's growth.

Mr. HOYER. Thank you.

Thank you, Mr. Chairman.

Mr. ADERHOLT. Mr. Harris.

Mr. HARRIS. Thank you very much.

Thank you, Mr. Secretary, for being here.

First of all, let me just address the issue of the Federal Department of Education because I was one of the 161 who voted to eliminate it. Because you know it has been in existence for 42 years, and now 43, and I guess no one will argue that education prowess in the United States is better vis-a-vis our international competitors now than it was 42 years ago, 43 years ago.

I don't know. That kind of defines failure. We established the Federal Department of Education. And on a national level, we are worse off than we were 42 years ago. So one does have to ask do we need it? Or was President Reagan right when in 1982, 2 years after the establishment, he said this is just plain and simple a bad idea. It won't work.

And Mr. Secretary, by objective standards, it is not working. That is all I have to say.

We can create a strawman and say, well, if you eliminate it, you eliminate 48,000 teachers. Baloney. We have a $2,000,000,000, $3,000,000,000 surplus in Maryland. The States pick up the slack,

the local communities. That is where education decisions should be made, and there is plenty of money rattling around State coffers to pay for it. The question is with the Federal Government to do it.

Let me ask you a question. Were we right to close schools during COVID?

Secretary CARDONA. During the pandemic?

Mr. HARRIS. Yes, that is right. The COVID pandemic, yes. This is a simple question. Do you feel we were right to close schools?

Secretary CARDONA. During the pandemic, I was serving as Commissioner of Education, and the decision to temporarily close schools to protect students and families and educators was made at the local level, and it was the right decision in those communities.

Mr. HARRIS. So you believe it was a good decision to close public schools, and there is a good scientific reason to believe it was a good decision?

Secretary CARDONA. Absolutely. And I also believe that it was important to reopen our schools safely, and when I became Secretary of Education, 47 percent of the schools in this country were open full time. Within 9 months, I had over 98 percent open.

Mr. HARRIS. Well, I hope so. Because the pandemic was over by then. I certainly hope so.

And again, I disagree with you. I would just say that the scientific evidence is pretty clear that children were at very low risk or increasingly also still at very low risk, and all we did was harm our standing in the international community with regards to our performance by students.

But let me address what the chairman brought up in his opening remarks. We spend our time on Title IX new policies instead of making sure we have enough people in our workforce that perform the duties necessary in the 21st century. Now you said you taught fourth graders, and your policy, this new Title IX proposed policy—let me ask you first thing. What scientists were involved in developing it?

Secretary CARDONA. I would be happy to have my team of——

Mr. HARRIS. Please get back to me.

Secretary CARDONA [continuing]. Office for Civil Rights reach out to you on which scientists were involved.

Mr. HARRIS. Very good. Thank you.

Because you were actually a fourth grade teacher. You are well aware, because the policy says that elementary schools have to allow people to participate in teams based on their preferred gender. Is that right? My reading of the policy, elementary schools?

Secretary CARDONA. The proposed—the proposal that we have——

Mr. HARRIS. Correct.

Secretary CARDONA. Correct.

Mr. HARRIS. Now you are aware that even pre-puberty stark contrast exists between the performance of boys and girls, and I mean biological—for the purposes of this discussion, I am going to talk about biologic boys and girls.

For instance, a study in Australia, 9-year-olds. Nine-year-old boys run 16 percent faster miles than 9-year-old girls. Six-year-olds, 9.7 percent longer long jump in a boy than a girl.

So under your framework, you are going to take and mix biological males and females on the same team, call them all girls if you want, and I would propose all you are going to do—because there are differences physiologically. I am sorry. I can't change chromosomes. You can't change chromosomes. Six thousand five hundred different genes between men and women. Three thousand different ones that affect skeletal muscle.

If you have a seven-girl team, six biologic girls and one biologic boy, and there is a cut off at six, that seventh person, most likely to be a girl because that is the way biology works, will be discouraged from doing anything further in their athletic career. That is just plain wrong.

And as a father of a daughter who is a six-time All American, she has told me point blank to my face, if those rules are enforced, I am not an All American anywhere. I would suggest, Mr. Secretary, you didn't base it on science. You based it on woke politics, which is rampant through your department and the reason why we continue to fail on an international scale.

Yes, I am proud to be one of the 161. We need to completely rethink the U.S. Department of Education.

I yield back.

Mr. ADERHOLT. Mr. Pocan.

Mr. POCAN. Thank you, Mr. Chairman.

Thank you very much, Mr. Secretary.

So I really want to ask more concerned about the cuts and specifically about a program that I know Mr. Fleischmann brought up, the Pell Grant. I have been one of the lead advocates for doubling Pell Grants in 5 years, being a Pell Grant recipient myself. That allowed me to go to college. I didn't get a chance to do spring breaks and a lot of other things. I worked all through college, but Pell Grants were really extremely important.

And when I paid tuition and when I talk to students now, what they are paying for tuition, it is considerably more. So my concern is that as you look at what, hopefully, when we see a budget proposed by the Republican majority, from what we have heard they are talking about, you could see 22 percent cuts in discretionary non-defense spending. And I am concerned what that means for financial aid, specifically for Pell Grants.

In my State of Wisconsin, if you had that kind of a cut, 1,200 children outright or students outright would lose the ability to have Pell Grants. The maximum award would go down about $1,000 for the remaining 83,000-plus students who are receiving that. Further, nearly half of those Pell Grants are going to families who earn less than $20,000 annually. So this is very helpful.

I know there have been some other bills introduced by some Republicans, particularly Representative Biggs has a bill that would eliminate all Federal funding for student financial assistance, including Pell Grants. I am extremely concerned about that. But could you just talk a little bit about if you were to face something like a 22 percent cut and how that would affect Pell in particular and the people who are receiving Pell?

Secretary CARDONA. Sure. Thank you, Congressman Pocan.

And it is good to hear stories of folks who benefitted from Pell and seeing you advocate for that now.

Pell, as I said earlier, opens doors for students who wouldn't otherwise have that opportunity. We know college graduates on average make $1,000,000 more over the course of their lifetime than students who graduated from high school. So I always remind folks. That is not only good for the student, their families, because it has generational impact, but it is good for the community, right? Economic development.

So, as I said before, there are about 6.6 million Pell recipients. All of them would have a decrease of about $1,000. So that $1,000 for some might be the difference between registering and not registering. We know that.

A thousand dollars is a lot for someone, as you said, working through spring break and trying to make ends meet and has very difficult decisions to make in terms of do I pay the bill, or do I get food, right? So we know that.

We also know that for approximately 80,000 recipients, they will have their total Pell funding cut. Again, what that translates into are more students not going to higher education and their talent not being tapped for this country.

I look at higher education as an investment in our country. We have an opportunity here, especially with the legislation—and I want to thank those of you—in a bipartisan fashion, who passed some amazing things in the last couple of years that are going to provide opportunities for our students. To me, Pell is a necessary component to make sure that we are taking our students, giving them the opportunity for higher education, whether it is 2-year or 4-year, and getting into those high-skill, high-paying jobs that add to the economy.

I have talked to Governors, Republican and Democrat. I have talked to State legislators, Republican and Democrat, who are excited about the job growth opportunities for their State.

So, Pell—yes, it gives that child an opportunity to see themselves as a college student. But what it does for the local community, local economy also cannot be overstated. It is a win for all.

Mr. POCAN. In the minute that is left, I know that the administration is trying to double them in 5 years, and we have been several years into that effort. Can you just talk a little bit more about that effort, the positive side of what you are trying to work on?

Secretary CARDONA. Sure, sure. So over $900 in the last couple of years is historic. Thank you. And we are asking for another $820 this year.

We recognize, you know, we still have a ways to go to catch up to the percentage of what it covered when it was started in the 1970s. But we want to be realistic, but we want to be bold, too. As you said before, many students count on that to make ends meet, and there is so much untapped potential in this country that the Pell Grant helps tap. That is a good way to put it.

Mr. POCAN. Thank you very much.

And just as someone, again, who received Pell and worked through school, didn't take the spring break, worked through the summer, all of those things, I didn't want to take up the ladder

from others, right? And I would hope that this is a program I think that has bipartisan support. I hope we are especially focused as we look at these cuts that this is not something that falls too blunt of an object.

So thank you very much, Mr. Chairman. I yield back.

Mr. ADERHOLT. Thank you. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Mr. Chairman.

Mr. Secretary, thanks for being with us today.

Secretary CARDONA. Good morning.

Mr. MOOLENAAR. Just following up on Mr. Pocan's comments on Pell, one of the things I hear in my district is the need to adapt to some of the workforce development needs.

Secretary CARDONA. Right.

Mr. MOOLENAAR. And even giving greater flexibility in Pell for shorter-term programs that may grant some industry-approved program that would get someone into a job right away. Are you supportive of those efforts?

Secretary CARDONA. Thank you, Congressman Moolenaar.

I have been telling educators throughout the country, evolve. You have to change your programming to meet the demand. And I think part of that is us also recognizing the benefits of short-term Pell and being open to the benefits of programming that gives students the skills that they need in a shorter period of time.

And in the same breath, I want to share with you that if we are to consider that, we have to also make sure that we are not putting our students in a disadvantage where they are using Pell dollars, not having it later and not ensuring high-quality or accountability for good programming there. So I am a big believer in let us look at different options, but let us also make sure that we are increasing accountability and making sure that they are quality programs.

Mr. MOOLENAAR. Okay. Thank you.

I am hearing reports of delays in funding or errors in the formula share for charter school program funding. Are you hearing that, and if so, what measures is your department taking to ensure charter schools are receiving access to the funding they need and deserve? And especially for new and expanding charter schools.

Secretary CARDONA. Sure. Thank you for that question.

I agree that making sure the funding goes quickly is a priority for our charter schools, and making sure that they have the money for those programs is critical. I am not aware of that, but I will look into that, sir, and I will have my team reach back out to you, update you.

Mr. MOOLENAAR. Okay. Thank you.

The Chinese Communist Party is in the news a lot these days. Are you aware of efforts to influence U.S. education by the Chinese Communist Party?

Secretary CARDONA. No, sir. I don't have any information around specific efforts to try to influence——

Mr. MOOLENAAR. Okay. Are you familiar with the Confucian Institutes, Confucius Institutes?

Secretary CARDONA. I don't have information on the Confucius Institute now, but I can—I am sure my team may be aware of it and can look into that.

Mr. MOOLENAAR. Okay. Thank you.

And then TikTok, a lot of students on TikTok. What are your thoughts on TikTok? Is it a learning tool? Is it something that we should ban? What is your sense?

Secretary CARDONA. Well, let me go back to the other topic first. It is really important for me that we protect education, higher education, and make sure that our school is not influenced by others. So that is something that I take very seriously.

And with regard to social media in general, I think we have to make sure that our students are aware of digital citizenry and making sure that they use social media responsibly and in a way that is positive. Because as a father of two teenagers, I know that social media can have positive impact, but it could also have some negative impact.

Mr. MOOLENAAR. Mm-hmm, okay. The Washington, D.C., Opportunity Scholarships.

Secretary CARDONA. Mm-hmm.

Mr. MOOLENAAR. Are you supportive of that effort?

Secretary CARDONA. I certainly want to make sure we support the students that are in the program now, but sir, I don't believe Federal dollars should be used for voucher programs.

Mr. MOOLENAAR. So you are opposed to that?

Secretary CARDONA. I don't want to—I want to make sure the students that are in the program now are supported, but I don't believe in using Federal dollars to support voucher programs.

Mr. MOOLENAAR. So if the students and the families said that they felt supported by using their dollars the way they most effectively could, you would say that the Department should make the decision as to whether or not those students and families are supported, rather than the parents or the students?

Secretary CARDONA. Right. I believe what has happened and what I am concerned with, sir, is at the expense of quality local public education school, what we are seeing is those same dollars being considered to go somewhere else, which would further negatively impact the education that students are getting in their local neighborhood school.

I am in favor of families having options. I chose a technical high school. So—I had choice. But I don't believe that it should be done at the expense of the local public education schools.

Mr. MOOLENAAR. But you realize families with resources could make that choice.

Secretary CARDONA. Right.

Mr. MOOLENAAR. It is families that don't have resources for their children that cannot make that choice under your policy.

Secretary CARDONA. Well, sir, I believe that all the more reason because there are children that don't have the resources to go to a private school, we have to invest in our local neighborhood school. And to me, one of the best options a family should have is the school right down their street.

And when I speak to families in my travels, that is what the parents are telling me. I want the school down the street to be a great option for my child. And that budget reflects that, sir.

Mr. MOOLENAAR. Okay. Thank you. And I yield back.

Secretary CARDONA. Thank you.

Mr. ADERHOLT. Mr. Harder.

Mr. HARDER. Thank you so much, Chair Aderholt and Ranking Member DeLauro, for hosting today's hearing.

And thank you, Secretary, for being with us.

I just wanted to start by saying thank you. Thank you for the work that you and your team have done working with our office and others to expand the Public Service Loan Forgiveness Program for physicians to California and Texas, which inexplicably were excluded from this program for many years. This is something that I have been working on since day one in my office because it is so important.

At the height of COVID, the ICU beds in my district and across California's Central Valley were more than 100 percent full not because we didn't have the bed space, but because we didn't have the nurses and doctors to really take care of people. And that has been a persistent issue. It doesn't help to have a health insurance card if you can't actually get an appointment. And all too often across our area, that is the case.

And we have some successful residency programs. We don't have a single medical school for 6 million people, but that is another issue. But even our residency programs, once those physicians graduate, all too often, they move to other States or other areas where they can make an income, and this Public Service Loan Forgiveness Program is going to help address that, keep our doctors where they need to be.

This is really important. A local TV station in my area, Fox 40, just reported that on a report that said 1 in 5 hospitals in California are at risk of closure due to a dire shortage of healthcare workers, physicians chief among them. So many folks are already driving hours to get an appointment. This is a health equity issue, and it is really imperative to make sure that we get this executed.

The Department of Education has stated that California and Texas doctors can begin applying for the Public Service Loan Forgiveness Program for the first time ever on July 1st of this year. Is that timeline still accurate, to the best of your knowledge?

Secretary CARDONA. To the best of my knowledge, it is. And Congressman Harder, if I can—I appreciate your advocacy there on behalf of folks in California, and obviously, Texas as well is benefitting from that. But just to put it in perspective, the investment in our FSA and our higher education programming has led to major improvements that has helped our public servants.

You are talking about shortages in healthcare. There are tremendous shortages in education. So we set out to fix the Public Service Loan Forgiveness Program. From 2017 to 2021, this bipartisan effort—PSLF was passed in 2007, bipartisan support—provided only 7,000 participants with support, 7,000 in those years.

From 2021 until today, there have been over 450,000 public servants who have received loan forgiveness. And every once in a while, I will get a letter, I will get an email from someone, an educator—all those people that we called essential 3 years ago—saying thank you. Now I can buy a home. Now I can help my children go to college.

So I am glad to see it is working. Yes, the July 1st deadline, I will have my staff follow up with you on that if there is any changes. But that is an example of what we are trying to do to fix

a broken system to get our public servants the support that they need so they could get into those jobs, or else we are going to have a problem if we don't have doctors, nurses, or teachers.

Mr. HARDER. That is great. Well, thank you so much for your efforts on that.

And I know this is a program that has gone through a lot of iterations, and I appreciate you simplifying it and making sure that folks actually receive the support when they need it.

Given all the talk about budget cuts, what are the risks to the PSLF program? Specifically, given the physician shortage, do you think that this extension of the PSLF program to California and Texas doctors is at risk of being cut, given the conversations going on in Washington?

Secretary CARDONA. I am concerned in general about Federal student aid funding. If we don't have significant funding, not only will PSLF, but borrower defense, the loan repayment process, FAFSA, all that would have an impact. We are really—and I want to commend James Kvaal, Richard Cordray, the entire team, who are really working really hard to try to fix a broken system and provide opportunities. So, to answer your question, yes. There will be impact for Public Service Loan Forgiveness.

So the public servants that we promised debt relief, loan forgiveness after 10 years of public service, that would be impacted. Returning to repayment, we will have challenges there. We will have challenges following up on some of those borrower defense claims.

Look, I want to stress the importance of the funding in particular to FSA and the millions of Americans who are waiting for support and service that whose services will be impacted if we don't—if we cut funding there.

Mr. HARDER. Thank you. I appreciate that.

This will extend this program to 10,000 doctors in California, and I am so overjoyed that it is going to be online on July 1st. Thank you for your efforts.

And with that, I yield back.

Mr. ADERHOLT. Ms. Letlow.

Ms. LETLOW. Thank you, Mr. Chairman.

And thank you, Secretary, for being here with us today. I share your passion for education. As a former educator myself, I believe if you educate a child, you give them a future. So I was encouraged to hear you say that.

I was also honored to bring forth H.R. 5, the parents bill of rights, last month. I think this legislation received a false narrative that we were going to be dictating curriculum or telling librarians what they could and could not have in their libraries, and I want to debunk that because it was really just about creating transparency for parents and that we should have a true partnership between our schools and our parents.

And I believe it is important to empower families with accurate and understandable, usable data about their students and their schools. And that transparency provided by effective data systems can help families make good educational decisions for their children.

So I am wondering how could expanding investments in data systems through the statewide longitudinal data systems and other grant programs support and encourage family engagement?

Secretary CARDONA. Thank you, Congresswoman, for your advocacy and for your years of service as an educator.

Look, I think it is really critical that when we talk about reimagining education, we reimagine how we engage with families, and we really improve giving them access to student performance data. I recently read something that in some communities, an A doesn't really mean an A if you look at it compared to the standardized standards that they have for learning.

So, to me, using data systems that are strong gives parents an opportunity to understand how their children are performing and their level of success compared to standards that the State should have. We take that very seriously. I want to make sure that families have the information.

I am really proud of some of the stuff that we are doing around full-service community schools because it engages families in a way that gives them not only the data systems, but the partnership to understand what those data mean and how they can engage in learning and support learning and drive some of the learning that is happening in the schools.

Ms. LETLOW. Yes, I was encouraged to see that this data will show whether students are ready for kindergarten. I am very concerned after COVID and the pandemic. In Louisiana, 4 in 10 Louisiana third graders can't read at grade level.

And so I am just hopeful that you are hopeful yourself that this data is going to help us notify parents and share that information with them. Because we know if they get to the third grade level and they can't read, then it is going to set them up for failure later on in life. And there is data out there that shows that they will never catch up.

Secretary CARDONA. Right.

Ms. LETLOW. So I am gravely concerned about our kids.

Secretary CARDONA. I share the emphasis that you are placing on early childhood education. We know early on, using different screeners or different data points, which students need support early, right?

Ms. LETLOW. Right.

Secretary CARDONA. And we can intervene early to prevent gaps from widening. By third grade, if a child is not reading, we see negative impacts not only on academics, but on their self, feeling of self-worth or their connectedness with school.

So I agree with you. Early childhood education is something that the data, we should be looking at data to drive what we are doing, but also investing in making sure that we have robust early childhood education programs that follow the research on how we know children learn best at those levels. So I agree with you on that.

Ms. LETLOW. I agree with you.

Secretary CARDONA. Thank you.

Ms. LETLOW. I am switching gears here. Mr. Secretary, do you believe it is important for Government agencies to have a contingency plan on the different outcomes that might come from any pending litigation?

Secretary CARDONA. It is important that our team carefully weighs the risks of any litigation and potential implications of them.

Ms. LETLOW. Okay. That is good to hear. So is the Department's Office of Federal Student Aid being proactive in contingency planning and working on clear guidance for student loan servicers and students, should loan repayment be required to begin?

Secretary CARDONA. Yes, we are working diligently to make sure that we are improving our systems to be more clear, to have what we call a long on-ramp so that borrowers know what is needed from them and when it is needed from them.

Ms. LETLOW. Because the COVID–19 public health emergency officially ends on May 11th, and student loan payments have been on pause long enough, the Department should not continue to drag out this repayment pause for many more additional months when they could be using this time to prepare regulations and expectations for servicing companies and students.

Secretary CARDONA. Thank you, Congresswoman. Yes, we agree.

Ms. LETLOW. Okay. I yield back.

Mr. ADERHOLT. Ms. Frankel.

Ms. FRANKEL. Thank you.

And thank you for being here.

Secretary CARDONA. Thank you.

Ms. FRANKEL. So, like many of my colleagues, Democratic colleagues, I am extremely concerned about what looks like might be a 25 percent budget cut in the education issues. I am especially concerned about what is going to happen to the teachers. Because we have a tremendous teacher shortage in Florida and also around the country, and I don't know what that means. Maybe the Republicans think we are going to replace humans with robots. Watch out, folks. The robots are coming.

All right. That was serious. That is not even a joke.

In my county, I live in Palm Beach County—famous for other things—we have one of the largest school districts in the country. We have about 400 teacher vacancies now. There is 5,000 teacher vacancies in Florida, and I understand hundreds of thousands nationwide. So I am very concerned if we cut your budget, the education budget, what is that going to mean for teacher vacancies, especially in our poorer schools that we fund with Title I? So I am going to start with that question for you.

Secretary CARDONA. Congresswoman Frankel, we don't have a teacher shortage issue, we have a teacher respect issue. And it is resulting in less people wanting to go into the profession and less people staying in the profession. All the research shows the most influential factor in a child's success is the teacher in front of the classroom.

And we have done a disservice to the teaching profession, which is why we are working on public service loan forgiveness, which is why in our budget there is a total of $3,000,000,000 to support high-quality teaching. We have a $342,000,000 increase requested for Teacher Preparation, Development, and Leadership. It is not enough to hire teachers. We have to make sure we are providing professional development.

Our children are coming in with what the Surgeon General called a youth mental health crisis. So if we are not investing in the professional development of our educators to meet our students where they are, we are going to have educators that are doing their best, but without the skills.

So we, in our budget, are putting dollars to that. We, for the first time ever, are putting dollars toward the Hawkins grant, Augustus Hawkins grant, that creates pipeline programs to tap high school students on the shoulder and say, hey, I think you would make a great teacher. Here is a program that connects to a 4-year school, and you will have an option to go back to that district that you love to teach.

We are trying to create programs. I am asking Governors, State chiefs to create programs to make sure our high schools students are tapped on the shoulder to become teachers.

So we have an investment there, but I think it goes beyond the dollars. We need to respect our educators. We need to look at them as partners. Second to parents, our educators are the most influential folks to get our students to where they need to be.

Ms. FRANKEL. Well, I do respect and appreciate your enthusiasm for our teachers. I agree with you on that. My concern is the proposed budget cuts and what that would mean to us having these teachers that we need in the classroom.

Secretary CARDONA. So I remember getting a letter when I was Commissioner in Connecticut from a parent in New York, once my name was mentioned as potential Secretary of Education. It was a letter from a parent in New York who talked to me about—she wrote about how her child who has autism was not allowed to go back to school because of the risks in the community and the negative impact that had on her family and the sibling of the child.

So she was so excited about schools reopening. She saw that we were pushing to reopen schools in Connecticut and was hopeful that by me being Secretary that will happen throughout the country.

So that student with autism who had tremendous need during the pandemic is now going back to a school. Budget cuts, like what is being proposed, would make it more likely that that student who had greater need during the pandemic is now going to a school without a certified classroom teacher, without a certified special education teacher, and the services that the student needs more of would be decreased even further.

It would be catastrophic for all children, but in particular for children with disabilities and children who are not reading at grade level.

Ms. FRANKEL. I would say for all children, if you don't have a teacher, it is going to be very hard to learn.

And with that, I yield back.

Secretary CARDONA. Thank you.

Mr. ADERHOLT. Mr. Ciscomani.

Mr. CISCOMANI. Thank you, Mr. Chairman.

And thank you, Secretary Cardona, for coming before us today to discuss the Department of Education's fiscal year.

Now, my background real quick. I am a first-generation American. I was born in Mexico. So I immigrated with my family when

I was a young kid, first in my family to attend college. I am proud of that background.

I am also a product of the community college world. I received Pell Grants as well. So I definitely have benefitted from a lot of what is being discussed here today, and I want others to have an equal shot at the same American dream that I have had as well.

So when I went to college, and I started out at Pima Community College before going to the University of Arizona, where I eventually earned my bachelor's degree. And like many other students, I worked my way through school. And in your testimony, you spoke about the administration's Federal free community college plan, and I think it is important for us to acknowledge that community college is already an affordable option for a lot of students.

And according to the College Board, the average in-State tuition at a public 2-year college for the '22–'23 school year, it is about $3,860. The average Federal Pell Grant is $4,512. And that is the average. Depending on the cost of their education and other factors, students could qualify for a maximum Pell Grant of $6,895 this year.

This means the Pell Grant can make community college tuition free or very close to it. So we need to be careful and not think that the massive new spending is the answer. We have seen the inflationary effects in the economy from too much spending over the past few years. That is why I am concerned by this budget proposal and the Department's other policies like mass student loan forgiveness. It will not help inflation, and quite frankly, it is wildly unfair in a lot of ways.

So, Mr. Secretary, looking specifically at the administration's blanket loan forgiveness, can you explain to me and the millions of others who have maybe never went to college or to the graduates who live modestly so they could pay off their loans or even during their college years to be able to live within the Pell Grant—what the Pell Grant allowed, how is this option fair to them, and what can responsible borrowers learn from this?

Secretary CARDONA. Thank you for the question, and thank you for sharing your story and the benefits of community college.

I agree with you. In some cases, Pell can cover the costs. In other cases, it cannot. The Pell increases have not kept up with the increase in college costs, and I think the number that I said earlier was about 80 percent of the cost of 4-year colleges were covered in 1979, 100 percent of community college. And today, it is 54 percent on average across the country, 54 percent of community college costs are covered by Pell. So I do support continued focus on Pell to give more students an opportunity.

With regard to the targeted debt relief, 90 percent of the dollars for the 43 million Americans that are currently paused and will begin loan repayment for many of them, 90 percent of the dollars in the targeted debt relief plan go to people making under $75,000. So this is really targeted toward middle class Americans who need a little bit of support getting back on their feet after the pandemic.

And the work that we have done from day one until now is really targeted to those who were either taken advantage of, for example, borrower defense. There were a million borrowers that received

loan discharges, and this borrower defense means that in many cases, they were taken advantage of.

They were told you are going to get a degree, and you are going to get a job making this much money when they were sold a bill of goods that were never delivered. And sadly, in many cases, a lot of these were veterans coming out and looking for another opportunity. So we stood up for those borrowers.

Total and permanent disability. There were 470,000 borrowers who had—were classified as totally and permanently disabled who were still required to make payments, and these folks needed help. So we jumped in and helped with that.

Mr. CISCOMANI. Mr. Secretary, let me jump in here because I am running out of time. And when you are listing the people that you have helped and the process of how people get into loans, in spite of my personal journey here of being able to cover with the Pell Grants, due to advice or misadvice, you do get into loans like I did as well, and that is exactly the narrative. "You are going to be able to make so much money, you will pay these off immediately."

So I actually jumped in and did the same thing individually and probably didn't need to borrow as much as we did. And you know what I had to do? I had to pay it back. I had to pay it back.

And my first years of raising a family—I now have six kids, three boys and three girls—we had to tighten the belt, and we had to do what we had to do to be able to pay these loans back. And I just want to make sure that we are not creating an environment where this is seen as an additional Pell Grant for people that have actually borrowed loans because the Pell Grant is already in place, and the loan should be that, a loan that needs to be paid back.

Because if people like me as the first generation that didn't know much more, my parents couldn't guide me into how to borrow or what not to borrow or anything else. I didn't have any guidance, and I went and made those mistakes. And I ended up having to pay them back.

So I think that that—and that created an additional grid and everything else that actually has helped us be where we are. So I just want to add that perspective. I am from that group that you are trying to help, and I get that. But I think there is a better way.

I yield back.

Mr. ADERHOLT. Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Chairman and Ranking Member.

Good morning to you, sir. It is good to see you here.

Back in 2019 before the pandemic, I headed an emergency task force on mental health and suicide particularly among black youth, and I see in your proposal that you are including an additional $420,000,000 to fund schools with mental health services and with professionals. I am concerned, number one, is that I have no idea what percentage of need that represents, but I am wondering what your proposal would look like if you had to operate under a 2022 funding cut to present these services to students who really suffered before the pandemic, during the pandemic, after the pandemic, and particularly, BIPOC students.

Minority students sometimes have no exposure to health—mental healthcare, and oftentimes, their behaviors in schools are mis-

interpreted as they are being uncooperative and bad children. And they are classified and qualified and isolated. And we all know that we have not addressed the kind of traumas that some of them experience in just getting to school.

So I would like to know what your proposal would have looked like if you can get the 2024 proposed spending that you are asking for, and what happens if your funding is cut to the 2022 level that some of our colleagues are proposing on the other side of the aisle?

Secretary CARDONA. Thank you, Congresswoman Watson Coleman.

Let me start off by saying we are at a point in our country's history that I have been in education about 25 years. I don't ever recall the level of need, mental health need—and I appreciate you bringing up the fact that symptoms of trauma are often addressed with disciplinary measures, if not understood and if we don't invest not only in providing our students with mental health supports, but investing in professional learning opportunities for educators in our schools.

So what we have in our budget for mental health support is grounded in what we know from the CDC report that said that 1 in 3 high school girls over the last 3 years has considered suicide. The CDC report told us that 1 in 5 LGBTQ youth in the last 3 years has—1 in 5 has attempted suicide. This is unprecedented for our schools and for our educators.

We are proposing a total of $578,000,000 for school-based counselors, psychologists, social workers, and other mental health professionals. We are also including support for higher education. I have spoken to countless college age students who told me to focus on mental health supports, changing how colleges are set up to make sure that they provide more.

Now with regard to the cuts, a $50,000,000 cut to mental health supports would cut funding for 40 new grants and the support, it would cut the support for 300 existing programs, which would mean less support at a time when the CDC's report came out and when our U.S. Surgeon General is saying we have a youth mental health crisis. It is the wrong way to go. Students will suffer. Families will suffer.

Mrs. WATSON COLEMAN. Thank you.

And I am also concerned that at a time when we are dealing with the impacts of gun shootings, mass shootings at schools—sorry. I am very concerned about as we experience the gun shootings, the uncontrolled access to illegal weapons, I do—I am very concerned that our children are even more traumatized than ever before and that this impacts their forward movement, their forward contribution to their communities.

And so I wholeheartedly support anything that you can do to ensure that our schools have greater access. And I am particularly concerned what happens with minority students because disciplinary actions are very much discretionary, and the statistics show that minority students, particularly black students, boys and girls, who both experience the devastation of the lack of mental health services are often those who are also disciplined, which adds to that pipeline that we want to cancel out.

And I am also concerned about HBCUs and what we plan to do. What you all are proposing is an increase in some areas, still not enough. Very concerned about the impact for capacity and infrastructure should the 2022 funding cuts be realized and be nothing more than the bad rumor that they are.

Thank you, Mr. Chairman. I yield back.

Mr. ADERHOLT. Thank you. Mr. Simpson.

Mr. SIMPSON. Thank you, Mr. Chairman.

First, let me say I understand every committee I have been on we have heard about the death and destruction that is going to happen if all of these cuts go into effect and everything. The reality is nobody knows yet. We don't know yet what this is going to be. And even in this bill, if there was a 20 percent cut, doesn't mean it is going to be in education, could be in other areas.

So all of these stories and fear tactics about what is going to happen are just that, speculation. Because nobody really knows yet. Now I hope we get to it sooner rather than later and what we are going to do.

Secondly, let me mention when you talk about free college tuition or paying off student loans, that type of stuff, there is another aspect of it that you briefly mentioned in passing. And that is if the individual getting the benefit of something—and you mentioned the 4-year college graduate is going to make $1,000,000 more—they are going to get the benefit of this.

The people providing that benefit, the colleges, have no incentive to keep costs down if the person receiving that benefit doesn't look at it and say, well, I am going to go to this school because it is cheaper, and I think I can get just as good education. There is no competition anymore between the schools.

You mentioned that one of your goals is to keep the cost of college down. What are you doing to do that?

Secretary CARDONA. Thank you for that, Congressman.

And look, I do believe if we have pathways from our high schools to the 2-year colleges to the workforce, I do believe that is going to make sure that our 4-year schools will say I need to stay competitive and I need to stay active. But I appreciate that question because while we spend a lot of time talking about targeted debt relief and discharging of loans, I am just as proud of the work that we are doing to hold higher education institutions accountable for a good return on investment.

The cost of college has gone up, and the President told me to focus on making sure that not only the targeted debt relief we are focusing on that, but also making sure we are not in this quagmire again in 5 years. So we have done several things. We are improving gainful employment rules. We are tightening that up to make sure that if you are telling students this is what the program costs, and this is about how much you are going to make, we are holding them accountable to that.

We are putting out a watch list of poor programs, both for-profit and not-for-profit, schools. If you are charging $150,000 for a degree where you could get it down the street at half the price, we are going to put your name out there. And that is going to mean some institutions that are very well known being on that list.

We have increased oversight, and we increased transparency with college outsourcing, too, to make sure that we are still keeping our students at the center of the conversation and that they are not being taken advantage of.

Borrower defense is now going to seek restitution from school CEOs. So if you are engaging in bad practices and taking advantage of students, we are going to hold you personally accountable to that.

And then we reinstated our enforcement team that is going after those bad actors who are looking at students as profits and not providing a good education.

So I agree with you. We have to make sure that if we are providing targeted debt relief, we have the responsibility to have equal amounts of accountability to make sure that these costs don't go out of control. We should never be in the position that we are today that we have to provide targeted debt relief because it has gotten out of control.

Mr. SIMPSON. Thank you for that.

Secretary CARDONA. Thank you.

Mr. SIMPSON. One other question. I serve as the co-chair of the Congressional TRIO Caucus and have for a number of years. I want to talk to you for just a minute about the TRIO McNair program, which, as you know, provides individualized mentoring research opportunities and other support to enable first-generation, low-income, and underrepresented students to prepare for and enter graduate school in a variety of disciplines.

In 2022, the grant competition, the Department of Education awarded three additional competitive preference priority points to institutions applying for a McNair grant if they identified as a minority-serving institution. The additional CPP points meant that multiple institutions with a history of operating successful McNair programs lost funding as they did not qualify as a minority-serving institution and were unable to obtain these additional points, even though they had successful programs.

It is my understanding that these grants are to be awarded to applicants that demonstrate a need for and the ability to provide high-quality services to students to enable them to pursue postgraduate study. Low-income, first-generation students come from a range of backgrounds and ethnicities and also attend a wide variety of institutions and still need support.

I want to ensure that all institutions in my district and across the country with track records of success can continue to serve their McNair scholars. What is the Department doing to ensure these grants are awarded based on merit and not just on the status of the institution?

Secretary CARDONA. Thank you for that, Congressman.

I agree with you. TRIO programs are critical for first-gen students. My wife is a TRIO grad, first-generation college student. And I have seen firsthand in my community how many students were given the opportunity.

And I recognize what you are sharing with me. What I would like to do is ask for my team to follow up with you and your team directly to see the impact it had and to communicate how the changes are and what—hear from you and your folks the impact

that it has. Because I agree that we need to expand TRIO and provide more opportunities, and I want to make sure all students have access to programs like this.

Mr. SIMPSON. I appreciate that. And it is—again, it is the individual we are trying to help.

Secretary CARDONA. Right.

Mr. SIMPSON. Not necessarily the institution.

Secretary CARDONA. Right.

Mr. SIMPSON. Regardless of the institution they go to, we can help the McNair scholars. That is what we are trying to do.

Secretary CARDONA. Thank you.

Mr. SIMPSON. So I appreciate that, and I will follow up with you.

Secretary CARDONA. Please. Thank you.

Mr. ADERHOLT. Mr. LaTurner.

Mr. LATURNER. Thank you, Mr. Chairman. I appreciate it.

Mr. Secretary, President Biden has repeatedly talked about the fact that increasing funding for the Pell Grant is a top priority for this administration. While I understand that your budget proposal includes increases to this program, the support that has actually been given to Pell pales in comparison to the amount lavished on college graduates in the form of debt cancellation, the student debt pause, and your proposed IDR program.

CBO estimates that these student loan policies will cost nearly $1,000,000,000,000, which is not just triple what we will spend on Pell this decade, but more than the Federal Government has spent on postsecondary education over its entire pre-pandemic history.

Let me repeat that. The nearly $1,000,000,000,000 is not just triple what we will spend on Pell this decade, but more than the Federal Government has spent on postsecondary education over its entire pre-pandemic history. Given that some projections have shown that the student loan portfolio will balloon back into the trillions in just over 5 years, what we need now is real accountability and reform to ensure that institutions of higher education are invested in the success of their graduates rather than simply pumping more money into a model that has failed to protect the neediest students, increase options for families, or provide competencies valued by employers.

If you are someone sitting in Cherokee County, Kansas, without a college degree, what is the rational justification for spending this money to cancel debt for college graduates?

Secretary CARDONA. Thank you——

Mr. LATURNER. Why should your tax dollars go to this?

Secretary CARDONA. Thank you very much for your passion around the importance of Pell and access to higher education. I can tell you that the targeted debt relief, as a result of the pandemic, was intended to help middle class Americans making less than $75,000 get back on their feet. That was the intention of that.

With regard to the cost, the economic strategy over the last 2 years has resulted in a $1,700,000,000,000 deficit reduction, and the 2024 budget would reduce the deficit by $3,000,000,000,000 over the next 10 years. So it pays for all the investments.

With regard to opportunities, our budget reflects that those folks in Kansas, we want to give them opportunities to access higher education at an affordable rate. And if you look at the budget, part

of it is making sure that we have clear pathways that connect to the workforce. We are doing a lot of work around pathways not only for our 17- and 18-year-olds that graduate high school, but also for the underemployed adults that need another opportunity to get back into the workforce, to take advantage of some of these careers that are going to be made available, thanks to the bipartisan support of some of these bills that were just passed recently.

Mr. LATURNER. I don't think you answered my question. The man or woman sitting out there in Cherokee County, Kansas, without a college education. Explain how it is fair to them.

Secretary CARDONA. The targeted debt relief plan was based off the pandemic, and it was aimed at making sure folks are not worse off after the pandemic than they were before. Similar to the small business loan forgiveness, we are helping regular, everyday Americans get back on their feet.

If it weren't for the pandemic, the targeted debt relief plan would not have happened. But we are doing it to help folks recover from the pandemic like we did in other things.

So I think another thing that I would say is when borrowers default, it hurts the entire community. So it is worse for the local economy when you have folks who are defaulting on their loans and not being to get back on their feet. So it's targeted debt relief. It is aimed at those who are negatively impacted by the pandemic. It is a one-time thing, and it is part of our overall process to hold colleges accountable and make sure we are fixing a broken system.

I would welcome your input and thoughts on how we could do it better, and I would hope our teams could come together to hear your perspective on how we can make sure we communicate it better, but also help those who you represent.

Mr. LATURNER. Mr. Secretary, respectfully, the reason you are struggling to answer my question is because it isn't fair. That is the real answer. That is the truthful answer.

Mr. Chairman, I yield back.

Mr. SIMPSON [presiding]. Rosa.

Ms. DELAURO. Thank you very much, Mr. Chair, sitting in for Mr. Chair.

Mr. SIMPSON. Temporary chair.

Ms. DELAURO. Thank you.

Mr. Secretary, I would like to follow up on my colleague—my colleague Mrs. Watson Coleman on the issue of school-based mental health professionals. I have had countless conversations with Connecticut parents, educators, district leaders. With that in mind, I created the School-Based Mental Health Services Grant Program in 2020 on the Labor-HHS bill to help school districts really increase the number of qualified, well-trained mental health professionals who are working in our schools.

I was also pleased that in the Bipartisan Safer Communities Act, we provided an additional $500,000,000 to this program on top of the resources in the Labor-H bill. So the grants expand the program's reach. They help us move closer to the goal of ensuring that every child goes to a school that has a qualified mental health professional on staff.

Let me just run this series of questions down, Mr. Secretary. Should every child in America go to a school that has a qualified mental health professional? A yes or no question.

Secretary CARDONA. Yes.

Ms. DELAURO. Does every child currently go to a school that has a qualified mental health professional?

Secretary CARDONA. No.

Ms. DELAURO. What would it take for every child in this country to go to a school with a qualified mental health professional on staff? What is it that we need to do to address this problem?

Secretary CARDONA. Well, Ranking Member, I think we can talk about the $578,000,000 that we are asking for to double the number, but I think what we need to do prior to that is really understand the importance of having mental health supports available to students as a foundational prerequisite for schooling. It shouldn't be thought of as an afterthought. It shouldn't be when children have an outburst or a traumatic experience. We should be thinking about Tier 1 interventions.

I visited schools, Ranking Member, where they had a very well-developed program in partnership with local social work providers. We know the community health center, for example, in Connecticut, where we have our social worker in our school, but we also have access to a local provider that is connected with our schools.

I have seen programs go from hospitals connecting with K–12 districts, but that takes a mentality and an understanding that if our students are not well, then they are not going to achieve as well. And I think, yes, our budget reflects the importance of it, but I think the mindset that we have to have should include the importance of mental health and well-being.

Ms. DELAURO. So with the grants, you have added to the capacity of schools to deal with mental health?

Secretary CARDONA. Absolutely.

Ms. DELAURO. Okay. Over the last 2 years. And now you have requested, what, over $300,000,000 to increase, to expand that impact?

Secretary CARDONA. Correct.

Ms. DELAURO. Okay. Thank you. Let me just ask one more question here.

This is about what I view as a predatory, for-profit university, and that is the University of Phoenix. They are desperate for a buyer, and the school is looking to strike a deal with the public University of Arkansas, that system.

The University of Phoenix has a documented history of receiving sanctions, reaching settlements for unscrupulous behavior, including False Claims Act violation findings by DOJ, unlawful recruitment on military bases found by DOD, deceptive advertising findings by the FTC. So, and I am concerned that the university's shareholders are looking to offload their troubled asset onto our public higher education system.

What measures, Mr. Secretary, will the Department take to protect students and taxpayers from waste and abuse through a transition like this? Can the Department ensure that any outstanding

liabilities against the school could still be met after the transaction?

Secretary CARDONA. Thank you, Ranking Member.

There is no current transaction in front of us at the Department of Education. So I can't really comment on the specifics about that school.

But what I will tell you is our regulations from last year laid out what we do when looking at transitions like this or transactions. We make sure that the owners are financially sound. We ensure that there are no inappropriate relationships with prior owners, and we put in place protections that we deem necessary to make sure that the students are well served.

We are aware of in some cases where decisions are made, and it negatively impacts students. So we are paying to that, and if that comes up in front of us, we are going to be very attentive to that.

Ms. DELAURO. Thank you, Mr. Secretary.

Just to go back for a second on the mental health issue, I know there is this view that we are just, if you will, making up the fact that there is the going back to the 2022 numbers for the 2024 budget. In fact, I just would repeat that the Speaker of the House yesterday on Wall Street indicated that that was something that was part of the plan to move forward with regard to Government funding.

So if he doesn't believe that that is the case, he certainly said it on a nationwide stage, which would mean—and I am just going to conclude with this. Which means that the mental health efforts that you have been making to deal with the aftermath, the before the pandemic, the after the pandemic, and moving forward with mental health would be severely curtailed if we make a move to go back to the 2022 figures. Is that accurate?

Secretary CARDONA. Absolutely.

Ms. DELAURO. Thank you. Yield back.

Mr. SIMPSON. Mr. Clyde?

Mr. CLYDE. Thank you. Thank you, Mr. Chairman.

And thank you, Mr. Secretary.

Following the civil rights movement of the 1960s, lawmakers established Title IX rules to prohibit discrimination on the basis of sex in federally funded education programs, making a historic impact on girls' and women's sports. For example, before Title IX, female athletes only received 2 percent of college athletic budgets, and athletic scholarships for women were quite rare. Title IX unquestionably transformed women's sports, ensuring female athletes enjoy the same opportunities as their male counterparts.

Earlier this month, on April 13th, your department filed a proposed rule amending Title IX regulations to unilaterally force schools to allow biological males to participate in women's athletics. This proposed rule would withhold Federal assistance from schools across the Nation seeking to maintain the integrity and safety of women's sports. Since Title IX prohibits discrimination between male and female to ensure that each gets appropriate funding, I think it is important that the country sees that HHS understands the difference.

So can you please tell me or can you please define for me what is a woman?

Secretary CARDONA. Our focus at the Department is to provide equal access to students, including students who are LGBTQ, access free from discrimination.

Mr. CLYDE. Is that—so what is the definition of woman? You haven't given me that. You haven't answered my question.

Secretary CARDONA. Well, I think that is almost secondary to the important role that I have as Secretary of Education to make sure——

Mr. CLYDE. My question is not secondary. My question is very simple. What is the definition—what does HHS say the definition of a woman is?

Secretary CARDONA. I lead the Department of Education, and my job is to make sure that all students have access to public education, which includes co-curricular activities. And I think you highlighted pretty well the importance of Title IX in giving students equal access, whether it is scholarship and facilities, participation as well.

Mr. CLYDE. Okay. So you are not going to answer my question. Do you believe that a biological male who self-identifies as a woman should be allowed to compete in women's sports?

Secretary CARDONA. I believe our focus needs to make sure that all students have access to public education.

Mr. CLYDE. A yes or no is sufficient.

Secretary CARDONA. I think it is not answered with a yes or no. I think all students should have access to co-curricular activities.

Mr. CLYDE. I think that is a yes or no question. Do you believe that a biological male who self-identifies as a woman should be allowed to compete in women's sports?

Secretary CARDONA. I believe all students should have access to things that public education provides.

Mr. CLYDE. You are not going to answer my question. Do you believe allowing biological males to compete in women's sports benefits female athletes?

Secretary CARDONA. I believe it is important that we take into account the needs of all students when they are engaging in extracurricular——

Mr. CLYDE. So, again, you are not going to answer my question. Do you believe allowing biological males to enter women's private spaces, such as bathrooms and locker rooms, is safe for female students?

Secretary CARDONA. It is critically important that we make sure all students feel safe in their school environment, all students.

Mr. CLYDE. Okay. So that means——

Secretary CARDONA. And that is the responsibility of the schools.

Mr. CLYDE. So what does that mean? Does that mean then that biological males should not be allowed in women's personal spaces? Is that what you are saying?

Secretary CARDONA. It means—it means that the perspective of all students should be taken into account when decisions are made around facilities.

Mr. CLYDE. Okay. Is that what your rule is doing?

Secretary CARDONA. Well, it is a proposed rule, as you know. And the proposed rule says there is no complete bans. It provides flexibility for schools, and we have an open comment period, which we welcome comments from different perspectives up until May 15th.

Mr. CLYDE. Okay. I want to be clear. Female athletes across this country are bravely speaking out against this dangerous and misguided policy that you are putting forth, and rightfully so.

Earlier this month, former college swimmer Riley Gaines reported being assaulted, physically hit by transgender protesters at San Francisco State University after speaking out against trans athletes' participation in women's sports. She was also forced to barricade for hours in classroom as protesters demanded money, ransom, if she wanted to safely leave the campus.

Are you familiar with the story?

Secretary CARDONA. That is unacceptable. Student safety should never be compromised on any of our campuses.

Mr. CLYDE. Thank you. I appreciate you clarifying that.

So, Mr. Secretary, what is your message to athletes like Riley Gaines, who have legitimate concerns about how your department's proposed Title IX rule change will destroy girls' and women's sports?

Secretary CARDONA. As I said, it is a proposal, and we are taking open comment. But it is our focus at the Department of Education to provide equal access, free from discrimination, in things that are available to students in our public schools.

Mr. CLYDE. All right. The reality is, though, that the Department of Education—through the Department of Education, President Biden, in my opinion, is attempting to weaponize Title IX, morphing it from a law that protects women to a law that disadvantages or endangers women. Further, the Department is doing so with taxpayer dollars, an action that spotlights where you and your President's true priorities lie, in my opinion.

How much money has been spent or will be spent crafting and implementing this proposed rule?

Secretary CARDONA. I can have my team get back to you on cost for the rule.

Mr. CLYDE. I would appreciate that. Thank you very much.

Secretary CARDONA. Thank you.

Mr. CLYDE. And I yield back.

Mr. SIMPSON. Mr. Ellzey.

Mr. ELLZEY. Thank you, Mr. Chairman.

Mr. Secretary, thanks for being here. You have dedicated an entire life to educating our youth, and I appreciate what you do. You have a very hard job, and especially when you have to sit up here and justify monies going to programs for our youth in tight economic times.

And I would prefer that my limited time be used to highlight some areas of agreement that you and I might have, but I feel like I must use my time to highlight an issue of opportunity and fairness, much like my colleague.

So going back to the 2016 decision of the DOJ and Department of Education mandating how a school that receives Federal funds deals with a boy who says they are a girl, a girl who says they are

a boy. And this was the tipping point when the Federal Government began to, in my opinion, dismantle Title IX.

The Department's latest attempt to rewrite Title IX administrative rules cites the 2016 guidance as a basis for rationalizing the rewrite. Title IX plainly states no person shall on the basis of sex be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance. In other words, Title IX prohibits sex-based discrimination in any education program or activity receiving Federal financial assistance.

Since Title IX and the education amendments of 1972 was enacted, female participation in sports has increased by over 1,000 percent at high school and 600 percent at postsecondary level. So it has been a fantastic program.

Title IX, indeed, revolutionized women's sports. But unfortunately, that progress is being, in my opinion, intentionally dismantled by this administration and this Department of Education, which has proposed regulations that will force schools to allow biological males, proposed, to compete in women's sports. And female athletes are vocal in their objection of the proposed rule.

Although States, including Texas, are passing laws to protect women and girls competing in sports, less than half of States have laws in place to protect the integrity of women's athletic competitions. In fairness and preserving opportunity, I believe the recipient of Federal education funding violates Title IX's prohibition against sex discrimination if the recipient operates, sponsors, or facilitates athletic programs or activities and allows a person whose sex is male to participate in an athletic program or activity that is designated for women.

In fairness and preserving opportunity, I believe that sex in the athletic context must be recognized based on only a person's reproductive biology and genetics at birth. In fairness and preserving opportunity, Federal law should not prohibit schools or institutions from allowing our male and female athletic programs to scrimmage against each other.

I have just described a thoughtful and fair piece of legislation that I am proud to cosponsor with my colleague from Florida, Greg Steube, H.R. 734. And thankfully, this week this bill will be voted on by the House. It should be sent to the President, and he should sign it.

It is a bitter irony that the ongoing intentional destruction of women's and girls' sports is occurring when we should all be reinforcing the sanctity of these athletic programs following the 50-year anniversary of Title IX. But this administration and your Department of Education's radical regulatory scheme, proposed, needs to be rejected, and the Federal law's existing protections for women and girls needs to be strengthened through H.R. 734.

To me, it is unacceptable that the Department of Education is taking it upon itself to unilaterally change Title IX. Functionally, the Department of Education's recent rule that rewrites Title IX is just the latest example of the overreach of the bureaucratic state. It is an end run around Congress. If the Title IX law needs to be changed, that is our job, not yours.

I will not support what the Department is trying to do, and I believe Congress should resoundingly not support what the Department is trying to do. It is not up to the Federal executive departments to write the law. It is their job to execute the laws that Congress writes.

In the end, the silver lining of the administration's actions is that it reinforces to millions of Americans that we stand with female athletes who object to men or boys being allowed to declare themselves as females and compete in women's and girls' athletic competitions.

And it is normally my practice to ask a question. I don't really have one on this round, but I felt that this is something that I feel really strongly about, the people in my district I know feel very strongly about. As a father of a 14-year-old girl who participates in sports, I believe very strongly that she should be able to participate only with girls.

So thank you very much for your time. I appreciate you being here. I know this is hard work.

Mr. Chairman, I yield back the balance of my time.

Mr. ADERHOLT [presiding]. Thank you. And as we are sort of transitioning back into round two, I want to go back, Mr. Secretary. We talked about student loans a little earlier, and I asked you about the fairness of the issue, and you mentioned about the fact that it is trying to make college more affordable. And I don't think anyone would disagree with that.

I guess what the bottom line is, I will go to places and will, I am sure, in the future be going to places. You probably go to places—because I know you talked about being in Kentucky.

Secretary CARDONA. Yes.

Mr. ADERHOLT. I think Hazard, Kentucky, you said you were at. But when you do have people that will come up and just say why is it fairness that you have these people that are get off free from paying their loans when they have had to make the difficult choice to make sacrifices to pay their loans back and those that didn't even go. What am I supposed to tell them, say what is the thinking of the administration in doing that?

Secretary CARDONA. Thank you, Chairman.

Look, when Congressman LaTurner mentioned it, it is important to remember the targeted debt relief was a result of the impact of the pandemic. And I often make it analogous, and I have had conversations with folks who asked, "I paid for my debt"—and me, too. I paid for my college. "Why is it fair that that is happening?"

Well, for many of the people who are getting the targeted debt relief, their parents were paying for their kids' college, but also it is important to remember the pandemic put people in a bad position. And like we provided relief for small businesses who were impacted by the pandemic, this program, I liken it to that, to say it is targeted debt relief for middle class Americans who right now are struggling.

We anticipated and we anticipate that defaults are going to increase, that folks are not going to be paying their bills. So this was an intent to prevent that from happening. One-time targeted debt relief.

And to the folks that say, well, I didn't have to do that, this is happening during the pandemic. If it weren't during the pandemic, this wouldn't be brought up. So I think it is really important to connect it to the pandemic. This is the argument that we have for the HEROES Act to give us that authority to do that, which is consistent with the previous administration holding—pausing loans using the same authority that I use for this.

So it is important to remember that this is connected to the pandemic, that it is a one-time deal, and that it is not unlike what we have done for small businesses. I think that is the conversation that I had with folks.

And we often think about college student getting debt forgiveness. In many cases, it is a parent who is trying to help their child pay for college who could use this respite to get back on their feet.

Mr. ADERHOLT. Yes. And I will be honest with you, when the President first came out with the proposal a few months ago, I was thinking it would be more like Democrats would probably support it and Republicans would probably, by and large, be against it. I was shocked by how many Democrats that spoke out against it at the time.

But anyway, but it has been more than 3 years since borrowers have had to make payments on the Federal loans. And as you know, some borrowers have never had to pay. And yet your budget says virtually nothing about your plans for returning to repayment schedules. Are you planning on returning borrowers to repayment to recoup the taxpayer money that the Government has loaned, and when do you anticipate that?

Secretary CARDONA. Yes, Chairman. We are working diligently at our Student Aid Office, Higher Education Office. As recently as yesterday, we met to discuss the path to repayment for borrowers, making sure we are clear on communication of how to get back on, making sure that we have resources and assets available to support borrowers who, as you said, in many cases this is the first time they are making payments.

We understand that that is going to be a huge undertaking. Never has this ever been done where, depending on the decision of the Supreme Court, up to 43 million borrowers are going to start repaying. It is a huge lift for our team, but we are committed to making sure we do a process that communicates well with borrowers and gives them the information that they need so it can be as smooth as possible.

Mr. ADERHOLT. There is a GAO report out there. In 2022, the Department didn't have email addresses for about 25 percent of the borrowers who were in default. First of all, do you know if there is any truth to that? And if it is, how do you plan to transition these borrowers into repayment if you don't even know how to reach them?

Secretary CARDONA. Right. So we work closely with GAO and their recommendations to make sure we continue to improve our systems. I will tell you that we have a new program, the Fresh Start program, that gives folks an opportunity to get back on if they were not able to make payments in the past and they haven't communicated.

We have other mechanisms to try to reach out to those folks, and it is an all hands on deck. We are working with our State folks. We are working with our universities. We are trying to make this, as I said before, this is unprecedented. We are doing everything that we can to reach the borrowers out there to provide them a pathway to repayment.

And for so many of them who have felt that they can't make any payments, trying to get them back on in a way that is reasonable for them, but getting them back on the repayment.

Mr. ADERHOLT. But that GAO report that we heard, is that true, that 25 percent?

Secretary CARDONA. I can have someone follow up with your team about the specifics of that report and our response to that. I would be happy to give you more accurate information.

Mr. ADERHOLT. That is a big percentage. I would like to get some more information on that. So, yeah, okay.

Secretary CARDONA. Sure. Absolutely.

Mr. ADERHOLT. All right. Mr. Hoyer.

Mr. HOYER. Thank you, Mr. Chairman. I have got two questions, but I have an observation at the beginning.

I would hope that every member of this committee would read Governor Cox of Utah's veto message on the issue, which is a very complicated issue, very difficult issue. But he pointed out what the numbers were in Utah.

"Here are the numbers most impacted my decision—75,000, 4, 1, 86, and 56. Seventy-five thousand high school kids participating in high school sports in Utah. Four transgender kids playing high school in Utah. One transgender playing girls' sports. Eighty-six percent of trans youth reporting suicidality. Fifty-six percent of trans youth having attempted suicide."

That is the Republican Governor of Utah. This is a complicated issue. He also said in that veto message the sector that is supposed to deal with ensuring fairness, the NCAA, the Utah high school sports authority, et cetera, were, in fact, dealing with this.

I make that observation, Mr. Secretary, simply to say that treating this issue, as I believe it is being treated, as a divisive issue, as a pejorative issue, is unfortunate. And I would urge everybody on this committee to read his veto message.

Now let me say you have mentioned accountability a couple of times, a number of us. It is easy to talk about we want more numbers or we want less numbers. It is easy. Accountability is tough. I think I mentioned this to you, Mr. Secretary. Head Start started in 1965. The first Head Start that was canceled for nonperformance was in 1995 by Secretary Shalala, which I applauded her for.

We need to make sure that when we spend the taxpayers' money—and I am one of those who believes we need to invest, as you know—we need to make sure that that tax money is spent effectively. And therefore, I think accountability is a very big part—it is part of the Judy program in Maryland. I said there are 69 centers, thousands of children—to make sure it works.

So I would urge you to pursue that. And it is tough. Again, it is easy to, oh, we are going to cut over the next——

Secretary CARDONA. Right.

Mr. HOYER. Lastly, let me ask the question, which I think is a very important one. Because we talked about and we all talked about and parents talk about and counselors talk about how much money you can make more if you go to college.

We have just passed a number of pieces of legislation, which I think are going to expand the ability in the United States to manufacture goods and to be self-sufficient and not be reliant on unreliable sources of supply. We found that very dramatically in the pandemic.

So while I—probably everybody on this panel went to at least 4 years of college, maybe more. It is very important I think to have the psychology of counselors, of educators, to understand there are some kids who want to be maybe computer people that after 2 years of a junior school or 2 years of a technical school, if you are a welder in America, and you are a senior welder in America, you are making a six-figure income.

And so while I agree that we ought to all press people to attain the highest level that they are capable of and desirous of doing, we ought not to in any way denigrate those who want to go to technical schools. The CTE that we talk about has been increased. I think that is critical.

If we are going to make, as I think we want to make, the infrastructure bill, the CHIPS and science bill, the Inflation Reduction Act, and the other pieces of legislation we passed to infuse an energy in our economy, we are going to have to make sure that we have people doing all the skills necessary to do that. Some of which are college skills, but many of which are not.

Secretary CARDONA. Absolutely.

Mr. HOYER. I would like your comment.

Secretary CARDONA. I often joke that my plumber travels more than I do. He is a good friend of mine.

I studied automotive technology in high school, and it was a teacher that tapped me on the shoulder and said you should consider teaching. I think in this country we have a 4-year or bust mentality, and it is hurting us. I am excited about that, but the most purple issue that I talk to folks about is the pathway.

We had a supply chain issue 3, 4 years ago that really devastated things. And thanks to you, in a bipartisan fashion, we got legislation passed that gives me an opportunity to really double down on talking about high school, 2-year school, and workforce partnership as a pathway. This is an opportunity for our country.

The pandemic was horrible, but it gave us an opportunity to reimagine, and this is one of those areas. When we talk about career-connected learning, every high school should have internships, paid internships. Every K–12 superintendent should be talking to the community college president to make sure that their curriculum are connected.

Our 4-year colleges should be listening, too, to make sure that there are options there. And our workforce partners need to be brought to the table.

When we talk about public-private partnership, I am all for that. I am excited about the opportunity, but what I am concerned about is complacency of us going back to the old system. So you will see in our budget a bold investment in career-connected learning, in

pathway learning. I do believe 2023 could be the year where we really make that shift and go away from that mentality of 4 years or bust.

And we are aggressively partnering with—and it is not red States or blue States—it is all States to make sure that all students have options when they graduate. That is something that this budget reflects as well.

Thank you.

Mr. HOYER. Thank you. Thank you, Mr. Chairman.

Mr. ADERHOLT. Dr. Harris.

Mr. HARRIS. Thank you very much.

Let me just follow up on a couple of things that you said. One is you talked about the President's budget, but just correct me if I am wrong. The President's budget never balances in the future. Is that right? I mean never, ever, ever, ever, ever. Not 20 years, not 30 years, not 40 years. Is that right?

Secretary CARDONA. The budget——

Mr. HARRIS. I think it is the first one ever that a presidential budget maybe since wartime that never balances.

Secretary CARDONA. So, as I said earlier, the cost—the question was about the cost here, and I——

Mr. HARRIS. No, my question is very simple. Do you know if the President's budget ever balances? Because you bragged about the $3,000,000,000,000 in deficit reduction and all, but you presented a budget that never balances, ever.

Secretary CARDONA. The economic strategy over the last 2 years have resulted in——

Mr. HARRIS. Okay. I got to move on. I have limited time. If you don't know the answer, I suggest you call the Budget Office and ask them what the answer is to that.

The gentleman from Kansas is absolutely right. I have a district where I have a lot of people who didn't go to college, but maybe they need a pickup truck for their work or something. They had a loan payment on that pickup truck. I didn't see the administration say we are going to forgive loan payments on a pickup truck that maybe they decided not to go to a 4-year college. Maybe they decided to do some of that career-connected learning, and a pickup truck is what they needed to do their job.

So I am a little disappointed because the administration—I get the politics of it. You shouldn't play politics with it because you hurt people. You do. People in my district come me and say I didn't go to college. Why am I paying for somebody's college loan who did? That is just a comment on that because I know there is no loan repayment program for pickup trucks.

With regards to Title IX, I associate myself with the comments of the gentleman from Texas. Title IX uses the word "sex" in it. That is it. S-e-x. I mean, look, it is. And when it was passed, there was a clear meaning to sex because most people believe in the scientific meaning, which the gentleman from Texas used, which is the reproductive biology definition.

And I agree with him. If we need to rewrite it, it shouldn't be done at the agency level. It should be done at the congressional level.

I want to close out my time on a topic that is important to me, and I am sorry I have to step out into another hearing. But my understanding is that you suggested that you really didn't think the Department of Education should spend any money on vouchers. Is that right, voucher programs?

Secretary CARDONA. I don't believe Federal dollars should be spent on vouchers.

Mr. HARRIS. Is that right? So Federal dollars can be spent on everything else in the Department of Education, but it really shouldn't be vouchers. I mean, right, you spend a lot on a lot of things.

So do you think that is because voucher programs don't work to improve education? Do you think we shouldn't be looking at it? Because I know there are grant programs in the Department that look at innovative strategies to improve performance.

Look, you and I both see the same proficiency levels. D.C. performance, 10 percent proficiency. Baltimore performance, 23 schools have 0 students proficient.

Fortunately, D.C. has a voucher program. It is not large. It has one. Unfortunately, in Maryland, we have a very small one, less than—little more than half the size of D.C.'s, which our Governor, despite having billions of dollars in surplus, decided he wanted to cut.

So he must agree with you that, basically, public dollars shouldn't go to vouchers. They should go to public schools, but they can't go to alternative schools, which parents choose.

So do you just believe that the Federal Department of Education and the bureaucrats there, the Federal bureaucrats, know more about what is good for that child than the parent does? Is that the philosophy that informs your decision about not spending Federal dollars on vouchers? Even though some studies have shown—I agree, they are divided, the results—that voucher students perform better in the voucher school than they did in the public schools that they left.

Secretary CARDONA. There has been a historic disinvestment in public education, which has resulted in the data that we are looking at now. And what I am——

Mr. HARRIS. Excuse me. You have to——

Secretary CARDONA. What I am——

Mr. HARRIS. You have to define "disinvestment" to me because public education spending, at least in my State, goes up every year. Department of Education funding goes up every year. So disinvestment to the average person would be a cut in investment.

Now, Mr. Secretary, you are not suggesting that we spend less on education now than we ever have?

Secretary CARDONA. What I am suggesting is that because the public schools are not getting the support that they need, they are not performing at the level that they should be. You brought up——

Mr. HARRIS. Mr. Secretary, Mr. Secretary——

Secretary CARDONA. I would love to answer your question.

Mr. HARRIS. You haven't answered me about disinvestment. You are not suggesting that we are spending less now than we did ever historically?

Secretary CARDONA. This budget proposal is asking for dollars to make sure that students in Maryland, the districts you represent, can read on grade level. I am advocating for the students that you represent.

Mr. HARRIS. So you are advocating—and I will go back to the point that I made in the first—in my opening questions. You are doubling down on failure.

The education system in Maryland is failing in Baltimore City. Thousands of dollars per student, Federal dollars, goes into Baltimore City to prop up a failing system, and you are unwilling to fund an alternative that has worked in some jurisdictions called vouchers. Is that a good summary of your feelings on that?

Secretary CARDONA. I welcome the opportunity to work with you to support the Maryland schools and avail to you and Maryland the resources that our Department has to ensure all students can achieve in their local public schools.

Mr. HARRIS. And I yield back. All I can tell you is you haven't been ensuring anything up until now.

I yield back, Mr. Chairman.

Mr. ADERHOLT. Ms. Frankel.

Ms. FRANKEL. Thank you.

So, hopefully, this is something we can all agree on, which is really the importance of sports to the development of young children and to adults. And I want to talk about the real issue here when it comes to Title IX, and that is girls and women are not getting the legally required fair share of athletic opportunities in both high schools and colleges.

I am going to read you something. According to a recent report by the Women's Sports Foundation, 86 percent of NCAA schools offer athletic opportunities to men at disproportionate rates compared to their study body makeup. And male athletes receive $252,000,000 more in sports scholarships than females.

At the high school level, your department has reported receiving over 3,000 complaints in 1 year under Title IX based on gender inequities in high school sports opportunities. Now I do think those who are watching basketball most recently saw that the women, the NCAA women's tournament was quite much more exciting than the men's. Correct?

Ms. DELAURO. Amen.

Ms. FRANKEL. Amen. All right.

Ms. DELAURO. Sorry about the Huskies.

Ms. FRANKEL. So really is a two-sided question here. First is how does your budget improve enforcement of Title IX so that girls and women get the opportunities that they legally are entitled to? And number two, how do these proposed budget cuts, how would that affect that?

Secretary CARDONA. Sure. So, thank you.

And I agree. When we talk about Title IX, while it has gotten a lot of attention here today, in a manner that, in my opinion, tries to create a division and a wedge, I am really proud that we can all agree that Title IX has given women athletes an opportunity to engage much more, free from sex discrimination. It has created safe school environments without harassment or violence.

And we are proud of that work, and we are going to continue to push to make sure that all students can participate fully, free from discrimination. That is what we are fighting for.

The Office for Civil Rights is asking for an increase of approximately 135 enforcement staff, basically to protect the civil rights, including claims of students with disabilities. I mentioned that we received 19,000 complaints last year. In 2019, there were 10,000 complaints. Okay? Almost double.

Disability discrimination has really gone up. There were nearly 5,700 complaints in fiscal year 2022 on that. So a cut would make it so that these cases are not being heard as quickly. It could be that the students graduate before their case is even looked at.

We have to recognize that the volume of cases has gone up significantly. Many of the cases are about making sure sex discrimination is not happening. And if we don't have the adequate staffing for that, we won't be able to protect the rights of those students who are bringing up the complaints.

So that would be the impact of a cut in Title IX.

Ms. FRANKEL. So let me ask you this. Other than enforcement obviously, which is very important, any other ideas coming out of your department in terms of how to get these high schools and the colleges to give women and girls their fair share of opportunity?

Secretary CARDONA. Yes. We strongly encourage—I have heard several folks here mention that they have children who have participated in athletics. I, too, have had that, and I have seen, as you mentioned—you started with this—the impact of being a part of a team. What you learn about yourself. You set goals for yourself, and leadership traits are developed for students.

This is why we are so passionate about making sure that every student has access to co-curricular activities like athletics. We work—we have more technical assistance being offered in this area for districts and States. We have held several workshops. We have had participation from all over the country. We have done it through Zoom. We have done it in person. We have traveled to locations to provide support and technical assistance.

We have partners in the field who are working really hard to try to provide more opportunity for girls in our schools, and we are proud of that. We are proud of that because, as a father and as an educator, I know the important role that athletics has had in the development of my children. And I want to encourage that for all students.

So while some choose to look at our Title IX proposal as a point of division, I look at it as an opportunity for me to express as a father and as an educator the passion that I have for all children benefitting from those opportunities that our schools provide, all students. All means all.

And we will not tolerate discrimination. We will not stand by idly while some groups—groups who have had higher rates of suicide attempts. In Maryland alone—and I am sorry he left—43 percent of LGBTQ youth have considered suicide, 40 percent attempted it.

I will not sit idly. I will take the hits. We are going to make sure all students have access to opportunities to engage in what my children benefitted from. All students deserve that, and we are going to fight to make sure that that is possible.

Ms. FRANKEL. Thank you. I yield back.

Mr. ADERHOLT. Ms. Letlow.

Ms. LETLOW. Thank you, Mr. Chairman.

And Mr. Secretary, I share your belief that education is the answer, and my heart is for our kiddos and how we get them on a clear path to success. And we talked today about several programs that offer a variety of support for students and families, but these programs don't reach all of our schools, do they? Especially in my area, which is mostly rural.

And I support options that allow parents to have control over what school best meets their needs for their family. So, in turn, I support school choice, which you shared with Mr. Moolenaar earlier that you do not support.

In higher education, which is my background, we attach money to the student, FTEs. Is there a way that we could use the same principle for elementary education? Why do we continue the model of funding poor-performing schools and denying parents the choice to choose the best school for their child?

And before you answer this, I just want to share some concerning statistics from my home State, Louisiana. Six hundred seventy-five thousand kids are in public schools. We have 170,000 that are in a D or F school. Why can't I, as a parent, take my child out of that school and choose a different path for them, when we know all of these amazing programs that we have talked about, that I believe in many of them, are not making their way to every school in Louisiana?

So do I just have to choose to keep my child in a failing school in the hope that these schools are going to get better? Because in Louisiana, they have not. They have remained stagnant over the last 10 years. So I am just curious, how can we work together find a solution here?

Secretary CARDONA. Yes. Thank you very much, Congresswoman Letlow.

And I, too, feel it is really important that we continue to work together, that we find common ground on what we can agree on. And I just want to make sure I am very clear. I do support choice. I am not opposed to choice. I chose a technical high school. I didn't go to my neighborhood school, right?

So I am a product of school choice, and I do believe parents should have choices to attend where they want. What I don't support is public school dollars being taken away from the local public school and funding a private option because what ends up happening is those students who remain in that local public school will have less support, which will then create greater failure.

And I think that is kind of where we are right now. When we are talking about the potential cuts here, if we cut Title I, the reading levels will go lower because there are less teachers. We will have less qualified teachers.

So I am in favor of parental choice. I really am.

Ms. LETLOW. So you are in favor if a child is in a D or an F school in my home State, that I, as a parent, can move them to a different public school that is not in a D and F?

Secretary CARDONA. Oh, absolutely. In Connecticut, we supported magnet programs. We supported charter programs when I

was Commissioner and I had more specific role in funding for particular schools. What I am not in favor of is public school dollars being used to fund private schools.

And I think there are deliberate attempts in this country to break down our public schools in an effort to privatize and commercialize education. Every school should have high-quality standards, high-quality educators, and I am fighting for a budget here that makes sure that the schools that you represent, those that you are talking about with the Ds and Fs, have a better day with greater support, greater accountability, high-quality teaching.

I mean, we know the components. As a fourth grade teacher, as a school principal, as a district superintendent, I know what it takes to make schools great. And I want to make sure that we have the resources targeted to those strategies that we know work. That is my intent.

Ms. LETLOW. So going off of Mr. Moolenaar, what he mentioned earlier, I want to also share the 90 percent of these kids who are in D and F schools in Louisiana are from economically disadvantaged areas. So we are hurting those kids that we are, in turn, trying to help.

And it has been 10 years, Mr. Secretary, and I am just concerned that we are not improving, that we are actually going backwards. And if anything, COVID hurt us.

Secretary CARDONA. Right.

Ms. LETLOW. So I definitely think there has got to be another alternative. And if it is charter schools, if it is vouchers, why can't we explore those things? Why can't we look into that if we are failing our students right now?

Secretary CARDONA. I share your concern. I recognize that, unfortunately, the pandemic exacerbated disparities, and many times black and brown students or students in underserved areas are hit the hardest. This is why when we rolled out the American Rescue Plan dollars, we made sure that the dollars were going to the schools that needed it the most.

Similarly with this budget, if you look through our budget proposal, you will see Title I. I mean, we are asking for $20,500,000,000. Seventeen billion dollars for IDEA, students with disabilities. Students that you are referring to.

Title I. I would argue that a high percentage of the schools that you are talking about are Title I schools.

And Pell Grants. Intended for those who are less fortunate or don't have as much dollars. So our budget reflects focusing on those schools, and I share that passion with you, that experience with you, and I look forward to working with you to find areas where we can support the students you represent.

Ms. LETLOW. I appreciate that. I hope maybe you would be a little bit open-minded about other possibilities as well.

Thank you so much. I yield back.

Mr. ADERHOLT. Mr. Simpson.

Mr. SIMPSON. Thank you.

And I would just like to tell my good friend Mr. Hoyer that I did read that Utah message. I read it two or three times, and then I had my staff read it.

One of the things I found interesting is—is I thought it was a very well-written veto message. One of the things I found interesting in it was they were working to create a commission. Hadn't been done yet, but they were working to create one, and this commission would look at transgender individuals playing in women's sports on an individual basis.

The impression I got from this was that if the individual could compete in women's sports and not dominate them, then they would let them compete in women's sports. But if they were going to dominate the women's sport, they wouldn't be allowed to compete in women's sports.

That is a commission I don't want to serve on. That would be really hard. I understand why they have a hard time trying to come to some agreement in that, but at least they are looking, and I applaud them for that.

A couple of quick issues. My district is home to the Shoshone-Bannock Tribe located on Southeast Idaho on the Fort Hall Indian Reservation. When I grew up, a lot of the Indian students came to Blackfoot High School that I went to school with.

While they do have BIE schools, most of the tribe's children, as I said, attend non-BIE schools and attend local schools. It is my understanding that as a result of those schools receiving funding, and they are supposed to be consulting with the tribes as part of their grant. One issue that has come to my attention is that the schools may not be properly consulting with tribal governments. Rather, they are hosting a community meeting, presenting some information, and calling it a consultation.

Are you aware of this issue? And if not, I would like to encourage you to work with me and my office to ensure that local schools are holding proper consultations with tribal governments.

Secretary CARDONA. Thank you for that, Congressman.

I am aware of that issue. I have met with different tribal councils. I visited at least four tribal nations and had heard from their education folks of this. And then I have spoken to folks who represent the 90 percent of Native American students who attend traditional schools who say on paper, it says we should be consulted more, but we are not seeing it. I have had them come to my department to share specifically, and I have a lot of interest in this because it is the responsibility of the State to consult.

As a matter of fact, they are a great resource. And many of our Native American students bring a lot of assets to the table that are not being recognized because of the lack of consultation. So I will ask the White House Initiative for Native American Leader Naomi Miguel to reach out to your office to understand that issue better and to work collaboratively with you and your team to make sure that the consultation is happening the way it should be happening.

Mr. SIMPSON. I appreciate that. It is very interesting. I spent a couple of days with the chair of the National Endowment for the Humanities, and we went out to Fort Hall and visited their immersion school where they are teaching the children to speak in Shoshone.

Secretary CARDONA. Yes.

Mr. SIMPSON. They don't want to lose that language, and we shouldn't lose those languages. But it is fascinating to watch these

young children learning to speak Shoshone and stuff. So they do a really good job. So I appreciate that.

One last question. Do you have any idea how many dollars of pandemic relief that were sent to school districts are sitting in school districts unspent?

Secretary CARDONA. Yes. So the COVID dollars or the ARP dollars that were sent out are being used, and we see the drawdown moving effectively. I do believe by the deadline, they will be used.

We set up Covid-Relief-Data.ed.gov.—got to make that shorter—so that folks could see. We want to make sure there is transparency around it as well.

But, yes, we do know the drawdown. It has been used for safe school reopening. There were more kids in summer school this last summer than ever before. Afterschool programs, mental health supports. I was talking to someone recently in my hometown who is a new school social worker, and he said the position was funded through ARPA dollars, and I was pleased to see that the dollars are being used to help students and families.

So the drawdown is there. Again, it is Covid-Relief-Data.ed.gov. I want to make sure that it is open and people could see where the money is being used.

Mr. SIMPSON. Thank you. Thank you for being here today.

Secretary CARDONA. Of course.

Mr. ADERHOLT. Before we adjourn, I am going to turn to the ranking member, and she has got a couple of comments.

Ms. DELAURO. Thank you very, very much, Mr. Chairman, and I appreciate the time.

I just wanted to—there is a number of claims with regard to the potential budget cuts, let me put it that way, that there is speculation around that. And that some of my colleagues on the other side of the aisle claim that the cuts would not be implemented evenly across the board.

That, to me, is even more dangerous. If other programs are exempt—and there are lots of people talking about various exemptions—we know that education programs, that students and families that they rely on are going to be impacted in some way.

But I want to take a look for a very quick moment at the issue of speculation on these cuts. We had, as I said, the Speaker of the House only yesterday say that we were going to revert, that part of his plan—and I have to assume that is your Republican Conference plan—will move to apply 2022 budget numbers to a 2024 budget.

That implies overall an 8 to 9 percent across-the-board cut if everyone is equal. If you take out defense, if you take out veterans, now looking at 25 percent in terms of cuts. There are people who want to talk about increasing defense. That would mean between a 25 and 30 percent cut to everything else. That is reality.

We already had in the House a vote where 75 percent of House Republicans voted for Representative Massie's amendment to H.R. 5 that funding for all K through 12 education should be terminated by December of this year. A very respected, very, very respected think tank, the Heritage Foundation—and this is documented. I don't make up this. They testified before this committee at the invi-

tation of the majority. This is what eliminates the U.S. Department of Education and transfers certain programs to other agencies.

Return all Pell funding to discretionary spending and eliminate mandatory add-ons. Eliminate the Federal supplemental opportunity grant program. It is—and eliminate the Federal GEAR UP program.

Then you have got a former OMB Director who has another think tank called the Center for Renewing America, and there is a whole variety of education programs that would be cut in some way. And I just say this is a former OMB Director under the prior administration who would like to abolish the TRIO program.

So it is not speculation. There appears to be a pattern of looking at serious cuts overall, and I just would—this would decimate public education, harm students, and we cannot move in this direction because I believe there are many of our colleagues who don't subscribe to this. And they want to move.

I would just end with Horace Mann, the great equalizer is education. That is what your role has been, Mr. Secretary, whether you served as Commissioner of Education or now in your current job as the Secretary of Education. And that means that we have the opportunity to make sure that the resources are there so it is that great equalizer.

That it doesn't make any difference what your gender, what your socioeconomic status is, what your religion, your political party, doesn't make any difference. But it is that God-given talent that we can help to foster to make you successful. That is what the role of the Department of Education is, and that is what the role of the Federal Government is, and that is what the role of this committee is.

Thank you, Mr. Chairman.

Mr. SIMPSON. Would the gentlelady yield?

Ms. DELAURO. I would be happy to yield.

Mr. SIMPSON. I was just—I appreciate the gentlelady's passion, and I think it is shared by many people. We also have obviously concerns about inflation and the things that are going on and the excessive spending we think that has gone on in previous years.

But could you tell me which seat on this committee is the Heritage Foundation seat?

Ms. DELAURO. I would just say this. First of all, I would just say to my colleague this great interest in inflation and deficit only arises on sporadic occasions. I heard no one complain about a $1,700,000,000,000 windfall for the richest one-tenth of 1 percent of the people in this country and many of the corporations, the biggest corporations, who pay no taxes at all.

That didn't seem to bother everyone. There is no seat on this committee for Heritage.

Mr. SIMPSON. Thank you.

Ms. DELAURO. However—however, there are people who do listen to the Heritage Foundation and take their lead. And they vote in this institution, and a whole number of them have already played their cards of what they want to do. This is a pattern that is coming forward of all of these institutions to look at going back to 2022 and seriously impairing our ability in education and in every other realm of public service.

Thank you. Thank you, Mr. Chairman.

Mr. SIMPSON. Thank you.

Mr. ADERHOLT. Thank you.

Well, Mr. Secretary, thank you for being here. Mr. Kean, thank you for being here today, even though you didn't get to speak as much as we would like for you to maybe. [Laughter.]

Mr. ADERHOLT. But you had it easy, but anyway, I know you got a hard job with your being Director of the Budget.

But anyway, I think we have had a robust hearing today, and it has been good to talk about some of these issues and bring them to light. And as you can tell, Mr. Secretary, there are some real concerns about some of the issues, and certainly, I know my colleagues on this side have their concerns that they voice as well.

But as we have chatted on the phone, as you know that I know, we ultimately want to find some common ground as we move forward on this. And at the same time, as we both have mentioned before, we don't want to compromise but do find common ground. And so that is what I hope we can as we move forward.

Thanks for being here and look forward to working with you, and we stand adjourned.

Secretary CARDONA. Thank you, Chairman.

[Questions and answers submitted for the record follow:]

Submitted by Representative Julia Letlow

Office of Federal Student Aid

Question: It is my hope that the Office of Federal Student Aid is spending this time during the payment pause to proactively work on clear guidance for servicers and students so that if loan repayment is required to restart, an explicit understanding of all requirements and expectations will be ready to go. The COVID-19 Public Health Emergency officially ends on May 11, and student loan payments have been on pause long enough. The Department should not continue to drag out this repayment pause for many more additional months when they could be using this time to prepare regulations and expectations for servicing companies and students.

Secretary Cardona, is the Department's Office of Federal Student Aid being proactive in working on clear guidance and expectations for student loan servicers and students should loan repayment be required to begin? If so, when does the Department plan on sharing this plan with student loan servicers? How much time will elapse between sharing this information with loan servicers and when payments will begin again for borrowers?

The Department remains in constant contact with servicers, and we will be in direct contact with borrowers before repayment resumes. Tens of millions of borrowers want to know whether the Supreme Court will grant our request to proceed with cancelling their loans so they can succeed in repayment. The Supreme Court decision will allow us to tell borrowers with certainty what their payments will be each month and when those payments are due.

Engaging with servicers to ensure they are communicating directly with borrowers about successfully returning to repayment is an important part of the Department's efforts to smoothly transition borrowers back into repayment.

Many servicers have expressed a desire for additional flexibility and resources to reach at-risk borrowers, ensure millions of borrowers are enrolled in the best repayment plans for them, and ensure the accuracy of their account details. Given the limited resources

provided to FSA in FY23, the Department continues to explore ways to ensure all borrowers, including those most at risk of default, are able to smoothly transition back

19

into repayment. Setting these borrowers up for success remains one of our highest priorities, but to do so FSA will need a substantial increase in FY24.

Rural Educational Achievement Program (REAP)

Question: Louisiana's Fifth Congressional District is mostly comprised of rural communities. These communities have shared with me they do not have the financial resources to hire professional grant writers to help them through a complex and burdensome grant process. Often, they are not even aware of the different grant opportunities available to them.

The Department has a grant program with targeted resources to assist rural schools called the Rural Education Achievement Program (REAP). This program exists to "help rural districts that may lack the personnel and resources to compete effectively for Federal competitive grants and that often receive grant allocations in amounts that are too small to be effective in meeting their intended purposes."

Secretary Cardona, how has the REAP program been successful in assisting rural schools fill educational gaps and how could expanding investments in this program better address the needs of our rural students?

The majority of school districts receiving funding under the Rural Education Achievement Program (REAP) use at least a portion of those funds to improve or expand access to technology. Educational technology can be a powerful tool for accelerating learning and leveling the playing field for rural students. Another common use of REAP funds is professional development which can help ensure that students have equitable access to well-prepared, qualified, experienced, and effective teachers and principals. Districts can use their REAP awards for a variety of other activities as well, including improving academic achievement for disadvantaged students, offering language instruction for English learners, and improving school safety. Through these varied activities, further

investments in REAP would continue the Federal effort to address the significant obstacles faced by many rural school districts.

Additional information on uses of funds can be found at the Department's Guide to Using Rural Education Achievement Program (REAP) Funds.

Question: What percentage of the Department of Education workforce was working at a workplace 5 days-a-week prior to the pandemic and what percentage of the Department of Education workforce is currently working at a workplace 5 days-a-week?

Prior to the pandemic, the Department of Education Telework Policy allowed for 1-day of telework per week. 78% of employees participated in the program. The remaining 22% of employees came to the workplace and were scheduled to come into the workplace 5 days a week.

20

In 2021, the policy was expanded, and employees have the option to work 0-5 days per week at a workplace. As of March 2023, 82% of employees participate in the program either remote or report to the workplace 1 day a week. 18% of employees come to the workplace 5 days a week. Total ED workforce – 4,250.

Charter Schools

Question: I firmly believe education is key to success and if you give a child an education you give them a future. Part of that success is allowing parents and children to have options to choose schools that fit their educational needs. A 2022 national survey conducted by The Harris Poll found that 81 percent of parents support expanding the number of slots in existing public charter schools in their area and 78 percent want more public charter school offerings in their area. Even among parents who might not choose to enroll their own children in a charter school, 84 percent agree that charter schools should be available to the families who would choose them.

I was disappointed to see the Department's FY24 budget request flat funded the Charter Schools Programs (CSP) for a third straight year despite high parental support of charter

schools and increasing demand.

Unfortunately, it seems that this Department has been set on increasing burdensome regulations to the CSP that are almost impossible to uphold and do not apply to other public schools. Last year the Department introduced a proposal that was so restrictive that it would fundamentally change the Charter School Grant Program. It is my understanding that the 2022 proposed Charter School Programs regulations were drafted by the Department without consultation of the charter school community as required by law.

Secretary Cardona, what steps have you taken in 2023 to engage the charter school community, specifically on federal K-12 programs and regulations, as well as the CSP?

The Department regularly engages the charter school community, including grantees in the Charter School Programs, through its outreach related to new awards, technical assistance and monitoring of grantees, and other broader engagement. For example, the program office has created and promptly responded to correspondence in the Charter Schools email account inbox to respond to grantees' questions, offered opportunities to meet one-on-one with grantees to provide consultations, and has worked directly with grantees to provide detailed instructions and guidance.

When the Department runs a new competition in the Charter School Program, we publish the funding opportunity (Notice Inviting Applications) in the Federal Register and share this link in other public sites, including on the Department's website. Additionally, the Department works with the National Charter School Resource Center, which shares competition information with a broad, national audience. For example, for the FY2023 State Entities competition, which was announced on Monday, March 20, 2023, in the Federal Register, the Department hosted a pre-application webinar on April 6, 2023, and is hosting office hours on May 4, 2023, for prospective applicants. Information on these opportunities is posted on the Department's website and was also distributed through other broader channels including through the National Charter School Resource Center. Additionally, there are many broader opportunities for the education community to

weigh in on Department K-12 policies, such as through public comment related to proposed rules or priorities. The 2022 Charter School Programs regulations were drafted after hearing from various stakeholders, including the charter school community. 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 each read and given careful consideration—revealed ways to further strengthen our proposal for this grant program. For example, some commenters expressed concern that regulating collaborations with traditional school systems might create a barrier for charter applicants in certain authorizing contexts. In the final rule, the Department revised our proposed priority related to these collaborations to ensure that it is not implemented in a manner that would make it more difficult for eligible applicants to obtain charter approval or to qualify for Charter School Program funding. We welcome the charter school community to continue participating in these avenues for engagement

Submitted by Representative Mike Simpson Question:

On April 11th, the Department announced that it was denying recertification for the Florida Career College System, effectively blocking future access to the federal student aid programs for thousands of students who would wish to attend one of the 11 campuses in Florida and Texas. These campuses train future electricians, dental assistants, automotive technicians in short term programs that fill real jobs that are open right now. The parent of the Florida Career College system is International Education Corporation (IEC), which also operates two Sage Truck Driving Schools in my district. I understand the Department made this decision without conducting a single face-to-face meeting with IEC to give them an opportunity to discuss this situation. Mr. Secretary, can you assure me that there will be a fair process on this matter going forward? There must be a better solution than denying all of these students access to student aid programs.

On April 11, 2023, the Department announced that it denied Florida Career College's (FCC's) application to continue to participate in the Title IV programs. FCC's application was denied based on evidence demonstrating serious violations of the Department's ability-to-benefit regulations, which govern when a student who does not have a high school diploma or its equivalent can receive federal student aid, as well as failure to meet the fiduciary standard of conduct and failure to meet the administrative capability standards. To minimize disruptions to current students, the Department provided FCC with the option to continue to participate in the Title IV programs for a limited time with certain conditions. On April 18, 2023, FCC accepted the Department's conditions to delay the end of the school's federal student aid program participation. At the request of FCC, we agreed to delay the end of FCC's participation until January 31, 2024, to allow time for more current students to complete at FCC if they wish. FCC is not allowed to enroll new students using federal student financial aid during this time period. Prior to the announcement, on October 20, 2022, the Department sent a 20-page letter to FCC outlining our evidence and concerns and giving it an opportunity to respond. The school responded with a 134-page letter (that also included over 65 attachments) setting forth information and defenses, which the Department considered and analyzed in deciding whether to take action. This letter was not required by statute or regulations but was undertaken by the Department to ensure that we heard from the school and understood its responses before deciding whether to take an action. In addition, the school has an opportunity to seek reconsideration of the Department's decision, a process that is also not required by statute. The school was given two weeks to submit its reconsideration and was then granted a four-week extension to the deadline once requested. 18 We take very seriously the importance of this matter and are affording the school an opportunity to challenge our findings. If the school submits a request for reconsideration it will be carefully reviewed, including any additional evidence that the school may provide. We also take very seriously our oversight obligations and our duty to protect students, taxpayers, and the Title IV program. Finally, for your awareness, the Sage Truck Driving School, which does have locations in your district in Idaho, is not a Title IV eligible institution.

Submitted by Representative Juan Ciscomani

Literacy and Math Proficiency

Since 2020, our students have fell behind from the COVID-19 pandemic and the school closures that resulted from the pandemic. The National Center for Education Statistics put out a 'report card' in October 2022 that showed significant drops in literacy and math proficiency, including a 6% drop in math proficiency for 4th graders and a 9% drop in math proficiency for 8th graders in the state of Arizona. Question: The Department of Education's Fiscal Year 2024 budget request includes another $10.8 billion increase from the previous fiscal year. How does the Department plan to target the requested funds to address the falling literacy and math proficiency rates across the country?

While not all of the Administration's requested increases relate to elementary and secondary education ($6.6 billion are under elementary and secondary education accounts), there are several investments that can help support overall student achievement including literacy and math. States and local school districts are best situated to determine how to improve student proficiency, and the Department provides best practices and technical assistance to help implement various programs. The programs under which the Administration has proposed increases in some key areas:

• An increase of $2.2 billion for Title I, for a total of $20.5 billion, to help students in schools with high rates of poverty meet challenging State academic standards and help schools and districts close gaps in funding that undermine the ability of our public education system to prepare all students to succeed.

• An increase of $2.7 billion under the Individuals with Disabilities Education Act to help States and school districts better meet the needs of our nation's 7.4 million students with disabilities.

• An increase of $385m for School Safety National Activities, for a total of $601 million, for activities to improve students' safety and well-being; the new funding is targeted towards programs to increase the number of credentialed schoolbased mental health services providers, to help address the impact of mental health on learning.

• An increase of $342 million in competitive programs that support a diverse and well-prepared pipeline of educators and strengthen teacher retention.

• $500 million for a new competitive Preschool Incentive Demonstration Program to expand access to preschool in school- and community-based settings for children eligible to attend Title I schools. Preschool is an important researchbased strategy proven to reduce disparities before kindergarten entry, particularly for low-income children. Research shows that preschool improves performance in reading and math; reduces placement in special education programs; and the likelihood that students are incarcerated while in high school; and improves post-secondary outcomes.

• An increase of $305 million for English Language Acquisition (ELA), for a total of $1.2 billion, to expand Federal support for State and local efforts to help the growing number of English Learners attain English language proficiency, meet challenging State academic standards and close achievement and opportunity gaps

Submitted by Representative Jake Ellzey

Mental Health and Academic Performance Question: What actions does a local school district need to be taking to best help students recover from the negative impacts on students' mental health and academic performance as a result of the COVID-19 pandemic?

First, school districts should prioritize wellness for each and every child, student, educator, and provider; they should also take steps to enhance mental health literacy and reduce barriers to access; and implement evidence-based practices to address mental health needs, including practices that establish positive and safe environments and routines. In addition, school districts should aim to enhance workforce capacity across the board, as all school staff (e.g., administrators, educators, school nurses, community health workers, family advocates, etc.) will likely need to assist in providing mental health support to students, albeit in different ways. Furthermore, school districts should use data for decision making to promote equitable implementation and outcomes, and regularly collect, analyze, and act on data to support the mental health needs of children, students, and staff. Further detail on these and other strategies may be found in the Department's report Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs, available at https://www2.ed.gov/documents/students/supporting-child-student-socialemotional-behavioral-mental-health.pdf. To help students recover academically from the COVID-19 pandemic, school districts should take steps to reengage students and their families and to accelerate students' learning through instructional approaches, tutoring, and expanded learning time. Additionally, the Department issued an updated guide further reenforcing the key strategies districts and states should use to address academic recovery. The ESSER and GEER Use of Funds, including FAQ B-13 and all the FAQs in section C, outline how ESSER and GEER funds may be used to address the impact of the pandemic on student learning. In addition, States must reserve ARP ESSER funds to implement programs aimed at addressing the impact of lost instructional time. States were required to submit plans to the Department outlining how those reserved funds would be used, and the Department worked with the States to ensure that effective approaches are being implemented at the State level. Further, the State plans also outlined how the SEA intended to work with LEAs to ensure successful implementation of local strategies to address the impact of lost instructional time. Finally, to support States and school districts in this critical work, the Department has developed multiple guidance documents, including FAQs and the Department's Volume 2 of the COVID-19 Handbook, which is available at: https://www2.ed.gov/documents/coronavirus/reopening-2.pdf.

Question: What percentage of the Department of Education workforce was working at a workplace 5 days-a-week prior to the pandemic and what percentage of the Department of Education workforce is currently working at a workplace 5 days-a-week?

Prior to the pandemic, the Department of Education Telework Policy allowed for 1-day of telework per week. 78% of employees participated in the program. The remaining 22% of employees came to the workplace and were scheduled to come into the workplace 5 days a week. 20 In 2021, the policy was expanded, and employees have the option to work 0-5 days per week at a workplace. As of March 2023, 82% of employees participate in the program either remote or report to the workplace 1 day a week. 18% of employees come to the workplace 5 days a week. Total ED workforce – 4,250.

Submitted by Representative Barbara Lee

Children's Mental Health Question: I am deeply concerned about mental health of children. Under BSCA which was passed in a bipartisan manner, the Department is awarding grants to help schools address the mental health gap. Can you talk more about these grants, and other work you are doing to provide mental health services in schools? What would the impact of a 22% cut in your budget mean for supporting mental health programming? At a time of great need for mental health providers in schools, 25 what would these cuts mean for schools ability to hire and train social workers and other mental health providers?

The COVID-19 global pandemic intensified the mental health challenges many children and students struggle with that impact their full access to and participation in learning, accelerating the need to provide school-based mental health support. Although all educators have a role in providing mental health supports, school based mental health services providers bear key responsibilities in this area. However, increasing the number of credentialed mental health providers is critical to addressing the need for such providers. According to the American School Counselor Association, the national average ratio of students to school counselors was 408-to-1 for the 2021–2022 school year, even though the organization's recommended ratio is 250-to-1 students to school counselors. A 22 percent cut would greatly hinder the ability of 115 grantees supported with School Safety National Activities funds under School Based Mental Health Services grants and Mental Health Services Professional Demonstration grants to increase the number of credentialed mental health providers serving school districts with the most need. These grants support a number of strategies to accomplish this goal, including increasing recruitment and retention-related incentives for school-based mental health services providers; promoting the re-specialization and professional retraining of existing mental health services providers to qualify them for work in school districts with demonstrated need; increasing the diversity, and cultural and linguistic competency, of school-based mental health services providers; supporting partnerships between institutions of higher education and school districts to place postsecondary education graduate students in school-based mental health fields into high-need schools served to complete required field work, credit hours, internships, or related training; and developing mental health career pathways as early as secondary school. These cuts would affect not only 81 new grantees under both mental health programs but would also affect 34 current grantees nearing the end their projects, reducing resources at a time when they are most needed to meet final project goals, complete program evaluations, and carrying out activities to address sustainability. Furthermore, these cuts would come at time when emergency funds are expiring and school districts are seeking ways to maintain the services, build on the outcomes achieved with that support, and find ways to address unmet demand for mental health services in schools. Additionally, many school districts use Title IV-A funding to address and advance mental health and student wellness. Under a 22% cut, we would see $347 million cut from these programs, limiting educators' abilities to address student mental health issues and prevent violence, suicide, and drug abuse.

HBCUs and MSIs Question: Our nation's HBCUs, TCCUs, and MSIs by definition are under-resourced institutions that serve large numbers of low-income students and students of color. These 26 institutions need more support, not less. I am concerned that if the Republicans push through their draconian discretionary spending cuts, it will come at a large cost to these critical institutions serving large populations of low-income students and students of color. What does the proposed 22% cut mean for these institutions?

HBCUs, TCCUs, and MSIs enroll a large proportion of students of color and students from low-income backgrounds. Funding supports improvements to an institution's academic programs and administrative and fundraising capabilities. Many of these colleges and universities have low endowments and below-average educational and general expenditures. Cuts would seriously impact grant award sizes and severely hamper activities supported by the Title III programs that disseminate funding by formula, i.e., to HBCUs, HBGIs, TCCUs, HBCU Masters, and predominantly Black institutions. Noncompeting continuation awards in the ANNH, AANAPISI, NASNTI, and HSI programs would be reduced; and institutions would not be able to fulfill their project objectives. In addition, many of the competitions for new awards proposed in the fiscal year 2024 request would not be conducted. A 22 percent cut to the HEA Titles III and V programs would decrease the President's FY 2024 Request from a total of $1.2 billion to $898.8 million, a decrease of $253.5 million.

Open Textbook Pilot Question: Attending college is prohibitively expensive for many people, and one of the leading drivers of that cost is the high price of many textbooks, especially in the STEM fields. The Open Textbook pilot program at the Department of Education was established in FY 2018 to provide grants to institutions to allow them to create new open textbooks or expand the use of open textbooks in degree-granting programs. Several California institutions of higher education have been a recipient of this award including UC Davis, and it has expanded the resources available to students specifically those from a disadvantaged background. I'm concerned because the FY 2024 budget request did not request funding for the Open Textbook pilot program. Is this still a priority for the administration? Does the Department plan to invest in the development of open educational resources in other ways? What other steps is the Department taking to decrease the cost of attending postsecondary education?

The Open Textbooks Pilot (OTP) program received $12 million in the FY 2023 Omnibus Appropriations bill, which is increased funding from previous years. The OTP investments from FY 2018 – FY 2022 grant awards include 18 grant funded projects that engage and support 394 consortium partners at institutions of higher education in building and expanding open educational resources and infrastructure to address student affordability, equity, and access to education. As we build upon these investments, the Department will continue to support efforts to increase affordable and equitable access to quality open educational resources for all students. 27 The Administration is committed to decreasing the cost of attending and completing a postsecondary education and has proposed several historic investments in college affordability. The FY 2024 Budget would – increase the maximum Pell Grant by $820 for the 2024-2025 award year, through a combination of discretionary and mandatory funding. An estimated 6.8 million students for low- and middle- income backgrounds would receive assistance to help overcome financial barriers to attending college. This increase is one piece of the Budget's comprehensive proposal to double the maximum Pell Grant by 2029. invest mandatory funding to create a new program to expand free community college across the Nation. The Budget also includes $500 million in a new discretionary grant program that will enable community colleges to provide up to two years of free postsecondary education for students enrolled in high-quality programs that lead to good paying jobs or programs that lead to four-year degrees. provide mandatory funding over ten years to lower the cost of tuition for two years for students from families earning less than $125,000 enrolled in a participating fouryear HBCU, TCCU, or MSI. In addition to ensuring that education beyond high school is accessible and affordable, the Administration is also committed to providing students with equitable access to resources and supports needed to persist in and complete a postsecondary education. The FY 2024 request would –

support innovative strategies to improve student success and degree completion through increased funding for the Postsecondary Student Success Grants in the Fund for the Improvement of Postsecondary Education (FIPSE) using a tiered evidence model. promote student success through new funding in FIPSE for postsecondary mental health supports, and investments in critical resources to support students' basic needs, including $30 million to help build systems that enable students to access nonstudent aid public benefits. provide $95 million to help institutions provide affordable childcare for low-income student parents through the Child Care Access Means Parents in Schools (CCAMPIS) program. provide significant increases for the Federal TRIO programs and GEAR UP to expand services that promote access and success in postsecondary education for underserved individuals. 28 create a new Postsecondary Education Advancement Technical Assistant Center, focused on evidence-based practices and data driven solutions to improve student outcomes and ensure inclusive and equitable postsecondary education opportunities for all students.

Basic Needs Grant Program Question: I was heartened to see the large, proposed increase for the Postsecondary Student Success Grant program in FY 2024 and the new $30 million proposed for a Postsecondary Advancement and Success Technical Assistance Center. The cost of living remains incredibly high in many of the states and cities where our nation's students are attending college, leading to many students struggling to meet their basic needs. In the University of California system, two out of every five students report facing food insecurity. I was surprised to see the Department of Education did not request funds for the Basic Needs Grant program, which was funded at $10 million in FY 2023. Given the persistence of the issue surrounding student basic needs, what does the Department plan to do to support students in this area?

The Administration is committed to closing equity gaps and ensuring that all students have the resources they need, including basic needs, in order to persist and be successful in postsecondary education. An increasing share of students from low-income households are enrolling in college and about half of current undergraduates are independent students. Students who are unable to meet their basic needs have worse academic outcomes, which is why it is critical that students have access to supports and public benefits. Over the last two years, the Department has taken steps to better support students' basic needs, including the following: Awarded $198 million in American Rescue Plan (ARP) funding for students and institutions with the greatest unmet need, prioritizing community colleges and rural institutions that serve a high percentage of low-income students and underserved students that have experienced enrollment declines. Awarded $10 million in Basic Needs grants in fiscal year 2023. Proposed an increase to the maximum Pell Grant award of $820, requested a $20 million increase to Child Care Access Means Parents in School (CCAMPIS) to help institutions provide affordable childcare for low-income student parents, and continued to pursue Free Community College as part of the budget. Provided new guidance to further help institutions seeking to provide basic needs support to students using ARP funds and new grant funding for supporting basic needs. 29 Released a Dear Colleague Letter reminding institutions that they can now use FAFSA data to inform their students about certain other federal programs. Contacted students directly to inform them of their potential eligibility for programs such as Supplemental Nutrition Assistance Program (SNAP) and broadband access. Released guidance on the sunset of the public health emergency and the impact it will have on student eligibility for SNAP benefits. The guidance includes steps that institutions of higher education can take to support SNAP applications now and after the sunset as well as ways in which state higher education offices can partner with state SNAP agencies to support benefits coordination. The Department is also working with the Department of Agriculture

(USDA) to finalize a memorandum of understanding to regularly communicate with students and institutions about their potential eligibility for SNAP benefits. Additionally, the fiscal year 2024 budget request includes $30 million to support new System-wide Holistic Student Supports program. This program would award grants to State agencies, systems of IHEs, or other large consortia of IHEs to provide cross-agency supports to improve the systems necessary to simplify and expand student access to federal and local benefits beyond financial aid. This includes access to food and housing assistance and improving coordination of critical services such as mental health care and childcare

Exclusionary Discipline Question: What strategies have schools used to successfully reduce the use of exclusionary discipline and create a positive school climate supports all students, and how can these strategies be replicated in other schools and districts? *In March 2023, the Department released "Guiding Principles for Creating Safe, Inclusive, Supportive and Fair School Climates." This resource provides guidance on how to maintain safe, inclusive, supportive, and fair learning environments for students and school staff and includes specific recommendations for evidence-based practices to give students what they need to learn and grow. This resource includes evidence-based practices that may be replicated in schools across the country. More specifically, the resource includes a range of policy and practice strategies that may be used to create supportive and fair school climates including – providing academically rigorous and challenging learning environments with clear and consistently high expectations are associated with mutual respect between students and educators; establishing a multitiered system of supports; investing in integrated student supports; and requiring preservice and ongoing professional development, learning and mentoring opportunities for educators. More promising practices and strategies can be found in the resource. In addition, Secretary Cardona sent a letter to governors, chief state school offices, and school district and school leaders urging them to move swiftly toward condemning and eliminating the practice of corporal punishment in schools.*

Pell for Incarcerated Individuals Question: In July, incarcerated populations will become eligible for the Pell Grant once again. The Department of Education recently released a Dear Colleague Letter with guidance related to the final rule published in October 2022. What steps has the Department taken to ensure smooth implementation of the regulation ahead of the restoration of Pell Grant eligibility in July? Is the Department planning to take any other steps to ensure incarcerated populations are not being taken advantage of by predatory institutions and have access to high quality programs?

The Department has taken several actions to ensure the smooth implementation of the regulation ahead of the restoration of Pell Grant eligibility in July. To support communication with the field, the Department has set up a specific email address (PEP@ed.gov) and has posted over 20 resources, materials, and links on a dedicated page on the Knowledge Center website. These materials include Dear Colleague Letters, Electronic Announcements, Federal Register Notices, and webinar recordings. We will continue to use this page to disseminate additional guidance and provide a repository for all relevant information. The Department has also created a Prison Education Program (PEP) application which is currently going through the comment process. This application will help schools, correctional agencies, accreditors, and other stakeholders with the PEP application process. The Department has also created additional tools, like an incarcerated student factsheet, which was shared with the Federal Bureau of Prisons and various state departments of correction, and is also translated into Spanish. To further support the field, the Department has a signed Memorandum of Understanding (MOU) with the Vera Institute of Justice (Vera) to provide technical assistance. To date, Vera has held numerous webinars in conjunction with the Department, providing information to correctional and educational stakeholders.

Vera has also been providing technical assistance to Second Chance Pell institutions and is using this subject matter expertise to prepare various stakeholders for full reinstatement in partnership with the Department. The Department will continue to stress the importance of high-quality programs and lift up promising programs delivering postsecondary education to incarcerated students. As mentioned above, the Department will also release a final application for prison education programs that will ensure educational and correctional stakeholders are working together to support high quality programs that are operating in the best interests of students.

Submitted by Ranking Member Rosa L. DeLauro

Graduate Student Debt Question:

Once again, according to the President's budget, excluding consolidations, graduate student loans are expected to make up 47 percent of new federal student loan originations in fiscal year 2024. This is way up from the 34 percent of new loan originations graduate student debt represented in fiscal year 2014. Last year, I asked whether the Department had concerns about the disproportionate share of new student loan originations represented by graduate student programs but did not get the impression the Department believes there is anything specifically concerning about this category of borrowing. Further, the Committee included language in House Report 117-403 under the paragraph "Postsecondary Research and Analysis" expressing interest in analysis around the rapid growth of graduate student borrowing and whether this expansion in borrowing is beneficial to student borrowers and the overall economy. Since this question was asked last year, does the Department have any specific concerns regarding the disproportionate share of new student loan originations represented by graduate student programs? In addition, please share any analysis the Department has conducted, consistent with the interests described in House Report 117-403, regarding the rapid growth of graduate student borrowing and whether this expansion in borrowing is beneficial to student borrowers and the overall economy.

The Department strongly believes we must fix our broken student loan system. This includes taking steps to ensure that all borrowers are able to afford their loan payments. This is true regardless of whether they are borrowing for an undergraduate certificate all the way up to a doctoral program. As we've announced previously, we are working on proposed regulations that would bring greater accountability for career-training programs, including those at the graduate level, and increased transparency for all programs at all types of institutions of higher education. Staff in our Office of the Chief Economist have been analyzing some of the factors underlying trends in graduate student borrowing, and we look forward to continuing the conversation with experts and policymakers on this topic.

Borrower Defense and For-profit Online Program Management (OPM) Companies During the hearing, Secretary Cardona described the large number of unresolved borrower defense claims the Department was facing at the start of his tenure and cited a desire to avoid a similar situation regarding borrowers enrolled in OPM-managed online degree programs.

Question: How many borrower defense claims related to online programs offered by public or nonprofit institutions have been filed to date? What is the Department's anticipated timeline for resolving them?

The data the Department has related to borrower defense claims is not tracked in a way that would provide this information. Students do not always indicate if their program was online or not when they file a claim and Department data systems do not include information as to whether individual students are enrolled fully online or not. The Department is working as swiftly as possible to resolve all pending borrower defense applications. As noted in our budget request, a number of these claims have deadlines by when they must receive decisions, or they will be approved. Our budget request for additional resources is critical for helping us to meet our deadlines.

Third Party Servicers

Question: In 2013, the Department revised the preamble of the incentive compensation regulations to explain that the payment of bonuses based upon student retention is considered to violate the Higher Education Act's prohibition on incentive compensation. Therefore, retention is considered a covered activity under the incentive compensation ban. In a blog published on April 11, 2023, the Department announced it will be issuing a revised guidance letter regarding third- party servicers, and in the process of revising the guidance, that the Department will consider narrowing its scope in several areas, including student retention. Can you provide detailed rationale for narrowing the scope of 'retention' in the Department's third-party servicer guidance, especially when retention is considered a covered activity under the incentive compensation ban?

An entity engaging in recruitment activities is covered by the incentive compensation requirements regardless of whether they are identified as a thirdparty servicer or not. Similarly, there are many third-party servicers that are not subject to the incentive compensation requirements because they are not engaging in covered activities. The Department's goal with the third-party servicer guidance is to ensure that we established better transparency and oversight around the companies that have contracts with institutions relating to the administration of the Title IV aid programs. Our greatest concern in this effort is a lack of transparency into the areas of recruitment and marketing, which GAO has flagged are areas that need improvement for the Department. We are carefully reviewing areas of confusion and considering clarifications based on the extensive public comments received so that institutions and companies understand what services are covered and are prepared to comply with the guidance.

Bundled Services

Question: The public has yet to see an announcement of enforcement actions regarding the 2011 incentive compensation bundled services guidance, despite the Department being made aware of numerous examples of institutions that are out of compliance and the evidence presented by the Government Accountability Office that the Department has conducted little to no oversight of institution-OPM arrangements. Likewise, the Department issued guidance regarding written arrangements that clarifies how institutions should calculate what proportion of their programs have been outsourced to companies like OPMs. Please provide an update regarding enforcement of both the 2011 incentive compensation bundled services guidance and the 2022 written arrangements guidance.

On March 17, 2011, the U.S. Department of Education (Department) issued a Dear Colleague Letter (DCL-ID: GEN-11-05) providing the Department's interpretation on Title IV, HEA program integrity issues in 34 C.F.R. § 668.14(b), including incentive compensation and the "bundled services" exception. On February 16, 2023, the Department convened virtual listening sessions scheduled for March 8th and 9th and accepted written public comments, recommendations, and suggestions through March 16th to improve guidance on the incentive compensation prohibition under Title IV of the Higher Education Act of 1965, as amended (HEA) to determine what, if any, changes to the incentive compensation guidance might be appropriate, particularly regarding the "bundled services" exception. The Department invited comment from institutions of higher education (IHEs), faculty, OPMs and other third-party contractors, scholars, advocates, and students on a variety of questions. Additionally, the Department issued a Dear Colleague Letter (DCL-ID: GEN-22-07) on June 16, 2022 providing additional guidance regarding written arrangements between Title IV-eligible institutions and ineligible third-party entities providing a portion of an academic program. That Dear Colleague Letter guidance was prompted in part by observations

made by Federal Student Aid's (FSA's) Third Party Servicer Oversight Group within FSA's Kansas City School Participation Division while conducting some program reviews. In one instance, on April 5, 2022, shortly before the June 16, 2022, guidance was issued, FSA instructed one IHE to cease and desist from awarding and disbursing Title IV funds to students attending an ineligible entity's programs for semesters beginning after April 5, 2022. After the IHE provided a signed certification and supporting documentation on April 19, 2022, demonstrating that it had complied with FSA's instructions and it had ended its partnership with the ineligible entity, FSA finalized the program review. In a second instance, on April 8, 2022, FSA instructed an IHE to cease and desist from awarding and disbursing Title IV funds to students attending an ineligible entity's programs for semesters beginning after April 8, 2022. After the IHE provided a signed certification and supporting documentation on April 22, 2022, 23 demonstrating that it had complied with FSA's instructions and it had ended its partnership with the ineligible entity, FSA finalized the program review. In a third instance, on June 25, 2022, FSA instructed a third IHE to cease and desist from awarding and disbursing Title IV funds to students attending an ineligible entity's programs for semesters beginning after June 25, 2022. The third IHE responded on June 27, 2022, that it would immediately cease and desist from awarding and disbursing Title IV funds to students attending the program provided by the ineligible entity. Additionally, FSA has provided individualized guidance to a small number of IHEs that wrote to the designated email address to request guidance consistent with Q&A #5 of DCL-ID: GEN-22-07. Regarding the request for updates on enforcement of both the 2011 incentive compensation bundled services guidance and the 2022 written arrangements guidance, the Department does not comment on institutional oversight activities, program reviews, or investigations—including the acknowledgment that they exist—until any final outcomes officially have been communicated to the institution. Section 498A of the HEA [See: 20 U.S.C. § 1099c-1(b)(8)] requires the Department to maintain and preserve at all times the confidentiality of any program review report (PRR) until a final program review is issued. Under Section 498A of HEA, an IHE must be afforded an adequate opportunity to review and respond to a PRR and relevant materials related to the PRR before any final program review report is issued. Additionally, Section 498A of the HEA requires that ED review and consider the IHE's response to the PRR before issuing the final report and include in the final report or determination a written statement addressing the IHE's response a written statement of the basis for such report or determination, and a copy of the IHE's response. Previously, FSA's Administrative Actions and Appeals Group (AAASG) provided to GAO as part of its audit (GAO-22-104463) information about settlement agreements AAASG agreed to, between August 2015 and October 2020, on behalf of the Department to resolve four separate qui tam (whistleblower) matters in Federal District Court regarding bundled services violations. The underlying work on these cases was completed primarily by the U.S. Department of Justice in collaboration with the U.S. Department of Education's Office of Inspector General. These settlements resulted in fines being paid to the Department to resolve these matters. Details about these four settlements are provided in the enclosed spreadsheet.

Joint Consolidation Loan Separation Act

Question: On Oct. 11, 2022, the Joint Consolidation Loan Separation Act was signed into law to allow joint spousal consolidation loan borrowers to separate their joint loan obligations into new individual Direct Consolidation Loans. Per Federal Student Aid's website, the 24 Department is currently in the process of working to implement a process for joint consolidation loan co-borrowers to apply to separate their joint loan obligation into individual Direct Consolidation Loans. Further, per Federal Student Aid's website, the exact time frame for when this process will become available is currently

still being determined. When does the Department plan to announce this new process? How will the Department proactively reach out to joint consolidation borrowers to notify them regarding the process and their ability to separate their joint consolidation loans into new individual Direct Consolidation Loans?

The Department recently posted an update for borrowers to https://studentaid.gov/announcements-events/joint-consolidation-loans. In addition, the Department has put together a communications plan to reach both Departmentmanaged and commercially held joint consolidation loan borrowers. In May of this year, the Department emailed Direct Loan borrowers and servicers emailed commercial FFEL borrowers. These emails provided borrowers with information on what we anticipate the process to look like when fully implemented. They also explained that borrowers who take the action to split their loans when the process becomes available will still be able to get the benefits, they are eligible for, including the IDR account adjustment. Upon completion of this initial email campaign, we plan to assess the success of the open rate and whether borrowers' contact information is up to date. Following this review, we will determine if additional outreach is needed to reach this population with the initial messaging. The Department also established a process for joint consolidation loan borrowers to contact the Federal Student Aid Ombudsman Group to indicate that they intend to apply for separation of their joint consolidation loans when the new application and promissory note become available. These borrowers may request that their loans be placed in an administrative forbearance status until the joint consolidation separation process is implemented, and the borrowers will be notified when the application process is available.

WEDNESDAY, APRIL 19, 2023.

CENTERS FOR DISEASE CONTROL AND PREVENTION, ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE, AND NATIONAL INSTITUTES OF HEALTH

WITNESSES

ROCHELLE WALENSKY, M.D., M.P.H., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

HON. DAWN O'CONNELL, ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

LAWRENCE TABAK, D.D.S., PH.D., PERFORMING THE DUTIES OF THE DIRECTOR, NATIONAL INSTITUTES OF HEALTH

CHAIRMAN'S OPENING STATEMENT

Mr. ADERHOLT. Well, good morning. The subcommittee will come to order.

And first of all, I would like to sincerely thank all of our guests here today. Thank you for being here and for taking time out of your schedule to share with us a little bit today about your outlook for your departments and your agencies and especially from the budget aspect.

And collectively, your offices have the responsibility for ensuring that we, as a nation, are prepared to mitigate, respond to, and ideally preempt biological and, in some cases, manmade threats to the American people.

Those of us who are blessed with the responsibility of public service and leadership understand that while not every choice comes with a cost, every choice comes with a price. Sadly, I think those who will pay the price for the many mistakes made during the COVID pandemic era are the most vulnerable among us.

The child with a disability who couldn't learn over Zoom and lost years of progress and who may never be able to regain those skills. The young teens just on the cusp of unlocking the wonder of learning, who completely checked out of school and in all too many tragic cases lost interest in life itself, whether because of the depression, anxiety they experienced being cut off from their friends and the community.

And of course, the families that were torn apart by arguments over lockdowns and vaccines that were fueled by social media and public health messages that patronized and mocked anyone who dared ask any questions. Obviously, it was a very uncertain time for all of us, and we were going through very uncharted waters. And so we have to certainly take that in consideration.

We don't have time during this hearing to enumerate every tragic outcome, but I will simply say that public health, especially in

a time of crisis, is an inherent political activity, and public trust is very delicate. And once that trust is lost, it is very hard to regain it.

We must work collectively to admit our missteps and make necessary changes to the way we have governed and rebuild the public trust. The specific responsibility and focus of this subcommittee is safeguarding and ensuring that effective use of taxpayer dollars in doing just that.

Also it should be noted that the price of reckless spending is runaway inflation, which is a tax on every American. The burden of out-of-control social spending sold as a necessary response to the COVID–19 pandemic is borne most heavily by the lower income and by the seniors who are living on a fixed income.

The cost of selling political priorities as public health necessities is the further erosion of an already-diminished public trust. I hope we can have an honest conversation here this morning about lessons learned and changes that you have made to your respective agencies that are under your leadership to make sure these mistakes are never repeated and that the public trust can be rebuilt.

Today is our annual budget hearing to discuss your respective budget proposals for fiscal year 2024. It is disappointing to see that the Biden administration once again putting forth a partisan budget proposal that seems to be little more than a lengthy liberal wish list.

For example, the budget proposes to implement partisan priorities such as climate change, gun research, and even a Sexual and Gender Minority Research Office within the NIH. Basic biomedical research at the NIH is essentially flat-funded, while the new ARPA–H, which was created only last year, is proposed for a $1,000,000,000 increase.

We recognize the importance of investing in the next generation of vaccines supported through BARDA investments. However, it is notable that the proposed increased investment for BARDA is dwarfed by the requested creation of a $400,000,000 slush fund to be used as the Secretary, as he sees fit.

With the expansive and elastic definition of public health the administration has adopted, I have little confidence that such flexibility would be used to exclusively prepare for pandemic preparedness and biodefense as the words are understood by the American people.

Finally, I question the magnitude of the increases requested for the Centers for Disease Control and Prevention. While some of the requests put a priority on core capacities necessary to respond to the threats of infectious disease, unfortunately, many of the requested increases are outside CDC's core mission.

For example, the budget request nearly triples the amount of funding for firearm research. You are also asking $250,000,000 for new youth violence prevention programs and $135,000,000 for climate activities, which are rebranded as environmental health.

I think the question we have to ask, are these kind of activities in the same category as combating chronic diseases threatening our most vulnerable population or reducing antibiotic resistance? I would argue that they are much different and that we should focus our CDC resources on infectious diseases, transmittable diseases,

and certainly chronic diseases rather than controversial political-charged activities.

With all that said, I do sincerely look forward to our conversations today and have a chance to talk about some of these issues and to discuss how we can do better in the future, and that is a lesson certainly for all of us.

And at this time, I would like to recognize my friend and ranking member of this subcommittee and the full committee, from Connecticut, for her opening statement. Ms. DeLauro.

RANKING MEMBER OPENING STATEMENT

Ms. DELAURO. I thank the chair for holding this hearing, this critical hearing, and I am pleased to welcome our witnesses—Director of the Centers for Disease Control and Prevention, Dr. Rochelle Walensky; the National Institutes of Health Director, Dr. Lawrence Tabak; and the Administration for Strategic Preparedness and Response, ASPR, Assistant Secretary Dawn O'Connell.

So welcome, and thank you for the work that you are doing. Thank you for being here today.

You have all dedicated your lives to really what is sacred work, making our communities healthier and safer by strengthening public health, treating illness and disease through research and development, and advising on and delivering emergency assistance during disasters and public health emergencies.

And given the painful health crisis we faced over the last 3 years, your collective dedication during this difficult period has been integral to bringing our Nation forward. When I think back to where we were 2 years ago, I know it is thanks to your agencies that we have made such progress. To support this important work and continue to make our communities healthier, this committee made historic investments through the 2022 and the 2023 appropriations packages in our public health infrastructure and the health and well-being of American families. But the price of not doing so is too high.

In the 2023 Government funding law led by this committee, we increased funding for the CDC by $760,000,000. That funding bolsters our Nation's public health infrastructure and its capacity. It strengthens our public health workforce. It helps State and local health departments keep our constituents safe. It modernizes our public health data so that information is shared quickly and interventions to address public health needs are implemented in a timely manner.

And as NIH continues to be at the forefront of transformative medical research, we also included an increase of $2,500,000,000 to bolster those lifesaving scientific research the agency leads. This includes historic investments to support breakthroughs in the Cancer Moonshot Initiative, Alzheimer's, ALS, HIV, and universal flu vaccine development.

We also included funding to continue confronting urgent health crises, including through gun violence prevention and opioid misuse research. These are national crises that we must continue to tackle head on.

And because ASPR has been repeatedly called upon to respond to emerging threats, this subcommittee provided increased funding

over the past several years, including an 18 percent increase in 2023 to advance ASPR's efforts.

Today, we gather to discuss the 2024 budget request for CDC, for the NIH, and for ASPR. Dr. Walensky, I am pleased to see that the CDC's request includes $1,900,000,000 increase to bolster our Nation's public health and help our State and local public health agencies strengthen theirs. I don't think it is recognized that our State and local public health agencies are the backbone of the work that CDC and the work of what our public health infrastructure looks like.

You have made strides in infant, maternal, and behavioral health and gun violence prevention. As you and I agree, CDC's impact reaches far beyond its fight against infectious diseases. Because of this, your budget would strengthen our public health agencies so that we can support food safety, early detection and prevention of cancer, and opioid use prevention.

As I have said before, we must be ready for any current and future crisis. We must end the cycle of complacency that leaves us scrambling when a crisis hits.

Assistant Secretary O'Connell, I am so glad to see that the request also includes new resources within ASPR to prepare specifically for future pandemics and biological threats. Your work is so critical to keeping us healthy and safe, as our country has simultaneously confronted COVID, mpox, and an infant formula shortage, which your agency fought by helping to increase safe supply of formula for babies.

Dr. Tabak, as I mentioned before, NIH is so critical to advancing solutions to the most pressing health issues that face our communities. I appreciate your focus to prioritize innovation, including in nutrition research to reduce diet-related diseases.

But given the importance of strong investments in biomedical research, I need to mention my worry that the proposed increase of less than 2 percent for the NIH is insufficient and threatens the projects this committee has made through significant sustained investment in biomedical research. Over the past 8 years, this committee has increased the overall funding for NIH research by 60 percent, and we did that on a bipartisan basis. Finding treatments and cures for cancer, Alzheimer's, diabetes, infectious diseases, substance use disorders, and other debilitating illnesses should never be partisan issues. They impact every one of us.

Americans depend on the work that CDC, NIH, and ASPR does. They rely on you to stay healthy. You improve the quality of our lives. You ensure that we are constantly developing new treatments. You protect us from public health threats, including from the COVID pandemic, which has so tragically taken more than 1 million American lives over the last 3 years.

That is why I must mention how deeply concerned I am over some of my House Republican colleagues' calls for massive spending cuts to many of the programs that keep families and communities healthy. These cuts would be deadly and would be felt by everyone, including children, families, seniors, veterans, and our rural communities.

And I just might add, we deal with a lot of things through appropriations—roads, bridges, helicopters, all kinds of areas—but no-

where is it more important than to address the issues that you all deal with because you are in the business of saving lives. There isn't anything more important that we do at the Federal level, which is why we cannot sustain substantial cutbacks to the programs that you are engaged in.

Yesterday—or 2 days ago on Wall Street, Speaker McCarthy reiterated Republicans' intent to cut funding back to the 2022 level and to impose caps for the next 10 years. Make no mistake, caps are just another name for more cuts. Caps are cuts.

I am not sure that some of my Republican colleagues realize the impact that these cuts would have, so I would just like to run through some of them. If implemented, 5,000 fewer research grants would be given out yearly and would impact the funding thousands of existing recipients can get. This means less research to cure cancer, Alzheimer's, diabetes, heart disease, and so many other debilitating illnesses.

The cuts will dramatically impact the CDC's ability to support States, local agencies, weaken our public health infrastructure and capacity. More than 70 percent of CDC funds go to our public health partners, including those agencies. Such extreme cuts would make our communities much less healthy.

Progress in ASPR programs that improve our Nation's preparedness for public health emergencies include BARDA, BioShield, pandemic influenza. That would be taken back years, leaving our country so much more vulnerable to the impact of health crises. These cuts threaten so much of the progress that we have made in recent years.

Please listen to what I am saying. They would be deadly. We should learn from the lessons of the pandemic, not send the health of our Nation back years. It is unconscionable that we could support such cuts to these critical agencies.

I know and I believe that our witnesses agree. I thank you for the dedication. And I think I know and I believe that so many of my colleagues on both sides of the aisle agree as well.

So thank you for your dedication. Look forward to hearing your testimony.

With that, Mr. Chairman, I yield back.

CDC Opening Statement

Mr. ADERHOLT. Thank you, Ms. DeLauro.

And I would like to begin with Dr. Rochelle Walensky, who is the 19th Director of the Centers for Disease Control and Prevention and the 9th Administrator for the Agency for Toxic Substances and Disease Registry.

Dr. Walensky served as the Chief of the Division of Infectious Diseases at Mass General Hospital from 2017 to 2020 and was Professor of Medicine at Harvard Medical School from 2012 to 2020. She served on the front line of the COVID–19 pandemic and conducted research on vaccine delivery and strategies to reach underserved communities.

So, Dr. Walensky, thanks for being here, and we look forward to your testimony.

Dr. WALENSKY. Thank you. Chair Aderholt, Ranking Member DeLauro, and distinguished members of the committee, it is an

honor to appear before you today to discuss how the President's budget for fiscal year 2024 will better position our Nation to respond to known and novel health threats.

The Centers for Disease Control and Prevention and its partners have stabilized the foundation of the U.S. public health system, which in late 2019 was in a weakened condition after years of underinvestment. Thanks to supplemental funding over the past 3 years, Americans today are better protected from public health threats.

For example, funds supported the distribution and administration of more than 670 million vaccines and introduction of effective treatments. Americans are now buffered from the risk of severe disease and death from COVID–19. Further investments in data systems have supported real-time health data through electronic case reporting in all 50 States, and county-level information is available to decision-makers in every U.S. community.

These are just two examples of how one-time supplemental investments have improved our Nation's public health and our infrastructure. These investments to date support critical capabilities around outbreak response, workforce, data, and forecasting. From monitoring illness in mothers and babies to measuring life expectancy, to monthly reporting of overdose data, these investments are changing how we do public health now and into the future.

CDC has also been providing funding which reaches every community in the United States to hire the workforce that they need to address their most crucial public health needs. These funds are already making a difference.

In February 2023, Ohio utilized resources to provide unanticipated surge staffing to support the East Palestine response. Alabama has already hired 23 community health workers for staffing for improving operations, and this number will grow to 135 by the end of the grant. Tennessee has already hired 64 staff and will use some of its funding to support rural health research.

While CDC has always quickly deployed experts to public health emergencies, the number, pace, and nature of these emergencies is escalating. Likewise, Americans' expectations for rapid Government response has grown as well.

At this moment, CDC employees are in Equatorial Guinea and Tanzania to support separate ongoing outbreaks of Marburg virus, a close cousin of Ebola, and to prevent them from spreading. Recently, CDC deployed support for Michigan in response to an outbreak of blastomycosis at a local paper mill affecting about 850 employees.

CDC's employees embrace the opportunity to serve, whether in an emergency or in day-to-day work of keeping infectious diseases and other public health hazards at bay. But to continue this work, we need your help. CDC's fiscal year 2024 budget request is the right budget for where we are now. It includes $11,600,000,000 in discretionary budget authority, prevention and public health, and public health services evaluation funds. This budget request prioritizes investment in cross-cutting functions and core public health capabilities at Federal, State, and local levels.

The budget request also increases CDC's effectiveness as a public health response agency. For example, it will enable us to provide

danger pay to staff who respond to deadly outbreaks and build on progress we have made in collecting and swiftly sharing back to jurisdictions data for their own faster decision-making. The budget would also authorize a new program to provide the 13 recommended vaccines to uninsured adults.

CDC is implementing recommendations from our partners to build a CDC that is ready, capable, and responsive through our priority areas identified in CDC Moving Forward to share scientific findings and data faster, to enhance laboratory science and quality, to translate science into easy-to-understand policy, to prioritize communications, to develop a workforce prepared for future emergencies, and to promote results-based partnerships.

The President's fiscal year 2024 budget will leverage the work it started during the pandemic to modernize CDC to protect the American people. Public health investments have a profound and lasting impact on all of our lives. Investing in data, workforce, and infrastructure gives us power over the conditions that allow diseases and injuries to thrive. Investing in public health means longer, healthier lives for everyone.

Thank you, and I look forward to your questions.

[The information follows:]

TESTIMONY

OF

ROCHELLE P. WALENSKY, M.D., M.P.H.

DIRECTOR

CENTERS FOR DISEASE CONTROL AND PREVENTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

UNITED STATES HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

HEARING ON THE FY 2024 BUDGET REQUEST FOR THE NATIONAL INSTITUTES OF HEALTH, CENTERS FOR DISEASE CONTROL AND PREVENTION, AND THE ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

APRIL 19, 2023

INTRODUCTION

Chair Aderholt, Ranking Member DeLauro, and distinguished members of the Committee, it is an honor to appear before you today to discuss how investments in the Centers for Disease Control and Prevention (CDC) are protecting Americans' lives every day, now and in the future. I am grateful for the opportunity to address this Committee and for your long-standing commitment to improving the health of people in our nation and the world.

It is my privilege to represent CDC at this hearing. For more than 75 years, CDC has been working 24/7 to protect America from health, safety, and security threats. Whether diseases start at home or abroad, are chronic or acute, are curable or preventable, or due to human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

CDC cannot meet its public health mission without the help of Congress. Together, we must stop the cycle of investing and disinvesting in public health infrastructure. In addition, just as the world has changed, CDC's mission has grown and become increasingly complex. While CDC has always raced to deploy experts to the heart of whatever public health emergency is unfolding, the number, pace, and nature of these responses has escalated. Americans' expectations for rapid, effective government response have grown; CDC must have the tools it needs to meet these expectations. Today, I will outline how the President's Budget for FY 2024 will better position our nation to continue responding to known and novel threats to our health.

The President's Fiscal Year (FY) 2024 Budget request includes $11.6 billion in discretionary budget authority, the Prevention and Public Health Fund (PPHF), and Public Health Service (PHS) Evaluation Funds. In addition, the FY 2024 Budget request includes other mandatory funding proposals not cited here. This request is $2.4 billion above the FY 2023 enacted level and prioritizes investments in cross-cutting functions and core capabilities to enhance the public health system at federal, state, and local levels. In addition to streamlining CDC's budget structure, the budget also includes several legislative authorities to allow CDC to function as a public health response agency more effectively and efficiently.

The FY 2024 Budget request includes—

- advancing public health core capabilities and cross-cutting support;
- preventing and mitigating the impact of infectious diseases; and
- empowering communities to protect mental health, particularly among youth, and preventing suicide, violence, and overdose.

To meet these goals, CDC will continue to build on recent response activities, incorporate lessons learned over the past three years, and integrate longstanding agency expertise in disease control and prevention to best serve the nation and protect against new, emerging, and known health threats.

LEVERAGING THE FY 2024 BUDGET REQUEST TO ADVANCE CDC'S RESPONSE MISSION AND CAPABILITIES

The FY 2024 budget will help modernize the way CDC collects, analyzes, and shares data; improve the ability to forecast threats to health; improve protective measures for population groups most vulnerable to largely preventable deaths, hospitalizations, and infections, advance how we hire and train a workforce to meet everyday responsibilities and surge for emergencies; and bolster global health security. Our nation's ability to respond to the next public health crisis will depend on whether we invest in a public health system today that is highly functional, sensitive, and responsive to communities that are underserved, operating well on a day-to-day basis and able to ramp up to meet new threats in the future.

One year ago this month, CDC announced an effort to refine and modernize our structures, systems, and processes with particular focus on how to swiftly move from science and program to policy, and promptly operationalize guidance for the public. In August 2022, based on this review and other substantial internal and external input, the CDC Moving Forward initiative was launched to—

- share scientific findings and data faster;
- enhance laboratory science and quality;
- translate science into practical, easy to understand policy;
- prioritize public health communications;
- develop a workforce prepared for future emergencies – CDC and nationwide; and
- promote results-based partnerships

In January 2023, we initiated a CDC reorganization, one of several foundational steps to achieve progress in the improvement areas outlined above. This reorganization aims to eliminate bureaucratic reporting layers, break down silos in the agency, promote foundational public health capabilities that incorporate health equity, and improve accountability at CDC. We are now implementing recommendations from Moving Forward, such as publishing critical scientific findings faster, streamlining our structure for more rapid decision making, and improving and disseminating our communications directly to the public. In addition to other FY 2024 budget proposals outlined below that support the Moving Forward initiative, the FY 2024 budget request includes increased funding for the Public Health Leadership and Support funding line to support policy, science, and communications at CDC.

CDC is also requesting additional funds to support CDC's Public Health Infrastructure and Capacity line for continued investment in health departments to effectively protect the health of their communities. With this funding, jurisdictions—along with funded partners who are providing technical assistance and support—will make critical investments in foundational capabilities, aligning with the Public Health National Center for Innovations framework, in the areas of assessment and surveillance, community partnership development, health equity, organizational competencies, policy development

and support, accountability and performance management, emergency preparedness and response, and communications including greater language access ensuring all communities receive credible scientific information.

With additional funds for Advancing Laboratory Science in the FY 2024 budget request, CDC will continue to implement agency-wide solutions to promote improved laboratory capacity—including shortening the development time for diagnostic tests and implementing a new Infectious Disease Test Review Board—improving the speed and quality of CDC laboratory test results.

In addition to funding initiatives, this proposal includes legislative authorities that allow CDC to be more responsive in the face of public health threats. These include authorities for recruiting and retaining public health professionals, lifting caps on overtime pay for employees working on response operations, providing danger pay adjustments to employees serving in high-risk environments, moving CDC's appropriation to a one account structure to enable the agency to access and utilize its resources to meet an urgent public health need, and collect necessary public health data more efficiently. The budget also includes a legislative proposal that would allow CDC to dedicate a small percentage of funding to support a cadre of response-ready staff for short- and long-term emergency details or deployments, who can recognize emerging threats and intervene before they become larger crises.

The FY 2024 budget also proposes a Vaccines for Adults (VFA) program that would begin to expand access to Advisory Committee on Immunization Practices (ACIP) recommended vaccines at no cost for uninsured individuals. While a public health infrastructure exists for children to receive recommended vaccines from their pediatricians, the current infrastructure for adults is not robust. Establishing a robust infrastructure for adult vaccination will build on the progress and investments made during COVID-19 to improve adult access to vaccines while supporting response readiness by reducing vaccination coverage disparities, improving outbreak control of vaccine-preventable diseases, and enhancing and maintaining the infrastructure needed for responding to future pandemics.

Finally, the budget includes mandatory funding for pandemic preparedness across HHS to transform the nation's capabilities to prepare for and respond rapidly and effectively to the next emerging health threat.

BUILDING READINESS THROUGH CROSS-CUTTING INITIATIVES

CDC's surveillance systems are crucial for understanding and preventing the causes of disease, injury, and death that affect all Americans. These systems, and a dedicated workforce in every jurisdiction that operates them, help identify contaminants in food, water, soil, and air; infectious disease outbreaks in hospitals; the drivers of maternal and newborn mortality and how to address them; and whether antimicrobial resistance has reduced options for treatment of bacterial and fungal infections. To have a U.S. public health system that is quickly responsive to changes in health and can rapidly analyze and

communicate the latest data, the nation must continue to invest in public health surveillance.

CDC's Data Modernization Initiative

The Data Modernization Initiative (DMI) is a multi-year effort to make core public health data and surveillance infrastructure current with today's technology and build the systems for the future. Thanks to investments to date, the country is in a vastly different position for recognizing and responding to health threats than it was before the pandemic. The value of these gains—to gather, analyze, and share information for communities' use in decision making—cannot be overstated. DMI investments improved the efficiency of nearly every surveillance tool in use by state and counties around the country. Further investment in FY 2024 with annual resources as requested in the Budget will continue to enhance health security for every American and anticipate future public health data needs.

Americans are already benefitting from investments in data modernization, including through DMI and other efforts across numerous CDC programs. CDC will continue to improve public health with FY 2024 requested increases, including each of the following:

- Speeding up transmission of digital laboratory reports through the Electronic Laboratory Reporting (ELR) from laboratories to state and local public health departments, healthcare systems, and CDC.
- Increasing connectivity for public health departments to communicate with the National Notifiable Diseases Surveillance System.
- Advancing real-time syndromic surveillance using de-identified data from participating emergency departments.
- Advancing real-time, automated case reporting to health departments using electronic Case Reporting (eCR), including expanding use of eCRs from rural health clinics.
- Enabling earlier and more robust information about deaths in the United States by increasing interoperability of systems pulling data for the National Vital Statistics System.
- Bringing state-of-the art analytic and predictive capacity to Americans through the Center for Forecasting and Outbreak Analytics at CDC.
- Protecting patient safety through CDC's National Healthcare Safety Network.
- Reducing maternal deaths using information from Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET).
- Advancing U.S. capacity for gathering and analyzing data by integrating federal, state, and local government and hospital system data through the Ready Response Enterprise Data Integration platform (formerly HHS Protect).

This funding, paired with a modernized data authority requested in the budget will support public health agencies at the federal, state, and local levels to share quality and timely data, while reducing burden on providers.

Building the Public Health Workforce of the Future

Public health agencies at all levels require substantial changes to address the vulnerabilities highlighted by COVID-19. Local and state public health agencies and related organizations have lost thousands of workers in the past decade and need highly trained public health leaders who represent our nation's communities and populations at disproportionate risk for disease, and who have the requisite interdisciplinary skills and experience to execute effective public health initiatives. CDC's pipeline and training programs, though comparatively small relative to the overall public health workforce, serve a pivotal role in training the future leaders in public health. Our budget request includes funding and legislative proposals to boost internship and fellowship recruitment and participation, enable more deployments, allow noncompetitive conversions of fellows to permanent positions, and leverage existing resources to support additional student loan repayment as a recruitment and retention incentive.

EFFORTS TO STOP THE SPREAD OF INFECTIOUS DISEASES

Emerging Infectious Diseases and Quarantine

As the world sees an increase in newly emerging pathogens and responses become increasingly complex, CDC requests an increase in funding for Emerging Infectious Diseases to allow funds to be used for novel pathogens for which a funding line does not yet exist. CDC is a global leader in studying and responding to emerging pathogens due to its groundbreaking research and state-of-the-art laboratories, public health expertise, and collaborative networks with state, local, and tribal health departments that quickly identify and characterize emerging pathogens and allow for coordination of multistate investigations and responses. Increased funding for Emerging Infectious Diseases will provide resources needed to harness these unique capabilities in the face of uncertainty.

The requested increase for quarantine activities will be used to scale-up migration systems that protect against future international outbreaks and pandemics. CDC will sustain investments made with COVID-19 supplemental funds to support innovative solutions that focus on a modernized and flexible traveler management program aimed to engage with travelers before, during, and after travel.

Antimicrobial Resistance

Antimicrobial resistance happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them. Resistant infections can be difficult, and sometimes impossible, to treat. Antimicrobial resistance is an urgent public health threat. With increased funding requested in the budget, CDC will expand state and local capacity to detect and prevent emerging and existing threats through strengthened antibiotic stewardship data collection and quality improvement efforts, improve data sets addressing health equity and disparities, and expand the Global Antimicrobial Resistance Laboratory and Response Network. Investments will provide support to implement and

achieve the goals under the National Action Plan for Combating Antibiotic-Resistant Bacteria (CARB), 2020-2025.

Vaccine-preventable Diseases

Vaccines continue to be one of our most effective tools to protect health. For example, during the 2021-2022 flu season, flu vaccination prevented 1.8 million flu-related illnesses, one million medical visits, 22,000 hospitalizations, and nearly 1,000 deaths in the United States. Recent reductions in vaccine coverage and confidence across the world create vulnerabilities to health security at home and abroad. The budget includes significant investments to support the immunization infrastructure throughout the United States. This includes modernizing immunization information systems, implementing new strategies for vaccine equity, building vaccine confidence, expanding the scientific evidence base, and enhancing support in human papilloma virus (HPV) vaccination efforts, which aligns with the Biden-Harris Administration's Cancer Moonshot initiative.

The budget also proposes an expansion of the Vaccines for Children program to include all children under age 19 enrolled in the Children's Health Insurance Program, and as I mentioned earlier, a complementary system for adults—the Vaccines for Adults program—to begin to expand access to vaccines recommended by the ACIP at no cost for uninsured adults.

The budget also includes an increase for the Global Immunization program to achieve priority goals including shifting children out of zero-dose status, increasing life-course vaccination, preventing and mitigating large outbreaks, which can cross borders, and working toward essential service targets globally.

Ending the HIV Epidemic

The budget includes an increase to advance our work, in partnership with other parts of HHS, to end the HIV epidemic. In FY 2024, CDC will expand innovative and successful interventions, implement approaches that integrate health equity into the entire HIV prevention portfolio, test novel service delivery models designed to increase access to prevention services, and strengthen engagement of community-based organizations in implementing the Ending the HIV Epidemic in the U.S. initiative.

MOVING BEYOND INFECTIOUS DISEASE THREATS TO PROTECT THE NATION'S HEALTH

CDC works collaboratively with state, tribal, local, and territorial health departments to bring science and interventions to all communities. Working at the community level promotes healthy living, helps prevent injury and chronic diseases, and brings the greatest health benefits to the greatest number of people in need, while investing in local communities and addressing the drivers of health disparities seen in this country. Greater engagement of enduring community institutions such as faith-based organizations, civic groups, and others have been instrumental in embedding health promotion and disease prevention as community values.

Protecting Americans from Environmental Health Threats

CDC's budget request for Environmental Health Activities within the National Center for Environmental Health will support expanded laboratory and health investigation efforts under the Cancer Moonshot Initiative and provide additional funding to health departments to address environmental hazards and health. CDC programs funded under the Environmental Health Activities budget line support core environmental health programs, workforce capacity, and research that protect Americans from emerging and everyday environmental health threats wherever they live. CDC and the Agency for Toxic Substances and Disease Registry employees work with state officials in assessing how environmental exposures affect health, such as evaluating Hawaii's drinking water and analyzing chemical exposures in the aftermath of the train derailment in East Palestine, Ohio.

These programs are critical for ensuring environmental public health practitioners at state, tribal, local, and territorial health departments have the resources, tools, and evidence-based guidance to detect, prevent, and control environmental public health hazards, including threats from wildfires, hurricanes, or other extreme weather events.

CDC's Childhood Lead Poisoning Prevention program focuses on primary prevention of lead exposure as well as detection, early intervention, and support for those children already demonstrating elevated blood lead levels. The requested funding increase in the budget will enable CDC to add another 38 grants for a total of 110 grants nationwide. Data from CDC's nationally representative National Health and Nutrition Examination Survey (NHANES) show that children's mean blood lead levels are going down over time, and continued support for this program would allow resources and strategies to be directed to those children with highest exposures and at greatest risk to further these gains.

Advancing Efforts to Address Cancer Prevention and Control

The experience of cancer —getting a cancer diagnosis, surviving cancer, or losing someone to cancer — has touched virtually every American family. The Biden-Harris Administration's Cancer Moonshot initiative seeks to cut 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. The funding requested in the budget builds on investments CDC has made in a comprehensive, coordinated cancer prevention and control portfolio for more than 30 years. Funded programs will demonstrate how proven strategies advance health equity, such as Patient Navigator programs, and build community capacity in cancer prevention and control. Outcomes include improving the provision of clinical preventive services, facilitating planning among partners to promote evidence-based strategies in communities, and improving cancer surveillance. The FY 2024 budget increases support for cancer prevention and control programs across CDC, in addition to tobacco prevention, HPV prevention, and analysis of cancer clusters related to environmental concerns.

The Built Environment and Food Security

The characteristics of places and resources where people live, learn, work, and play have an enormous impact on the likelihood of achieving healthy outcomes. CDC has funded projects in jurisdictions to develop one-year accelerator plans addressing key aspects of CDC's priority social determinants of health (SDOH): the built environment, food security, clinical-community linkages, social connectedness, tobacco-free policies, and healthcare access and quality. Funds requested in the FY 2024 budget for CDC's SDOH program will be used to implement and evaluate action plans and to build the evidence base for interventions through applied research, data collection, and surveillance.

In support of the White House National Strategy on Hunger, Nutrition, and Health, the FY 2024 Budget includes funding to expand the State Physical Activity and Nutrition (SPAN) program to all 50 states, the District of Columbia, and 14 territories. The SPAN program works with jurisdictions to implement evidence-based strategies to reduce chronic diseases by improving physical activity and nutrition. Through this program, the Active People, Healthy Nation initiative makes physical activity safe and accessible for all by implementing state and community-level policies and activities that connect pedestrian, bicycle, or transit opportunities to everyday destinations.

Combating Maternal Mortality

CDC released data visualization presenting national-level provisional counts of maternal deaths based on a current flow of mortality data in the National Vital Statistics System. The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019; this increase was more profound among people of color and that the COVID-19 pandemic exacerbated factors associated with maternal mortality such as lack of access to care. The data visualization dashboard is updated quarterly and show that the rates are declining in 2022. However, underlying conditions that result in racial and ethnic disparities need to be addressed. The Biden-Harris Administration continue to support efforts to reduce maternal mortality.

The FY 2024 Budget includes an increase for CDC programs aimed at reducing maternal mortality. Specifically, additional funding for the Maternal Mortality Review Committees will promote representative community engagement to further expand support for all states and territories and increasing support for tribes. Additional funding will also be directed to expand Perinatal Quality Collaboratives to every state, support community engagement in maternal mortality prevention, and increase support for the Pregnancy Risk Assessment Monitoring System. CDC will also support tools to help states develop coordinated regional systems to help those at high risk of complications receive care at a birth facility that is best prepared to meet their health needs.

PROMOTING MENTAL HEALTH AND ADDRESSING VIOLENCE

Mental health is an important part of overall health at every stage of life, from childhood and adolescence through adulthood, and includes our emotional, psychological, and

social well-being. CDC promotes and supports efforts to improve mental health, especially among youth and adolescents, and prevents violence in communities.

Protecting Children

In the FY 2024 Budget, CDC requests an increase in funding to expand the number of states implementing strategies that have been proven to reduce adverse childhood experiences (ACEs) and promote positive ones. Through the Essentials for Childhood: Preventing Adversity through Data to Action program, CDC will increase investments in surveillance and research activities for the prevention of ACEs.

CDC's Healthy Schools Program plays a unique role in bringing together the education and public health sectors to support physical education, physical activity and healthy nutrition, management of disabilities and chronic conditions, emotional well-being, and healthy and supportive school environments. In FY 2024, CDC plans to use its increase in funding as requested in the budget to implement the Healthy Schools program in all states.

In addition, the budget includes additional funds to promote adolescent mental health through CDC's What Works in Schools program. The program works to strengthen schools' prevention activities. Using data from multiple large-scale surveys of school-aged children and adolescents, CDC developed guidance and curricula that have substantially reduced risk behaviors, experience of violence, substance use, and poor mental health among students. Increased funding as requested in the budget will be used to expand support for up to 75 of the nation's largest local education agencies to implement these proven practices and focus specifically on school connectedness in the wake of COVID-19.

Preventing Violence

Violence is a serious and growing problem in the United States affecting people in all stages of life. CDC is the nation's leading authority on violence and injury prevention. The FY 2024 Budget would create a Community Violence Intervention (CVI) program within CDC that would support community-based organizations in implementing proven public health strategies that reduce violence. With CVI resources requested in the FY 2024 President's Budget, CDC will fund cities and communities demonstrating the greatest need for intervention and programming to stem the tide of community violence. Research, surveillance, and program evaluation efforts will be prioritized to emphasize those interventions and populations where evidence strongly suggests that public health approaches will reduce the burden of community violence.

Once again, we are reminded of the terrible toll that firearm injuries take on our young people. Injuries are the most common cause of death among children, adolescents, and young adults between one and 24 years of age in the United States. For more than 60 years, motor vehicle crashes were the leading cause of injury-related death among this age group. However, beginning in 2017, firearm-related injuries surpassed motor vehicle

crashes as the leading cause of death from injury.[1] CDC will continue to fund research to identify the most effective ways to prevent firearm- related injuries and deaths. As requested in the budget, CDC plans to use increased funding for firearm injury and mortality prevention research to provide additional funding opportunities to support R01 research grants that improve understanding of firearm injury; inform the development of innovative and promising prevention strategies; and rigorously evaluate the effectiveness of strategies to keep individuals, families, schools, and communities safe from firearm-related injuries, deaths, and crime. CDC will fund additional research grants to support new investigators and will focus on improving collection and dissemination of timely data on firearm-related deaths, nonfatal firearm injuries, and behavioral issues related to firearms such as safe storage. This will include the expansion of the Firearm Injury Surveillance Through Emergency Rooms (FASTER) program to as many states as possible.

In the FY 2024 Budget, CDC requests an increase to build and enhance the primary prevention capacity of state, territorial, and tribal sexual assault coalitions for rape prevention. This will complement work funded through existing rape prevention funding opportunities.

In the FY 2024 Budget, CDC requests additional funding for the National Violent Death Reporting System (NVDRS) to implement and maintain the system, monitor and report data, and use data to inform prevention efforts to save lives. CDC will continue to increase the use of NVDRS data by characterizing manner of death and identifying key populations at risk for violence for further study.

In the FY 2024 Budget, CDC also requests an increase for expanding the reach of the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) program, which aims to decrease risk factors in communities that may lead to intimate partner violence and to increase protective factors that prevent it.

Preventing Overdose

The opioid epidemic has shattered families, claimed lives, and ravaged communities across the nation—and the COVID-19 pandemic has only deepened this crisis. Addressing the current overdose epidemic remains a priority for CDC. The Biden-Harris Administration's strategy brings together surveillance, prevention, treatment, recovery, law enforcement, interdiction, and source-country efforts to address the continuum of challenges facing this country due to drug use. CDC's unique role in preventing overdose stems from its ability to gather data on the circumstances surrounding overdose deaths, which states use to spot trends and understand risk factors leading to these deaths.

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[1] N Engl J Med 2022; 386:1485-1487
DOI: 10.1056/NEJMp2200169

CDC's budget request for Opioid Overdose Prevention and Surveillance funding will support integration of state and local prevention and response efforts, provide support for providers and health systems prevention (including use of prescription drug monitoring programs as a clinical decision support tool), enhance partnerships with public safety and first responders, establish and improve linkages to medications for opioid use disorder and other supportive services through harm reduction activities, and empower individuals to make informed choices. These activities support multiple initiatives included in the Office of National Drug Control Policy (ONDCP) Policy Priorities and the National Drug Control Strategy.[2]

Preventing Suicide

In 2020, 46,000 people died by suicide in the United States; this is one death every 11 minutes. Multiple factors contribute to suicide at the individual, relationship, community, and societal levels, including issues related to substance misuse, physical health, jobs, money, interpersonal violence, stigma, and access to lethal means among people at risk. The goal of suicide prevention is to reduce factors that increase risk and encourage factors that promote resilience. CDC's vision is, "no lives lost to suicide." CDC uses data, science, and partnerships to identify and implement effective suicide prevention strategies. The FY 2024 budget requests an increase to expand the Suicide Prevention Program to all 50 states, the District of Columbia, and 18 tribal and territorial communities, as well as other nongovernmental organizations and university research programs to reduce suicide.

CONCLUSION

CDC is taking the necessary steps through our Moving Forward initiative to drive needed changes in the operations, incentives, and structure of the organization to address costly and longstanding challenges and fully meet the public health needs of the American public today and in the future. Funding levels included in the FY 2024 budget request will enable CDC to better prepare for, and equitably respond to, the next emerging public health threat, and to continue to protect Americans from existing threats.

We will continue to apply lessons learned and advance bipartisan solutions to be better prepared for future public health challenges. Congressional action to support these budget and legislative proposals will improve how CDC responds to future emerging threats and support the agency's modern-day mission.

I look forward to working together to implement the solutions that will make this agency—the work of which is so critical to America's health—and our partners at the state, Tribal, local, and territorial level, better prepared for what comes next.

Thank you, and I look forward to your questions.

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[2] https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf

ASPR OPENING STATEMENT

Mr. ADERHOLT. Thank you, Dr. Walensky. Thanks for your testimony.

We also have joining in the panel today Dawn O'Connell. Ms. O'Connell has served as the Assistant Secretary for Preparedness and Response within the U.S. Department of Health and Human Services. In that role, she is the Secretary's principal adviser on public health emergencies, and her office leads the Nation in preventing, responding to, and recovering from the adverse health effects of manmade and naturally occurring diseases.

Prior to this role, she served as a senior counselor to Secretary of Health and Human Services for COVID–19, also she was the Director of the U.S. Office for Coalition for Epidemic Preparedness and Innovation.

Secretary O'Connell, we are glad to have you here and look forward to your testimony.

Ms. O'CONNELL. Chair Aderholt, Ranking Member DeLauro, and distinguished members of the committee, it is an honor to testify before you today on ASPR's work and our fiscal year 2024 budget request.

But first, let me thank you for the funding you provided to ASPR in the fiscal year 2023 omnibus. These dollars are allowing us to continue our many critical programs that help the Nation prepare, respond to, and recover from public health emergencies and disasters.

Today, ASPR is working on more high-consequence, no-fail missions than ever before. ASPR must have the necessary funding to keep up with the evolving and expanding threat landscape. That is why we have asked for a $4,270,000,000 in fiscal year 2024. And with this fiscal year 2024 budget request, I am trying to solve three key problems.

The first problem I am trying to solve is how ASPR maintains the capabilities we built during COVID so we have them for future responses as well. Many of these capabilities were funded with COVID dollars and will go away with that funding unless we can transition them to our annual budget.

One example is our supply chain capabilities. Throughout the pandemic, we used supplemental appropriations to invest in and strengthen the domestic industrial base and supply chain for key medical supplies. This work was born out of the initial supply chain pinches the country experienced in March 2020 when the whole world needed the exact same products at the exact same time, and they were all manufactured elsewhere.

As we are seeing supply chain challenges in other medical products outside of COVID, it is important that we maintain the capabilities we have built and broaden them so we can apply them to head off shortages or supply chain pinches in the next outbreak or disaster we face. We need to move these programs to our annual budget to keep this capability, so we don't have to build it from scratch again when we are hit by the next public health emergency, outbreak, or disaster.

That is why we are requesting $400,000,000 for pandemic preparedness and biodefense within the fiscal year 2024 budget to support continued efforts and activities in this area.

The second problem that I am trying to solve with our budget request is how we stop losing time and start preparing for the next biological threats. Among the reasons we were able to move out so quickly with the countermeasures against COVID–19 was because so much work was already under way on coronaviruses due to prior outbreaks of SARS and MERS.

We know the next viral families most likely to cause a significant biological threat. While we have time, it is important to get the same head start we had on coronaviruses with these other families. We need funding to develop prototype vaccines, therapeutics, and diagnostics that we can put on the shelf and pull down when or should a virus from one of these families emerge and begin to spread.

The fiscal year 2024 request includes $20,000,000,000 to support preparedness against biological threats, of which about $10,500,000,000 would come to ASPR to begin work against these viral families.

ASPR TRANSITION TO STANDALONE AGENCY

And finally, the third problem I am trying to solve with our budget request is making sure that ASPR has the funding we need to fully transition into a standalone agency. It would be management malpractice for us to look like the same organization we were at the start of the pandemic. We have learned too much and grown too much in these last 3 years to move backwards as an organization.

The Secretary, in recognition of all of the work we are doing in our expanded mission space, made us an agency last summer. This was to ensure that we have the independence to build the human resources, contracting, and finance capabilities we need to be able to quickly respond to whatever public health emergency or disaster is at hand.

The fiscal year 2024 budget requests an additional $35,000,000 in operations to start building out our acquisitions and IT workforce, two functions critically important to our success as a standalone agency within HHS.

Let me thank you again for your strong support of ASPR in previous budget cycles and assure you that this year's budget request is targeted to solve key problems as the ASPR organization continues to do all it can to help the country prepare for, respond to, and recover from public health emergencies, disasters, and whatever comes next.

I look forward to working with you as you draft the fiscal year 2024 appropriations bill.

Thank you again for inviting me to testify today. I look forward to answering your questions.

[The information follows:]

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE

Testimony before the
House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Hearing on the FY 2024 Budget Request for the National Institutes of Health, Centers for Disease Control and Prevention, and the Administration for Strategic Preparedness and Response

Dawn O'Connell
Assistant Secretary for Preparedness and Response

April 19, 2023

Chair Aderholt, Ranking Member DeLauro, and distinguished members of the Subcommittee, it is an honor to testify before you today on the Fiscal Year (FY) 2024 President's Budget request submitted by the U.S. Department of Health and Human Services (HHS) Administration for Strategic Preparedness and Response (ASPR).

ASPR is working on more high-consequence, no-fail missions than ever before. We are living in an increasingly interconnected world where diseases and other threats can travel quickly, unnoticed for days. With infectious disease outbreaks becoming more frequent, we are also experiencing an increase in the frequency and intensity of natural disasters. To keep up with the evolving threat landscape, ASPR must remain nimble and ever vigilant while learning from each response it leads. I am grateful for the strong Congressional support we receive for the work that we do, but there are three key problems I am trying to solve through our budget request.

The first is how ASPR can maintain the capabilities built and used extensively during the COVID-19 pandemic as supplemental COVID-19 funds are exhausted. We know some capabilities—like ASPR's industrial base management and supply chain work—will be important to prevent shortages of critical supplies during our next response. With significant supplemental investments provided during the COVID-19 response, ASPR has built a program to ensure we have COVID-related personal protective equipment (PPE) and critical supplies manufactured in the United States moving forward. We have also invested in capabilities to ensure we have visibility into the supply chain for those supplies. These efforts, however, are funded with COVID-19 dollars. In FY24, we are seeking funding to move this important capability to annual funds, which will allow us to use them in future responses and apply them to supplies other than those needed to respond to COVID-19. We have asked for funding to sustain this work as part of our $400 million request for Pandemic Preparedness and Biodefense.

A second problem I am trying to solve through our FY24 request is how we can be more prepared for the next pandemic. We were able to move out so quickly with countermeasures against COVID-19 because of past investments in coronavirus research and development due to prior outbreaks of SARS and MERS. We know the seven viral families most likely to cause a pandemic. While we have time, it is important to get the same head start on these viruses as we had on coronaviruses. With enough funding, we can develop vaccine, therapeutic, and diagnostic prototypes that can be pulled off the shelf whenever one of these viruses with high pandemic potential emerges. The Department's FY24 request includes $20 billion to support pandemic preparedness, of which about $10.5 billion would come to ASPR to begin work against these viral families. Also, the $400 million Pandemic Preparedness and Biodefense request will also ensure we have ready resources to immediately scale up manufacture of those prototypes when we have the first indication of an outbreak.

The third problem that I am trying to solve with our FY24 budget request is how to ensure that we have the increased funding needed to support ASPR as its overall responsibilities and programs continue to grow. As many of you are aware, in the summer of 2022, ASPR was designated an Operating Division—or agency—within HHS. ASPR now has the independence to build human resources, contracting, and finance capabilities to meet our unique mission and respond to whatever public health emergency or disaster is at hand. The FY24 budget requests an

additional $35 million in Operations to start building out our acquisitions and IT workforce—two functions critically important to our success as a response organization.

While I have focused specifically on three of the problems our FY24 request is trying to solve, our overall request directly supports ASPR's mission to help the country prepare for, respond to, and recover from public health emergencies and disasters.

Overview of ASPR's FY24 Funding Request

ASPR is responsible for many aspects of our country's preparedness and response infrastructure. ASPR leads the development, acquisition, and stockpiling of medical countermeasures (MCMs), such as vaccines, therapeutics, PPE, medical devices, and other resources needed during public health emergencies, and is working to prepare for future emergencies by expanding and sustaining the requisite industrial base. ASPR also deploys National Disaster Medical System (NDMS) response teams to states and territories during or following disasters to bolster the local response. ASPR helps prepare the health care sector for emergency events through the Health Care Readiness and Recovery (HCRR) program and safeguards it against cyber threats through its role as the Sector Risk Management Agency. Also, through the Medical Reserve Corps (MRC), ASPR supports the mobilization of volunteer units to assist in communities' public health needs, such as vaccination clinics, blood donations, and more.

Given the significant work for which ASPR is responsible, I am pleased to present the discretionary FY 2024 President's Budget request for ASPR is **$4,271,913,000**, which is $642,236,000 above FY 2023 enacted. The President's Budget also proposes $20 billion in HHS-wide mandatory pandemic preparedness funding, of which $10.5 billion would support ASPR activities. Today, I will take a few minutes to highlight a few of the key requests and provide details on how funds would be used to strengthen operational capabilities.

Biomedical Advanced Research and Development Authority
Having MCMs ready in a public health crisis requires long-range investment in the research and development of highly specialized products. ASPR, through the Biomedical Advanced Research and Development Authority (BARDA), works with both public and private sector partners to support the advanced research, development, regulatory authorization, and procurement of life-saving medical products—drugs, vaccines, therapeutics, diagnostics, and medical devices.

BARDA's advanced research and development program bridges gaps in national preparedness that no other federal agency does. BARDA supports and invests in the late stages of development that are necessary to reach authorization of medical products to address chemical, biological, radiological, and nuclear (CBRN) threats, emerging infectious diseases, pandemic influenza, and the growing public health threat of antimicrobial resistance.

To date, BARDA's efforts have led to 70 FDA licensures, approvals, and clearances of MCMs. Through investments in innovation, future products developed by BARDA have the potential to revolutionize emergency response and basic health care for all Americans.

The FY 2024 President's Budget requests over $1 billion for BARDA, or $65 million above FY 2023 enacted, to develop innovative vaccines and therapeutics, as well as non-

pharmaceutical interventions that protect Americans from health security threats. With the requested funding, BARDA will continue to invest in MCMs to prepare and respond to CBRN threats through the development of vaccines and therapeutics.

In addition to funding CBRN investments, the FY 2024 President's Budget provides $375 million for the Pandemic Influenza program at ASPR, which BARDA will use to implement an end-to-end strategy to prepare for the next influenza pandemic by supporting the development, authorization, and manufacturing of better diagnostics and treatments to prevent and respond to seasonal and pandemic influenza. The influenza MCM program supports the formulation and development of alternative vaccine delivery methods for flu vaccines that do not rely on an egg supply, as well as faster platforms, more sustainable approaches for vaccine and therapeutic development, and the expansion of national flu vaccine manufacturing capacity.

Pandemic Preparedness and Biodefense
The $400 million requested in FY24 for Pandemic Preparedness and Biodefense will ensure we are able to quickly respond to emergent pathogens with pandemic potential. The request would enable ASPR to rapidly close critical gaps identified during the acute phase of response and accelerate progress within long-term programs while mitigating impacts to other programs. The requested funding would accelerate advanced development and additional manufacturing of medical countermeasures for clinical trials and, when appropriate, patient care as part of an emergency response. During the recent Ebola Sudan outbreak in Uganda and ongoing Marburg outbreaks in Equatorial Guinea and Tanzania, ASPR had to reallocate funding planned for the advanced development of antimicrobials as well as chemical, radiological, and nuclear MCMs to quickly ramp up manufacturing of investigational vaccines and therapeutics. Similarly, during the mpox response, ASPR delayed Rad/Nuc investments to accelerate the fill-finish of the JYNNEOS vaccine. With the $400 million requested, ASPR would be able to accelerate delivery of medical countermeasures in response to an outbreak without delay and with minimal impact to other priory threat areas. In addition, these funds will ensure that we are able to continue supporting our industrial base management and supply chain work and continue to onshore key components of the medical countermeasure supply chain.

Strategic National Stockpile
The Strategic National Stockpile (SNS) manages and delivers lifesaving MCMs when and as needed during public health emergencies and disasters. The SNS is the largest federally owned repository of pharmaceuticals, critical medical supplies, federal medical stations (FMS), and medical equipment available for rapid delivery to support federal, state, and local responses to health security threats.

In the past few years, the SNS has supported several important response efforts. Throughout the COVID-19 response, the SNS has been on the front lines of distributing PPE and other critical supplies to states that need them. During the first six weeks of the COVID-19 pandemic, the SNS deployed 90 percent of its PPE to help frontline health care workers across the United States. In addition to PPE, the SNS deployed thousands of ventilators to help treat critically ill patients and all 32 of the SNS's federal medical stations to provide surge capacity when hospitals ran out of beds. In the summer and fall of 2021, the United States saw a surge of COVID-19 cases and hospitalizations related to the Delta variant. Using medical material procured during the

pandemic, the SNS responded to this uptick in cases by deploying 2,919 ventilators and 1,279 high flow nasal cannulas. The SNS also supported the national COVID-19 vaccination efforts, including the vaccine distribution process through procuring PPE, supporting testing, and distributing ancillary supplies for vaccination.

In addition to supporting the ongoing COVID-19 response, the SNS provided critical vaccines and therapeutics to help stem the mpox outbreak that began last year and deployed Tamiflu to states that needed additional courses to treat flu during the surge of RSV and flu cases this winter. The SNS also provided FMS capabilities to support deployed deployed NDMS teams as they responded to hurricanes and other natural disasters throughout 2022.

The FY 2024 President's Budget requests $995 million for the SNS, an increase of $30 million above FY 2023 enacted. These funds will ensure the SNS's assets are available and ready to protect America from 21st century health threats in FY 2024. The increased funding will be used to sustain current product lines and to procure targeted countermeasures previously supported by BARDA that lack a significant commercial market.

HHS Coordination Operations and Response Element
Last year, HHS successfully transitioned the operations and logistics capability that the Department of Defense (DoD) brought to Operation Warp Speed (OWS) into ASPR's HHS Coordination Operations and Response Element (H-CORE). With funding provided in the Consolidated Appropriations Act, 2023, H-CORE is now formally established within ASPR as a permanent logistics and operations hub.

H-CORE has incorporated early lessons learned during the COVID-19 response and has been able to quickly pivot to support the distribution of dozens of vaccines and therapeutics, based on new scientific data and an ever-changing virus, to ensure that those who need COVID-19 countermeasures have access to them. With its partners, H-CORE stood up innovative new models for equitably delivering preventative measures like test kits and masks to the American public.

The FY24 President's Budget requests $83 million for H-CORE, an increase of $8 million above FY 2023 enacted. This funding will support critical data collection and management systems, staff with scientific, contracting, operational, and other expertise, and will be used for logistics and operational needs across ASPR and the Department.

National Disaster Medical System
Last year, ASPR successfully executed one of the largest deployments of personnel and equipment of the past five years in support of a hurricane. ASPR deployed ten NDMS teams, with hundreds of additional incident management, logistical, and regional staff, supporting seven free-standing emergency room sites around Florida in the aftermath of Hurricane Ian. Throughout 2022, ASPR's NDMS teams provided care for over 4,000 patients in need across the United States.

The FY 2024 President's Budget requests an increase of $33 million dollars above FY 2023 enacted, for a total of $130 million. This increase in funding will provide expanded personnel

recruitment and training, continue the Pediatric Disaster Care Program, and maintain NDMS equipment prepared for immediate deployment in the event of a disaster.

Health Care Readiness and Recovery
ASPR's Health Care Readiness and Recovery (HCRR) portfolio invests in programs and activities that strengthen health care entities on the local and regional levels to provide innovative, coordinated, and lifesaving care in the face of emergencies and disasters.

Recent events, such as the COVID-19 pandemic, revealed critical gaps in the nation's health care preparedness and response infrastructure, demonstrating the need to support care delivery and improve coordination between different levels of care to improve patient outcomes and eliminate preventable deaths. The HCRR budget line's portfolio focuses on building emergency preparedness capabilities throughout the health care delivery system, and as a result, is uniquely positioned to address many of these challenges.

The FY24 President's Budget requests $312 million for HCRR, an increase of $7 million from FY 2023 enacted. Of those funds, $29 million will be used to support the National Special Pathogen Service Care Strategy, with $21 million dedicated to expanding the Regional Ebola and other Special Pathogen Treatment Centers network to reach 15 total operational sites, and $8 million for the National Emerging Special Pathogens Training and Education Center program. The budget would also provide $240 million in funding for Hospital Preparedness Program (HPP) cooperative agreements with states and territories throughout the United States.

Operations
Our request also supports our transition to an Operating Division while ensuring ASPR can continue to rapidly respond to new and emerging threats going forward. The FY24 President's Budget requests $69.8 million to support these efforts.

Funds will support enhancing and sustaining ASPR's contracting capabilities. Throughout the COVID-19 response, ASPR relied on assisted acquisitions support from DoD. That relationship is set to expire at the end of FY23. ASPR needs to be able to absorb the work that DoD handled for ASPR, as well as continue to perform the standard contracting work ASPR manages on a day-to-day basis. In FY22, for example, ASPR executed over 1,500 contract actions and obligated over $4.1 billion. ASPR accomplished this with a much smaller number of acquisitions specialists than are employed by other similarly situated agencies, such as the Federal Emergency Management Agency (FEMA) and the Defense Logistics Agency. The FY24 budget request will support the building out of ASPR's workforce to continue this work internally.

The requested funding will also ensure ASPR has appropriate financial experts and subject matter experts onboard to support the mission. Additional staff will ensure adequate capacity for formulation, execution, monitoring, and funds control of ASPR's financial resources.

Our FY24 budget request for Operations also includes support for ASPR's information technology infrastructure. Now that ASPR is an Operating Division, it must purchase several tools and applications it used to receive through the Office of the Secretary, as well as hire full-time employees, to support implementation and overall management of such systems. The

requested funding will also ensure ASPR is able to perform cyber risk assessments to ensure compliance with federal and departmental mandates.

Conclusion

I have laid out some of the problems we are trying to solve through ASPR's FY24 budget request. I have also offered examples of why this funding is needed to support our many nationally important programs and staff. Thank you again for inviting me to testify before you on the FY24 President's Budget request for ASPR and how funding will enhance overall operations and preparedness for future public health and medical incidents. I look forward to answering your questions.

Mr. ADERHOLT. Thank you very much.

And last, but not least, joining the panel today is also Dr. Lawrence Tabak. He is performing the duties of the Director of the National Institutes of Health, officially taking office on December 20, 2021.

Dr. Tabak has served as the Principal Deputy Director and the Deputy Ethics Counselor of NIH since 2010. He previously served as the Acting Principal Deputy Director of NIH and, prior to that, as the Director of the National Institute of Dental and Craniofacial Research from 2000 to 2010.

So, Dr. Tabak, we are honored to have you here and look forward to your testimony as well.

Dr. TABAK. Thank you, Chair Aderholt, Ranking Member DeLauro, and distinguished subcommittee members. I am honored to be here today representing the National Institutes of Health.

Our mission at NIH is to seek fundamental knowledge about the nature and behavior of living systems and apply that knowledge to save lives and improve health. Fundamental, translational, and clinical research are critical components of the biomedical research enterprise.

However, fundamental or basic research rarely makes headlines. Understanding how proteins fold and are subsequently decorated or how gene activity is controlled doesn't often improve human health immediately, but fundamental research is essential for breakthrough discoveries that lead to treatments and cures.

An independent analysis by researchers at Bentley University found that NIH funding contributed to the development of every new drug—all 356—approved by the FDA from 2010 through 2019. NIH supported the foundational evidence that pharmaceutical companies leveraged to develop lifesaving drugs and many thousands of patents.

I have spoken to this subcommittee previously about how fundamental research from NIH-supported scientists and collaborators positioned the U.S. to develop COVID–19 vaccines on an unprecedented timeline, but there are many other examples of how fundamental research has led to improvements in the health of Americans. One such case is the breakthrough stroke treatment that resulted after decades of work to understand the basic biology of how enzymes can dissolve blood clots.

Researchers first described the enzyme that would become known as tissue plasminogen activator, or tPA, in 1946. Three decades later, cancer cells grown in the lab were found to produce large amounts of tPAs. A decade after that, NIH-supported clinical trials led to the approval of tPA to treat heart attacks. And then, in 1990, the tPA transformed the treatment of stroke, allowing most patients who are treated within 3 hours to make full recovery with far-reduced healthcare costs.

Many of our most important advances have come when we were not even thinking about a direct application. For example, decades ago, NIH funded research on how bacteria protect themselves from viruses. No one involved in that work could have predicted that

that effort would lead to tools that would revolutionize all of medicine.

Because of research on recombinant DNA in the 1960s, it became possible to produce drugs at large scale, like insulin and tPA. Starting in the 1980s, continuing research on gene editing tools more recently led to CRISPR, an extremely versatile method that is paving the way for cures for multiple diseases, including sickle cell and antibiotic-resistant urinary tract infection.

Discoveries build upon each other in ways that we cannot necessarily predict. Your sustained public investment in fundamental research is essential to the discovery and development of new medical treatments. To foster the application of fundamental research, NIH continues to support translational research studies and collaboration with industry to advance crucial interventions for the public.

NALOXONE

As most of you know, naloxone is a lifesaving treatment that can quickly restore normal breathing when someone overdoses on opioids. This drug is an essential tool in the fight against the opioid overdose crisis, which claims 188 lives in the United States every day.

Injectable naloxone was used for years, but an easier intervention was needed. In 2013, scientists from the National Institute on Drug Abuse created a stable formulation of concentrated naloxone for use in a nasal spray injector developed by an industry partner. Working together, they conducted clinical trials to evaluate the nasal spray formulation, providing pivotal data to support FDA approval of Narcan in 2015. And just a few weeks ago, the FDA approved Narcan for use without prescription.

NIH-supported discoveries affect nearly all of our lives from research studies that laid a foundation for future biomedical advances to clinical trials that evaluate potentially lifesaving interventions. Your continued support of our mission to help people live longer and healthier lives is crucial.

I thank you for your time and welcome your questions.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Hearing on the FY 2024 Budget Request for the National Institutes of Health, Centers for Disease Control and Prevention, and the Administration for Strategic Preparedness and Response

Witness appearing before the

House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies

Lawrence A. Tabak, D.D.S., Ph.D.

Performing the Duties of the Director, National Institutes of Health

April 19, 2023

Good morning, Chair Aderholt, Ranking Member DeLauro, and distinguished Members of the Subcommittee. I am Lawrence A. Tabak, D.D.S., Ph.D., privileged to be Performing the Duties of the Director of the National Institutes of Health (NIH). Thank you for the invitation to appear before you today so that I may provide you with information about our efforts in pandemic preparedness and our Fiscal Year (FY) 2024 budget request.

I truly appreciate the Committee's ongoing bipartisan support for NIH. As a result of this support, scientific advances have been made that reach people of all ages across the United States. From improving treatment options for substance use disorders to developing vaccines to prevent infectious diseases to discovering novel cancer treatments, the investment Congress continues to make in NIH improves the health of your communities.

The FY 2024 President's Budget builds on the Committee's investment in numerous public health challenges including maternal health, mental health, and health disparities research. In addition, it builds on the Reignited Cancer Moonshot^{SM}, continues efforts to develop a universal influenza vaccine, increases focus on substance use disorders, and prioritizes innovative nutrition research to reduce diet-related diseases.

Steady Progress on Pandemic Response

The COVID-19 global pandemic demonstrated how fundamental research, and early-stage discovery, design, and development of vaccines and therapeutics can yield impactful results in a short amount of time. As we continue to address the effect of the pandemic on the public's health, a sustained investment in biomedical research is necessary to ensure our momentum on current vaccine and treatment options against future emerging infectious agents.

NIH was able to respond efficiently to the COVID-19 pandemic by capitalizing on decades of basic and applied research to facilitate the rapid development of vaccines, therapeutics, and diagnostics. These continue to be important tools to reduce the threat of disease. Over the past three years, NIH established networks and initiatives that are cornerstones in the study of and response to pandemic threats. This includes the Antiviral Program for Pandemics, the Rapid Acceleration of Diagnostics (RADx®) initiative, and the Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) public-private partnership.

We are also grappling with a new public health challenge as we begin to understand the long-term effects of the COVID-19 pandemic, including Post-Acute Sequelae of SARS-CoV-2 Infection (PASC, also commonly known as "Long COVID") and the mental health effects of the pandemic. Furthermore, NIH continues to apply lessons learned during the COVID-19 pandemic to address other public health issues, including the recent mpox Public Health Emergency, and to help prepare for future pandemics.

Capitalizing on Vaccine Research for Universal Influenza

Influenza viruses are deadly and costly pathogens that place a substantial health and economic burden on the United States and across the world each year. In the United States, the CDC estimates that the disease burden of influenza has resulted in between 9.2 million and 35.6 million illnesses, between 140,000 and 710,000 hospitalizations, and between 12,000 and 56,000 deaths annually since 2010, all of which results in an estimated $27 billion in health costs. Pandemic influenza—which occurs when a new, non-human flu virus emerges from an animal source with the capacity to spread readily from person to person—can pose an even greater threat. Current influenza vaccination strategies rely on the development of an annual vaccine targeting the circulating strains that are anticipated to spread in the United States. However, this approach does not always yield high levels of protection against seasonal strains and offers little to no protection against pandemic influenza viruses.

NIH seeks to develop a universal influenza vaccine that would generate robust, long-lasting protection against multiple subtypes of influenza, eliminating the need to update the vaccine each year and protect against newly emerging strains with pandemic potential. In 2022, a Phase 1 clinical trial began enrolling healthy volunteers at the NIH Clinical Center to assess the safety and efficacy of a novel universal flu vaccine candidate.[1] Building upon the success of mRNA vaccines developed during the COVID-19 pandemic, NIH is working to apply this platform to the universal influenza vaccine development. Additionally, NIH-supported researchers are actively identifying and developing novel adjuvants for influenza vaccines to increase their immunogenicity and effectiveness. Continued investment in this research will enable the development of more broadly protective and longer-lasting influenza vaccines. The FY 2024 budget request includes $270.0 million for universal influenza vaccine research, the same as the FY 2023 Enacted level.

A Reinvigorated Cancer Moonshot

In FY 2024, the President's Reignited Cancer Moonshot Initiative[2] will support priority investments to advance the goals of the Reignited Cancer Moonshot which includes cutting America's cancer death rate by 50 percent over the next 25 years. Since its establishment in 2016, the Beau Biden Cancer Moonshot has supported over 250 research projects that pushed the boundaries of discovery and collaboration on behalf of cancer patients. The President's Budget includes an increase of $500.0 million for the Cancer Moonshot from the FY 2023 Enacted level, for a total of $716.0 million, with further increases proposed in FY 2025 and FY 2026 using mandatory funding.

Clinical trials play a prominent role in evaluating new cancer prevention, screening, and treatment approaches. NIH National Cancer Institute (NCI) funding will focus on doubling the

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[1] www.nih.gov/news-events/news-releases/trial-potential-universal-flu-vaccine-opens-nih-clinical-center
[2] www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative

number and increasing the diversity of people who enter NCI-sponsored clinical trials to develop new prevention, diagnostic, and therapeutic approaches at a more rapid pace. Funding will also support continued work towards increasing the pipeline of new cancer drugs. Additionally, the resources will fund a major trial to evaluate multi-center detection tests, the Cancer Moonshot Scholars program, and the NCI Telehealth Research Centers of Excellence, allowing the agency to sustain progress towards meeting the President's goal to end cancer as we know it. The FY 2024 proposal fully aligns with the following seven pillars of the Reignited Cancer Moonshot, which include diagnosing cancer sooner; preventing cancer; addressing inequities; targeting the right treatments to the right patients; accelerating progress against the most deadly and rare cancers, including childhood cancers; supporting patients, caregivers, and survivors; and learning from all patients.

Enhancing Nutrition Research and Food Security

The Office of Nutrition Research (ONR), within the NIH Office of the Director, focuses on advancing nutrition science to promote health, and to reduce the burden of diet-related diseases and nutrition health disparities. The budget includes an increase of $120 million to support nutrition research, including investments that will advance the goals of the White House National Strategy on Hunger, Nutrition, and Health. Resources will expand the efforts of the NIH Common Fund Community Partnerships to Advance Science for Society, and help to ensure diversity and inclusion in nutrition, health, and food security research. Funding will also allow NIH to focus on expanding and diversifying the nutrition science workforce and investing in creative new approaches to advance research regarding the prevention and treatment of diet-related diseases, including the Food is Medicine initiative and an Artificial Intelligence for Precision Nutrition program.

ONR is also collaborating with the NIH Institutes and Centers on a transformative research

program examining the role of diet, food environment and related environmental exposures on the Developmental Origins of Health and Diseases. There is increasing concern that food environment, life stress, traumas, medications, health and nutritional status, microbiome ecology, and related environmental exposures are responsible for future diet-related disease risk. This discovery science program will also include a comprehensive study of human milk composition, dietary intake, and nutritional status measures and outcomes, answer mechanistic questions about the developmental origins of disease, and ultimately, lead to an optimized diet for the health of the mother and child.

Revolutionizing Mental Health with Precision Medicine

With the FY 2024 President's Budget Request, NIH intends to direct increased attention towards mental health across all ages. 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. Exacerbated by the pandemic, suicide rates for youth have risen over the past 2 decades in the United States; in 2020, an estimated 6,643 youth ages 10 to 24 died by suicide.[3] Despite advances in the treatment of depression and other serious mental illnesses, there remain few evidence-based interventions that rapidly reduce suicide risk within health care settings. Finding the right treatment for a specific individual required a trial-and-error process that can lead to unacceptable delays in receiving effective treatment. The President's Budget includes efforts to apply the concepts of precision medicine to the field of psychiatry through the Precision Psychiatry Initiative. This initiative includes two component parts: 1) an innovation funnel to rapidly identify and assess biomarkers for the treatment for depression with the intent to lead to large-scale clinical trials; and 2) a data-driven refinement of precision diagnostics to study patterns of clinical trajectories and treatment response across large cohorts over time.

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[3] wisqars.cdc.gov/data/explore-data/explore

Serious Mental Illness (SMI) is a major, albeit less known, risk factor for COVID-19,[4] and people with SMI are more prone to SARS-CoV-2 infection and are more likely to require hospitalization and die from severe COVID-19. NIH supports research on many facets of mental health including rapid interventions to reduce severe suicide risk, funding adaptive interventions to optimize adolescent mental health treatments, and aggregating data to address mental health disparities research gaps. In response to the pandemic, NIH launched a project to support research focused on the social, behavioral, and economic impacts of COVID-19. The project supports research on the secondary effects of the pandemic, such as financial hardship, reduced access to health care, and school closures.[5] This initiative includes NIMH-supported research on: the impact of COVID-19 mitigation efforts on socioeconomic disparities in mental health and health care utilization; the effectiveness of digital health apps like Headspace as a just-in-time approach to immediate, personalized behavioral health care; the effectiveness of a digital platform on depression/anxiety symptoms of healthcare workers during the COVID-19 pandemic; and effectiveness, barriers, and facilitators to the implementation of a gold standard exposure treatment for post-traumatic stress disorder in healthcare system employee assistance programs serving frontline healthcare workers.

Making Progress on Health Disparities and Inequities in Research

Building on investments made by this committee over the past several years, NIH hopes to continue the agency-wide effort to reduce health disparities across racial and ethnic minority, rural, low-income, and other underrepresented and marginalized populations. The President's Budget requests $95 million to sustain health disparities research across the Institutes and Centers that are developing and testing interventions appropriately tailored to the breadth of clinical and community services found in diverse settings and contexts.

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[4] nimh.nih.gov/health/statistics/mental-illness
[5] covid19.nih.gov/news-and-stories/covid19-ripple-effects

UNITE, launched in February 2021, is an NIH-wide, collaborative effort comprised of five workstreams with distinct but coordinated objectives to tackle the problem of racial and ethnic equity in science while developing data-driven methods to promote diversity, equity, and inclusion across the biomedical and behavioral enterprise. To thoroughly address structural racism that may exist within the enterprise, UNITE works across three domains—Health Disparities and Minority Health Research, the internal NIH workforce, and the external biomedical and behavioral research workforce. Data gathering and analysis are central to all activities, and therefore evidence drives the work of UNITE. UNITE goals and charges are aligned with fundamental tenets of the NIH-Wide Strategic Plan for 2021–2025,[6] the NIH Minority Health and Health Disparities Strategic Plan 2021–2025,[7] and the NIH-Wide DEIA Strategic Plan for 2022–2026, released in March 2023.[8]

Combatting Overdose and Addiction

Opioid misuse, addiction, and overdose are among several widespread public health crises that were exacerbated by the pandemic. Since the pandemic, studies have found increases in the use of illicit drugs including fentanyl, cocaine, heroin, methamphetamine, cannabis[9], and most recently xylazine. Founded in 2018, the Helping to End Addiction Long-term (HEAL) initiative strives to address opioid addiction by developing new treatments and strategies to address both pain and opioid use disorder as well as advance healthy equity by acknowledging the environmental factors that contribute to drug use and chronic pain. In FY 2024, HEAL will focus on the health effects of taking multiple drugs together, find tailored treatment approaches, such as combination therapies, for different environments, and continue research on health disparities

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[6] www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2021-2025-508.pdf
[7] www.nimhd.nih.gov/docs/nimhd-strategic-plan-2021-2025.pdf
[8] diversity.nih.gov/about-us/strategic-plan
[9] https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use

in treatment for opioid use disorder, neonatal opioid exposure and maternal health, and integrated pain and mental health treatments.

Opioid use is not the only alarming trend in addiction and overdose. The misuse of stimulants, such as methamphetamine, is also increasing, as are deaths attributed to combining opioids and stimulants. Improved prevention and treatment strategies are needed for both opioid use disorder and co-occurring conditions such as mental health conditions and polysubstance use for a range of at-risk populations and in various settings. Recently launched HEAL programs aim to develop safe and effective treatments, as well as define approaches to improve treatment access and retention in various settings.

Preventing Maternal Morbidity and Mortality

Even during a global pandemic, NIH continued to focus on other long-standing yet urgent public health needs. The CDC estimates 1,200 women die each year in the United States of maternal causes, 80 percent of which are preventable, and thousands more experience severe pregnancy-related morbidity.[10,11]

To address this alarming trend, NIH established an agency-wide collaboration called the Implementing a Maternal health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative[12] which is an evidence-based approach to reduce preventable maternal and pregnancy-related deaths and associated health disparities for women at all stages of pregnancy. To build on the momentum made by the committee's previous investments, the FY 2024 President's Budget requests $30 million to continue the IMPROVE Initiative. In addition, the request also includes $3 million for the *Eunice Kennedy Shriver* National Institute of Child Health and Human

[10] www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm
[11] www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html
[12] www.nih.gov/research-training/medical-research-initiatives/improve-initiative

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.

In summer 2023, IMPROVE will implement a national network of Maternal Health Research Centers of Excellence to support research projects that build on previous research and take innovative, community tailored approaches to address health disparities and risk factors for maternal morbidity and mortality. This research supports the development of earlier interventions to decrease or prevent negative maternal outcomes and promote maternal health equity.

NIH Buildings and Facilities

Facilities must co-evolve with science for NIH to achieve its full potential. A major component of the NIH Building and Facilities (B&F) program is the Repair & Improvement (R&I) program, which enables NIH to maintain and improve the performance of existing facilities throughout their life cycle. A key aspect of NIH's strategy is to sustain the condition of existing facilities to prevent premature deterioration and the curtailment of research. These investments help reduce the likelihood and consequences of building emergencies associated with NIH's Backlog of Maintenance and Repairs (BMAR) of nearly $3.8 billion across all campuses as of the end of FY 2022. NIH requests a funding level for B&F of $350.0 million, maintaining the FY 2023 Enacted level. This level is designed to address the pressing campus-wide infrastructure needs identified in the independent review of the facility needs of NIH's main campus in 2019 by the National Academies of Sciences, Engineering, and Medicine (NASEM). In addition to the B&F appropriation, NIH has received support for critical infrastructure projects in recent years from targeted allocations from the Nonrecurring Expenses Fund (NEF). In FY 2024, NIH is requesting a total of $120.1 million in NEF funding for five critical infrastructure projects on the Bethesda campus.

NIH plans to execute various modernization and repair projects to NIH's research hospital, replace research animal facilities with a centralized and more efficient facility, improve facilities that advance computational and data science, replace temporary and obsolete administrative support facilities with permanent buildings, improve the energy and water efficiency of buildings, and support the co-evolution of science and buildings.

Conclusion

Turning discovery into health remains the central goal and mission of NIH. Improving health across the lifespan is essential to maintaining our country's greatest asset: its people. The NIH research community is fervently working on all fronts – from individualized medicine to societal level pandemic response – to foster new discoveries and catalyze breakthroughs in research. With the support of this Committee, NIH looks forward to tackling timely public health challenges through rigorous and innovative science in FY 2024. I look forward to answering your questions.

Mr. ADERHOLT. Thank you, Dr. Tabak.

And what I will do is I will just open it up, my questions, and we will go by the 5-minute rule. And we each will be given 5 minutes. So we will try to keep your answers as succinct as possible so that we can try to get around to everyone at least on the first round.

CDC COVID MISSTEPS

So I will begin. And I would like to just pose a question for each of you to answer, and I just—as I mentioned, looking back, we learned things that we—mistakes we have made that maybe even obviously there was some accomplishments that were made as well. But what do you see or you think was the greatest misstep from your agencies that was made during the COVID pandemic?

And second of all, could you mention any changes that you are looking at or you have implemented so these mistakes would not happen again?

So I will just open it up to whoever would like to go first.

Dr. WALENSKY. I am happy to take that on. Thank you very much for that question.

As you know, there were many challenges associated with this pandemic. We started with a frail public health infrastructure, an underinvested public health infrastructure that presented challenges, and we had many tragedies, 1.1 million deaths.

As part of the CDC Moving Forward initiative, we looked at the capabilities of what CDC has done over the last 3 years and have done the work to prepare CDC to be the agency, the public health agency of the future.

Two key initiatives there have been related to moving our science faster so that people can see our science in real time. We saw that as we put out technical reports on our mpox. We were the first in the world to report on how the vaccine was doing. We have decreased our scientific clearance time by 50 percent, and we have more work to do in that area.

Another area is in communication. It is the case that in 2018, many Americans didn't know what CDC was and didn't know what CDC stood for. And all of a sudden, during the pandemic, we had people coming to our website to try and understand what the latest guidelines were.

We are now needing to communicate to the American people, not just to our public health partners, not just to our academic partners. As part of that, we are doing an overhaul now of our CDC website, which has 200,000 scientific Web pages, making sure that those Web pages are accessible to the communities that need them.

And we have increased our communications towards more accessible communications for all Americans. There is much more work to be done, but I want to yield to my partner.

Thank you.

Mr. ADERHOLT. So communication would be one of them. What was the first one?

Dr. WALENSKY. Moving our science out faster.

Mr. ADERHOLT. Thank you.

Ms. O'CONNELL. Thank you, Chairman. I am happy to go next.

ASPR LESSONS LEARNED

So I think one of the things that the ASPR organization learned early on is that we need a fully stocked, fully purposed for the moment Strategic National Stockpile. Early in the pandemic in March 2020, everyone was looking for the same medical supplies at the exact same time, and they weren't in the stockpile in the ways that people expected. That was one of the things that we have been growing from and learning from in our experience.

We continue to invest heavily in the supplemental funding that you guys have given us to be able to restock and make sure that the SNS is ready with the PPE it needs for whatever comes next.

One of the critical pieces of that work that we are doing is that we are doing it with domestically manufactured PPE wherever possible. We think it is critically important that we begin to manufacture these critical medical supplies here in the United States, and we have invested over $16,000,000,000 in our domestic manufacturing, expansion of the industrial base.

And so those are things that we are continuing to apply as we evaluate, but I can assure you we are doing the lessons learned constantly, looking at mistakes that have been made, and trying to improve as we go.

RESILIENT SUPPLY CHAIN

Mr. ADERHOLT. Let me just follow up on that. You mentioned about the lack of preparedness. Of course, that was really leading up to March 2020, as you mentioned. But during the time of the COVID itself, after COVID starts, what if any missteps do you see?

Ms. O'CONNELL. Well, we continue to need to make sure that we have a resilient supply chain, and so one of the big focuses that we have and one of the reasons why we have made this request in our fiscal year 2024 budget is to be able to institutionalize this work in ASPR. It is critical in disasters that we have what we need when we need it.

I have made a reorganization that we did. A few months ago, I made the Industrial Base Expansion Management and Supply Chain Office a permanent office within ASPR, with the Director reporting to me. So we are going to keep our eye on these issues moving forward.

Mr. ADERHOLT. Dr. Tabak.

NIH LESSONS LEARNED

Dr. TABAK. From our perspective, early on, a number of investigators, either with direct or indirect NIH support and very well-intended, launched rapid trials that unfortunately were underpowered. And with the benefit of hindsight, I think we could have done a better job engaging with the extramural research community to try and do a better job of coordinating to ensure that these types of trials were properly powered from the get-go.

Going forward, we have been engaged in a clinical trials reform, if you will, within the agency to see how we can do these things better. And this was one of the elements that informs that discussion.

Mr. ADERHOLT. Great. And so are you all implementing those changes now?

Dr. TABAK. We are. We are beginning to do so. It requires quite a bit of discussion across the agency and with members of the extramural community.

Mr. ADERHOLT. Thank you. All right. I will turn now to my ranking member, Ms. DeLauro.

2024 FUNDING CUTS

Ms. DELAURO. Thank you very much, Mr. Chairman.

And thank you to the three of you for letting out where you want to try to move forward and what we try to need to do to move forward in an effort to not find ourselves in similar circumstances that we did 3 years ago.

Which is why I am very much concerned, as I said, that we have some members of our House majority demanding massive funding cuts in the 2024 appropriations bills. And if you apply the 2022 numbers, that we could look at cutting domestic funding by at least 22 percent below current levels.

So as leaders of the agencies that are focused on protecting and improving our health, I would like to have each of you give us an idea about the real impacts, consequences of the cuts being proposed with regard to use of that 2022 number for 2024.

And I would like to have you describe this in human consequences. What are the consequences to children, to families, to seniors, to the millions of people across the country?

Dr. Tabak, how would you—how would these proposed cuts impact the millions of patients who depend on NIH's research?

Dr. Walensky, with approximately 70 percent of CDC's funding going out to public health partners, how would these cuts be felt in our communities?

Assistant Secretary O'Connell, how would the cuts make us less prepared for a public health crisis or a new outbreak of avian influenza?

Dr. TABAK. Cuts of that magnitude would, of course, require that we dramatically reduce the number of new grants that we would be able to fund. We would estimate roughly a diminution of 5,000 grants. In part, that is because we would want to preserve the ongoing investments so as not to lose them, although they would be subject to some cut as well.

The net result, of course, is delay of potential interventions that could help people. The net result is a chilling effect on the biomedical community. Will a young person want to go into science if they watch their mentors struggle with support? And unfortunately, in situations that dramatic, younger investigators would likely be selectively disadvantaged.

Ms. DELAURO. Dr. Walensky.

Dr. WALENSKY. Thank you. As you know, Ranking Member DeLauro, most of the resources that CDC receives goes directly out into the States and local jurisdictions. I think we can all agree that we were not in a state of pandemic preparedness from a public health standpoint at the beginning of this pandemic.

Ms. DELAURO. When you say jurisdictions, you are talking about States and cities?

Dr. WALENSKY. And counties.

Ms. DELAURO. And counties.

Dr. WALENSKY. And counties, local jurisdictions. Yes, exactly. Sometimes they go through the States to the counties. Sometimes they go directly to counties and local jurisdictions to your people.

So we have made huge investments over the supplemental funding during COVID to bolster that public health infrastructure in workforce, in personnel, in data systems, to build the public health system that we need for the future to address our being prepared for the next pandemic.

To cut those back would be to regress, to backslide to an area of not being prepared again for a pandemic. Specifically, we have resources in this budget that will—last year, we screened a million women—uninsured women for breast cancer. Those things would not happen.

Last year, we were able to send disease detectives into your jurisdictions to help with outbreak investigation. We will have fewer of those to go. We will have less resources to do interventions to prevent opioid use, to prevent—to allow people who are using opioids to link to care.

And finally, one of the biggest equity challenges that we had during this pandemic in vaccine distribution was in the rural-urban divide. We will not have those resources in rural health if we cut those resources in this budget.

Thank you.

Ms. O'CONNELL. Thank you, Chair DeLauro—Ranking Member DeLauro, for the opportunity to respond.

A real concrete example, as Dr. Walensky mentioned, the Marburg outbreak that is currently happening in Tanzania and in Equatorial Guinea. Over the last 6 months, we have had a second viral hemorrhagic fever, an Ebola Sudan outbreak in Uganda. Both Ebola Sudan and Marburg lack licensed vaccines and therapeutics.

BARDA has made a request for $162,000,000 in this year's budget to advance two promising candidates from Phase I into Phase II to protect Americans. Everyone is aware that all of these outbreaks are just one airplane ride away. So if we lose funding and move back to fiscal year 2022, we lose the advantage of having the potential protection that these investigative therapies and vaccines could bring.

Ms. DELAURO. Thank you. My time is up.

Thank you, Mr. Chairman. I yield back.

Mr. ADERHOLT. Okay. Mr. Fleischmann.

NIH TRIALS

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

And Dr. Tabak and Dr. Walensky and Secretary O'Connell, thank you so much for appearing before us today.

Dr. Walensky, I want to thank you for the phone call that we had about a month or so ago, and we addressed the portfolio and a lot of our mutual concerns. And I so appreciate that, appreciate the call.

As most of you know, I represent east Tennessee, Chattanooga and Oak Ridge not too far away from Atlanta. And I have enjoyed my time, now about a decade, on this distinguished subcommittee.

My first volley will deal with the NIH. The NIH plays a key role in bolstering the Nation's clinical trial capabilities to ensure that we have the ability to rapidly translate new medical discoveries into drugs, vaccines, devices, and diagnostics for patients at the bedside. The Clinical and Translational Science Award Program at NCATS is focused on that mission.

The CTSA program consists approximately of 60 hubs at medical research institutions across the country. We are fortunate in Tennessee that Vanderbilt University Medical Center in Tennessee is one of these hubs. Vanderbilt is also helping to lead the NIH Trials Innovation Network.

Dr. Tabak, can you speak about how NIH uses the Clinical and Translational Science Award Program to advance clinical trial capabilities, sir?

Dr. TABAK. Well, the CTSA program, as you note, is a nationwide consortium. And for example, the efforts collectively of the CTSAs during the response to the pandemic were very important. They provided, for example, electronic health record data to the N3C platform, which allowed us to rapidly assess the status of the disease.

We also have used the CTSA program as, if you will, the laboratory to learn better ways of performing clinical trials, and then these best practices are disseminated throughout the network and beyond. And then, in addition, the CTSAs are a site for training the next generation of clinical investigators, and people beyond just the institution that holds the CTSA program benefit because of relationships that each of these centers makes with surrounding institutions.

Mr. FLEISCHMANN. Thank you, sir.

A follow-up. How can we do a better job of expanding clinical trials to improve rural communities, which generally do not have access to care, sir?

Dr. TABAK. So, in this instance, of course, the key is to engage people at the local level. Traditionally, research of this type has been done at tertiary and quaternary care centers around the country. What we are learning increasingly that it is important to reach out to the community hospitals and either provide them with the necessary training so that they can participate in this type of research in partnership or, indeed, alone as their own individual network.

And we have some experience with that, for example, in the response to the opioid crisis where the clinical research has been done in rural communities looking at how best to treat babies with so-called NOWS syndrome.

Mr. FLEISCHMANN. Thank you.

CANCER RESEARCH

Doctor, now I would like to talk briefly about something that is near and dear to my heart, cancer research. I speak with Dr. Jordan Berlin at Vanderbilt on a regular basis, and we talk about different forms of cancer and where are progress and sometimes the lack thereof. Which areas of cancer research, Doctor, have seen the greatest progress in the last 5 years? Where is the greatest poten-

tial in cancer research in the next 5 years? And what will it take to get us to maximize that potential, sir?

Dr. TABAK. Well, of course, there is tremendous hope and promise in various forms of human immunotherapy, where we teach your own body's immune defense system to seek out and destroy cancer cells. As part of the so-called Cancer Moonshot, the need to diagnose cancers earlier is very much at the forefront, and it is very likely that platforms where one can do a simple blood test to potentially detect multiple types of cancer, which need, of course, additional testing, that will probably pave the way to the future where we can find cancer sooner to ensure treatment quicker.

Mr. FLEISCHMANN. Thank you. And by the way, I wish you every success in those endeavors.

I yield back.

Mr. ADERHOLT. Mr. Hoyer.

Mr. HOYER. Mr. Chairman, thank you. Thank you very much.

CORRECTING PAST MISTAKES

Mr. Chairman, I am constrained to respond to your statement at the beginning. I think much of it is accurate and that we need to make sure that whatever mistakes were made are corrected and that we address those mistakes. But I am constrained to say that, unfortunately and sadly, the chief executive of our country responded in an irresponsible, reckless, and dismissive fashion in February and in March, telling the American people that this was going to be resolved in just days, and it would go away.

That obviously was not the truth. We lost more people as a result of this pandemic than we lost in World War II. So, yes, we need to learn from our mistakes, but we also need to learn that we cannot be dismissive of the challenge that confronts us in the future, and we must respond to it effectively.

I also believe that the Obama administration had an outline on how to respond and what steps to take that was dismissed and eliminated. Nobody needs to comment on that. It is not question. It is an observation.

I have a—have had since 2010 an agenda that the Democrats have pursued. It is called Make It in America. The pandemic showed us that we were relying on the unreliable. Not only the unreliable allies as manufacturers, but also unreliable supply lines.

Secretary O'Connell, I want to congratulate you on pursuing vigorously manufacturing here in the United States of America so that we do not confront that situation again. Can you briefly expand upon that? Because I chair an organization that was formed by Leader Jeffries, which is about implementation to that evident need of Making It in America.

Ms. O'CONNELL. Thank you, Congressman.

Yes, absolutely, this is one of the critical learnings coming out of the early days of the pandemic is that we absolutely need to have these critical supplies manufactured here in the United States. We have been able to—and thanks to the support of Congress—invest supplemental dollars, $16,000,000,000 supplemental in domestic manufacturing, over 87 different projects from PPE to advanced pharmaceutical ingredients, critical components that we need to be

able to have the resources available in the United States when we need them.

And we have—so one of the worries I have, as I put this budget forward, is how do I maintain that capability? I have got these 87 projects. So when we reorganized ASPR as a result of becoming an agency, I made sure that we had the standalone office within ASPR that does industrial base management and supply chain work. So we continue to be able to provide the technical assistance needed to keep those 87 projects moving.

Part of the $400,000,000 that we have requested will go to supporting that technical assistance. It would be wonderful if in the future annual budgets would include additional funding to be able to invest in future projects because we are just at the beginning of this, of needing to reestablish this industrial base here in the United States.

Mr. HOYER. Madam Secretary, thank you for that.

We are also going to have a stockpile that evolves so that new stuff doesn't become so old that it is no longer necessary. You need to get that back on the market. So I will follow up with you on that.

Dr. Walensky, thank you for your service. Thank you for bringing your extraordinary talent to public service.

I am going to ask quick questions, and you give quick answers because we don't have any time.

MENTAL HEALTH

What is the CDC doing to address the effects of COVID–19 beyond the immediate health effects in terms of mental health, in terms of other health, longer-term health aspects?

Dr. WALENSKY. Many of our programs in the community—mental health, substance use, youth violence—many of these things, prevention of adverse childhood events, those are some of the things that we are doing looking at data and how we can prevent those adverse childhood events and prevent the downstream impact of those childhood events.

Linking people within the community, making sure people have community within their schools, working in what works in schools, projects within the schools, how it links with youth within the schools, their community, ensuring economic stability, family unity within the community. There is a lot of work that is happening.

Maternal mortality again another issue. The Hear Her campaign. There is a lot of work happening in maternal health in mental health, in opioids, as well as the prevention of chronic diseases that lead to severe outcomes of COVID–19.

Thank you.

Mr. HOYER. Thank you.

NIH EXTRAMURAL GRANT CUTS

Again, because my time is short, it is almost out. NIH, I am very concerned about the cuts to the extramural grants that will adversely affect the inclination of people to go into basic biomedical research. I think it is a crisis, and we will see other countries going past us very quickly in terms of the capability they have in terms of personnel.

Dr. Tabak.

Dr. TABAK. It is a real issue. We already have challenges in attracting young people to biomedical research. In fact, my National Advisory Committee has a special working group to look at how we can best shore up the career path for people entering postdoctoral training and beyond.

Mr. HOYER. Just briefly, in closing, Mr. Chairman, I have a chart that shows how drastically, since my last service on the committee many years ago, the payline for extramural has declined precipitously where it used to be. And experts say a third would be where we ought to be. We are in the teens in most institutes.

Thank you.

Mr. ADERHOLT. Dr. Harris.

Mr. HARRIS. Thank you very much.

BALANCING BUDGETS

And thank you all for being here with us.

Look, I wish I lived in the fairy land of President Biden's budget. I wish I did. I wish I could pretend we don't have a $31,000,000,000,000 deficit, that our cost on managing that interest is going to top $1,000,000,000,000 within the CBO window. I wish I lived in that fairy land.

We don't live in the fairy land. In fact, when the Washington Post, the day after the President's budget—which, by the way, was a month late, which is why we are meeting late here—the Washington Post said the United States—this is their editorial. Now I rarely agree with the Washington Post editorial board. But, boy, a stopped clock is right twice a day, and they are right on this one.

"The United States has a debt problem. Biden's budget won't solve it."

I am going to ask you all a simple question. You all handle budgets. Dr. Tabak, do you balance your budget every year at the NIH?

Dr. TABAK. We are obligated to.

Mr. HARRIS. Thank you. Dr. Walensky, do you balance your budget?

Dr. WALENSKY. We are obligated to.

Mr. HARRIS. And Ms. O'Connell, do you balance your budget?

Ms. O'CONNELL [nodding yes].

Mr. HARRIS. So you all realize you have to balance the budget because you can't print money, but somehow the President believes we don't have to balance the Federal budget. In fact, all of you—Ms. O'Connell, I don't know if you did a lot of math, but you two did a lot of math in your training, right? You realize the President's budget that he submitted never, ever balances—ever, ever, ever?

It is one of the first presidential budgets to never balance in the future. You all did enough math to know that is not sustainable. So our goal is to say, look, we have to reprioritize spending. And I wish we could spend every dollar of that President's budget—well, most of every dollar—on everything, but we don't have the money.

ROUTINE VACCINATIONS FOR CHILDREN

So I am going to just start with the scientific questions. Dr. Walensky, we have talked about this before. Since we met in our

office, the World Health Organization has recommended against routine vaccinations for children. Is the CDC going to change its recommendation to comply with that?

Dr. WALENSKY. I think the World Health Organization comment was to be country specific. Certainly, countries that can't vaccinate or haven't vaccinated for polio have zero-dose children to not prioritize COVID. We are in a——

Mr. HARRIS. So you are not going to change your recommendations based on the World Health Organization?

Dr. WALENSKY. No, our recommendations—given the resources we have in this country, our recommendations for pediatric vaccinations will stand. Because we have clean water and——

Mr. HARRIS. Sure. Okay, I am talking about COVID in particular. I am not talking about other vaccines. I am talking about COVID in particular because my concern is that, as we discussed, about those COVID studies that recommended vaccination were based on immunobridging. The World Health Organization said quite specifically that almost all infants and children now have COVID antibodies, and that is why—that was the basis of their recommendation.

So I am going to disagree with you. I think that is a move that has more politics than it has science.

INDIRECT COSTS

Dr. Tabak, we want to maintain the grants, but we have to somehow constrain the budget. So I am going to ask you, when Stanford University has a $37,800,000,000 endowment, why are we paying a higher indirect cost to them than they—for your NIH grant than they would if they did an agriculture grant, which is capped at 30 percent? Many private foundations cap it at 10. Some don't allow any indirect costs.

So why shouldn't this committee, in an effort to maintain the number of grants while cutting back, ask these universities—Stanford University, $38,000,000,000 endowment; University of Michigan, $17,000,000,000; Washington University, $12,000,000,000; Duke University, $12,000,000,000—why shouldn't they pay their fair share? Why shouldn't they have some skin in the game of research, especially since in other areas, one that I oversee in agriculture, we cap it at 30 percent?

Why shouldn't we do that in order to constrain our budget to, again, move out of the fairy land that President Biden lives in and move into the real world.

Dr. TABAK. As you know, Dr. Harris, NIH does not set indirect cost rates.

Mr. HARRIS. I understand that, but why—but we could, in fact, cap it. Congress could cap the—just like they do in the agriculture. When Stanford University has $37,800,000,000—that was fiscal year 2022. I don't know how they did in the market last year. That is a pretty significant chunk of money. One would ask why are we—why do we have to pay such high indirect costs? And I don't know what Stanford is because, quite honestly, NIH is a little not forthcoming with information on indirect costs.

Don't appreciate that because taxpayer dollars pay those indirect costs. Why should we do it? Why shouldn't Stanford—why should we pay any more than 30 percent indirect cost?

Dr. TABAK. Indirect cost recovery is based on a formula, and we don't control it.

Mr. HARRIS. All right. But we could.

I yield back, Mr. Chairman.

Mr. ADERHOLT. Okay. Mr. Pocan.

Mr. POCAN. Thank you very much, Mr. Chair, and thank you to the panel.

IMPACT OF CUTS ON OPIOID PROGRAMS

I guess I might say it this way. I wished I lived in a world where you could cut expenses 25 percent and not actually hurt real people. The problem is I think a lot of the cuts that are going to be proposed are going to hurt real people.

One in particular, Dr. Walensky, is around trying to deal with opioid abuse. Forty-five million Americans have a substance abuse problem. Over 100,000 people die from overdose every year, including recently an old friend of mine I found out over—during COVID, her daughter died of an overdose.

CDC awards grants. You track overdose data. We raise public awareness. We do lots to help in this, especially as much as people love to talk, rightfully so, about fentanyl in the communities.

Can you talk a little bit about the programs at CDC that would be reduced or eliminated if Republicans were successful in slashing funding for affecting opioid use?

Dr. WALENSKY. Thank you, Congressman.

So 107,000 deaths last year. This was just reported, as you note. This is exacerbated a problem that was rising during the pandemic and—rising before the pandemic, was exacerbated by the pandemic.

We do a lot of work on the prevention. On the up scale, this is an all-USG response in terms of our opioid work. But a lot of work in the prevention in the community, in understanding where the challenges are and in linking people to care, in training and Narcan use, and in treating and creating communities so that people have places to go.

One important thing we also do is Overdose Data to Action. I just mentioned 107,000 opioid deaths. What we see in our emergency departments is 10 times that number for nonfatal overdoses. And so if we don't know where those are coming into the emergency departments, we can't target our interventions. Our Overdose Data to Action is an intention to find those emergency departments, have them report to us so that we can target those interventions to where they are needed most.

Thank you.

Mr. POCAN. The effect is in our local communities most directly?

Dr. WALENSKY. In your emergency departments everywhere, yes.

Mr. POCAN. Thank you.

PUBLIC HEALTH WORKFORCE

Second, a Harvard study found that nearly half of public health agency employees left their jobs over the last few years. Can you

talk a little bit about, again, what CDC does—just briefly because I want to get to one other question—to attract, retain, and support public health professionals that we have a workforce?

Dr. WALENSKY. We have resources from the 2023 budget where we have worked to promote our workforce. That is—promoting a workforce as diverse as the community that we serve. That workforce really needs to be trained in many different things.

In your local area, the Upper Peninsula of Michigan, we are doing work right now on a blastomycosis outbreak that people might not have seen coming, right? But we have a workforce that is there. So we have training that is happening at CDC and local training. We have training in partnerships to promote loan repayment programs so we can retain people, and then we do training in the local health departments and work with the local health departments to allow them to expand as well.

Mr. POCAN. If you received a 25 percent cut in this area?

Dr. WALENSKY. You would have less people doing it. As you noted, we were 60,000 public health work jobs in deficit when the pandemic started. Half the people who were there have left. We have 15 percent of our CDC workforce ready to retire.

Mr. POCAN. Thank you.

BAYH-DOLE

A question for Dr. Tabak. Thank you for being here. Really, I think, what is great is there is a lot of bipartisan support for NIH. There always has been since I have been here in Congress, and we see the work in our communities. And thank you for that.

However, I do have to say I have some concern around the fact that NIH has never in the last four decades used their authority under Bayh-Dole to break monopolies on taxpayer-funded treatments. I was disappointed to recently see us pass up on the opportunity yet again by denying a petition to lower the price of Xtandi, a cancer drug that costs Americans four times more than in other countries.

Can you just talk—I know the President is putting a working group together, interagency working group on this. But can you talk about what your role will be within that group, and when you will expect results? But also how can you move the needle on lowering drug prices now without waiting for the interagency?

Just so you know, I ask every year this question of whoever is in the NIH if we are going to use this and just want to raise that as you are new here.

Dr. TABAK. Well, and Bayh-Dole is not the instrument, in our view, to regulate drug pricing. It would be a very blunt instrument, one which we think would in the long run inhibit relations with industry. And so this is why the Xtandi petition was denied.

But as you point out, we do need a whole of government approach to figure this out, to see what instances where Bayh-Dole might make sense. And so the Department, together with colleagues at the Department of Commerce and NIST, will be working together to look at this. There is actually an interagency working group on Bayh-Dole, and hopefully, this is where we will be able to come up with a logic tree that would enable a way forward for future effort.

Mr. POCAN. Timeline on that?
Dr. TABAK. Pardon?
Mr. POCAN. Timeline?
Dr. TABAK. So that effort is beginning now.
Mr. POCAN. Thank you. I yield back.
Mr. ADERHOLT. Mr. Clyde.

COVID ORIGINS

Mr. CLYDE. Thank you, Chairman Aderholt, for holding this hearing and to the witnesses today.

Mr. Tabak, did American taxpayer dollars go toward funding the Chinese Wuhan Institute of Virology?

Dr. TABAK. Yes.

Mr. CLYDE. All right. More specifically, was there gain-of-function research done at the Wuhan Institute of Virology, which received American taxpayer dollars?

Dr. TABAK. No.

Mr. CLYDE. No. All right. Did the COVID–19 virus originate from the Chinese Wuhan Institute of Virology?

Dr. TABAK. I have no idea.

Mr. CLYDE. All right. What do you know about the origin? I mean, you are the NIH.

Dr. TABAK. Well, again, the origins, there are two prevalent theories. A lab accident or, as you say, a lab leak versus a zoonotic transfer from animals to humans. In my mind, the available evidence favors the latter, but of course, our minds are open to the former possibility.

Mr. CLYDE. It favors the latter as in that it came from——

Dr. TABAK. A zoonotic transfer.

Mr. CLYDE. So that is what you favor, just a natural transfer from—from, what, bats to the human beings?

Dr. TABAK. Through things like accipiters and such animals like that, yes.

Mr. CLYDE. Okay. All right.

VIRUS TRANSMISSION

Director Walensky, in March 2021 on MSNBC, you stated that "Vaccinated people do not carry the virus. They don't get sick." Do you remember making that statement?

Dr. WALENSKY. Yes, under the—I do—well, I remember such a statement, but I don't know if I remember that one.

Mr. CLYDE. Okay. Was that statement correct?

Dr. WALENSKY. At the time, it was. It was a wild-type virus that we had. It was even before the Alpha variant, it was the initial wild-type virus, and all the data at the time suggested that people who were vaccinated, even if they got sick, couldn't transmit the virus to someone else.

Mr. CLYDE. All right. Is that statement still correct?

Dr. WALENSKY. Well, so we have had an evolution of science and an evolution of the virus. We have since that wild-type virus had the Alpha variant, the Delta variant, now the Omicron variant, and numerous subvariants. That statement is no longer correct with the Omicron subvariants we have right now.

Mr. CLYDE. Okay, all right. A recent review of face mask studies by the Cochrane Collaboration suggested that common face masks worn by the public probably make little or no difference. Do you believe Americans should still be wearing face masks? A yes——

Dr. WALENSKY. Can I just comment for a minute on that Cochrane Review?

Mr. CLYDE. Sure.

Dr. WALENSKY. Cochrane is known as the gold standard, and I think it is notable that the editor-in-chief of the Cochrane actually said that the summary of that review was—she retracted the summary of that review and said that it was an inaccurate summary.

[The information follows:]

Clerk's Note: The Subcommittee subsequently received the following communication from the authors of this Cochrane review, who have asked that it be incorporated into the hearing record at this point.

Dear Chair (Congresswoman Kay Granger), (Subcommittee Chair: Robert Aderholt) and Congressman Clyde, House Committee on Appropriations

We are writing to you as the lead and corresponding authors of the recent Cochrane Review entitled "Physical interventions to interrupt or reduce the spread of respiratory viruses" which was published Jan 30 2023.

On April 19th 2023, the Committee held a hearing (Budget & Oversight Hearing – Fiscal Year 24 Request for the CDC, ASPR, & NIH) to discuss the appropriations for the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). During questioning, Congressman Clyde asked CDC Director, Dr Rochelle Walensky about the Cochrane review that looked at masks and asked her if Americans should continue to wear facemasks.

Dr Walensky answered: "I think it's notable that the Editor-in-Chief of the Cochrane actually said that the summary of that…of that review was…(pause) she retracted the summary of that review and said that it was an inaccurate summary….."

That exchange between Congressman Clyde and Dr. Walensky can be found from 1.23.04 https://youtu.be/LKPpxEiZe6k

Dr Walensky's response was factually incorrect. The Editor-in-Chief has neither retracted the study summary nor has any part of the study been corrected in any way. The article remains completely intact from its original publication on Jan 30 2023. You can view the study and see this at the following link. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub6/full?utm_source=substack&utm_medium=email

A Communiqué statement was released by the Cochrane's Editor-in-Chief (EIC) which stated in its final paragraph as follows:

"The original Plain Language Summary for this review stated that 'We are uncertain whether wearing masks or N95/P2 respirators helps to slow the spread of respiratory viruses based on the studies we assessed. This wording was open to misinterpretation, for which we apologize. While scientific evidence is never immune to misinterpretation, we take responsibility for not making the wording clearer from the outset. We are engaging with the review authors with the aim of updating the Plain Language Summary and abstract to make clear that the review looked at whether interventions to promote mask wearing help to slow the spread of respiratory viruses."

This Communiqué statement does not constitute any form of retraction and it remains to be determined by the authors if any changes to the Plain Language Summary and abstract will ever occur.

The remarks of the CDC Director were not factually correct as stated, and we kindly ask that the record be corrected.

Yours sincerely

Tom Jefferson MD MSc MRCGP FFPHM DRCOG DTM&H

John Conly CM MD CCFP FRCPC FCAHS FAMMI FACP FIDSA FSHEA

The review of the Cochrane, which looked at randomized trials of face mask use versus not use, only had a couple of studies in it that actually were for SARS–CoV–2. Many of them were for influenza. But importantly, many of those studies people were actually not wearing the face masks when they were in the intervention. So, as I like to say, a parachute only works if it is used.

Mr. CLYDE. Okay. So can you answer the question?

Dr. WALENSKY. Right now, we have recommendations for face mask use based on hospital burden. We have, fortunately, 99 percent of places around the country, populations around the country that are not in high hospital burden, and we would not recommend face masks at a population level in those situations.

ECOHEALTH ALLIANCE

Mr. CLYDE. All right. Mr. Tabak, earlier this year, the Inspector General's report found that between 2014 and 2021, the NIH did not adequately follow its policies with respect to three grants totaling about $8,000,000 to EcoHealth Alliance. EcoHealth Alliance had a relationship with the Wuhan Institute of Virology in which it sub-awarded $600,000 to research coronaviruses in the years leading up to the COVID–19 pandemic.

NIH terminated the EcoHealth grant in April 2020, then later reinstated it, only to suspend it again after setting conditions for resumption that EcoHealth claimed it could not meet. NIH permanently terminated the award as of August 2022 for compliance issues, including the Wuhan Institute of Virology's failure to provide NIH with laboratory notebooks related to funded experiments.

On September 21, 2022, NIH issued a new grant to EcoHealth Alliance for a project entitled, "Analyzing the Potential for Future Bat Coronavirus Emergence in Myanmar, Laos, and Vietnam." The grant provides EcoHealth Alliance $653,000 covering a period through August 31, 2027.

And I ask unanimous consent to submit for the record the following project details from the NIH website, entitled "Analyzing the Potential for Future Bat Coronavirus Emergence in Myanmar, Laos, and Vietnam."

Mr. ADERHOLT. Without objection.

Mr. CLYDE. Thank you.

After NIH previously failed to ensure its policies and procedures were properly followed with respect to EcoHealth Alliance and given the recent Inspector General's report highlighting that EcoHealth Alliance failed to ensure its subawards were compliant with Federal regulations, I must ask why are we awarding this agency an additional $653,000 of taxpayer money?

Dr. TABAK. We accepted all of the GAO audit findings. We have made changes to our administrative approach to ensure that these things don't repeat. We typically, once an organization has met the issues that were found deficient, we continue our relationship with them.

We are not—we can't disbar an organization. Again, disbarment is done by another office within the Department of HHS.

Mr. CLYDE. All right. And I yield back.

Mr. ADERHOLT. Ms. Frankel.

Ms. FRANKEL. Thank you, and thank you to our guests today for all your good work.

CAP ON FEDERAL SPENDING

Now—especially in these challenging times. So our Speaker McCarthy has recently declared that the Republicans in the House would cap Federal spending at fiscal year 2022 levels and limit spending growth over the next decade to 1 percent annually. I suggest that is going to bring—that would bring misery and hardship to millions of Americans. Today, we are talking about the cuts to your agencies, cuts that are going to cause the most vulnerable in our community—women, children, and seniors—to suffer the most.

Less spending on healthcare will mean more breast cancer, more cervical cancer, more maternity deaths, more suicides, more drug overdoses, more pandemics, more violence against women, and less hope for Alzheimer's patients. Sorry to be a downer.

Okay. These proposed budget cuts have real consequences, human misery and hurt, especially for folks who are under resourced.

YOUTH MENTAL HEALTH

All right. I am going to go on with my questions, and this is to our CDC Director. In February, CDC published a report that is sad and alarming. It found that in 2021, nearly 60 percent of adolescent girls felt persistently sad or hopeless, double that of boys and a 60 percent increase since 2011. Nearly 1 in 3 girls seriously considered suicide, also up nearly 60 percent from a decade ago.

One in 5 girls experiencing sexual violence, also an increase. Girls feeling increased pressure to use alcohol and drugs. Over half of the LGBTQ students have experienced poor mental health, and 1 in 5 have attempted suicide in the past year.

And I would respectfully suggest that the recently enacted abortion bans in dozens of States will exacerbate these mental health issues now that girls are going to have to worry about and be forced to have to raise a family or bring a baby into life before they are ready.

So, question. What recommendations are CDC working on to address these mental health issues, and how would these suggested budget cuts make it harder?

Dr. WALENSKY. Thank you, Congresswoman.

As I have noted, these mental health challenges, especially that we have been able to see and publish through our Youth Risk Behavior Survey, have been alarming, and we are working in the communities in areas with mental health with youth, but also with adults, to work towards economic stability, towards keeping kids in school, education, early childhood education, family resiliency, as well as prevention of adverse childhood events within the family.

Mental and physical health, as you note, in the communities, and then really measuring these things so that we know where those resources are targeted and needed the most. Community engagement, understanding what is happening around the communities.

We are not already reaching all the communities that need support. When we can't reach the communities that we are already reaching, we will have more and more of these outcomes.

Ms. FRANKEL. And let me suggest that the great State of Florida is already pushing school districts to abandon the CDC's Youth Risk Behavior Survey, but what is new in Florida? How would a budget cut hurt these efforts?

Dr. WALENSKY. With the abandonment of the Youth Risk Behavior Survey, we don't get a sense—we are flying blind. We don't see where our—we wouldn't see data on these youth mental health challenges. We wouldn't know where we needed to target the resources.

So, unfortunately, it would be not seeing a window as to where places need help and not allowing us to then target the resources to give those communities the help that they need.

CANCER SCREENING AND PREVENTION

Ms. FRANKEL. Next question also to you has to do with the increase in cervical cancer in women, and what is CDC doing to support patient navigator programs, including the National Breast and Cervical Cancer Early Detection Program? How would the budget cuts affect that?

Dr. WALENSKY. So, last year, we were able to screen about a million uninsured women for breast and cervical cancer. A lot of the work we do is also in vaccination to prevent cervical cancer to begin with. That intersects with Cancer Moonshot, intersects with youth remaining healthy for HPV cervical cancer prevention programs.

Ms. FRANKEL. And what will the budget cuts do to that program?

Dr. WALENSKY. With the investment, we anticipate that we might be able to serve an additional 140,000 women and prevent 2,500 invasive breast cancer events. Without it, those will occur.

Ms. FRANKEL. Thank you. I yield back.

Mr. ADERHOLT. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Mr. Chairman.

And thank you all for being here today. I appreciate it very much.

First, Dr. Walensky, thank you for the work that you are doing in Michigan right now with the outbreak. And as we have discussed, I think the work of the disease detectives and the assistance for communities is very important, and I certainly support those efforts.

UNSPENT COVID BALANCES

To me, that is very high on the core mission of the CDC, as we have discussed. I have some concerns about mission creep in other areas, and that is something that I am sure we can talk more about that down the road.

But I want to begin with last week, President Biden signed a resolution, strongly bipartisan support, ending the COVID national emergency. According to a GAO report published in February 2023, Congress has appropriated nearly $350,000,000,000 to the Public Health and Social Services Emergency Fund intended to develop vaccines, drugs, devices, tests, PPE.

As of January 31st, there remains nearly $20,000,000,000 in unexpired, unobligated funds within the Public Health and Social Services Emergency Fund. Assistant Secretary O'Connell, can you

provide the committee with a detailed accounting and summary of the unspent COVID–19 emergency supplemental balances that remain available to ASPR?

Ms. O'CONNELL. Thank you so much, Congressman, for that question.

I can assure you that, first of all, we are grateful for the support that we have received in the supplemental funding, and we have allocated the dollars that have come to ASPR against the current needs. Money has either gone out or is on its way out, except in two critical places. So I want to be clear about this.

There are two places where we have taken the supplemental funds and used them against multiyear needs. One is in the industrial base expansion work I talked about. The investments that we have made in these construction projects are multiyear investments. It doesn't make sense to spend all of the money all at once until the factory lines are stood up, until the supply lines are running, until we know that the manufacturing is a success. So we have reserved some funds for that.

The second place where we have reserved funds is in our Strategic National Stockpile. So I think folks are aware that the stockpile is a series of warehouses located across the country, in your districts, in your areas, so we can move product as quickly as possible in times of emergency.

In order to take on the PPE that we did, in order to restock the stockpile so it would have what we needed, we have taken on more warehouses. Each warehouse has an additional lease, and with inflation, the lease prices have gone up.

It is important that we reserve some of the funds to be able to maintain these warehouses so we don't have to destroy this PPE in fiscal year 2024 and 2025. So those were two places where ASPR has held on to funds.

Mr. MOOLENAAR. Okay, thank you.

PROJECT NEXT GEN

And then also, last week, the White House announced $5,000,000,000 for a program for next-generation COVID–19 vaccines and therapeutics, Project Next Gen. Are you familiar with that?

Ms. O'CONNELL. I am.

Mr. MOOLENAAR. Okay. Can you describe what your role was in that process? Because Congress, most in Congress read about it in the paper, weren't really briefed about it. But were you involved with the creation of that?

Ms. O'CONNELL. So one of the things that we have been signaling, and we have continued to signal when we have requested additional funds, is the importance of doing this research in the next generation of therapeutics and vaccines. We have been grateful for the current tools that we have, but this virus has been unpredictable and continues to mutate, as Dr. Walensky went through the various variants and subvariants that we are experiencing. We are afraid that we are one mutation, two mutations away from our vaccines and therapeutics no longer being as effective as we need them to be.

So what this work would do would be invest in broader protection in vaccines and therapeutics in order to protect the American people moving forward.

Mr. MOOLENAAR. And where—where will it be housed? Where will this be housed?

Ms. O'CONNELL. It is an effort that will be led within the Department. And Dr. Tabak and I will share some responsibility. NIH has a role. ASPR will have a role. FDA would have a role. CDC would have a role. So it is something that will be done across the Department.

Mr. MOOLENAAR. And was this statutorily set up, or is this something that interagency developed, and where did—what was the source of the $5,000,000,000 funds?

Ms. O'CONNELL. So the $5,000,000,000, I think we have been very clear that we are running out of COVID dollars. We have indicated that over and over again. But we didn't have the winter surge we expected, and we had additional funds.

Now that we are winding down the public health emergency, now that we are moving these products to the commercial market, we looked across the remaining balances and are working to make sure that we are spending them as effectively as possible. And we think creating the next generation of tools to protect Americans from COVID is a reasonable use of these next dollars.

Mr. MOOLENAAR. Thank you.

Mr. Chairman, I will yield back.

Mr. ADERHOLT. Mrs. Watson Coleman.

ENDING THE HIV EPIDEMIC

Mrs. WATSON COLEMAN. Carrying the infrastructure up here. Thank you very much. I want to thank each of you for your very interesting and very important work that you do.

Dr. Walensky, I want to talk to you a little bit about HIV because we have made such tremendous strides. We are almost there, right? We are almost there.

So what, in your budget, are you proposing to do to get us there now? And what would be the impact of reducing your funding for that effort back to the 2020 funding levels that are proposed by some of our colleagues on the other side?

Dr. WALENSKY. Thank you so much. This is something near and dear to my heart, as you know.

As part of the End the HIV Epidemic, CDC works with 57 of the highest—of the jurisdictions with the highest amount of new HIV diagnoses. This is both State and counties that have the highest HIV diagnoses in the country. Our work is to prevent, detect, respond to, and treat these people who have new diagnoses with the HIV and people who are at high risk for HIV.

Unfortunately, we see a discrepancy in how communities are able to tackle the HIV challenges, and those who have the highest risk of HIV are often those that don't have access to the prevention interventions that are needed. I am talking PrEP and, actually, the new injectable PrEP.

Through the pandemic, we have been able to be creative and do things like self-testing. We had over 137,000 self HIV tests that

were done during the pandemic so people could make new HIV diagnoses by themselves.

We also used tele-PrEP. We were able to use the resources towards prevention activities where people didn't have to come in for a prescription every week. Injectable PrEP again, something like long-acting PrEP so people can get the prevention for longer periods of time. So all of these resources are baked into the 2024 budget, as well as all of the ancillary services that are needed for PrEP use, including laboratory monitoring as well as STI interventions as well.

Mrs. WATSON COLEMAN. Can you quantify the reduction in service, should you being forced to deal with the 2022 funding level?

Dr. WALENSKY. We would have to get back to you on those—on those numbers, but I anticipate that that would mean thousands of new HIV infections that would otherwise be averted.

CANCER RESEARCH

Mrs. WATSON COLEMAN. Thank you. Thank you.

Dr. Tabak, I wanted to talk to you about endometrial cancer research because we are making such tremendous strides in the whole cancer field, which we find new and different cancers each and every day. But it is my understanding that the endometrial cancer, there have not been these same declines, and in fact, the American Cancer Society's statistics show that over the last 10 years there has been more than 140 percent increase in endometrial cancer incidence and mortality.

And there is also significant disparities in endometrial cancer, finding that black women have the highest rate among those who experience that particular type of cancer. And previous studies have shown that we are also much less likely to receive evidence-based care and two times more likely to die.

We talked to the NIH on a number of occasions about clinicals, about research, and about those who get to choose who gets to research and whose research gets chosen, particularly as it related to what we consider to be an under-included population of African Americans. I would very much like to know what your plans are for your research, how you are planning to tackle what represents a disparity, how your funding now proposes to deal with it, and how a diminution to 2022 funding could possibly impact the work that you could do?

Dr. TABAK. Well, we certainly are aware of the disparities that you point out and are, of course, concerned about it. Advances for addressing endometrial cancer include three immunotherapy treatments for advanced endometrial cancer, which the FDA has approved within the last couple of years.

We have several relevant networks and trials. For example, the Epidemiology of Endometrial Cancer Consortium. We also have a Specialized Program of Research Excellence in endometrial cancer. And then, finally, there is the Discovery and Evaluation of Testing for Endometrial Cancer in Tampons, the so-called DETECT study. And so all of these are moving us in what I think is the correct direction.

And then, as you may know, a recent study from NIEHS found that women who use chemical hair straightening products had a

higher incidence of endometrial uterine cancer compared to those who don't report using these products. Now, of course, we need to do further research to see if it is merely an association, or if there is some causality involved.

Mrs. WATSON COLEMAN. I think that that is my question. What are you planning? Quantitatively, what would that mean differently than what you have been doing, and how would that be impacted if you were not given what you are asking for in resources?

Dr. TABAK. Right. So, again——

Mrs. WATSON COLEMAN. And with that, I would yield back after you answer that question.

Dr. TABAK. So, again, our unit of currency, of course, are grants awarded. And as I have indicated, if cuts of that severity occurred, we would lose about 5,000 new grants, no doubt among them some related to this topic.

Mrs. WATSON COLEMAN. Thank you, Doctor.

I yield back, Mr. Chairman.

Mr. ADERHOLT. Ms. Letlow.

Ms. LETLOW. Thank you, Mr. Chairman.

Thank you so much for our panel for being here with us today.

COVID ORIGINS

Coming out of the pandemic, there have been valuable lessons learned on how to attack and stop the spread of future pandemics. I have a personal story related to the pandemic, as do millions of others across this country who have a vested interest in finding out COVID–19's origin so we can hopefully prevent another pandemic like this from happening again.

Just this past February, the Department of Energy released a report detailing how COVID–19 was likely the result of a lab leak in China. The GAO also issued a report in January of this year detailing how there had been other lab leaks resulting in infections and death.

According to a New York Times report, it was known early on in 2020 that the CCP refused an American response team to assist in a response to the initial outbreak, where we could have had a better understanding of the infection and how to combat the spread. It seems to me that the CCP quickly realized there was an infection spreading, did not alert the U.S. Government until weeks into the spread, and then proceeded to not be compliant with our requests for information, data, and assistance.

Over the past few years, Congress has been raising the alarms about lab leaks, especially when it was discovered that EcoHealth Alliance was sub-awarding our Federal funding to the Wuhan Institute of Virology. The American people, especially those of us who lost loved ones, deserve answers and want answers to know that the U.S. Government is prepared for future threats.

Dr. Tabak, what is the status of the NIH's progress and plans going forward in finding the origins of the initial COVID–19 outbreak, and what is the NIH doing to redouble our efforts to ensure Americans are protected against these threats in the future?

Dr. TABAK. We continue to support research that may provide insight as to what the origins were. We don't know what the origin

was. And it is possible that it occurred from a so-called lab leak or, as I prefer, a lab accident. But it could also have, as I mentioned, resulted from zoonotic infection.

And unfortunately, we don't know the difference as yet, in part because of, frankly, the government of China not cooperating with us. They hold a key to unraveling this mystery.

Ms. LETLOW. How much of your funding is going towards those studies?

Dr. TABAK. We have—we do not have any specific study looking at origins, per se. We do support evolutionary biologists who study viral evolution, and these are the individuals who are typically called upon to comment on this type of issue.

Ms. LETLOW. I understand that the NIH provides grant opportunities worldwide for research. However, I do have grave concerns about providing those opportunities to adversarial nations with a vested interest in seeing harm to the United States. What is the NIH doing to ensure our Federal funding does not go to research-based countries that are adversaries, such as the CCP?

Dr. TABAK. So we, of course, are very sensitive to this. We have very minimal funding in China right now, and as was indicated earlier, the funding to the Wuhan Institute of Virology has been terminated for cause. And we are redoubling our efforts, as part of the GAO audit of our EcoHealth Alliance award, to ensure that our prime awardees do greater oversight of their subawardees, the sub-recipients.

The way the system works now is that NIH doesn't necessarily reach in to the subawardees. It is the primary awardee that is obligated to do that. We don't have the authority, frankly. Although, again, in instances where we see missteps, we can then write special terms so that we can sort of interpolate ourselves into more of that type of oversight.

Ms. LETLOW. But we do have minimal funding, you said, in China?

Dr. TABAK. Yes. The current funding, I will get to you for the record. I have it. I am just not finding it.

Ms. LETLOW. For the record——

Dr. TABAK. I will get it to you. It is a very modest amount.

Ms. LETLOW [continuing]. I have grave concerns with that. I feel like the American people definitely want to know the origins of the virus, and I would hope that there would be studies done on that.

Dr. TABAK. As do we at NIH. We are intensely interested in that question.

Ms. LETLOW. But you said there weren't any studies going towards the origin.

Dr. TABAK. There are no specific studies. But again, the community of evolutionary virologists that we fund, those are the people who would be doing these types of analyses.

Ms. LETLOW. Okay. I yield back.

Mr. ADERHOLT. Mr. Harder.

SCIENTIFIC BREAKTHROUGHS

Mr. HARDER. Fantastic. Thank you so much, Mr. Chair.

And thank you to all our witnesses for being here.

Dr. Tabak, I am a big fan of the NIH, and I think I speak for everybody on this panel when we wish you the greatest of success in your goals. But I will say I am concerned by the pace of scientific research that we are seeing.

One recent study that I read in Nature suggested that there has been up to a 90 percent slowdown in the pace of research breakthroughs funded by the NIH in major fields in recent decades. There has been tremendous innovation in how science is funded differently in the private sector and philanthropy. Just in recent years, we have seen Fast Grants, the Arc Institute between Berkeley, Stanford, and UCSF.

One idea, among many, that has been proven successful is setting prizes or bounties for specific breakthroughs. I know the NIH has done a little bit of this in the past, sort of basically saying you get $1,000,000 if you achieve particular milestones and a specific disease breakthrough, but only awarded if that is actually achieved.

Dr. Tabak, what have you learned from some of the innovative scientific funding models that we have seen outside in the private sector and in philanthropy, and do you see a greater role in the NIH for innovation prizes or other changes in the funding mechanisms?

Dr. TABAK. Well, we have created some of those innovative funding mechanisms that others have adopted, which is great. But we also watch experiments of this type and then bring them into the agency. So we have, in fact, done more prizes in recent years. There are certain types of science that lend themselves to prizes.

We have also made use of the so-called "shark tank" approach, if you will, an innovative funnel which drove the development of billions of over-the-counter tests for COVID. And now that technology can be employed for other reasons going forward.

And of course, there is this grand new experiment of ARPA-H, which will be using a completely different funding model from what the NIH does, where program managers are empowered to seek out bold, new ideas and monitor that directly, presumably speeding things in a serious way.

So we do make use of these other approaches, and we will continue to adopt things as they emerge.

Mr. HARDER. That is terrific to hear. I think my concern is that that is such a small percentage of the NIH's budget, right? We are talking about $50,000,000,000. My count—and correct me if I am wrong—less than 1 percent goes to these types of prizes or awards. The vast majority go to late career investigators.

And over time, that process seems to have gotten to be a lot more lower risk and not as focused on some of the high-risk, high-reward models. Is that fair, and what can be done, what opportunities do you see for the NIH to experiment a little bit more with how to change up the funding mechanism and try to reward more early career investigators and other types of funding?

REWARDING EARLY CAREER INVESTIGATORS

Dr. TABAK. We have made the support of early career investigators a major focus of the agency. Each year, we set a goal of funding at least 1,100 new early stage investigators. Last year, we

funded 1,600. And so we will continue to do this. This is a sort of preferential payline, if you will, to ensure that we are constantly getting new ideas into the system.

Mr. HARDER. What percentage of the NIH budget would you say goes to those 1,600 awards?

Dr. TABAK. Oh, it is a small percentage. I would have—I certainly understand that. But additionally, so just to give you another example of something that we have done innovatively, is we have created an award which requires no preliminary data, which basically frees a new investigator from having to work on the problem that they did for their postdoctoral and/or graduate experience.

This no preliminary data effort really frees people to be as creative as possible, and we are beginning to see some very interesting findings there. And so what happens is you pilot things. If it makes sense, you continue to expand it.

Mr. HARDER. I totally hear you. Let us expand a lot more. I think when I looked at the opportunities I think so much of the NIH budget is going to paying for work, as opposed to paying for success, is going through folks that are far late in their stage as opposed to these early career investigators. And if this is 99 percent of the NIH budget is going towards the same funding mechanisms that have existed for the last couple decades, there is an opportunity not for 100 percent, but for 10, 20 percent of the NIH budget. And I would love to work with you to identify some of those success stories that we might be able to scale up and pilot.

Dr. TABAK. We would be pleased to do so. Thank you.

Mr. HARDER. Thank you. Thank you for your work.

I yield back.

Mr. ADERHOLT. Thank you. We are going to need to conclude by noon. So what I am going to do on the second round, I want to let us go to the 3-minute round so we can try to get as many questions as possible before we do have to adjourn.

So I will begin. Dr. Walensky, let me pose this one to you.

MATERNAL MORTALITY DETERMINATIONS

I understand the maternal mortality is documented by CDC's National Center for Health Statistics and National Center for Chronic Disease Prevention and Health Promotion Pregnancy Mortality Surveillance System. That is a mouthful, but that is my understanding.

The accuracy of this data depends on the reliability of data provided on death certificates, which can be prone to error or can be incomplete. Are there limitations on the CDC's determination of maternal mortality in the United States?

Dr. WALENSKY. So we work—our National Center for Health Statistics works with our National Vital Statistics program to try and get accurate vital statistics on everyone. And through our data modernization efforts, actually we have been able to increase the vital statistics that we are getting to 70 percent within 10 days. That is up from 10 percent just 10 years ago. So we are actually now working closely with those data systems, and that is an impact of our data modernization.

Of course, there are challenges in how those deaths are categorized. But what we have seen, given those challenges, remains

static in terms of how people may or may not categorize them. And there are international vital statistics criteria for how these things get categorized for maternal mortality. So those are standardized.

We certainly do rely on our local jurisdictions, on local providers, on clinicians to make a determination based on the Vital Statistics recommendations on how they should be categorized, but they could be prone to error. But any vital statistic could be prone to error. And what we have seen is that error wouldn't be systematically different now than it has been over time, and so when we see differences in trends, that is when we get worried. We have seen increases in maternal mortality.

Mr. ADERHOLT. Yes. But you would say there would be limitations?

Dr. WALENSKY. There are limitations for any reporting of any death for any cause.

Mr. ADERHOLT. So would that also agree that there are limitations on the CDC's ability to identify abortion-related deaths?

Dr. WALENSKY. I would have to get back to you on the details of that because I would want to make sure that I would know exactly how those are characterized.

Mr. ADERHOLT. Yes, I would be interested in knowing that.

Dr. WALENSKY. Happy to.

Mr. ADERHOLT. So, all right. I am going to go ahead and yield to Ms. DeLauro.

Mr. HOYER. Mr. Chairman.

Mr. ADERHOLT. Yes.

Mr. HOYER. I will yield 3 minutes to the chair—to the ranking member, if that is possible?

Mr. ADERHOLT. Oh, yes, sure.

Ms. DELAURO. Thank you to Mr. Hoyer.

AVIAN FLU

Let me make just a comment. I wanted to ask about avian flu and universal flu vaccine and antimicrobial resistance, if I can. And Dr. Walensky, Assistant Secretary O'Connell, status of avian flu? What do we know? What do we need to do to be better prepared?

Dr. Tabak, strong supporter this committee has been to develop universal flu vaccine. Where are we in developing that flu vaccine? And I will ask you to just be brief in your answer.

Dr. WALENSKY. So we are tracking the avian flu challenge. This is the largest avian flu outbreak that we have seen historically. We have now about 12 cases across the world. The most recent one is a gentleman in Chile, and we are working closely with our collaborators in Chile.

We do a lot of work on both preparation as well as surveillance, where with influenza detection, scale-up of laboratory testing, so that we are prepared. Most recently, we posted a technical brief on the status of the avian flu not just in birds, but in other zoonotic spillovers like sea lions, as well as minx. And that technical report was just recently updated on Monday. Happy to provide the link for you.

Thank you.

Ms. O'CONNELL. And thank you, Ranking Member.

In close collaboration with our CDC colleagues, we are watching this very carefully and doing a couple of different things. We are in a position now where we have egg-based, cell-based recombinant vaccine candidates. So we are better positioned now than we have been before in our vaccine space.

But we want to push that one step further, and as part of our fiscal year 2024 request, we are asking for funding that will allow us to continue to invest in mRNA technology, which I think everybody is aware will allow us to flip between strains very quickly. We think that is going to be a critical piece of our defense in any avian flu spillover that we have.

We also continue to invest in antivirals to make sure that we have what we need on hand should we need to treat anybody with avian flu.

Ms. DELAURO. Dr. Tabak.

UNIVERSAL FLU VACCINE

Dr. TABAK. Among the many things that we are doing toward universal flu vaccine is a trial that began, a Phase I trial that began almost a year ago, using a chemically inactivated, multivalent whole influenza antigen. And it is going to read out in June. So it will be very interesting to see what those results are.

We have, of course, been exploring mRNA platforms, again because of the capacity to take multiple strains and put them together to present as an immunogen.

Ms. DELAURO. Based on what you have said about moving forward in all of these efforts, I think it is important that we reflect on really what the scale of the cuts that we are—that are really being talked about. It is not just in terms of this reinforcement by the Speaker of the House, I just want you to know.

And we had the Heritage Foundation as a witness here just not too long ago at the behest of the majority. This is about NIH funding. Funding should be reduced by at least $20,300,000,000, including the elimination of the Center for Minority Health and Center for Complementary and Integrative Health, and defunding of alternative medicine throughout the CDC.

For CDC, $3,000,000,000, reduce funding for diseases receiving disproportionate shares, HIV, TB; reduce or eliminate funding for social diseases; and reduce or eliminate global health funding.

There is a reality, my friends, out there that you have to come to grips with. We certainly do. And the Center for Renewing America, former head of OMB, Mr. Vought, would—CDC, $4,400,000,000. It would be a decrease of $2,600,000,000 for CDC. Repurpose chronic disease mission. Eliminate Global Health Center. NIH, reprioritize NIAID's mission. Eliminate foreign influence in public health.

Long and the short of it, these are realities that it is not just speculation, that these cuts are intentional. And so it is going to be imperative that the consequences are very relevant because this is not—the pattern is there. It is not true that every member, both sides of the aisle, concurs with that. But those who don't need to be made aware of what this is, what this is all about.

ANTIMICROBIAL RESISTANCE

I have got let me ask you about antimicrobial resistance and where that is with your agencies here.

Dr. WALENSKY. We had made great strides in our combating antimicrobial resistance prior to the pandemic. Methicillin-resistant staph, vancomycin-resistant enterococcus, C. difficile, as well as Candida auris. That was one of the largest threats that we were all worried about before the pandemic.

There was just a recent pre-print that demonstrated that we have 27 new antibiotics in the pipeline in clinical trials—that is compared to 1,300 new cancer drugs—and only 6 of them combat antimicrobial resistance.

During the pandemic we lost those great strides. We slipped back, and we have a lot of work to do to catch up.

Ms. DELAURO. Anyone else? Go ahead.

Ms. O'CONNELL. I would be happy to. So BARDA has invested over $1,800,000,000 across 150 different products to try to bring them forward. And they do this in three different ways.

They funded an accelerator, which brings these early stage products forward that they can then look at for their advanced research and development efforts to see if they are products that are worthy of pulling forward and through the pipeline. And then the Project BioShield allows them to procure the actual finished product.

So they are doing a lot in this space, and it is critical for our disaster preparedness that we have and continue to have this way to fight the bacterial infections.

Ms. DELAURO. Again, thank you for what you are doing to move the needle forward to try to play catch-up. We need to here.

Let us be mindful of where it goes because, as I said, we are not talking about roads, bridges, helicopters, dairy price supports, or anything else. We are talking about people's lives. And that is what we do on this committee, and this committee's efforts is to make sure that you have the resources that you need in order to be able to save lives in this country.

Thank you.

Mr. ADERHOLT. Mr. Ciscomani.

Mr. CISCOMANI. Thank you, Mr. Chair.

And thank you to all of you for being here with us today.

Ms. O'Connell, welcome, and Dr. Tabak, thank you for being here.

FENTANYL EPIDEMIC

Dr. Walensky, nice to see you again. Thank you for—enjoyed the meeting yesterday. I appreciate your reaching out and talking about some of the important issues here.

We were discussing towards the end of our meeting yesterday about fentanyl. So if I can just touch on that for a little bit here? We discussed the fentanyl epidemic here—we touched on it—that the U.S. is facing right now. Of course, the U.S. has had roughly 107,000 drug overdose deaths in 2021, and many of those deaths were attributed to fentanyl.

My county of Pima County—that is my home county—fentanyl overdose deaths is the number-one cause of death among young

people. So it is a tragedy. I have met with parents of young people that have—they have lost their family members to this terrific, terrific situation.

So since coming to Congress, I have had meetings with also treatment centers in my district, and my constituents have indicated that the opioid-related deaths have only increased last year. I don't believe my district is alone in this finding. While official numbers have not yet been released by the CDC for last year's mortality data, I know my colleagues and I are here today waiting for that data. I brought this question up to Secretary Becerra as well.

So I want to ask you a two-part question. What is the CDC doing to address the ongoing fentanyl crisis, and do you have any details on when we can expect that data?

Dr. WALENSKY. Thank you, Congressman.

I will tell you that as part of our data modernization efforts, we have been able to speed up the pace at which we are able to get those overdose data out from months down to weeks. So you should be seeing those soon.

Just in terms of the work that we are doing, a lot of the work is at the community level. Resources from CDC to States and local jurisdictions to navigate people into prevention services, into linkage to care services, syringe exchange services should they need them. And that is a lot of the work.

And then some of the work is to actually see where those things are happening. So we have work in our Overdose Data to Action, which we are looking to expand some resources with the fiscal year 2024 budget to say where are people actually coming into the emergency department. Because while you just capitalized on the—or spoke about the 107,000 deaths, we see about 10 times that coming into emergency departments that are not overdose deaths, but are, in fact, overdose-related events.

And we want to go to the communities where those are happening so that we can do a lot of the prevention work, intervention work to prevent those turning into deaths.

Mr. CISCOMANI. So I thank you for that, and I believe that this needs to be a full prone approach on tackling this issue. It starts with something that another hearing going on on this same topic of border security and what is happening in our ports of entry and our border, and I think that is mainly also where it begins for sure in terms of touching our country. But then, when it reaches our communities, it is concerning on the effects of this.

I think that there is a lot more that can be done. Now, in your opinion, would you be open to recommending to the President and Secretary Becerra to declare a health emergency based on the epidemic that we are seeing in fentanyl overdose deaths all across the country?

Dr. WALENSKY. My understanding is we already have a public health emergency for opioid—for opioid disorder, and so I think that is already ongoing.

Mr. CISCOMANI. So, for fentanyl, is that included in that?

Dr. WALENSKY. I think it would—I don't know the exact language. I would have to get back to you on that.

NARCAN TRAINING

Mr. CISCOMANI. Yes, I would like to see that because that would add additional resources in ways that we can combat this. We briefly touched on the small businesses in my community now are also being trained to carry Narcan and be able to distribute it if something happens on their property.

Law enforcement is obviously in that as well. But if law enforcement, that is not part of their usual training and now it is, imagine the small business owners who now say this has to be at your location as well to help someone in an overdose. If that wasn't bad enough, now we know that with the lacing of fentanyl with other drugs, especially xylazine, it is just—Narcan becomes not effective.

So this is—I feel like in some ways the bad actors out there are a step ahead of us on this, and we need to not only catch up but to get ahead of the game and play offense.

So in the last few seconds that I have on my time, I would like to touch on what else we can do besides the health emergency. There is more that I think needs to be done and that I am looking at you for answers on that.

Dr. WALENSKY. Great. So the overdose—the opioid challenge is a part of a whole USG approach. As you may know, ONDCP just last week at the Rx Summit pronounced xylazine as an emerging public health crisis. So more work is ongoing on that.

We, at CDC, work on the prevention side. And among the things we do, as you just noted, is Narcan training so that people can work on the prevention side, as well as the linkage into care. And then we work across USG through SAMHSA and other resources for an all of USG approach on that. We would be happy to work with you.

Thank you.

Mr. CISCOMANI. Thank you. Chairman, I yield back.

Mr. ADERHOLT. Mr. LaTurner.

Mr. LATURNER. Thank you, Mr. Chairman. I appreciate it.

ANTIMICROBIAL RESISTANCE

Assistant Secretary O'Connell, I want to also ask, as the Honorable Ranking Member of the whole committee did in her last question, about antimicrobial resistance. It is an important issue.

Antimicrobial resistance, or AMR, is contributing to 5 million deaths per year globally and significantly increasing our healthcare costs. Novel antibiotics will allow us to cure patients and discharge them from the hospital, improving their lives and reducing costs more rapidly. This is why last Congress, I supported the bipartisan PASTEUR Act. The PASTEUR proposal would be transformative to the fragile and failing antimicrobial ecosystem, revitalizing antimicrobial R&D and helping ensure American people have the products we need to treat resistant infections.

How would you describe the threat of AMR, and how will ASPR help strengthen the antimicrobial pipeline?

Ms. O'CONNELL. Congressman, thank you so much for that question.

I think AMR is one of the big public health threats that we are currently facing. So much of what we rely on in modern medicine

would be at risk if we lost access to antibiotics. Complex surgeries, organ transplants, chemotherapy, all of that would be on the table if we didn't have antibiotics available to stave off potential infection. So it is a critical component for us.

And from the ASPR perspective, it is either a primary or secondary effect of many of the threats that we currently face. So it has been a critical thing for BARDA to be able to invest in, both in this acceleration of the CARB-X accelerator to bring those early products forward, in the advanced research and development to make sure we have these novel candidates available, and then in the Project BioShield to make sure that we have them on hand in the Strategic National Stockpile moving forward for any of these threats that we face.

The fiscal year 2024 budget asks for a combined $305,000,000 for BARDA to be able to continue to invest in this work. I think that is critical. Their work so far, as I mentioned, is $1,800,000,000 across 150 different products that have led to the licensure of 3 products and 3 510(k) FDA clearances for devices.

So there has been some success. There is more that we should do, and I just want you to know that ASPR is committed to continuing this work.

Mr. LATURNER. Thank you.

I will stick with you. Earlier, Mr. Hoyer—I find myself in an unlikely position. I had been following up on lines of questioning—but they were important—from both of you. [Laughter.]

SUPPLY CHAIN

Mr. LATURNER. He talked about our reliance on foreign nations for stocking key active pharmaceutical ingredients and chemical compounds that are vital to medical supply chains. For example, heparin is an essential medicine used for treating blood clots, administered 300,000 times a day in the U.S. and used by 25 percent of all pregnant women. Yet we are completely dependent on China for the entirety of our supply, as heparin is sourced from pigs, and 50 percent of the global pig population is in that country.

I understand that ASPR's Office of Industrial Base Management and Supply Chain is working to coordinate efforts to ensure domestic supply and promote manufacturing of vital pharmaceuticals like heparin to reduce our reliance on adversarial foreign nations. What specifically is this office doing today to work with private industry to support domestic supply chains?

Mr. HOYER. Great question. [Laughter.]

Mr. LATURNER. Thank you. Thank you. Appreciate you approve.

Ms. O'CONNELL. And thank you for the question. So among the 87 projects that I mentioned of this industrial base expansion bringing domestic manufacturing here to our shores, we have invested $500,000,000 in API contracts. So making sure that we are able to bring, as you said, these critical raw materials and components into the U.S. and be able to manufacture them here. So that continues to be a place where we are focused and we are invested.

Again, we have made a request for the $400,000,000 in the fiscal year 2024 budget. A portion of that would go to maintaining the office that you mentioned, our Industrial Base Expansion and Supply Chain Office, so it can continue to provide technical assistance

to see these construction projects that we have started and invested in to make sure that they can continue to be on a path to success so we can free ourselves from some of this dependence on these other countries.

Mr. LATURNER. I appreciate that.

RESEARCH DOLLARS TO CHINA

Dr. Tabak, you earlier—I want to drill down on something that you said. It sounded as though you said that you have no issue with research dollars going to China. Can you expand on what you meant?

Dr. TABAK. I don't know if that is specifically what I said, but as part of our competitive grants process, if there is a unique opportunity, a question that can be solved only in the particular foreign country, we do support science in foreign countries. And as I did mention to Congresswoman Letlow, our investment in China right now is very modest.

And I apologize for not giving you the number. I have now found it. If I may? One-point-two million, 3 awards, and an additional $4,100,000 based on 22 subawards, and that is fiscal year 2022.

Mr. LATURNER. I am out of time. I yield back, Mr. Chairman.

Mr. ADERHOLT. Thank you. As I mentioned, because of time restraints we are going to allow everybody that has already asked one question 3 minutes on the next round, and I will go to Mrs. Watson Coleman next.

MATERNAL AND PERINATAL HEALTH

Mrs. WATSON COLEMAN. Thank you, Mr. Chairman.

Dr. Walensky, this is for you. CDC recently released its report that in 2021 the U.S. had one of the worst rates of maternal mortality in the country's history. And the report found that 1,205 people died of maternal causes in the U.S. in 2021. That represents a 40 percent increase from the previous year.

The maternal death rate, however, for black Americans is much higher than other racial groups. In 2021, it was 69.9 per 100,000, which is 2.6 times higher than the rate for white women. And medical experts contribute these trends in racial disparities to social factors and to failures within the healthcare system.

Funding supports the capabilities of the Perinatal Quality Collaboratives to improve the quality of perinatal care for mothers and babies in their States, and currently, New Jersey is one of our leaders. And it is one of the State-based PQCs working with the CDC to improve processes in the healthcare system to prevent maternal death and reduce racial disparity.

Dr. Walensky, what would cuts mean for such an important program? Would cuts impede the CDC's ability to expand State-based PQCs in other States?

Dr. WALENSKY. Thank you, Congresswoman.

First, let me just say before the pandemic, we were seeing the race and maternal mortality increase. We saw that through the pandemic as well. And the work that you are describing—and grateful to New Jersey for being a champion in that work—in the Perinatal Quality Collaboratives, looking at increased rates of hemorrhage, increased rates of infection, increased rates of prenatal de-

livery, all of which lead to poorer outcomes in both mom and in baby.

A lot of the work that we also do are in Hear Her campaigns, where the fiscal year 2024 budget looks to expand the campaigns that we have because many of those campaigns relate to how we address women who are in distress at the time—they know when they are in distress at the time of their—during their pregnancy. They are asking for help, and without these campaigns, we can't address the help that they need.

And then, finally, our Maternal Mortality Review Committee. We actually don't even access all of those data that we need. Those review committees that we are looking to expand through the fiscal year 2024 budget actually can shine a light and see where those women are. So cuts to the fiscal year 2024 budget would reduce Hear Her campaigns. They would reduce Perinatal Quality Collaboratives. They would reduce our ability to actually be able to see where those poor maternal outcomes are happening.

Thank you.

Mrs. WATSON COLEMAN. Thank you. Thank you, Mr. Chairman.

Mr. ADERHOLT. Dr. Harris.

Mr. HARRIS. Thank you very much.

STATUTORY AUTHORIZATION

Dr. Walensky, is the CDC authorized by Congress? Do you have statutory authorization?

Dr. WALENSKY. Um, we——

Mr. HARRIS. Because I am told you don't.

Dr. WALENSKY. We receive our authorities through the Public Health Service Act.

Mr. HARRIS. I am going to have to research that because I have been told CDC is not specifically authorized, and that is why it kind of wanders all over in terms of what it can do. But one of the things you do is you have a nutrition area, which I appreciate.

But what—and I just want to ask your opinion. It makes—the nutrition area makes a big deal about eating healthy, watching sugary substances, things like that. So do you find it a little strange that the Supplemental Nutrition Assistance Program, $100,000,000,000 of American taxpayer dollars, doesn't really require healthy eating in the foods that are purchased?

I mean, about 10 percent—it is estimated up to 10 percent is actually soda, $10,000,000,000 a year, Federal taxpayer dollars. Do you think that is a wise investment we are making in that program?

Dr. WALENSKY. So I would have to look at the details of that program specifically and the investments that it makes. What I would say is that a lot of the work of the CDC is to prevent chronic conditions, and so good nutrition is among those. We need to prevent chronic conditions because chronic conditions lead to poor outcomes, and poor outcomes in infectious and noninfectious threats.

Mr. HARRIS. Sure. I agree. I fully agree. I just don't think we should be spending taxpayer dollars in contradistinction to what the CDC thinks is a good diet, basically. And you know we have the WIC program, which obviously has nutritious food. And so it

is not like the Government hadn't decided nutritious foods are good for some populations.

GENDER

Dr. Tabak, I am going to ask you the same question I asked Dr. Collins last year. It is important that when we do clinical studies we investigate both men and women. I understand the difference between men and women based on reproductive biology. You know, Y chromosome, 6,500 different genes. Obviously, because you have an unopposed X chromosome, there is a difference in the X chromosome genes between men and women.

Should we be enrolling biological—men and women in these studies based on their reproductive biology or their sex assigned at birth in order not to muddy the scientific waters of outcomes?

Dr. TABAK. Differences in gender have existed for all time. We have only just begun to realize the nuances.

Mr. HARRIS. I am not talking about gender. I am talking about sex. I am talking about sex that is described as reproductive biology.

For scientific purposes—and I am sure you understand because you are a scientist—if you have 6,500 genes on that Y chromosome, and we don't know what they all do, we don't know how they all interact, if you don't properly assign that person to the sex categorization in looking at a study, wouldn't that muddy the waters in the outcome as to whether there is a difference between sex as based on reproductive biology in the outcome of the study?

Dr. TABAK. Depending on the nature of the study, you would want to know that information.

Mr. HARRIS. Thank you very much.

I yield back.

Mr. ADERHOLT. Mr. Clyde.

Mr. CLYDE. Thank you.

VIRUS ORGINS

Dr. Walensky, does finding the source of a virus help you defend against it?

Dr. WALENSKY. We have to defend against the virus regardless of the source. I think it would be helpful to understand——

Mr. CLYDE. But the question is——

Dr. WALENSKY [continuing]. The root of the source in order to defend against it.

Mr. CLYDE. So it is helpful?

Dr. WALENSKY. Yes. In order for prevention activities.

Mr. CLYDE. Great. Thank you.

Dr. Tabak, you said when I asked you was there gain-of-function research done at the Wuhan Institute of Virology, which received American taxpayer dollars, you said no.

Dr. TABAK. Correct.

Mr. CLYDE. You stand by that statement?

Dr. TABAK. Yes, sir.

Mr. CLYDE. Okay. Then why in this letter, October 20, 2021, that you said EcoHealth Alliance was testing if spike proteins from naturally occurring bat coronaviruses circulating in China were capable of binding to human ACE2 receptors in a mouse model. And

here is an article that says "NIH admits U.S. funded gain-of-function in Wuhan, despite Fauci's denials."

And at a Senate hearing where Dr. Fauci said, "The NIH has not ever and does not now fund gain-of-function research in the Wuhan Institute of Virology." That was under oath and under testimony. On October 20th, the NIH Principal Deputy Director in writing directly contradicted it. That would be you.

So you are telling me that what you are saying in this letter is not gain-of-function research?

Dr. TABAK. Sir, it is not. Gain-of-function research, as everybody is concerned about, is with ePPPs. The viruses that NIH approved and were studied in the Wuhan Institute of Virology, and then they subsequently published on that work, were viruses that were very, very genetically distinct from SARS–CoV–2.

They are not related in any way. They could not have given you SARS–CoV–2 in the result. And that is why I have made that distinction.

Mr. CLYDE. Okay.

Dr. TABAK. I can't speak to the other articles that you cited.

Mr. CLYDE. You told Congresswoman Letlow that you were intensely interested in finding the origin of the COVID–19 virus, but yet you don't have any dedicated resources to finding the source. Why?

Dr. TABAK. Again, sir, our role in this would be to support the researchers that have the expertise to do this type of work. We are supporting them, and they are doing evolutionary studies. The missing piece here are data from China, which we do not have access to.

Mr. CLYDE. Well, with all the money that you get, I would think that because finding the origin helps you defend against it, that you would be using some of the money that you get to find the origin.

Dr. TABAK. We will get back to you, sir, for the record, of the grants which are related to this. We have not specifically funded anything entitled origins of the virus.

Mr. CLYDE. Thank you.

And I yield back.

Mr. ADERHOLT. Ms. Letlow.

Ms. LETLOW. Thank you, Mr. Chairman.

PROJECT NEXT GEN

Ms. O'Connell, I would like to go back to Project Next Gen. I want to know how this—how this work impacts the core mission of ASPR to protect against a myriad of threats, not just COVID–19, especially now that the current public health emergency is scheduled to be terminated on May 11th.

Ms. O'CONNELL. Thank you. Absolutely.

So one of the things that we are looking at, and as I mentioned in my opening statement, are the viral families most likely to cause the next biological threat.

Ms. LETLOW. Right.

Ms. O'CONNELL. Among those are coronaviruses, and one of the things that would come out of the Next Gen work potentially is a

broader vaccine that would protect against all coronaviruses, not just SARS–CoV–2.

Ms. LETLOW. Right. Look forward to that.

When does this administration plan to release a detailed spend plan on what these allocated funds are being used for?

Ms. O'CONNELL. I will have to go back to our department's finance team and let you know, and we will be happy to get that information to you.

STRATEGIC NATIONAL STOCKPILE

Ms. LETLOW. I would appreciate that.

And then, last October, the Government, the GAO released a report titled "HHS Should Address Strategic National Stockpile Requirements and Inventory Risks." In this report, GAO found that SNS contained most medical countermeasure types recommended, but often not the recommended quantity.

How does the Administration for Strategic Preparedness and Response aim to bridge the gaps faced between the required amounts and the current stockpile?

Ms. O'CONNELL. Thank you so much for that question. That is absolutely one of the biggest concerns that I have is that we have not been funded appropriately to be able to protect ourselves against the current threats that we see.

We just shared with Congress the PHEMCE multiyear budget, which is a 5-year plan for the entire countermeasure enterprise, and it shows that the Strategic National Stockpile is funded half of what it needs. It needs $2,000,000,000 a year in order to keep up with the countermeasures that we require to be protected against the current threats, and it currently is funded in the $900,000,000 range.

Ms. O'CONNELL. Thank you so much.

I yield back.

Mr. ADERHOLT. Okay, thank you. Thank you.

Ms. DELAURO. I just want to make one——

Mr. ADERHOLT. Yes. Just—yes.

CLOSING REMARKS

Ms. DELAURO. Thank you, Mr. Chairman.

Again, I want to say thank you, and I know the chair will wrap it up to our witnesses today. Thank you again for the work that you do. Thank you for the prescient view of the budgets that you have put forward in order to continue the outstanding work that you do.

I will just—there is a couple of things I wanted to say. I would say to my colleague from Maryland who talked about living in a fairy land. I believe—and I don't say this because I am not in the business of ad hominem efforts. But I think the fairy land has been the $1,700,000,000,000 that was dispensed to the richest one-tenth of 1 percent of the people in this country and the corporations who today do not pay any taxes.

And as far as I know, there is little appetite from some on the other side of the aisle to look at those corporations. Making sure

that they pay that would give us additional revenues to do what we could do with lifesaving—lifesaving threats.

But the fairy land today, the fairy land today is that if we believe that you can leave—go back to 2022, leave defense out, leave veterans out, leave border security out, leave anything else out that people individually care about, then some of the issues that have been discussed here today are not going to be able to be addressed because that is the fairy land. And that is what we need to be guarding against here.

Just one last point. Mr. Harris, I would say to you, we ought to tax sugary beverages, which I introduced many years ago to do that, in which case that would cut down on some of the health impacts that we see today.

Thank you, Mr. Chair. I appreciate it.

Mr. ADERHOLT. Well, thanks, everybody, for being here. We look forward to following up on some of the issues that we had left outstanding, and we appreciate your service.

And the hearing is adjourned.

WEDNESDAY, APRIL 26, 2023.

PROVIDER RELIEF FUND AND HEALTHCARE WORKFORCE SHORTAGES

WITNESS

CAROLE JOHNSON, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ON BEHALF OF DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHAIRMAN'S OPENING STATEMENT

Mr. ADERHOLT. Well, good morning.

It is good to be here this morning with our special guest. And I am pleased this morning to welcome the Administrator of the Health Resources and Services Administration, Carole Johnson, to talk about the Provider Relief Fund and also about healthcare workforce issues in general.

The Provider Relief Fund was originally created in the CARES Act to reimburse healthcare providers for increased expenses or lost revenue as a result of COVID lockdowns and COVID treatments.

I think the original intent of the fund was actually commendable. We wanted to maintain a robust, high-quality healthcare system in the face of a novel pandemic. We also needed to ensure that providers were able to continue care despite the many challenges and the unknowns that were posed by COVID at the time.

The committee recognized that it is difficult to administer a new program of this magnitude in a short timeframe. But hindsight is 20-20. With the passage of time, we are seeing many instances of improper payments, wasted funds, and funds remaining in the Provider Relief Fund that are being used for purposes other than what it was originally intended.

For example, just last week, the Department of Health and Human Services announced that it will spend 1.1 billion from the PRF for ongoing free COVID vaccines and treatments for uninsured adults through 2024.

I think it is very interesting that Health and Human Services is going to provide payments for new vaccines and treatments while outstanding provider claims for treating the uninsured remain unpaid.

I am further concerned by reports of significant misuse of Federal funds previously under the COVID–19 Uninsured Program. I have some questions about what your agency will do to ensure that these mistakes are not repeated with additional funds.

This announcement, that the PRF will pay for activities not expressly authorized by Congress, is just one more example of an ever-growing list of ways the Biden administration is overreaching

its executive authority, from blanket loan forgiveness to free abortions in the VA, and now promises of free college and free healthcare. This administration appears to recognize there are no legal boundaries.

Finally, today I want to address the issue of healthcare workforce shortages in many rural areas. These areas, including my home State of Alabama that I represent, continue to represent many challenges that are worsened by these shortages, including access to quality healthcare, lack of specialty care, nursing shortages, high rates of opioid addiction, lack of facilities, and a disproportionate burden of chronic disease relative to the rest of the country.

I know from the hearing we held last month on rural issues that your agency oversees several Federal programs that touch on these very areas, and I appreciate your attention as you talk in your testimony today, and I look forward to our conversation as we move forward on this.

And, at this time, I would like to a recognize my friend from Connecticut, the ranking member, for her opening remarks.

RANKING MEMBER OPENING STATEMENT

Ms. DELAURO. Thank you so much, Mr. Chairman, for holding the hearing.

And welcome to today's witness, Ms. Carole Johnson, Administrator of the Health Resources and Services Administration, or HRSA. And happy that you took over the job in January of 2022.

Thanks for being here. Thank you for dedicating your career to the work of saving lives by increasing access to high-quality healthcare, especially for historically underserved and rural communities across this country. You make our communities healthier and safer by expanding a skilled healthcare workforce.

You are here in part today to discuss healthcare workforce shortages, an issue that impacts communities all over the Nation.

Even before the pandemic, healthcare workforce shortages were a major concern. In 2019, the American Association of Medical Colleges predicted a shortage of 122,000 physicians by 2032.

And that is just physicians. As you know, 1.5 million healthcare jobs were lost in the first 2 months of the pandemic. While we are mostly back to prepandemic staffing levels, issues still endure.

And though the Bureau of Labor Statistics projected that 275,000 additional nurses are needed before 2030 to meet demand, it is increasingly more difficult to hire new qualified nurses.

Given the need to address these and other enduring shortages made much worse by the pandemic, this committee made significant investments through the 2022 and 2023 appropriations bills to strengthen HRSA's health workforce programs.

This included a nearly $100,000,000 increase in the 2023 package passed and enacted in December. We increased funding for nursing and midwife programs, mental and behavioral health workforce education and training, and Children's Hospital Graduate Medical Education programs to train resident doctors.

But more must be done. That is why I am pleased to see the President's budget for 2024 prioritizes training programs for the healthcare workforce.

I would like to run through some of the funding.

The request includes $190,000,000 more for mental and behavioral health workforce education and training to address our mental health and substance use crises by expanding healthcare professionals.

You also requested an additional $50,000,000 for nursing programs, including to increase the nurse faculty essential to growing our workforce. To be honest, I am concerned that increase is not large enough given the need for a robust nursing workforce.

I am pleased to see your request for $50,000,000 in new funding to expand the National Health Service Corps, which offers scholarships and loan repayment to professionals who commit to serving in underserved areas. As you note in your testimony, National Health Service Corps participants are more likely to remain practicing in high-need communities after their service is completed.

And your budget would invest in innovative approaches to recruit, support, and train new providers. Americans depend on the skilled and robust healthcare workforce that keeps us safe and healthy.

That is why I must mention how deeply concerned I am over some of my House Republican colleagues' calls for massive spending cuts to many of the programs that keep families and communities healthy. These cuts would be harmful to children, families, seniors, veterans, and our rural communities—and they would be deadly.

PROPOSED FUNDING CUTS

Just last week, Speaker McCarthy introduced a bill to cut funding back to the 2022 level and to impose caps for the next 10 years—caps that are really just more cuts. And apparently we are getting prepared to vote on that piece of legislation today.

Though we should be doing everything to support healthcare workers and expand the workforce, these spending cuts would gut nursing programs, exacerbating our shortage of skilled nurses. There would be fewer mental health providers and substance abuse specialists as the country continues to combat an opioid and a fentanyl crisis. And it would mean fewer doctors and other healthcare professionals choosing to serve in rural and underserved communities because we removed incentives to serve there.

These proposed cuts would reverse much of the progress we have accomplished over the past 2 years, progress that began as we recovered from the COVID–19 pandemic.

Ms. Johnson, when you came into office hospitals and healthcare providers across the country were overwhelmed by COVID patients. At the peak of the pandemic, more than 4,000 Americans were dying every day from COVID. Many hospitals, healthcare providers, nursing homes would have gone bankrupt without emergency intervention from the Federal Government.

That is why I am proud that while I served as chair of the Labor-HHS Appropriations Subcommittee we responded quickly and forcefully to the COVID–19 pandemic, including by creating the Provider Relief Fund in March of 2020 to support our healthcare providers and to avoid a complete collapse of our healthcare sector.

In 2020, this committee provided a total of $178,000,000,000 for hospitals, health clinics, skilled nursing facilities, nursing homes,

and other healthcare providers. Unfortunately, the Trump administration did not allocate those funds according to congressional intent.

The truth is this subcommittee should be questioning HHS officials from the Trump administration. First and foremost, they sent too much money to hospitals that did not need it and not enough money to the areas that did.

As reported by both The Wall Street Journal and The Washington Post, hospitals were reimbursed based on their overall revenues and their Medicare billing rates instead of their financial need, which put safety net hospitals at a severe disadvantage.

It has become overwhelmingly evident that hospitals that serve a disproportionate share of uninsured patients and Medicaid patients needed much more support.

It should concern all of us that the financial need and condition of providers were not properly assessed. And children's hospitals, behavioral and mental health providers, dentists, and some of our smaller hospitals were left behind.

I know this firsthand from providers in Connecticut. Connecticut's 17 small and medium-sized hospitals struggled immensely, especially in the early months of the pandemic, when the Trump administration used arbitrary dates to determine eligibility for, quote, "hot spots funding."

When the Biden administration took office, you changed this process to ensure that aid was targeted to the providers most in need, and though this change was critical for some hospitals and healthcare providers, it had already been far too late.

And now Speaker McCarthy and some of my Republican colleagues are trying to rescind unspent COVID funds, which would further exacerbate the challenges faced by hospitals and healthcare providers that serve people most in need.

As I have made clear, I will not stop fighting these drastic proposals that would hurt the communities that most need our help.

Ms. Johnson, we have a lot of ground to cover today on these two topics. Look forward to working with you to ensure that we continue to invest in our healthcare workforce, support our healthcare providers.

Thank you so much for being here.

With that, Mr. Chairman, I yield back.

Mr. ADERHOLT. Thank you.

And, as I said, we are honored today to have Carole Johnson, who is the Administrator of the Health Resources and Services Administration, what we will refer to as HRSA. It is a Federal agency in the U.S. Department of Health and Human Services that is focused on health equity, supporting healthcare services for historically underserved communities, and working to build a robust and diverse healthcare workforce.

HRSA ADMINISTRATION'S OPENING STATEMENT

So, Ms. Johnson, we will turn it over to you, and we look forward to your testimony.

Ms. JOHNSON. Chairman Aderholt, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to talk with you today about our investments in training and re-

taining the healthcare workforce and our efforts to sustain the Nation's critical healthcare infrastructure through pandemic relief investments.

I am Carole Johnson, Administrator of the Health Resources and Services Administration, and as the Chairman noted, we are the agency in the Department of Health and Human Services that supports delivering healthcare in the Nation's highest-need communities, building a healthcare workforce, improving maternal and child health, caring for individuals with HIV, and meeting the healthcare needs of rural America.

I would like to begin by thanking the members of this subcommittee for your longstanding bipartisan support for HRSA's programs. With your help, we have made significant gains in expanding access to healthcare services, particularly in communities that have struggled for far too long to recruit and retain healthcare providers and access high-quality care.

Yet we know there is more work to do, including to help further support and expand the healthcare workforce.

One of HRSA's highest priorities is growing the healthcare workforce and connecting skilled healthcare providers to communities in need.

With the support of this subcommittee, our programs have trained and deployed healthcare providers across a wide array of disciplines, including primary care, nursing, and behavioral health.

Our budget prioritizes training more medical residents and incentivizing practice in rural and underserved communities, alleviating bottlenecks in the nursing training pipeline, investing in growing the behavioral health workforce, and spurring innovation in health workforce training.

First, the President's budget takes the important step of renewing and extending the National Health Service Corps. For more than 50 years, the National Health Service Corps has provided scholarships and loan repayments to students and clinicians in return for them practicing in health professional shortage areas.

We are also training medical residents directly in the communities that need them most through the Teaching Health Center Graduate Medical Education Program, which funds primary care residency programs in settings like health centers, recognizing that most primary care takes place in community settings.

To further support the primary care physician pipeline, our budget invests in rural residency training through our Rural Residency Planning and Development Program, which supports rural hospitals and facilities in creating new medical residency programs.

With our funding and support, rural facilities that would not otherwise have the bandwidth or capacity to launch residency programs are able to do so, which is an important resource, helping rural communities to develop the next generation of rural health practitioners.

Second, we recognize the need to expand the nursing workforce, and the budget proposes an increase of $50,000,000 over fiscal year 2023 to support this goal.

This includes a new investment that would help create more nursing faculty and clinical preceptors for the teaching faculty that oversee the clinical training of nurses.

Time after time, we have been told by nurse leaders and front-line healthcare administrators that the lack of faculty—and especially the challenge of recruiting clinical faculty—is a key roadblock in growing the nursing workforce. More people want to become nurses, and we need to support the infrastructure to help them to do so.

The budget would also train more certified nurse midwives as part of our larger strategy to improve access to care and respond to the maternal mortality crisis.

Third, we are also proposing to train significantly more mental health and substance use disorder providers through the President's budget, including both clinicians, like psychologists and licensed clinical social workers, as well as the critical community-based workforce, like peer support specialists.

A lot of important work is underway to expand access to mental health and substance use disorders, and the needs are well-known, but we have to invest in building the workforce to help meet these critical needs.

Fourth and finally, the budget includes an exciting new opportunity to spur innovation in healthcare workforce training models by funding new ideas and proposals to support creative ways to build a more modern and robust workforce pipeline.

PROVIDER RELIEF FUND

Turning to the Provider Relief Fund. As was noted, in the earliest days of the pandemic Congress created the Provider Relief Fund to help healthcare providers manage the impact of the pandemic. It was a lifeline to many healthcare providers who experienced financial losses and increased expenses due to the virus.

Since the program was established, HRSA has made over 800,000 payments to more than 440,000 providers across the country, and funding has reached every State and congressional district, and it has been critical for providers to continue delivering essential care to their communities.

As the implementing agency for the fund, HRSA has worked to responsibly get resources to providers in a timely way while taking stewardship of Federal funds very seriously.

Program integrity is an essential component of the Provider Relief Fund. And in order to ensure that payments are made fairly and to safeguard taxpayer dollars, HRSA implemented a variety of program integrity and risk mitigation measures, both before and after making payment. Providers are subject to robust requirements, and failure to comply exposes providers to recovery and debt collection.

Thank you for the opportunity to discuss HRSA's work, and I look forward to the conversation.

[The information follows:]

Statement by

Carole Johnson

Administrator, Health Resources and Services Administration
U.S. Department of Health and Human Services

Before the
Subcommittee on Labor, Health and Human Services,
Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives

Washington, D.C.
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Chairman Aderholt, Ranking Member DeLauro, and members of the Subcommittee, thank you for the opportunity to talk to you today about our investments in training and retaining the health care workforce and our efforts to sustain our nation's critical health care infrastructure through pandemic relief investments. I serve as the Administrator of the Health Resources and Services Administration (HRSA)—the agency of the Department of Health and Human Services that supports health care services in the nation's highest need communities, training and development of the health care workforce, and helps to meet the health needs of rural communities.

HRSA supports nearly 1,400 community health centers that provide primary care in rural and underserved communities regardless of patients' ability to pay; health services in rural communities and help for rural providers to remain financially viable; scholarships and loan repayment assistance for more than 20,000 clinicians in return for serving in underserved and rural communities; training and career ladder programs to grow the nation's supply of nurses, doctors, behavioral health providers, community health workers and other health professionals; care and treatment for more than half a million individuals with HIV; and, maternal and child health screenings, services, and support for more than 58 million women and children.

I would like to begin by thanking members of this Subcommittee for your long-standing, bipartisan support for HRSA's programs. With the support of this Subcommittee, we have made significant gains in expanding access to health care services, particularly in communities that have struggled for far too long to recruit and retain health care providers and improve access to care. We look forward to continuing to work with you on key initiatives that will enable us to meet our mission.

Expanding and Retaining the Health Care Workforce

One of HRSA's highest priorities is growing the health care workforce and connecting skilled health care providers to communities in need. HRSA administers over 50 programs aimed at strengthening the health care workforce, and our programs have trained and deployed health care providers across a wide array of disciplines including primary care, nursing, behavioral health, and dentistry. We recognize that there are many challenges facing the health care workforce, which is why our Budget prioritizes training more medical residents, alleviating bottlenecks in the nurse training pipeline, investing in growing the behavioral health workforce, prioritizing the health and well-being of the current workforce, and spurring innovation in health workforce training.

Primary Care Providers

The President's Budget takes the important step of renewing and extending expiring mandatory funding and increasing discretionary funding for the National Health Service Corps. The Budget also extends and increases funding for the Teaching Health Center Graduate Medical Education Program. Both programs focus on training the next generation of primary care providers and helping to deliver healthier communities.

For more than 50 years, the National Health Service Corps has worked to increase access to care by supporting health care providers dedicated to working in underserved urban, rural and tribal areas by providing scholarships and loan repayment in return for service in these high need communities. The National Health Service Corps includes medical, dental, and behavioral health providers and consists of the foundational Scholarship and Loan Repayment Program as well as dedicated resources for loan repayment in rural areas, and a dedicated loan repayment

program for substance use disorder providers. Additionally, the State Loan Repayment Program provides grant funding to states that administer their own health care provider loan repayment programs to assist states in meeting their unique primary care needs.

With the combination of mandatory funding, base appropriations and pandemic relief funds, more than 20,000 National Health Service Corps participants were practicing in underserved and rural communities in return for scholarships and loan repayment last year – the largest number in program history. National Health Service Corps participants tend to remain practicing in high need communities after their service commitment is completed. The two-year reported retention rate among National Health Service Corps participants who completed their service obligation in Fiscal Year 2020 is 86 percent.

Recognizing the ongoing demand for high quality clinicians, the President's Budget seeks to sustain this record level of National Health Service Corps participation by proposing $966 million in FY 2024 total funding, including $790 million in mandatory funding and a sustained three-year mandatory investment in the program. Without this increased investment, HRSA will be unable to maintain this historic field strength of providers, reducing the opportunity to leverage this flagship program for incentivizing new providers to practice in underserved communities at a time when these clinicians are needed more than ever.

By supporting primary care residency programs in health centers, rural health clinics, and other community settings rather than the traditional acute hospital care model, the Teaching Health Center Graduate Medical Education program prioritizes the needs of the community while delivering high-quality clinical training. The President's Budget would extend the Teaching

Health Center Graduate Medical Education Program's mandatory funding for three years. This proposal would provide funding to support more than 1,400 residents in various stages of residency training during Fiscal Year 2024 and grow to support more than 2,000 residents by Fiscal Year 2026. Continued mandatory Teaching Health Center Graduate Medical Education Program funding will provide teaching health centers with the confidence to continue recruitment efforts to fill and expand their primary care resident slots.

To further support the training of new physicians, HRSA is investing in and expanding rural residency training through our Rural Residency Planning and Development Program, which supports rural hospitals and other organizations in the creation and accreditation of new residency programs. The FY 2024 President's Budget includes $12.7 million to fund a new grant competition in FY 2024.

Nursing Workforce

It is critical that we continue to support the nursing workforce and build a robust training pipeline for the future. The President's Budget invests $350 million overall to expand, enhance, and modernize nursing education programs, with an increase of $50 million over Fiscal Year 2023. This includes a new investment to increase the number of nurse faculty and clinical preceptors – a key roadblock to growing the nursing workforce – and investments in expanding nursing student enrollment in Registered Nurse programs in states with the greatest shortages of nurses. The President's Budget also grows the maternal health nursing workforce by increasing the number of Certified Nurse Midwives to expand care options.

The Nurse Corps Scholarship and Loan Repayment Programs and the Nurse Faculty Loan Program are essential programs to bolster the nursing workforce to meet our nation's health care needs. Similar to the National Health Service Corps' structure, Nurse Corps participants receive scholarship support or educational loan repayment in exchange for working in Critical Shortage Facilities or serving as faculty in schools of nursing throughout the nation. There are currently more than 3,900 registered nurses and nurse faculty members fulfilling multi-year service commitments—the most in program history. Our data shows that 90 percent of participants remained committed to service in an underserved area for up to two years beyond the completion of their service obligation. Additionally, the Nurse Faculty Loan Program is expanding the number of qualified nurse faculty nationwide by helping schools of nursing provide loans to students enrolled in advanced education nursing degree programs who are committed to becoming nurse faculty. In the past academic year, 2,800 nursing students received loan repayments through school of nursing participating in this program.

Behavioral Health Workforce

At a time of considerable demand for mental health and substance use disorder care, the President's Budget would grow the behavioral health workforce by making significant investments in training new professionals such as psychiatrists, psychologists, clinical social workers, marriage and family therapists, counselors, and peer support specialists.

The President's Budget proposes an additional $190 million for HRSA's Behavioral Health Workforce Development Programs and would train 18,000 more mental health and substance use providers. In addition, the Budget includes an increase of $25 million in discretionary funding

through the National Health Service Corps for mental and behavioral health providers, including peer support specialists and crisis care providers, and an additional $25 million for loan repayment for clinicians to provide opioid and substance use disorder treatment.

Supporting the Mental Health and Well-being of the Health Care Workforce

In January 2022, HRSA awarded $103 million in grants to reduce burnout and promote mental health in the health workforce. Grantees are providing and improving access to mental health and support services for their workforce as well as addressing workplace environment challenges that contribute to added stress. The President's Budget includes $25 million to build on these grants and launch the new Supporting the Mental Health of the Health Professions Workforce program authorized through the Dr. Lorna Breen Health Care Provider Protection Act.

Investing in Innovation

At a time of increased demand and strain on the health care workforce, the health care community is looking anew at health care workforce training models to identify opportunities for innovation. Many training curricula and models for training health professionals remain unchanged from decades ago. In response, the President's Budget invests $28 million for a new program, the Health Care Workforce Innovation Program. Confronting the breadth and urgency of current workforce challenges – and delivering on the promise of the Administration's significant policy steps in support of behavioral health, health care coverage, and care in home and community settings – will require innovative new approaches to accelerate the transformation of health care workforce training into a more modern, robust, and diverse workforce pipeline.

Sustaining the Health Care Infrastructure Through Pandemic Relief Investments

The COVID-19 pandemic presented an unprecedented challenge for health care providers and the communities they serve. Many health care providers thought they would need to close their doors due to the rapid and unexpected reduction in non-emergency health care utilization. To address this existential crisis for our nation's health care system, Congress created the Provider Relief Fund in March 2020. During the course of the pandemic, the Provider Relief Fund provided a lifeline to health care providers who experienced financial losses created by the pandemic and helped to limit disruptions in care in communities across the country during this crisis. This vital funding helped health care providers keep their doors open, address workforce challenges, and make up for the lost revenues and increased expenses caused by the pandemic.

As the agency tasked with implementing Provider Relief Fund payments, HRSA moved quickly to begin making Provider Relief Fund payments just weeks after the CARES Act passed. In the start-up phase, given the urgency and the importance of the task, senior career leaders from across the Agency were pulled from their day-to-day work and deployed to build the programmatic, IT, fiscal, and other infrastructure necessary to implement the policy decisions on allocations being made by the Department. HRSA concurrently worked to hire and on-board program, audit, program integrity, customer service and other staff to manage the program while also developing contract and vendor management strategies to ensure accountability and oversight of the program.

Since the program was established, HRSA has made over 800,000 payments to more than 440,000 providers across the country. In addition to payments from the Provider Relief Fund, HRSA also distributed the dedicated Rural fund appropriated by the American Rescue Plan Act

of 2021. Provider relief funding has reached every state and congressional district across the country and has been critical for providers to continue delivering essential care to their communities.

Program Integrity is an essential component of the Provider Relief Fund. In order to ensure payments were made fairly and to safeguard taxpayer dollars, HRSA implemented a variety of program integrity and risk mitigation measures both before and after making payments. This included but was not limited to provider validation through Internal Revenue Service Tax Identification Numbers; validation of providers being in good standing with federal government payers including confirming providers were not on Medicare and other payment exclusion lists; identifying anomalous financial information; and screening for duplicate or suspicious applications. Upon receiving each payment, a provider is required to attest to Provider Relief Fund Terms and Conditions to retain payments. Provider Relief Fund terms and conditions require - among other obligations - that recipients submit timely reports on their use of the funds and their compliance with post-payment audits as required by law. Providers are subject to robust reporting requirements associated with each payment received from the Provider Relief Fund to ensure that resources were used in accordance with federal law. Failure to timely report exposes the provider to recovery and debt collection. Deadlines for reporting on use of Provider Relief Fund payments are linked to when a provider received each payment. To date, 99 percent of funds have been successfully submitted by providers. In addition to being subject to Agency audits for compliance, many providers are required to have independent audits completed as they are subject to Single Audit Act requirements or comparable program requirements for commercials audits. Independent audits are collected and analyzed for compliance issues. For those providers who are not in compliance with reporting on the use of funds, HRSA is taking

action to get them to come into compliance or to repay these funds, including pursuing debt collection against providers who have failed to comply with the program's requirements.

Conclusion

Thank you again for the opportunity to discuss these important issues with you today. I look forward to your questions.

Mr. ADERHOLT. Thank you, Ms. Johnson. Again, thank you for being here today.

I will begin with our rounds. We will do 5-minute rounds, so that we can try to make sure everyone gets in a question.

COVID UNINSURED PROGRAM

My first question deals with the unspent PRF balances. HRSA insisted that it had to shut down the COVID–19 Uninsured Program for testing and treatment claims effective March 22 back in 2022, and that was due to lack of funding.

As a result of this last-minute announcement, many hospitals, physicians, and other medical providers around the country were unable to submit claims for services they provided in good faith to patients in reliance on this program.

My question is, why did HRSA shut down the COVID–19 Uninsured Program with almost no advance notice to the medical community under the guise of insufficient funding, given that the Department now tells us there is actually more than enough funding remaining in the Provider Relief Fund to be reported to other programs, especially when these other programs are not even authorized?

Can you talk to us a little bit about that?

Ms. JOHNSON. Thank you for the question, sir. And thank you for the opportunity to talk about where we were at the beginning of 2022, when we were requesting additional supplemental funding to sustain the Uninsured Program.

We were at that point seeing a tremendous impact from the omicron surge with respect to claims for the Uninsured Program. As you know, in most healthcare programs there is a claims lag between when providers provide services and when they submit claims.

And so at that time we were seeing a tremendous surge in claims associated with omicron, at the same time that we were trying to make Phase 4 of the Provider Relief Fund general distribution payments and have resources available for the reconsideration process that we initiated to make sure that providers had the opportunity to come back in if they thought that there was an issue with their provider payments.

And so, at that time, we were spending around $2,000,000,000 a month on the Uninsured Program. And given the time lag in filing claims because claims are often filed months after they were processed, we had an unknown liability out there for claims, and we had the claims lag.

So pre-omicron, we got about 16 million claims in a 3-week period. In the 3 weeks between when we closed the fund—when we announced the closure of the fund and when the fund closed, we got 35 million claims.

And so, as a matter of good fiscal budgeting, we just didn't have the resources to be able to say we could sustain that with this unknown liability out there.

And so today, although there are considerably fewer dollars left in the Provider Relief Fund, we are in a more stable place, because we have been able to make many of the Phase 4 payments and we know the amount of claims that have come in in the Phase 4 recon-

sideration process. And at the same time as our program accountability work is underway, we are getting provider returns.

And so, with that, about 2 percent of the Provider Relief Fund is being used for the new initiatives that you point to that the administration has announced.

Mr. ADERHOLT. Well, it is my understanding that Moderna and Pfizer have pledged to make COVID vaccines free for the uninsured through patient assistance programs. If that is the case, why is the new program for the uninsured to access COVID vaccines funded by the government even needed?

Ms. JOHNSON. Yeah. Thank you for the question, sir.

I would have to—the details of how the Uninsured Program, this new bridge access program, will be funded and operated, I would have to refer to CDC.

But I will say what we saw throughout the pandemic was that, while the vaccines were purchased in bulk, the vaccine administration fee to the provider who administers it is an additional cost. And so that cost continues going forward regardless of the purchasing arrangement.

Mr. ADERHOLT. Okay. All right. But you said that you need to get some more information from CDC on that or some clarification?

Ms. JOHNSON. Well, on the particulars of the vaccine acquisition, I would defer to them. But there will continue to be vaccine administration costs, because throughout the pandemic providers have always been reimbursed directly for the cost of administering the vaccine.

Mr. ADERHOLT. Also, correct me if I am wrong, but I understand the program runs through December of 2024. Is that correct?

Ms. JOHNSON. Yes.

Mr. ADERHOLT. Why was that date or that timeframe selected?

Ms. JOHNSON. I believe part of that is about ensuring that there is as smooth as possible transition as products move to the commercial market.

Mr. ADERHOLT. Okay. All right. I yield back.

And Ms. DELAURO.

GOVERNMENT FUNDING CUTS

Ms. DELAURO. Thank you, Mr. Chairman.

Ms. Johnson, Speaker McCarthy and the Republican House majority are demanding massive government funding cuts in fiscal year 2024 appropriations bills.

Last week, as I mentioned, the Speaker introduced a bill to cut funding back to the 2022 level, to impose caps for the next 10 years.

To be clear, this bill would require them to cut health programs by at least 22 percent, possibly closer to 30 percent or more.

Question. As HRSA Administrator, give us an idea about the real impacts of the cuts being proposed by some Republicans. What would happen to community health centers, nursing programs, mental health and substance use disorder counseling programs?

And, if you don't mind, please describe the human consequences to children, families, seniors, veterans, and millions of people across the country.

Ms. JOHNSON. Thank you for the question, Congresswoman, and the opportunity to speak about this.

I will say the consequences are impacted by the fact that this subcommittee, in a bipartisan way, has helped us grow these programs in recent years. And so, as a consequence, a reduction of that size in the health center program would have a direct impact. We believe our estimates are about 2 million of the individuals served by health centers would potentially lose access to their care, including over 600,000 people who live in rural communities.

Our Nurse Corps Program, which is where we do loan repayment and scholarships for nurses in return for practicing in critical high-need areas, we think we would have to cut the number of scholarships we award in that program by about a quarter. We think the number of people who got loan repayment and are out in the field would drop from about 3,900 to about 2,500 nurses supported by that program.

We believe our Behavioral Health Training Program, which is where we are training a host of clinicians and community support providers, would drop by about 1,700 at a time when we are really working to grow the behavioral health infrastructure in the country to respond to the mental health and substance use disorder needs across the country.

I would also point out the Substance Use Disorder Treatment and Recovery Loan Repayment Program—this is our STAR Loan Repayment Program—is incredibly popular. We get significantly more applications for it than we can fund, but we expected to make about 160 new awards going forward. We would have to make probably about 35 less of those awards.

Our Ryan White Program is how we fund AIDS drug assistance programs, and we suspect that a little over 50,000 people would be unable to receive their antivirals or the insurance assistance we fund for them.

UNOBLIGATED COVID FUNDS

Ms. DELAURO. Okay. Let me just also, because the House Republican bill would rescind all unobligated COVID funds, including all the unobligated funds of the Provider Relief Fund.

What would be the result of rescinding the remaining funds in the PRF? Does that mean that HRSA would not be able to allocate billions of dollars to healthcare providers based on reconsideration of their applications for relief funding?

Ms. JOHNSON. That is correct, Congresswoman. One of the things that we have tried to do very consistently—we tried to be very consistent in the Provider Relief Fund in how we treat all providers.

And some providers—so we have the final payment allocations to providers in Phase 4 that we are at the tail end of doing. And then all of those providers had the opportunity to come in and ask for a reconsideration, make a request of us to relook at their application if they thought there was an issue. And we have all those pending applications.

And we did that in Phase 3. We want to make sure that providers get that same fair shot in Phase 4.

Ms. DELAURO. Do you have any idea where those providers are, what parts of the country?

Ms. JOHNSON. We get those kind of requests from across the country.

Ms. DELAURO. How many are outstanding?

Ms. JOHNSON. In the Phase 4 reconsideration requests, we have received 2,000 requests.

Ms. DELAURO. You have 2,000 requests, and those 2,000 requests would have to be jettisoned, if you will, as a consequence.

Ms. JOHNSON. That is correct. That is correct. They won't all necessarily be paid. We review them as part of the reconsideration process.

Ms. DELAURO. Okay.

Ms. JOHNSON. And those where an error is identified, we would correct for. But there are 2,000 of them that have asked for that opportunity.

Ms. DELAURO. Okay. I will yield back, Mr. Chairman.

Mr. ADERHOLT. Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Administrator Johnson, thank you for visiting with us today.

LONG-TERM CARE SECTOR

Our country's aging population and the workforce shortages in the long-term care sector are well documented, including in the President's recent executive order. We both agree on increasing access to high-quality care and supporting caregivers. Still, I am concerned about increased regulatory requirements and quality metrics without the necessary support and incentives to help address the workforce shortage causes.

In addition, I have seen some data that shows the assisted living sector was underfunded from the Provider Relief Fund compared to other care settings.

My question is, what is HRSA doing to ensure that assisted living operators have the necessary resources and support to overcome the ongoing financial impact of COVID and the workforce shortage to continue to offer seniors high-quality care?

Ms. JOHNSON. Thank you so much for the question. It is such a critically important area of services and the workforce to be able to deliver them.

I just start on the Provider Relief Fund. My understanding was in 2022 there were some issues about assisted living facilities having access. That was adjusted beginning in our Phase 2 payments. So by Phase 2, 3, 4 the allocations that we have operated, the assisted living facilities have been able to come in as others have.

With respect to the workforce, it is a really important area of workforce development. Historically, we at HRSA have funded the more advanced practice portion of the workforce and worked closely with the Labor Department on the portions of the workforce where people are in early career ladder programs, so CNAs and other critical parts of the long-term care workforce.

But what we have done increasingly in this administration is build a better relationship, a longer-term, stronger relationship with the Department of Labor so that we are creating career ladders so that we can get people into the workforce as certified nursing assistants, move them up to LPNs, move them into the RN workforce.

And so our goal is to really help leverage all Federal investments in ways that are sort of centered around the worker and not centered around how our programs are funded.

Mr. FLEISCHMANN. Thank you.

OPIOID EPIDEMIC

My second question involves the opioid epidemic. Tennessee is among the hardest hit States when it comes to the opioid epidemic. Approximately 70,000 Tennesseeans are addicted to opioids, leading to an increase in incarceration, emergency room visits, overdoses, and, sadly, death.

Can you talk about HRSA's Rural Communities Opioid Response Program or other initiatives that HRSA might be supporting to address this epidemic?

Ms. JOHNSON. Thank you. Thank you for raising that question.

I think there are a couple of things I would want to highlight on this point.

This is obviously a whole-of-government response. We all have responsibility here to respond to this crisis. But what we see as our critical role at HRSA is supporting the workforce, which is vitally important to getting services to people; to supporting rural communities, which sometimes, when there is a State program that funds broadly, some critical, smaller rural communities don't always have access to that, and we are able to provide funds directly to small rural communities; and supporting access and services in underserved and rural communities.

So on the workforce side, our National Health Service Corps Program has dedicated resources to substance use disorder providers, meaning that we are able to offer loan repayment for substance use disorder providers who practice in high-need communities.

Similarly, we have our Behavioral Health Workforce Training Program, where we are training more substance use providers, so that we are thinking holistically about the pipeline and not just about getting current providers into the communities they need.

And then our Rural Opioid Response Program, as you mentioned, that is a way that we are able—and what we really like about that program is we are able to go to rural communities and say: What is it you need? Where are your gaps? And we are able to fund and respond to that.

Mr. FLEISCHMANN. Thank you very much. Appreciate the answer to those questions.

And, Mr. Chairman, I will yield back.

PROPOSED CUTS

Mr. ADERHOLT. Mr. Hoyer.

Mr. HOYER. Thank you very much, Mr. Chairman.

And thank you very much, Ms. Johnson, for your service to our country and to those who have health needs in this country, which are very large.

I am a big proponent of—and I quote the former Governor of our State, Ted Agnew. He said: When the cost of failure far exceeds the price of progress.

And in the cuts that have been proposed, as far as I know, there is no estimate of the consequential additional costs that they will incur as a result of not servicing.

Let me refer specifically to a study that I am sure you are familiar with. The American Journal of Public Health, in a 2016 study, showed that people who went to public health centers were 33 percent lower spending on those folks by Medicaid and found 25 percent fewer inpatient admissions of those who went to these health centers and 24 percent lower spending overall.

Now, I don't have the figures of what that means. I don't know whether you have computed that. You may not. But it is worth looking at, because the cost that would be incurred as a result of the cuts that are proposed are not simply that which was cut, but that which resulted in additional costs for that cut.

Do you have any thoughts on that?

Ms. JOHNSON. So thank you for the question.

The data does increasingly show the more studies come out about the way our community health centers help prevent ED, emergency department, use help prevent other utilization of higher-cost settings, because people, once you connect someone to a usual source of care, they are more likely to get preventative care, they are more likely to have a place to go for services or a place to call rather than showing up in an emergency department.

And so it is a critical investment in healthcare services, both for the health of individuals, but also for our overall expenditures.

On a related note, sir, I would say the other sort of undocumented cost associated with not making these full investments is, with the health workforce, we are training people today who won't be in the field for several years. And so, if we don't invest in that training now, the cost will be felt along the long term.

Mr. HOYER. Thank you.

Now, am I correct that you mentioned a figure of 2 million patients that would not be served? Is that accurate?

Ms. JOHNSON. That is correct.

Mr. HOYER. So that effectively the costs—the consequential cost of that, 2 million people, very, very substantial number, in my view probably in excess of the savings that would purportedly be made.

Does that stand to reason?

Ms. JOHNSON. I understand your point. I don't know the exact data, but we can look at that.

TRAINING PEDIATRIC DENTISTS

Mr. HOYER. Okay. We had a young man, 12 years of age, in Prince George's County, which I represent, Deamonte Driver, had a toothache. His mom tried to find a dentist. She couldn't find a dentist, probably because she didn't know really how to, because some dentists certainly would have served.

He had a toothache. It went for some period of time, and it became abscessed. He went to the emergency room. The abscess went to his brain, and he died.

You train pediatric dentists. It is one of the biggest health problems that young people are experiencing, more than asthma, more than some other afflictions.

Can you speak to the—you just spoke to it briefly—to the supply of pediatric dentists that you are trying to resolve?

Ms. JOHNSON. Thank you for the question, sir. And I remember the case incredibly well and how it caused all of us in public health to think about not just service delivery, but how we were doing outreach to families to make sure families knew what was available. And it caused all of us to sort of double down on: Are we doing everything we can when it comes to oral health providers?

And we have created new programs in recent years, including our Teaching Health Center Program, which is training dental residents in the community, with the investment intended to help ensure that they continue to serve in the communities where they train.

And there are a host of other programs that we support, including our State Oral Health Program, that is really designed to help States highlight these issues and bring resources to bear on making sure that families can access oral health services.

Mr. HOYER. Not only here, but throughout the healthcare delivery system, what the pandemic showed us, what a critical shortage we have in almost every discipline in terms of healthcare.

And, again, Mr. Chairman, my view is investing in making sure that those shortages do not continue is a great savings to our country and to the budget.

I yield back.

Mr. ADERHOLT. Thank you, Mr. Hoyer.

Dr. Harris.

BALANCING BUDGETS

Mr. HARRIS. Thank you very much.

And thank you for being with us today.

When you were commissioner of the New Jersey Department of Human Services, did you have to balance your budget?

Ms. JOHNSON. Yes, sir.

Mr. HARRIS. Oh, you did? And in your agency right now, do you have to balance your budget?

Ms. JOHNSON. Yes, sir.

Mr. HARRIS. Okay. And, when you were in New Jersey—I read your bio—there were a lot of things you could get accomplished under a balanced budget requirement, New Jersey as a State writ large. Is that right?

Ms. JOHNSON. Yes, sir.

Mr. HARRIS. So that you can actually do things if you balance the budget, you can actually accomplish a lot of these things.

Now, did New Jersey have a program for loan repayment for primary care physicians and providers and for nursing faculty?

Ms. JOHNSON. I believe we did, but it was run within a different department.

Mr. HARRIS. Yeah, you did. New Jersey did.

So, actually, States can do that, can't they?

Ms. JOHNSON. They do, but they do some of it with our funding. We provide funding to States for State loan repayment.

Mr. HARRIS. Sure. I get it. But States can do it. And some States, in fact, do have, like the State of Maryland has a separate loan re-

payment program from the Federal Government. So it doesn't really require the Federal Government.

Now, when you list the things that affect healthcare providers right now, I will tell you that physicians my age who are in practice tell me that medical inflation is one of the greatest impediments to them continuing practice.

Would you agree that healthcare inflation is actually harming our medical practices because Medicare payments do not keep up with inflation?

Ms. JOHNSON. I can't speak to the specifics of Medicare payments, but I can say that anything that costs providers more to deliver care is something that we hear from our—the healthcare service delivery community that we fund—is it creates more pressure on them.

Mr. HARRIS. Sure does. And the majority of Americans, when you poll them now, know that increased Federal spending was the primary cause of inflation. They make that connection.

Do you agree that that is one of the primary causes of inflation?

Ms. JOHNSON. I am sorry?

Mr. HARRIS. Increased Federal spending is a primary cause of inflation in this country.

Do you agree that increased Federal deficit spending is one of the primary causes of inflation? Do you agree with the majority of Americans or not on that?

Ms. JOHNSON. I am sorry, sir. I haven't looked at the question specifically. I can tell you what we hear from providers across the country.

Mr. HARRIS. Okay. I don't—I just—it was a very specific question. So you don't know whether it caused inflation.

Well, I will tell you, I think the majority of Americans are correct. Inflation is actually the leading—I am sorry. Federal deficit spending, out-of-control spending, $31,000,000,000,000 debt, is a leading cause of inflation and instability in the primary markets, which I think is one of the major threats to the continuance of experienced healthcare providers staying in the profession.

And I would argue that our out-of-control Federal spending does need to be reined in. And I would also argue that the States can pick up the slack.

TRAINING HEALTHCARE PROVIDERS

My State has billions of dollars in their rainy day fund. They could actually do some of the things that HRSA does, and I would proffer they should be doing it given that.

Now, let me ask you about the role of the private sector in GME. Now, as you are aware, a couple of years ago, during the COVID pandemic, there was a shortage of emergency room physicians. And, in fact, large practices couldn't find them.

So one of the largest practices just decided they were going to train their own. They were actually going to do what the Federal Government had been doing woefully inadequately, which is train enough healthcare providers.

And what they did is they converted the emergency medicine physician supply from a deficit to now where it is a surplus. And that is good it is a surplus, because these are the physicians who,

in fact, work in urgent care centers, which unload our emergency rooms, which you know is a far more expensive way to deliver emergency care.

So what is the role of the private sector in training healthcare providers?

Ms. JOHNSON. Well, Dr. Harris, I would say that is an important part of the solution here, because we clearly need more.

And what our targeted resources do is really look at places, for example, in our Rural Residency Program, where a rural facility might be able to run a residency program, but doesn't have the capacity to stand up and get accredited and those types of things. So we invest in helping them do that part of the work.

Mr. HARRIS. Sure. Let me just interrupt, because I only have a few more seconds left.

So when you talk about these rural programs, do you require a State participation in the payment for them? I mean, do you require a copay, what we would call in physician parlance a copay?

Do you require States—if you go into a State and you provide loan repayment in a rural area, you provide setting up a rural residency, do you require the State to have skin in that game? Because they are the ones benefiting, their residents are the ones benefiting.

I don't benefit. I love Tennessee, but I don't benefit when Tennessee gets an extra primary care provider.

Do you require States to participate in paying for those programs?

Ms. JOHNSON. By statute, the State Loan Repayment Program that we fund has a State match in it. That was waived during COVID, but it is—there is a required State match.

Mr. HARRIS. So it is back in effect now, because the COVID emergency is over?

Ms. JOHNSON. If we have future money for that particular part of the program, for the State Loan Repayment Program.

Mr. HARRIS. Excuse me. If you what?

Ms. JOHNSON. If we have future funding, if we do future rounds of funding, because that is the State Loan Repayment Program, which is a subset of our National Service Corps Program.

Mr. HARRIS. Right. But we are requiring, once again, the States to pay?

Ms. JOHNSON. When we have a new round of funding for it.

Mr. HARRIS. Okay. I yield back.

Mr. ADERHOLT. Mr. Pocan.

Mr. POCAN. Thank you, Mr. Chairman.

And thank you, Ms. Johnson, for being with us.

HEALTHCARE WORKER SUPPORT PROGRAMS

So I want to talk a little bit about the healthcare worker shortage still, I think, that exists. Part of it was obviously coming out of COVID. I think a lot of people went through an awful lot, just like our economy. When the countries across the globe reopened, we have worldwide inflation because of that supply and demand issue.

But one of the other issues that I think also is what we are paying folks. We talk about the training we absolutely need to do. But

I think also what we are paying folks can help keep people in the profession.

One of the trends that we have seen, at least in my area in Wisconsin that I am concerned about, is these almost temp type firms, that someone maybe worked for a hospital, but in order to get paid just a little more, they are going to this temp firm, maybe not with the same benefit structures, hiring them back sometimes in the exact same position at two or three times the cost, really raising the cost of healthcare for everyone.

Have you looked at that at all? And is there something, a solution that can happen? Because I am hearing it from the hospitals, but also I know ultimately that is not in the best interests of the workers, to go from a nice, permanent, full-time job with benefits to something that is temp in nature. Even though there is a short boost in pay, it doesn't solve long-term goals.

Ms. JOHNSON. I appreciate the question, sir.

I am very aware of the phenomenon and very aware of the impact that it is having on worker mobility and stability in a facility and the challenges it is presenting to maintaining a health workforce; however, also the opportunities it is presenting to workers to be able to maximize their revenue.

We don't have regulatory or reimbursement authority to govern what happens there. But what I can tell you, what we are doing at HRSA is we recognize that part of the dynamics that are happening in nursing right now. Nurses were heroes across the pandemic. They were the front lines. That is who saved us. We are here today because of the nursing workforce.

But what has happened is that we are seeing more challenges in being able to train more nurses. And it is not—interestingly, I think people might say: Well, is that because nurses aren't coming into the field because they see how challenging it is?

That is not what we are seeing. We are seeing many people raising their hands wanting to be nurses. We don't have the infrastructure to support it. There are not enough clinical faculty. There are not enough people who can oversee and be that mentor in a clinical training facility to be able to train new nurses. And when that happens, we see too much turnover of new nurses, and that contributes to the larger environment that you are referring to.

That is why our budget is investing in more faculty, more clinical preceptors, really recognizing what it takes to support the clinical nursing workforce and to make sure that nurses feel supported and mentored and well trained to deliver the highest-quality care.

Mr. POCAN. Great. Thank you.

So, I mean, if we wind up with 22 percent cuts in this area, not only can you not expand, but you would actually have to contract what you are doing in this area, causing even more burden on the healthcare facilities?

Ms. JOHNSON. That is correct. We would not be able to do the kinds of things that we want and need to do to grow the nursing workforce, but we would lose ground as well.

Mr. POCAN. Gotcha.

PROVIDER RELIEF FUND

One quick question on the Provider Relief Fund.

Under the Trump administration, the way they distributed funds, there was Federal funding that was sometimes used to subsidize mergers and acquisitions. I know there is an example with Apollo Global Management that owned a hospital; Lifepoint Health got $1,600,000,000 in COVID aid. And, instead of using that to improve patient care and respond to the pandemic, they bought another private equity-owned provider, Kindred Healthcare.

I believe you guys are looking at potentially trying to get some funds back from that. I am curious what you are doing in that area, because I think that is not the intention of that fund, yet we know it was used by some in that way.

Ms. JOHNSON. Thank you for raising the question.

We did hear, and my colleagues who are on the career staff who have managed this program for a long time now certainly heard the concerns about whether the resources from the Provider Relief Fund were driving mergers and acquisitions.

We added some additional reporting requirements in Phase 4 when we initiated a new program so that we would be able to identify people who have done mergers and acquisitions so that that could be part of our risk assessment criteria when it comes to accountability in the program.

Mr. POCAN. Will there be any attempts to try to claw back any funds?

Ms. JOHNSON. Well, we have a robust program integrity mechanism here, and we will look for appropriate use of funds.

Mr. POCAN. Okay. And would it be appropriate use of funds if they used it for mergers and acquisitions?

Ms. JOHNSON. So appropriate use of funds should be consistent with the statutory requirement that this addressed, losses and expenses associated with the virus.

Mr. POCAN. So if I can get a yes or no if it is possible. Will that include funds to do mergers and acquisitions?

Ms. JOHNSON. Well, part of the reason why we asked for the mergers and acquisition data, sometimes it is quite complex data that might point to a reason for having additional providers as part of the response. But sometimes it might be different and not consistent with the statute, and that is where we would have more authority to be able to address it.

Mr. POCAN. Okay. I look forward to having a more direct conversation on that.

Ms. JOHNSON. Thank you.

Mr. POCAN. Yield back.

Mr. ADERHOLT. Mr. Moolenaar.

COMMUNITY HEALTH CENTERS

Mr. MOOLENAAR. Thank you, Mr. Chairman.

I would also like to submit a letter from the National Association of Community Health Centers for the record.

Mr. ADERHOLT. Without objection.

[The information follows:]



April 26, 2023

The Honorable Robert Aderholt
Chairman
House Appropriations Labor, Health and Human Services Subcommittee
Washington, DC 20515

The Honorable Rosa DeLauro
Ranking Member
House Appropriations Labor, Health and Human Services Subcommittee
Washington, DC 20515

Re: Oversight Hearing – Provider Relief Fund and Healthcare Workforce Shortages

On behalf of the National Association of Community Health Centers (NACHC), I want to thank you for your focus on the critical needs of the healthcare workforce and the opportunity to provide feedback on solutions to improve our nation's workforce crisis. NACHC is the preeminent national membership organization for federally qualified health centers (also known as FQHCs or Community Health Centers). FQHCs are federally funded or federally supported nonprofit, community-directed provider clinics serving as a health home. Health centers depend upon a host of providers, clinical support, and administrative staff to deliver affordable and accessible health care across the nation and its territories.

In 2021, health centers reached a historic milestone of serving over 30 million patients, including one in five Medicaid beneficiaries and one in three people living in poverty. As Community Health Center grantees, health centers must be in or serve patients in geographic areas designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA).

Health centers' model of expanded access to primary care generates savings for public insurance programs and the health care system overall. Adult health center patients on Medicaid show 15 percent lower costs compared to non-health center patients as a result of reduced utilization of in-patient care and preventable hospitalization. Medicaid spending is $2,400 less per year for adult Medicaid patients at health centers compared to non-health center patients.[1]

The collective mission and mandate of the 1,400 health center organizations nationwide is to provide access to high-quality, cost-effective primary, preventive, and behavioral health care. These primary care services include family and internal medicine, pediatrics, obstetrics/gynecology, diagnostic laboratory and radiological services, preventative health, urgent care, and pharmaceutical services. Health centers must also provide case management to support patients accessing community programs that enable them to utilize health center offerings such as transportation and language services appropriate to their community's demographics.

An Overview of Health Center Workforce Shortages

Over 270,000 dedicated professionals work at 14,000 Community Health Center locations across

[1] Nocon R. Research on Health Center Value and Financial Performance. Presented at the NACHC Community Health Institute. August, 2022. *Publication in- press.*

the United States, including territories. Health center staff, including physicians, nurse practitioners, physician assistants, dentists, pharmacists, behavioral health staff, licensed clinical social workers, case managers, allied health professionals, and administrative staff, are the backbone of the Community Health Center program – reaching millions of patients regardless of their socio-economic, language, racial, or ethnic status. Health centers' ongoing workforce challenges are a significant barrier to strengthening primary care. Challenges include growing salary gaps, burnout, early retirement, and marketplace competition. Severe workforce shortages, which existed long before the pandemic, threaten to destabilize an already fragile health center workforce. A 2022 NACHC survey found that 68% of health centers lost between five and twenty-five percent of their workforce in a 6-month period. Nurses represented the highest category of workforce loss, followed by administrative, behavioral health, and dental staff. Competition from other employers and pandemic stress were the most common reasons for staff departure.

In addition, policy changes from the unwinding of the Public Health Emergency (PHE) and the expiration of pandemic relief funding will financially impact health centers and reduce resources for direct patient care. A recent NACHC survey of health centers found that 30% of health centers may need to lay off staff due to these changes and the uncertainty of continued federal funding.

Difficulty of Keeping Pace with a Health Workforce Salaries

Rising wages combined with uncertainty around health centers' funding has hindered their ability to keep up with salary expectations in a competitive labor marketplace. Every year, NACHC surveys health centers to gather information about salaries and other forms of compensation for essential healthcare providers. When comparing health centers' salaries with salaries reported to the Bureau of Labor Statistics, health centers pay less than other providers for in-demand occupations. These circumstances limit the ability of health centers to compete in a tight labor market.

The greatest differences are seen for registered nurses who make an average of 25% more nationally as compared to the average salary at a Health Center, General Internal Medicine Physicians make 19% more nationally, and Obstetricians and Gynecologists make 14% more nationally. Anecdotally, health centers have shared stories about the difficulty in competing with larger health systems because of their inability to pay competitive salaries.



The Growing Need for a Robust Health Center Workforce

Primary Care Shortages

The National Academy of Sciences, Engineering, and Medicine reports that an increased supply of primary care providers is associated with better population health and more equitable health outcomes. Yet, the United States has historically underinvested in primary care. The U.S. now faces a worsening shortage of primary care providers. A recent study conducted by HealthLandscape of the American Academy of Family Physicians estimates that 100 million Americans – nearly one-third of the population – are at risk of lacking access to primary care due to a shortage of providers in their local community. This number is nearly double the findings of a similar report conducted in 2014. The lack of primary care providers in the United States poses a serious public health threat, leaving nearly one-third of the population vulnerable to preventable chronic diseases and emerging threats like COVID-19 and influenza.

Gaps in primary care persist due to a nationwide primary care provider shortage that is driven by increased medical specialization and an uneven distribution of providers. Clinical trainees are pursuing increased specialization, which has led to a decline in the proportion of students and residents entering primary care. Consolidation and clinic closures across the primary care field are also exacerbating the problem of unequal distribution. This pattern leaves fewer providers to care for rural communities that are more sparsely populated and may have a lower median household income. These barriers lead to delays in care, poorer health outcomes, and broader health disparities.

The current state of primary care is in crisis, but the situation could worsen as patients and doctors get older. The Association of American Medical Colleges reported that more than 40% of active physicians in the U.S. will be age 65 or older within the next ten years. Over 40% of physicians retire before age 65, according to the American Medical Association. Together, these trends could lead to a shortage of over 55,000 primary care physicians by 2033. Thus, the need to aggressively invest in successful professional and pre-professional programs to attract interested students to the profession and prepare current students for health careers.

To meet the increasing demand for health care services, Nurse Practitioners (NPs) and Physician Assistants (PAs) are playing a vital role in closing the physician gap. Continued investments in these career paths will be critical to fill gaps in primary care.

Behavioral Health Shortages

Health centers experience challenges recruiting and retaining specialty staff due to provider shortages and high rates of salary inflation. Health centers ranked behavioral health staff third in terms of highest vacancy rates, behind nurses and administrative staff, during a 6-month survey period in 2022. Health centers reported in 2022 that competition from other employers and pandemic stress were the most common factors driving workforce attrition.

Amid the workforce shortage, demand is increasing. In a survey of National Council for Mental Wellbeing members, 78 percent of mental health organizations surveyed reported the demand for their services had increased in the previous three months; 62 percent of organizations reported growing patient waitlists; and almost all, 97 percent, reported trouble recruiting and retaining

employees.

As demand for services increases, so does worker burnout. A study by The Center for Health Systems Effectiveness at Oregon Health & Science University found that higher client complexity, large caseloads, and increased administrative burdens contribute to worker burnout and high turnover. These issues can be more significant for providers who work in community-based facilities, particularly those serving under-resourced communities, tribal communities, and communities of color. Provider turnover causes additional administrative tasks related to case management, transferring health records, insurance, and billing. Turnover can delay care and further challenge patients to find a new provider, especially when needing a bilingual or bicultural practitioner. These factors lead behavioral health providers down a spiral of increasing costs, turnover, and stress on those seeking services.

Dental Provider Shortages

In a survey by several leading dental associations, staffing issues were cited as the most significant concern among dentists in 2022. Four in 10 dental practices indicated they were recruiting or had recently recruited dental assistants, and nearly the same percentage were recruiting dental hygienists. Nine out of 10 dentists recruiting for these positions described it as "extremely" or "very" challenging. Additionally, in July 2022, about one in three dentists who did not have full schedules indicated that vacant staff positions were at least part of the problem. Dental staff ranked fourth in vacancy rates among health centers.

The future appears to be even more challenging. Approximately one-third of the dental assistant and dental hygienist workforce expect to retire in five years or less. At the same time, the pipeline of new providers has grown smaller. Enrollment in dental hygiene and assisting programs declined from pre-pandemic levels in 2021 – 2022. Although the numbers have rebounded for dental hygienists post-pandemic, the decline in enrollment for dental assisting seems to be part of a long-term downward trend, as is the number of accredited dental assistant programs available.

Solutions to Address Health Center Workforce Needs

Effective investments in community-based workforce training programs will help address the healthcare workforce crisis. NACHC encourages solutions to focus and invest in primary care, behavioral health, and dental programs to support, develop, and expand a diverse, high performing, committed workforce. It also requires approaches that recognize and properly finance new models of team-based care that include various allied health professionals, navigators, peer counselors, and other staff while encouraging all clinicians to practice at the top of their license.

As the central primary care provider for underserved populations and communities, health centers rely on several critical federal programs with long-term demonstrated success to retain, recruit and prepare the next generation of the healthcare workforce. NACHC's policy recommendations focus on four areas:

1. Continued investment in long-standing HRSA primary care provider recruitment and retention workforce programs, including the National Health Service Corps and Nurse Corps.
2. Expansion of community-based training models to retain, recruit and prepare the next

generation of health care professionals, such as the Advanced Nurse Practitioner Residency Training Program.

3. Establishment of a flexible Health Care Workforce Innovation fund within HRSA to support allied health pre-apprenticeship, apprenticeship, and career laddering programs and incentivize health centers to participate in preceptorship/faculty programs with academic institutions.
4. Robust funding support for Behavioral Health Workforce Development Programs to increase the pipeline of behavioral health clinicians, professionals, and paraprofessionals, and enable provider organizations including health centers to implement employee wellness programs to address mental well-being and wellness.

Policy Recommendation #1: Continued robust investments in long-standing primary care provider recruitment and retention workforce programs, including the National Health Service Corps and Nurse Corps.

National Health Service Corps and Nurse Corps: Successful Primary Care Models

The National Health Service Corps (NHSC) connects primary healthcare clinicians to people with limited access to healthcare in high-need areas and invests in the next generation of primary care providers. The NHSC supports seven types of programs that place clinicians at NHSC-approved sites and provide scholarships and loan repayment to primary care, dental, and behavioral health providers with varying levels of support for their commitment to serve in medically underserved urban and rural areas. As of September 30, 2022, more than 20,000 primary care medical, dental, mental, and behavioral health providers served in the NHSC – representing the largest cohort in the program's 50-year history. Thousands of NHSC providers serve at more than 9,000 community health center locations, including school-based health centers. According to HRSA, 86% of NHSC participants continued to provide care in a health professional shortage area after two years. Robust discretionary funding for the National Health Service Corps Substance Use Disorder Workforce Program will increase the field strength of mental and behavioral health providers, including peer support specialists, and clinicians who provide opioid and substance use disorder treatment.

Like the NHSC, the Nurse Corps provides scholarships and loans to nurses and nursing students in exchange for a commitment to working in a healthcare shortage area after graduation. According to HRSA's Alumni Clinician Dashboards, 87 percent of Nurse Corps Alumni who completed service between FY2012 – FY2021 currently work in HPSAs. Since 2021, more than 2,300 Nurse Corps clinicians provide care to underserved patients at more than 1,900 sites in the U.S. including 1 in 5 serving in rural communities and more than 600 Nurse Corps clinicians serving at Community Health Centers in 2022. Robust investment in the Nurse Corps to support more than 22,900 Nurse Corps sites in the Health Workforce Connector. Over 600 Nurse Corps clinicians work at Community Health Centers, and more than 800 Nurse Corps participants serve at rural sites and schools.

Policy Recommendation #2: Expansion of community-based training models to retain, recruit and prepare the next generation of health care professionals, such as the Advanced Nurse Practitioner Residency Programs.

In its 2021 report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health*

Care, the National Academy of Sciences, Engineering and Medicine (NASEM) provided five recommendations for primary care financing, workforce, access, training, and research. In particular, Objective 3 in the report underscores the importance of training primary care teams in community-based settings. NACHC has embraced this approach as the foundation for its comprehensive health center workforce strategy.

Federally funded programs to support new graduate nurse practitioners with an additional year of training are a critical component of meeting the health center provider workforce challenge. The model for this program, which provides a year of postgraduate training, has its roots in health centers. Studies that have shown primary care nurse practitioners with residency training are more likely to mirror their patient populations and were more diverse, and more likely to provide care for underserved populations with limited English proficiency.

NACHC recommends continued funding for the Advanced Nurse Practitioner Residency Programs to increase the number of primary care and psychiatric/mental health nurse practitioners with an intensive one year of postgraduate clinical training. Today there are nearly 350 such programs operating in health facilities nationwide (delivering both primary care and specialty training), with 115 primary care programs in FQHCs alone. In FY2021, eighty-three percent of new nurse practitioners continued working in medically underserved communities and/or rural areas after completing a HRSA-supported nurse practitioner residency or fellowship program.

Policy Recommendation #3: Creation of a flexible Bureau of Health Workforce (BHW) Innovation Fund within HRSA to support allied health pre-apprenticeship, apprenticeship, and career laddering programs and incentivize health centers to participate in preceptorship/faculty programs with academic institutions.

Retaining and recruiting medical and dental assistants, pharmacy technicians, and other allied support staff is one of health centers' most persistent problems. There are limited options to promote these fields despite the significant need. A new flexible fund would enable new pipeline programs, such as pre-apprenticeship, apprenticeship, and career laddering programs that offer certifications for participants and provide a pathway to a rewarding career in healthcare. A new grant program would enable existing health centers and other community-based programs to be scaled and replicated, particularly in rural and frontier communities.

Flexible funding will also enable HRSA to provide incentives, including financial support, to health centers for establishing formal agreements with academic institutions that educate nurse practitioners, physician assistants, nursing, dental and medical students under which the health centers accept their students for formal clinical training experiences and provide preceptors as part of that training. Examples include the Area Health Education Center (AHEC) Program, which provides continuing education and community-based training activities for practicing health professionals. Approximately 70% of these training sites are located in medically underserved communities, including rural areas. The Health Careers Opportunity Program (HCOP), which recruits individuals from economically and educationally disadvantaged backgrounds to develop skills needed to compete, enter, and graduate from health profession or allied health programs. According to HRSA, funding for these programs is awarded to the academic institutions that administer them, and it is unclear how much of this funding goes to community-based

organizations, such as health centers. Often, Community Health Centers partner with academic institutions to support participants' experience in a community-based setting. However, many times health centers are not compensated for their training which involves significant provider and staff time to operate the program. The BHW Innovation Fund could foster greater collaboration between health centers and academic institutions to increase the numbers of health professionals who find meaningful work in community-based settings.

Policy Recommendation #4: Provide robust funding to support Behavioral Health Workforce Development Programs to expand the numbers of behavioral health providers, professionals, and paraprofessionals in medically underserved and rural communities; and continued investment in resilience and behavioral health programs for healthcare professionals to address burnout, fatigue, and mental well-being.

According to HRSA's 2022 Behavioral Health Workforce Projections, 2020-2035, there is a dearth of behavioral health providers across the industry, particularly addiction counselors to address the most recent spate of opioid overdoses and addiction. Strategic investments to expand Behavioral Health Workforce Development Programs will benefit millions of Americans of all ages who live in rural and medically underserved communities.

In 2020, over 2.8 million people received behavioral health services at Community Health Centers – a 100 percent increase from 2014 to 2020 due to significant federal investments in behavioral health services. However, HRSA estimates that another 7.7 million health center patients need behavioral health care. Federal investments in creating more comprehensive behavioral health pipelines will be critical to addressing the post-COVID mental and substance use crises. There are several HRSA-supported BHWD Programs health centers can leverage as recruitment tools including the Integrated Substance Use Disorder Training Program (ISTP) and the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP) to expand the pipeline of behavioral health practitioners.

Additionally, robust funding to support the mental health of the health professions workforce will enable health care entities including Community Health Centers to implement wellness, resilience and mental health programs for employees using established or evidenced-based practices. The COVID-19 pandemic hastened the departure of many primary care providers into retirement or to less-demanding jobs. Implementing evidence-based informed strategies that help health centers respond to workforce stressors, avoid burnout, promote suicide prevention, and address other risk factors to foster a healthy workplace environment will be key in retaining health center employees.

The success of the health center model demonstrates the importance of a consistent source of primary care to overall patient health. Health centers provide relationship-based care for everything from basic health needs to chronic disease management and coordination with specialists. Combining high-quality primary care and integrated services has resulted in a cost-effective care model that drives positive health outcomes. Health centers reduce the need for emergency room visits and inpatient care, and health center patients have 24% lower medical expenditures overall. Despite caring for clinically at-risk patient populations, health centers consistently exceed quality measures and achieve higher rates of positive health outcomes than private practices. Much of this success can be attributed to the commitment of a highly dedicated

and trained Health Center workforce.

NACHC recognizes the budget environment around federal spending, and if funding is available, Community Health Centers are a reliable provider to continue strengthening the nation's health care workforce and support the wellbeing of all patients. For decades, health centers have provided high-quality, cost-effective, comprehensive care to millions of patients in medically underserved communities. The health center model ensures that all individuals can access affordable care that is patient-centered and community-based, regardless of their income or insurance status.

We thank the House Appropriations Labor, Health and Human Services Subcommittee for their leadership to find solutions to strengthen the healthcare workforce, which will ultimately improve healthcare outcomes and access to services for health center patients. We appreciate the opportunity to support this work. If you have any questions, please feel free to contact Nicholas Widmyer, Director of Federal Affairs, or Deila Davis, Workforce Policy Lead at ddavis@nachc.com.

Sincerely,

Joe Dunn

Joe Dunn
Senior Vice President, Public Policy & Research
National Association of Community Health Centers

Mr. MOOLENAAR. Thanks.

Thank you, Ms. Johnson. I appreciate you being here.

I appreciated your comments on the workforce and the need to continue to grow the workforce. I just want to highlight some of the work that is being done by our community health centers.

Northwest Michigan Health Centers is one such community health center that has recently initiated workforce training for medical and dental assistants. And due to the workforce shortage for the area, they found it more beneficial to train and provide professional growth for their staff. And their workforce program is a great lifeline for the health center. And so I just wanted to highlight the work they are doing.

I also wanted to follow up with you on one of the questions raised when you talked about the Phase 4 reconsideration regarding the tail end of COVID.

You mentioned that there are 2,000 applications for that?

Ms. JOHNSON. That is correct.

Mr. MOOLENAAR. If you had to guess—I am assuming that those are people who were denied initially, and they are reapplying—what percent do you think will be adjudicated differently?

Ms. JOHNSON. I appreciate the question, Congressman. It is a fair question. I don't know the answer to that, because it is very application specific.

Mr. MOOLENAAR. Okay. And do you know the average amount, dollar amount, of applications?

Ms. JOHNSON. I don't, but we are happy to get back to you on that.

I will say it will be very small providers, very large providers. I am not sure the average will be particularly telling. But we will be happy to get back to you with it.

Mr. MOOLENAAR. But would you agree, if money is in Federal budgets or agencies that has not been obligated or allocated and it was given under the auspices of a COVID emergency, would you agree that those dollars shouldn't be spent just on different priorities other than addressing the COVID emergency?

Ms. JOHNSON. Well, I would say, sir, that throughout the life of the Provider Relief Fund it has been used both in the prior administration and this administration for doing some of the emergency needs response, including acquisition of products and other things. So that has happened across the Provider Relief Fund.

Mr. MOOLENAAR. Sure. During the emergency. But once the emergency is over, would you agree we shouldn't be spending those dollars for a different purpose than an emergency?

Ms. JOHNSON. Oh, I see your question.

I would say that there is a part—while the public health emergency is ending, we are making a thoughtful transition. It has always been the case that there would need to be a thoughtful transition from all the emergency response mechanisms to the commercial market, and ensuring that there is a smooth transition to the commercial market is something that I think we all have a vested interest in.

Mr. MOOLENAAR. Sure. So, I mean, there will always be spending needs. But, I mean, I guess, if I were saying, okay, this money was to be spent during an emergency, I think it would be somewhat dis-

ingenuous to then spend it on something that is not during the emergency, but rather just another priority spending, which should be handled by the regular appropriations process, I would think.

Does that make sense?

Ms. JOHNSON. I see your point, Congressman, but I would just say that I think that part of what the goal here is, is to make sure there is as smooth a transition as possible.

I think everyone would agree that commercialization of the products associated with the COVID response needs to happen and happen in an orderly way. But there are uninsured folks who will not be part of that, and so that is partially why this smoothing out is being invested in.

PROPOSED CUTS

Mr. MOOLENAAR. Okay. You have looked at proposed cuts. I am not sure exactly what number you are basing that on or what the proposal you are evaluating it on. What proposal are you using to make those?

Ms. JOHNSON. Those numbers are associated with the request with an estimate of a 22 percent reduction.

Mr. MOOLENAAR. Okay. And where did you get that?

Ms. JOHNSON. Those were estimates that we were, in general, asked about.

Mr. MOOLENAAR. And who asked you to do that?

Ms. JOHNSON. It is a really good question. I am not sure. We were asked to respond to an across-the-agency—across-the-department response.

Mr. MOOLENAAR. But do you know who asked that? I mean, what is that based on, that 22 percent?

Ms. JOHNSON. I don't——

Mr. MOOLENAAR. Oh, I am asking—if I could ask the witness to——

Ms. DELAURO. Sure, but I made the request of the agencies to get information, and that is why Ms. Johnson——

Mr. MOOLENAAR. Okay. So that was Ms. DeLauro. Thank you. Okay.

What have you been requested to look at if—if we don't address the $32,000,000,000,000 debt that we have, have you considered how your budget in the future and training would be affected by that if we don't adequately address that problem for our country?

Ms. JOHNSON. Well, I think, Congressman, there will always be a question about the larger backdrop against which investments are made. We think that the needs to invest in the healthcare workforce and the needs to ensure the health and well-being of our communities is always going to be a priority. And so that is why we want to make sure that we are investing now so that we have people in the training pipeline for the years to come.

Mr. MOOLENAAR. So I am going to take that as a no, that you haven't really looked at what the challenge of a $32,000,000,000,000 debt would mean for future investments.

Ms. JOHNSON. I don't——

Mr. MOOLENAAR. You haven't really analyzed that?

Ms. JOHNSON. I don't know that we have been asked that question specifically. I do know that we have weathered budget issues,

up and downs in the years past. And whenever there are cuts to health workforce programs, the repercussions are felt for years beyond.

Mr. MOOLENAAR. Sure. Okay. Thank you very much.

I yield back.

Mr. ADERHOLT. Ms. Frankel.

BUDGET CUT IMPACTS ON MATERNAL HEALTH WORKERS

Ms. FRANKEL. Thank you.

And to Administrator Johnson, thank you for your good work and for being here.

Ms. JOHNSON. Thank you.

Ms. FRANKEL. Today, or sometime this week, we are going to be voting on a bill that is called—what is the name of this bill? Well, whatever.

Ms. DELAURO. Default on America.

Ms. FRANKEL. What is it called?

Ms. DELAURO. Default on America.

Ms. FRANKEL. Default on America Act. Okay. Yes.

And really, this is going to be a terrible choice. It is a choice of whether we wreck our economy or we inflict cruel cuts on everyday Americans. That is what this is about.

So I want to get right to your programs and see what the proposed 22 or 25 percent cut is going to mean.

The United States has the highest maternal mortality rate in any developed Nation in the world. Women of color are disproportionately impacted by maternal mortality. And we need more maternal health workers to address the crisis, not less.

So tell us what these budget cuts would mean, a 22, 25 percent cut would mean.

Ms. JOHNSON. So thank you for the question. One of the things that is operationally as a program manager is interesting and challenging for us is that we got some additional resources in the fiscal year 2023 budget to help grow some of these programs, particularly our maternal depression program, which provides teleconsultation services from mental health professionals to OBs and OB/GYNs to help address the mental health needs of pregnant women. So we are going to make new awards this year that we may need to roll back next year. And so that is a very difficult funding environment as a program manager for us to be in, especially because that is such a—we have so much demand among States for that service, and there is so much interest in people applying for it.

We also have been able to grow our maternal mental health hotline with resources from the budget, and we would have to roll those resources back. And we are the funder of the Title V Maternal and Child Health block grant that helps every State across the country. Your State does newborn screening with those resources. It does early intervention services. It does a host of critical services for zero to 3 that we will have to roll back.

Ms. FRANKEL. In other words, if Republicans have their way, more women will die at childbirth than less. All right, I think that is what you just said.

Next, in recent years, there has been a steady stream of new stories reporting the closure of maternity care units in hospitals

across the country. In the past decade, over 200 U.S. hospitals closed labor and delivery departments. And, according to the most recent data of the March of Dimes, nearly 500 births occur in areas of low or no access to maternity care.

So, first of all, tell me how you have been using your investments to change that and what the budget cuts would do, the proposed 22 to 25 percent cut proposed by the Republicans.

Ms. JOHNSON. Well, thank you, Congresswoman, for raising the issue. I mean, if you asked me about what keeps me up at night, this is the issue that keeps me up at night, the closure of the labor and delivery services in not just rural areas, which has been happening for some time and continues to happen in rural areas, but more frequently now in like exurban and suburban areas, where the distance to get to a labor and delivery site is continuing to grow.

We are investing, particularly in rural communities, in building community networks, in putting the payers and the hospitals and the emergency services and everyone together around the table to find solutions, but they are patchwork solutions. We are investing in the healthcare workforce to put more providers into the community to be able to do prenatal care earlier so we are able to do better planned deliveries.

But we are doing a host of things around the workforce and around service delivery. We are going to make awards soon to invest more maternal care services in health centers, but all of those things are contingent on budget availability.

Ms. FRANKEL. All right. In other words, there are going to be less hospitals, delivery labor services than more.

And, just as a side note to this, in Florida, where we have very good sunshine, our new abortion law there, as a result, the doctors are leaving like crazy. So, folks, between the budget cuts and the abortion restrictions, those of us who live in red States are going to have a hard time finding gynecologists who deliver babies and who take care of them.

And, with that, I yield back.

Mr. ADERHOLT. Ms. Letlow.

CONTRACT LABOR AND CLINICAL FACULTY

Ms. LETLOW. Thank you, Mr. Chairman.

Thank you, Ms. Johnson, for being here with us. I enjoyed our phone call a couple of weeks ago and all that HRSA does for my district in Louisiana.

I want to go back to the contract labor issue. In my district alone in Monroe, Louisiana, St. Francis Medical Center was quoted $88 an hour for a single contract nurse. Some facilities, including St. Francis, are still struggling to respond to the workforce shortage, and this is the only option to ensure adequate staffing.

Relying solely on contract labor creates an unstable and unreliable workforce. We both know that adequate staffing has a direct impact on patient access to care. So while I know we have—you have covered this today, exactly what is holding us back from delivering on this workforce shortage? I heard you mention not enough clinical faculty, and coming from higher ed, then is the onus on our universities? Is there anything that HRSA is doing to collaborate

with the universities in order to increase the number of clinical faculties that we have so we can train more nurses to get them into the workforce.

Ms. JOHNSON. I so appreciate the question because it is what we really are honing in on, is how do we get more clinical faculty. And it is not just the onus on academic medicine. It is about the healthcare delivery sites as well.

Ms. LETLOW. Right.

Ms. JOHNSON. And so sometimes, when I talk to hospital administrators, they say: I would love to train more nurses in my site; I just don't have enough room to be able to do it.

And so part of our goal is to recruit more people into clinical faculty. It is hard, right, because we also want people delivering care.

Ms. LETLOW. Right.

Ms. JOHNSON. And so it is time away from care. So part of what we are able to do is support that work. But we also need holistically to focus on how to make sure there is clinical training delivery sites. And that is why we are continuing to use community health centers and other sites as ways to do nurse residency training, places where we can maximize our whole clinical footprint for training sites.

Ms. LETLOW. That is interesting. I am not hearing that clinical training sites are the issue in my district per se. I am not saying it is not across the country, but just that it is a matter of training the nurses and the shortage there with clinical faculty. I am just wondering, is it an accreditation issue? I mean, what is happening with our universities not being able to take in more nurses? Just like you said, people want to go into nursing.

Ms. JOHNSON. Yeah.

Ms. LETLOW. So I would like to hear your thoughts on that.

Ms. JOHNSON. You may be hearing something different. I would love to hear what you are hearing. But a part of what we hear is that, when there is resources to be made as traveling nurses or when hospitals are trying to fill slots, the competitive salaries for faculty may not be as easy to fit—may not make it as easy to fill. And so that is why we do loan repayment for faculty. That is why we are really focused on programs like our Nurse Corps program for faculty to try to get people into faculty roles and maybe not exclusively, maybe ensuring they can continue to deliver services as well so that they can meet the salary objective that they want.

Ms. LETLOW. So how specifically are you using that program to recruit them?

Ms. JOHNSON. So the one thing that is really great about our Nurse Corps program is it is like our National Health Service Corps program, where individuals come to us directly. A lot of our programs are mitigated through academic medical centers, and then we are sort of dependent on how the center runs the program. With Nurse Corps, nurses come directly to us to apply for loan repayment.

Ms. LETLOW. Okay.

DELTA REGIONAL RURAL HEALTH

In fiscal year 2022, HRSA funded five grants totaling $2.6 million for the Delta Regional Rural Health Workforce Training Pro-

gram, which supports the education and training of future and current healthcare professionals in rural communities and parishes of the Mississippi Delta region. Could you please provide an update on the progress these grants have made?

Ms. JOHNSON. Thank you so much for the question. If you don't mind, I would love to have the opportunity to brief you more fully about all the work that we are doing in this space.

I will say that it is an essential partnership for us. And we are grateful to the committee for supporting this work because it has allowed us to really focus on identifying what the workforce needs are and really being informed by—allows us to design our resources to meet the needs rather than us having a program and people coming applying to it trying to guess how it might align with what their needs are. And so the Delta Program is a really critical part of our work.

Ms. LETLOW. Great. How many competitive applications for this program are considered highly qualified and scored exceedingly well but did not get the funding? How much funding would it take to reach those that missed out on the grant opportunity?

Ms. JOHNSON. I am happy to get back to you with the specifics. I know that it is more than we could award.

Ms. LETLOW. Okay. I would appreciate that. Thank you so much for your time.

I yield back.

Mr. ADERHOLT. Mr. Harder.

CMS REIMBURSEMENT

Mr. HARDER. Thank you so much, Chair Aderholt and Ranking Member DeLauro, for hosting today's hearing.

Thank you, Administrator, for being here.

I am very focused on the workforce challenges that we have in our area. Cities in my district have been designated as health professional shortage areas. San Joaquin County has been classified as a medically underserved area. And these definitions have real consequences. They are definitely accurate. One in five hospitals across our region are in danger of closing right now. Life expectancy is 7 years less in my district than it is 2 hours away in San Francisco. So we are paying real costs for our lack of providers.

I want to learn about how your definitions are used elsewhere. So CMS manages reimbursement for all the physicians in our area. Does CMS reimburse medically underserved areas like ours more than they do areas that are not medically underserved?

Ms. JOHNSON. As a general matter, I don't believe so. But, in the Affordable Care Act, there was a targeted program linked to health professions shortage area, but as a general matter, that is not part of the standard——

NIH AND CDC IN UNDERSERVED AREAS

Mr. HARDER. And, in fact, the exact opposite. Right? I mean, because areas like mine are 50 percent or Medi-Cal or Medicaid. Physicians are actually paid a lot less in our area. What about the NIH? This committee manages the NIH budget. The NIH budget is 25 times the HRSA budget. Does the NIH give special consider-

ation towards their clinical research being done in areas that are underserved?

Ms. JOHNSON. I don't know that as a general matter. I know that, in this administration, the NIH has reached out to us repeatedly to say, how can we better integrate the community health centers and others who do work in underserved areas into clinical trials? That is something they are very focused on.

Mr. HARDER. I would love to see that because the vast majority of NIH budget is San Francisco, New York, Boston, areas that have a whole lot more physicians than they know what to do with, and not research being done in areas like ours.

The CDC is another organization that is under this committee's jurisdiction. They embed clinical researchers in public health departments. Do they embed a lot more in medically underserved areas?

Ms. JOHNSON. I don't know the answer to that question.

Mr. HARDER. The answer is no. Unfortunately, and this goes to what I think is probably the key issue in this hearing and on workforce shortages across healthcare, is this is not a challenge that is going to be fixed by HRSA. You guys are doing terrific work, and I am very grateful for you coming up with the definitions of zones like mine that are medically underserved. But, if we are really serious about this challenge, and I think we should be, then we have to do a much better job of trying to embed those criteria in the other parts of the healthcare budget. Because 99.9 percent of the Federal healthcare budget is not taking into consideration these workforce shortages, and that is the root of the issue.

So I am very grateful for this hearing. I think it is a really, really important issue, but I submit to the committee's leadership that, if we wanted to address these workforce shortages, this is not going to be fixed by changes with HRSA. This is going to be fixed by requiring other agencies under this committee's jurisdiction to consider HRSA criteria as important when actually divvying out those resources. And we can do a lot in order to fix this. If we actually make reimbursement rates higher in medically underserved areas, if we make NIH research go more toward medically underserved areas, we can actually entice a lot of doctors and nurses to come to areas that are desperately needed. And I hope we are successful in doing that.

So thank you so much for your work, Administrator. Thank you for the research and the work that you have done to highlight areas like my district that are in desperate need of more doctors, and I hope we can take more action to make sure that we can address these needs.

With that, I yield back.

Mr. ADERHOLT. Mr. Clyde.

HEALTH CARE WORK FORCE SHORTAGES

Mr. CLYDE. Thank you, Mr. Chairman.

And thank you, Administrator Johnson, for being here today.

The Health Resources and Services Administration is tasked with many important duties, including serving rural communities like mine in Georgia Nine.

While we are looking at your fiscal year 2024 budget, I have some concerns about how money is being allocated, especially regarding healthcare workforce shortages. We have seen a healthcare workforce shortage, including in my State of Georgia. For example, the Kaiser Family Foundation predicts that Georgia would need an additional almost 700 primary care professionals to fully serve the State just this year. So I think we really need to be looking for ways to attract and retain talent in these areas of need.

The statistics are alarming. The University of St. Augustine for Health Sciences predicts that our Nation will need 1.2 million new registered nurses by 2030 to address the shortage. Would you agree that where money is spent is directly related to what priorities are held?

Ms. JOHNSON. Yes, sir. And you will get no argument from me that we need to do more and more on the workforce in rural communities.

Mr. CLYDE. All right. Thank you.

The fiscal year 2024 budget request, $24,300,000 for the Nursing Workforce Diversity Program to increase nursing education opportunities for individuals from disadvantaged background, including racial and ethnic minorities.

With this mind, it leaves me to ask, is the priority of HRSA to fill the nursing workforce shortage, or is it to address the diversity in the nursing workforce?

Ms. JOHNSON. Our priority is to address the nursing workforce writ large. Part of that is the program you have referenced is about ensuring that we are giving every opportunity to people from disadvantaged backgrounds to be able to enter the nursing workforce and so that, in many communities, the healthcare workforce reflects the community served. We do similar work in rural communities to recruit people from the community to be able to serve their own community.

Mr. CLYDE. Okay. I kind of think maybe focusing just on merit and those who want to be nurses, regardless of what their background is, will probably help you get more people into the workforce.

Now transitioning to the COVID–19 vaccine, that mandate is still in place, correct, for healthcare workers?

Ms. JOHNSON. I don't know the answer to that, sir. I think so.

COVID VACCINE MANDATE

Mr. CLYDE. I believe so. So, if we want to increase the number of healthcare workers, I think it would be beneficial if we would eliminate those factors that are actually hurting recruiting for healthcare workers. And one of those is the COVID–19 vaccine mandate. We have seen that time and time again. In my district, we had numerous healthcare workers depart, the pattern, if you will, or leave the workforce simply because of the vaccine mandate. They didn't want to be part of what they thought would hurt them. So is that anything you are considering whatsoever?

Ms. JOHNSON. So, sir, that policy is not in my jurisdiction, but I will tell you, as I talk to healthcare providers now and I assume you have heard similar, what we hear consistently is we need more people in the pipeline. We need more people getting trained. And

so that is where we are really focused on getting people trained up and ready and available to be able to practice.

Mr. CLYDE. Right. But just like what we are seeing in the military, where we are seeing a reduction in recruiting and part of that is because people don't want to be forced to take the vaccine in the military—fortunately, that is over now, but that still exists when it comes to healthcare workers. That mandate is still there. And I think that really needs it be looked at and said: Okay. Maybe we need to eliminate that vaccine mandate so that people will then be more willing to enter the healthcare workforce.

Now, Administrator Johnson, is the Countermeasures Injury Compensation Program providing reimbursement for COVID–19 vaccine-related injuries?

Ms. JOHNSON. It is.

Mr. CLYDE. It is. Okay. It appears in your fiscal year 2024 budget request that you are asking for over a 100–percent increase in that area in your budget. Does this more than doubling of funding indicate that the Biden administration is anticipating a significant increase in vaccine injuries related to COVID–19 vaccines and a significant number—an increase in payouts?

Ms. JOHNSON. Sir, I believe you are referring to the line item in our budget that would go from $7,000,000 to $15,000,000.

Mr. CLYDE. That is correct, over 100 percent increase.

Ms. JOHNSON. And that is associated with the fact that, for the 10–year history of the Countermeasures Injury Compensation Program, we had 500 claims. Today, more than 700 million doses of COVID vaccine have been delivered. So, while rare, the number of claims we have gotten associated with potential injuries is higher than the history of the program. So we have 8,000 claims associated with potential vaccine injuries. We need, to ensure that people get timely consideration of their application, we need more medical reviewers. We need more capacity to be able to give people answers in a more timely way, and that is what our request is associated with.

Mr. CLYDE. Thank you. And I yield back.

HRSA OUTREACH

Mr. ADERHOLT. Mr. Ciscomani.

Mr. CISCOMANI. And my microphone isn't working so I will use yours.

On my committee, TI committee, I was sitting down there so I am just glad to have actually a seat at the table. But my time is running so I better stop.

Well, Administrator, thank you so much for being here. Thank you for answering our questions. My question is related to my own community college where I graduated from. I am a proud graduate of Pima Community College over in Tucson, Arizona. And one of the programs they offer to students includes degrees in nursing, certificates of practical nursing, and courses to help prepare nursing assistants as well. They do a terrific job at this, and even though Pima Community College does a fantastic job in training aspiring healthcare professionals, administrators at the community college have confirmed with me that they have not been receiving any funds from HRSA for their nursing program to help strengthen

the workforce yet. So my question is pretty simple: What type of outreach does HRSA do to make sure the nursing programs are aware of the grant opportunities that HRSA offers?

Ms. JOHNSON. I am so glad that you raised this question, sir, because one of the things that I, in my role as HRSA Administrator having been in this role for about 15 months, have prioritized is our outreach to eligible entities and being more clear in our funding opportunities about who is eligible. We tend in many instances to just repeat the statutory language that says, you know, all eligible entities, all entities that provide these services. And I want to be clear, where community colleges are eligible, that we are reaching out proactively to community colleges to make sure that they are accessing these resources as well. Because it doesn't make sense for our money to not be reaching the places where the work is happening and where we want to start building nursing career ladders.

Mr. CISCOMANI. Well, I totally agree with that. I have several community colleges in my district in several of the counties, more on the rural side as well. Would love to just make sure that all my community colleges in my district have a possible direct contact within your office to reach out and ask my questions on HRSA, but also on our——

Ms. JOHNSON. I would love to do that. I would love for us to have a townhall or webinar with your community colleges about all of our programs that they might be eligible for.

Mr. CISCOMANI. That would be great. That is something that I would love to take you up on.

GRANT SIMPLIFICATION

Do you have suggestions on how we can make sure that these grants are more competitive for newer applicants as well?

Ms. JOHNSON. Yeah, thank you so much for the question. We are working hard to simplify the application process, step 1. Right? Smaller community colleges don't often have the resources or capacity to have grant writers as a full-time job. People do it at nights, on weekends, and the like. We need our applications to be as simple and easy to understand and clear about our objectives and what we are trying to fund as possible.

Two, for a long time, we asked you to describe data back to us that we already had. We asked you to describe need in your community, but we have a lot of Federal data about need in your community. So we now make all that data available electronically for communities to tell us—for applicants to tell us which communities they intend to serve, and we are able to see what that data tells us about need in that community. So we are continually working to simplify the process so that as many applicants as possible are able to come in and that it is fair and equitable in terms of reaching as many people as possible.

Mr. CISCOMANI. Well, I am excited to hear that because I think both my questions—and I appreciate your answers here on, one, how to make sure that people are aware, that our community colleges are aware of these; I think it is the outreach piece. And one goes with the other; if you are outreaching and then you are simplifying had the process to make sure that this—these resources make

it back to the communities that are using it as well, including Pima Community College over in Tucson where I am from. And, again, I am a proud graduate of the community college system.

So that is it for me for this round. Mr. Chair, I yield my time.

Mr. ADERHOLT. Mr. Ellzey.

RURAL HEALTH CARE INFRASTRUCTURE

Mr. ELLZEY. Thank you, Mr. Chair.

Administrator Johnson, thank you for being here. I was reading your bio. You have a long history of service in the health community, and I thank you for your service. You have dealt with a lot of issues for a long, long time. And your work is extremely important, and you seem to be the right person for this job. I am glad you are with us here today.

Ms. JOHNSON. Thank you for that.

Mr. ELLZEY. Among the programs that I support is those dealing with rural healthcare, veterans in rural areas, veterans in general, as a 20–year Navy veteran myself, and behavioral mental health of rural residents. Availability of prenatal and postnatal care and maternal health generally are also particular concerns of mine. My district Texas Sixth is largely rural. It is just south of Dallas County. And, although it includes parts of Dallas and Tarrant County with Fort Worth, the other seven counties are mostly rural, about 1,000 square miles, 50,000 folks with a nice courthouse right in the center.

We have great providers throughout Texas Sixth, but they face significant challenges because the rural healthcare infrastructure is under considerable stress, unless you are being served by one of the major hospitals. We are well aware of the need for more nurses, doctors and other healthcare professionals in underserved rural areas. I think that is probably true throughout the country after COVID. There is a physician and nursing shortage in Ellis County, which is my home county, and its surrounding counties.

But, as an example of how HRSA can help my community, in October 2022, Hope Health, located in Ellis County, received a teaching health center planning and development grant from HRSA to institute a family medicine residency program in partisanship with Baylor Scott & White——

Ms. JOHNSON. Yeah.

Mr. ELLZEY [continuing]. Which is one of the big folks in the area. And the first class of three residency students will begin in July of 2024. And then three more are added each year. Hope Health with have a total of 12 residency students in the program once it is fully operational with three new students being added each year. So I would like to thank HRSA for helping us out on that.

So, expanding a bit on your testimony, how does Health Resources and Services Administration's programs address challenges and support rural healthcare, veterans in rural areas, and behavior and mental health of rural residents, which is the really tricky one?

Ms. JOHNSON. Thank you so much for the question. Thank you for raising the teaching health center program. It really has been an innovative way for us to get, you know, grow-your-own-physi-

cian programs into the community directly. And so I am so glad to hear that it is working well for you.

We are laser focused on the mental health and substance-use disorder workforce and how we get more providers into rural communities. You know, in fact, in the President's budget proposal, we propose making mental health and substance-use disorder a required service in community health centers and funding that support because community health centers have the footprint in communities across the country. They are often the provider in rural communities. And, if we can build their capacity on mental health and substance-use disorder, they see a sizeable number of veterans as well, that would be a really useful thing.

In addition, in the budget, we propose providing grant resources for behavioral health to rural health clinics. We haven't traditionally had grant resources available for rural health clinics. During the pandemic, we were able to do that. We learned a lot from that. We think there is a lot we can do working together with rural health clinics to expand capacity and access to care in rural communities.

TELEHEALTH AND RURAL BROADBAND

Mr. ELLZEY. Well, I think also we have a hard time getting specialists. Like I said, those counties are very, very large; 1,000 square miles, we have one county with 12,000 people in it. They can't get specialists down there. And they are 2 hours from the closest specialty clinic. Are you all trying to work with broadband providers? And do we couple with——

Ms. JOHNSON. Yes.

Mr. ELLZEY [continuing]. Rural broadband and the huge amount of money we have spent on that to try to get access to that for specialists?

Ms. JOHNSON. In addition to being the home of the Office of Rural Health Policy, we also run the Office of Telehealth for the Department. And so we work closely with our colleagues across government on broadband access because the promise of telehealth only works if you have broadband access. And we have several programs that are focused not just on patients getting access to providers but providers getting access to specialists and using teleconsultation as a way to bring more specialty care into high-need communities.

Mr. ELLZEY. Good. Well, whether we like it or not, broadband is now a utility. It is an absolute must have, and COVID pointed that out.

Thank you very much for your testimony and your time. It is a pleasure.

Mr. Chairman, I yield back.

Mr. ADERHOLT. Okay. We had our first round, everybody. We will go ahead and start our second round. I will begin.

IMPROPER PAYMENTS

I mentioned in my opening remarks this morning about the improper payments regarding the provider relief fund. My question is, what is the total amount of improper payments that HHS has identified in the COVID–19 uninsured program?

Ms. JOHNSON. I can tell you—if I can step back and speak about improper payments writ large, you know, we conducted an improper payment testing in 2022 in accordance with the Program Integrity Information Act by reviewing provider relief fund payments. We reported those in 2022 in the agency final fiscal report, and the improper payment rates where the PRF was 0.32 percent or $.04 billion. We are conducting another round of improper payment for this year's reporting, and this year's reporting will also be the first round of improper payment reporting for the uninsured program. So I don't have a percentage amount for you because the first year we did the provider relief fund, and this year we will do the uninsured program.

Mr. ADERHOLT. Okay. And so when do you expect you will have those numbers?

Ms. JOHNSON. I believe that these are—let me not commit to something without knowing. I will get back to you on the timing of that.

Mr. ADERHOLT. All right.

Ms. JOHNSON. But we report those on a regular annual basis.

Mr. ADERHOLT. What procedures do you have in place to assure this committee that these new proposals to provide services for the uninsured will not result in waste, fraud, and abuse that you have seen in the past?

Ms. JOHNSON. So the Bridge Access Program that the Department has identified as a way to help smooth the transition to the commercial market is not a reimbursement program that the uninsured program was. The uninsured program was stood up in 2022 as a way to incentivize and help ensure providers that were seeing uninsured patients had access to reimbursement for testing and, at that time, treatment and then, over time, vaccine administration and therapeutics. And there are a host of program integrity measures associated with that program.

The new program that will be this Bridge Program will run through sort of more established mechanisms. So some of those resources will be in contract partnerships with pharmacies. Some of them will be through traditional partnerships with public health departments and health centers. So it really is about just ensuring that those places where uninsured individuals seek care that there is a mechanism for them to receive care during this transition to commercialization.

Mr. ADERHOLT. Thank you.

PROGRAM INTEGRITY

I am grateful that law enforcement officials within the Department of Justice are now pursuing bad actors who took advantage of the COVID–19 uninsured program. Such bad actors appear to have stolen funds that were specifically intended to reimburse hospitals, physicians, medical professionals who provided care to uninsured Americans during the pandemic.

While the Department of Justice is conducting their investigation, I just wondered what HRSA has done as an agency to try to in any way recover improper payments, or have they done anything to try to recover these payments?

Ms. JOHNSON. So, if I could start, sir, with saying that the findings you are seeing the Department of Justice announce are because of our close HRSA working relationship with the Office of Inspector General at HHS. We refer suspicious providers to the Office of the Inspector General. The Office of the Inspector General works hand in glove then with DOJ on indictments and action on those folks. We do the analytics and the detailed analysis to be able to share with the Office of the Inspector General where we see suspicious activity. They then pursue the investigation, and then they work with DOJ on the law enforcement action associated with it. And our experts have testified at those trials. We have worked very hard to be part of an essential part of that program integrity effort to ensure that bad actors are held accountable.

But, stepping back, on our own, what we do on the front end of claims is ensure the validity of the provider. The provider has to be validated through their IRS taxpayer ID number. The provider has to be through their NPI number with Medicare. They were checked against all Medicare exclusion lists to make sure they are in good standing with Medicare. They had to certify and attest to terms and conditions, ensuring that they had checked for healthcare coverage for individuals in the uninsured program. Every time they submitted a patient roster, they had to again attest that they had checked for healthcare coverage. We then review those claims prepayment, and we review against all those checks and then ensure that they are—check them for completeness and the like. And, in fact, 15 percent of claims never moved to payment because they were screened out in that early intervention.

Then, on the postpayment review process, we work quickly to make sure that we are reviewing and analyzing and looking for suspicious claims, looking for places where there are suspicious patterns of referral of claims or dates of service, and those are the ones that our risk assessment mythology digs in on and works closely with OIG on referrals so that actions like the ones you saw from DOJ can take place.

Mr. ADERHOLT. Thank you.

Ms. DeLauro.

Ms. DELAURO. Thank you very, very much, Mr. Chairman.

I wish we could apply the methodology that you have just outlined to other departments in taking a look at what might be suspicious claims, et cetera. Really just, bravo.

Ms. JOHNSON. Thank you.

PEER SUPPORT SPECIALIST

Ms. DELAURO. Let me ask a question about peer support specialists. In my district in Connecticut, I have spoken to a lot of the specialists, as well as with individuals who benefit from working with the peer support specialist. So I am a strong supporter of their work. They are particularly effective because they have a personal experience with mental health, with substance abuse, homelessness, incarceration, or some sort of other behavioral health crisis. So I think that they can be regarded as trusted healthcare messengers. Can you talk about how a peer support specialist can play a role in responding to someone in crisis, helping that person be

successful in recovery? And how does HRSA support education and training for the peer support specialists?

Ms. JOHNSON. Thank you very much for raising this, and thank you for your support for peer support specialists. Dr. Harris mentioned my work in New Jersey. When I was in New Jersey, we were able to support, to deploy peer support specialists in emergency departments. And, when people came in post overdose and naloxone was administered and they were revived, they were often very resistant to treatment. The emergency room department doctor wasn't always as familiar with how to work with someone to get them into treatment.

The peer support specialists made a huge difference in that encounter because that is a person often with experience who can say: I have been where you have been. I know what it takes. Here is what it is going to look like. Here is what your path is going to look like.

And so we think they are a vital part of the healthcare workforce. We think, going forward, community health workers writ large, really thinking about that connective tissue between the healthcare provider and the community and making sure people get to care, retained in care, get back for their appointment. We find this in HIV care. We found this throughout COVID. It makes a huge difference, and specifically peer supports in substance-use disorder treatment, it is just a meaningful part of the healthcare workforce.

Ms. DELAURO. And what is your training?

Ms. JOHNSON. We support training through the behavioral health workforce training program for peer support specialists. And we are able to recruit and help people get into the workforce that way. And many of our programs that support people in the community health workforce, we also then are available to help bring those people up the training pipeline into other clinical jobs if they choose to pursue them.

Ms. DELAURO. Really terrific. Just to say, it would be, really would be so detrimental if a program like that couldn't continue. That is really at risk.

MENTAL HEALTH OF HEALTH CARE WORKERS

A quick question if I can about mental health care workers. We in the American Rescue Plan funded programs to promote mental health and address substance use in the workforce. Can you talk about your request for a new program to support the mental health of healthcare workers, and how are you proposing to work with health workers to help them deal with the stress and trauma?

Ms. JOHNSON. Thank you for raising this. In the American Rescue Plan, we had $103,000,000 in awards that we made to health systems around the country to focus both on the health and well-being of their workforce at a time when we all knew how stressed and strained the workforce was and on the workplace environment, making the workforce environment as worker-friendly as possible.

The clinical research in evidence here continues to support that is both about providing services to workers, but it is also about making the workplace less stressful and more worker-centric and worker-friendly.

In the interim, Congress passed the Lorna Breen Act, which was intended to further develop and support these programs. And so our budget proposal would allow us to make additional awards in this space to support not just—one of the things that we want to do is to make sure we are supporting more community hospitals going forward.

Ms. DELAURO. Is that worker stress or the mental health issues attached to the workforce, what is that relationship to the nurse shortage?

Ms. JOHNSON. Oh, they are all hand in glove. Much of it is anecdotal, but the reports that we hear are that, you know, that stress and strain, that over—the incredible amount of stress and strain on the workforce, the nursing workforce, has caused people to make different decisions about their careers whether that is—many people stayed in nursing who were eligible to retire, they may have made the decision to retire. People have moved to administrative jobs in nursing. There are a lot of decisions that have been made that are inextricably linked to the mental health and well-being of the workforce.

Ms. DELAURO. It is very interesting because sometimes we talk about the nursing shortage, but we are not examining some of the causes. And this may be it so that there is potentially the view that such a program is really not that necessary or, you know, it would be nice if you could do it and not make the connection as you just have made with what it means to the future of the healthcare workforce and with nurses.

Ms. JOHNSON. We think of it not just as a critical need for the well-being of the workers; we also think of it as a retention program.

Ms. DELAURO. Thank you very much.

I yield back, Mr. Chair.

Mr. ADERHOLT. Mr. Ciscomani.

Mr. CISCOMANI. Thank you, Mr. Chair.

NURSING SHORTAGE

Ms. Johnson, again, a question actually on the nursing shortage, as well, as my colleague was mentioning, if I could follow up with that a little bit. One of the most consistent issues that I have heard about from stakeholders in industries across every sector since coming to Congress is regarding labor shortages, just about everywhere, small businesses to large businesses. Well, this is no exception. My colleagues and I have heard from a number of healthcare providers on the need for more doctors, nurses, and staff that support operations at healthcare facilities and ensure positive health outcomes for patients. It is estimated that, by 2034, the U.S. will have a shortage of 124,000 physicians, also, the Bureau of Labor and Statistics is projecting over 190,000 annual openings for registered nurses through 2030. And, with more experienced registered nurses nearing retirement, the need for qualified nursing staff is becoming more and more urgent.

This shortage is even more of an issue for rural areas, as you can imagine, like those in my district that struggle to attract qualified health professionals to the areas that they really need it.

In your testimony, you mentioned over 50 programs aimed at expanding and retaining healthcare workers in areas such as primary care, nursing, behavioral health, and dentistry. How does HRSA target the funds for these programs to address health workforce shortages in rural areas? Is it based on population, number of providers, designated rural areas? How does that work?

Ms. JOHNSON. Thank you for the question. Most of our workforce programs are funded under title VII and title VIII of the Public Health Service Act, where we give special consideration to rural and underserved communities, which individuals document in their applications to us. But the other thing that we do in the application process is factor in need. So it is really important to us that the resources are going where they are most needed. And one of the things that is really important is that we do this through an objective review process. So this isn't me looking at these applications. We bring together experts to be able to review applications and score them based on that assessment of need, the project plan and how people will deliver outcomes for the resources that we are providing.

Mr. CISCOMANI. Okay. I think that is—thank you for that answer.

FINANCIALLY SUSTAINABLE PROGRAMS

Now the last question here, what is the agency doing to make sure that these grants create financially sustainable programs that do not depend on Federal support to continue serving their populations?

Ms. JOHNSON. Yeah, thank you for that. If we didn't include sustainability in our grant factors, we would be funding the same people forever. So we have to include a pathway and a plan for sustainability and factor that into the scoring of applications because that is really important to us.

One of the ways that our resources are most effective is building capacity and building infrastructure and putting new ideas together and making them actionable so that they can then be supported by other traditional payer resources.

Mr. CISCOMANI. Thank you.

I yield back. Thank you, Mr. Chair.

Mr. ADERHOLT. Mr. Hoyer.

CONSEQUENCES OF CUTS

Mr. HOYER. Madam Administrator, I am not going to ask you a question, but I am going to take 4 or 5 minutes. First of all, I hope there are a lot of people watching this. I don't know that there are. I suspect not a great deal but as somebody who represents [inaudible], you get a lot of flak, somebody who presents as well as you, who has command of your subject matter, who runs a $9,000,000,000 to $10,000,000,000 agency would be paid far more than your—and now I hope you heard what I said.

Ms. JOHNSON. Thank you, sir. I am part of a very broad agency who do incredible work.

Mr. HOYER. I understand. And I am not surprised at your humbleness. But you have given an extraordinary performance, I think, here—not a performance in the sense of acting but in terms of dis-

playing the depth of your knowledge of your subject, of your budget, and of your mission. And every taxpayer that is watching ought to be heartened by the passion and ability you bring to this job.

Secondly, let me say we have now spent 2 hours looking at your budget. The fact of the matter is, of course, we have about a $1,700,000,000,000 discretionary budget, at least half of which—probably 60 percent of which goes to the Defense Department, which is one subcommittee. And the 11 other subcommittees deal with the balance.

I made the point of Governor Agnew saying: The cost of failure far exceeds the price of progress.

And you have made that point on a daily—on a regular basis at this hearing.

Mr. Chairman, one of the things I have noticed as I have sat here is, while there is a proposal to cut drastically the domestic programs of America and that investment, it is interesting that almost everyone was saving one exception. My Republican colleagues, your Republican colleagues, have talked about what is needed in their districts, what kind of investment that we need to make sure we have health professionals available to take care of the health of our people.

So cutting sort of in a broad stroke can sound very appealing until you come down to what the ramifications of those cuts mean. In this small part of the budget, because, Mr. Chairman, as you know, this part of the budget is about 12 to 13, maybe even 14, percent of the entire budget. And we spend all of our time talking about it in the particular at hearings like this and very little time talking about the rest of the spending, either because it is too controversial or we think that it will be increased, i.e. Veterans, we want to take care of veterans; i.e. Defense, we want to make sure our country is secure.

But when we Democrats talk about the consequences of cuts, it is not because we are not concerned about the deficit; we are. I am concerned about the deficit. And I have been concerned about the deficit all the time I have been here. And, very frankly, both parties have made expenditures; some are called tax expenditures, and some are called other spending. But both result in the same thing: a disconnect between resources and needs, or at least investment.

So, Mr. Chairman, I am simply taking this time—I don't know that anybody is watching; I don't know that anybody cares. But, as a country, we have to consider the consequences of not investing in things that are absolutely essential. And, as I said, and Mr. Natcher said, the education of our young and not so young and the health of our people are absolutely critical.

And that is why I think all of my colleagues, from right to left or left to right, depending upon what your perspective is, have talked about the needs of their people in their district.

And, Administrator Johnson, you are one of the critical people that sees those needs on a daily basis. And I want to join the ranking member and the chairman. We are all concerned about fraud, waste, and abuse. We ought to eliminate fraud, waste, and abuse. I talked about fraud, waste, and abuse.

I have four great-grandchildren, I know that it sounds kind of—every time they go to the bathroom, there is some waste. Oh, they

love to pull that roll of toilet paper out; it is just a game with them. And I would like to eliminate that, but I don't know that I can because they are kids and small kids.

And we ought to eliminate waste.

I was heartened by the ranking member when we heard your 15 percent never got compensated and never got to the place because you caught it. And certainly there is some that we did not catch, and we ought to catch them because they are stealing from those who need. And we ought to put them in jail.

And there ought to be no thinking by the people watching these hearings that we Democrats are not concerned about both the deficit—we need to manage that better, and it will take tough thinking, which most people don't want to do on both sides of the aisle. And it will take administrators like you, who know what they are doing, care about what they are doing, care about the waste, and understand that we have waste and fraud and abuse, not nearly as much as somebody would think. And we could never balance the budget just on waste, fraud, and abuse, as some found out, like Mr. Reagan found that out. So I thank you for your service.

Mr. Chairman, I thank you for having these hearings because I think they are very important, but I would emphasize that we are looking at a very small piece of the expenditures and ignoring, as the Bible says, the lumber in somebody else's eye.

Thank you very much.

Mr. ADERHOLT. Thank you Mr. Hoyer.

CLOSING REMARKS

And I think the ranking member has some closing remarks before we conclude.

Ms. DELAURO. Thank you so much. You really have been an outstanding witness, and thank you for the information, it really—sometimes people don't know what HRSA does and how well you do it.

And your discussion about the healthcare workforce shortages, our communities need more nurses, not less; more doctors, not less. We need more mental health substance use providers, not less. And I am very proud that, in 2022 and 2023, in the appropriations bill, we agreed to invest in the healthcare workforce programs. We did it on a bipartisan basis. We passed bills in March. We passed a bill in December. And it is really unfortunate and sadly that Speaker McCarthy and some of the House Republicans introduced a bill this week and prepared to vote on it this week that would require massive cuts to the healthcare workforce programs. It would mean fewer nurses, fewer doctors, fewer mental health and substance use providers. That is not—that defeats the mission of HRSA and what kind of transformation it can make in people's lives.

It meets the needs of our communities. It meets the needs of individuals. And, in many respects, it saves people's lives. So we are grateful to you for that, and we will do everything we can to keep those cuts from going into place.

Thank you very much.

Thank you, Mr. Chairman.

Mr. ADERHOLT. Thank you, Ms. DeLauro.

And thank you, Administrator Johnson, for being here. We appreciate your testimony and answering questions for us. You have done a very good job in trying to explain what your office does and also how we can be of help.

So, with that, we will stand adjourned.

WITNESSES

	Page
Anderson, K. H	34
Bass, J. C	25
Becerra, Hon. Xavier	147
Cardona, Hon. Miguel	299
Cochran-McClain, Carrie	287
Crowley, A. P	40
Davis, T. C	287
Forsythe, Clarke	120
Hott, Brittany	287
Jacobs-Simmons, Lenita	287
Johnson, Carol	553
Kean, Larry	299
Kutcher, Michael	18
Landsman, Hon. Greg	2
Longino, Kevin	48
McGuire, K. B	128
Morris, Tom	287
O'Connell, Dawn	475
Persing, Brian	63
Plucker, Jonathan	56
Rittling, Sarah	79
Ryder, Ruth	287
Scheibe, L. K	287
Schroeder, P. W	95
Simpson, Felicia	112
Staursky, Dorothea	72
Stern, Richard	136
Tabak, Lawrence	475
Templeton, Amy	88
Walensky, Rochelle	475
Wilson, Yolanda	9
Zink, Anne	104